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Abstracts

Systematic Review of the Literature: Understanding Adolescents and Young People's Lived Experiences of Social Anxiety Disorder (SAD): A Meta-Aggregation.

Background: The under-recognition of social anxiety disorder (SAD) in adolescence suggests a better understanding of its presentation and the process of help-seeking is needed. Growing evidence supports the application of the Clark and Wells (1995) model in treating adolescent SAD to improve outcomes. However, it is unclear whether an adult model aligns with adolescents' lived experiences. This review attempts to explore the direct lived experiences of young people with SAD in the context of developmental stage/age to better understand areas of alignment and divergence with the Clark and Wells (1995) model.

Methods: Five databases (PsycINFO, EMBASE, CINAHL, MEDLINE and PubMed) were searched in March 2025 to identify peer-reviewed qualitative studies examining adolescents and young people's experiences of SAD. The Joanna Briggs Institute (JBI) data extraction tool and quality checklist were used to inform extraction and evaluate the rigor of included papers. Themes were synthesised through meta-aggregation and grouped according to shared meanings.

Results: 817 screened references yielded 14 studies of mixed methodological quality. The mean age of samples ranged from 11 to 23 years old. Studies were published from 2016 to 2025 and spanned 6 countries. Aggregation of 106 findings generated 21 categories and 4 synthesised findings: symptoms, coping and help-seeking, promoting change, and barriers.

Conclusions: Participants' lived experiences of SAD shared similarities with the Clark and Well's (1995) model, with some variation noted relevant to stage/age. Recommendations for clinical practice are discussed.

Key words: social anxiety disorder, SAD, adolescence, lived experiences, meta-aggregation.

Service Improvement Project: Perspectives on Barriers and Facilitators to 'Babies 1st' Video Interaction Guidance Based Community Bonding Groups.

Background: Access to parent-infant services in the UK is variable. This service improvement project aimed to identify the facilitators and barriers to access and engagement with community-based parent-infant bonding groups to inform meaningful recommendations for development. 'Babies 1st' commissioned the study based on hypotheses that only a small percentage of potentially eligible parents were attending their video-interaction guidance (VIG) based bonding groups.

Methods: A mixed-methods study was conducted between July 2023 and June 2024. Ten participants from parent, facilitator, and referrer groups participated in semi-structured interviews. Reflexive thematic analysis from a realist stance was conducted. Qualitative data was supplemented by an evaluation of attendance records to better understand engagement.

Results: Four themes were constructed from the data, with twelve sub-themes: (1) landscape of parent-infant services (2) generating referrals (3) from referral to attendance and (4) experiences in the group.

Discussion: Findings outlined multiple positive benefits from group attendance and highlighted the value of familiarity and consistency for promoting access, alongside barriers of parental stigma, anxiety, and different perspectives on bonding. Ten service recommendations were developed from the findings.

Key words: bonding groups, parent-infant intervention, video interactive guidance, VIG, reflexive thematic analysis.

Theory Driven Research Project: Exploring the Impact of Childhood Memories of Warmth & Safeness and Self-Compassion on Trauma-Related Shame in Adults with Complex Post Traumatic Stress Disorder.

Background: Some adults with Complex Post Traumatic Stress Disorder (CPTSD) experience significant trauma-related shame that carries a high allostatic load. Childhood experiences of warmth and safeness are considered to guide adjustment to traumatic events: helping us feel safe, respond to ourselves with kindness, and reach to others for support during times of difficulty. However, many survivors have not had the opportunity to experience early relational safeness or develop self-compassionate abilities. *Aims:* to extend our understanding of trauma-related shame in adults with CPTSD.

Method: Participants (n = 192) with a probable diagnosis of CPTSD completed 5-measures: The International Trauma Questionnaire (ITQ), Trauma Related Shame Inventory (TRSI), Early Memories of Warmth & Safeness Scale (EMWSS), Compassionate Engagement and Action Scale Self-Compassion Subscale (CEAS-SC) & The Patient Health Questionnaire (PHQ-8).

Results: Hierarchical regression showed the full model (age, gender, ethnicity, depression, CPTSD symptoms, early memories of warmth and safeness, and self-compassion) explained 18.3% of the variance in trauma-related shame. Self-compassion and CPTSD symptoms were significant predictors of trauma-related shame. Adults with CPTSD who reported lower than average self-compassionate abilities (relative to the UK general population) reported higher trauma-related shame compared to those with higher self-compassionate abilities.

Discussion: These findings suggest that self-compassion is a worthwhile therapeutic target to address trauma-related shame in CPTSD. Limitations and future research directions are discussed.

Key words: warmth and safeness, self-compassion, trauma-related shame, complex post-traumatic stress, CPTSD.

Systematic Review of the Literature

Title: Understanding Adolescents and Young People's Lived Experiences of Social Anxiety Disorder (SAD): A Meta-Aggregation.

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Proposed Journal: The Journal of Child and Adolescent Mental Health (CAMH)

Rationale: This journal was chosen for its focus on publishing original research that provides clinically relevant guidance for its primary audience of mental health practitioners working with children and adolescents. It has a CiteScore of 8.3 and Impact Factor of 6.8. Author guidance can be found here and is presented in Appendix F.

Abstract

Background: The under-recognition of social anxiety disorder (SAD) in adolescence suggests a better understanding of its presentation and the process of help-seeking is needed. Growing evidence supports the application of the Clark and Wells (1995) model in treating adolescent SAD to improve outcomes. However, it is unclear whether an adult model aligns with adolescents' lived experiences. This review attempts to explore the direct lived experiences of young people with SAD in the context of developmental stage/age to better understand areas of alignment and divergence with the Clark and Wells (1995) model.

Methods: Five databases (PsycINFO, EMBASE, CINAHL, MEDLINE and PubMed) were searched in March 2025 to identify peer-reviewed qualitative studies examining adolescents and young people's experiences of SAD. The Joanna Briggs Institute (JBI) data extraction tool and quality checklist were used to inform extraction and evaluate the rigor of included papers. Themes were synthesised through meta-aggregation and grouped according to shared meanings.

Results: 817 screened references yielded 14 studies of mixed methodological quality. The mean age of samples ranged from 11 to 23 years old. Studies were published from 2016 to 2025 and spanned 6 countries. Aggregation of 106 findings generated 21 categories and 4 synthesised findings: symptoms, coping and help-seeking, promoting change, and barriers.

Conclusions: Participants' lived experiences of SAD shared similarities with the Clark and Well's (1995) model, with some variation noted relevant to stage/age. Recommendations for clinical practice are discussed.

Key words: social anxiety disorder, SAD, adolescence, lived experiences, meta-aggregation.

Understanding Adolescents and Young People's Lived Experiences of Social Anxiety Disorder (SAD): A Meta-Aggregation

Adolescence is typically conceptualised as the period between ages 10 to 19 (World Health Organisation, 2019) and is marked by rapid developmental changes across social, emotional, and physical domains with concomitant shifts from reliance on family members towards peers and romantic relationships (Ernst et al., 2024; Troop-Gordon & Neblett, 2024). Emerging adulthood, or young personhood (United Nations, 2013; World Health Organisation, 2019), is often considered to be a fledgling stage between late adolescence and full-adulthood from ages 15 to 24 that is characterised by neurobiological shift and emerging maturation (Hochberg & Konner, 2020). The period of adolescence into emerging adulthood is underpinned by a greater vulnerability for the onset of depression and anxiety disorders (Rapee et al., 2019).

One example is social anxiety disorder (SAD) which has a median onset in early adolescence of around 13 years (NICE, 2013). Epidemiological data approximates that in almost all cases, symptoms of SAD begin by the point of emerging adulthood/early twenties (Kessler et al., 2010). SAD impacts an estimated 8.3% of adolescents globally (Salari et al., 2024) and is one of the most enduring anxiety disorders across the lifespan (Kessler et al., 2005; NICE, 2013).

SAD is understood as a persistent fear of social interactions (ICD-11; World Health Organisation, 2022) due to perceived embarrassment or social judgement from others (Taylor et al., 2021). Common fears can include (but are not limited to) being viewed as ‘boring’ or ‘weird’ (Warnock-Parkes et al., 2022). Cognitive behavioural theories, derived from adult populations, propose that one way anxiogenic difficulties are maintained is through increased self-focussed attention, e.g. viewing oneself from an observer perspective (Clark & Wells,

1995). However, these self-images are often biased by (often excessively) negative beliefs that are then reinforced through physical and or mental safety-seeking behaviours, such as avoidance. Safety-seeking behaviours mitigate against perceived social threats but can reinforce beliefs longer-term (Evans et al., 2021) and prevent the appraisal of less-threatening explanations (Salkovskis, 1991).

The ICD-11 outlines the need to differentiate adolescent SAD from normal developmental fears, such as episodic shyness (World Health Organisation, 2022). To be diagnosed in adolescence, social fears must arise in peer interactions as well as with adults (DSM; American Psychiatric Association, 2013). There is ongoing work to consider other adolescent-specific features related to developmental stage. Factors such as heightened self-consciousness and sensitivity to peer influence have been identified as potentially specific features/contexts for adolescent SAD (Leigh & Clark, 2018) as well as avoidance and impression management behaviours (Evans et al., 2021).

Impact of SAD

The impact of untreated SAD is high. Adolescents experiencing SAD report lower social competence in comparison to peers (de Lijster et al., 2018), higher insecure attachment styles, and greater interpersonal difficulties (Swee et al., 2021). Epidemiological studies indicate that between ages 14 and 25 there is increased risk for developing co-morbidities (Wittchen et al., 1999), such as depression (Ernst et al., 2024), that upholds more broadly in cross-cultural studies (Pham et al., 2024). Some adolescents with SAD have shown lower academic attainment relative to their predicted abilities (Van Ameringen et al., 2003). Moreover, SAD has the lowest natural remission rate of adolescent anxiety disorders (Bruce et al., 2005; Leigh, 2023) with a waxing and waning trajectory into adulthood if untreated (Krygsman & Vaillancourt, 2022; Spence & Rapee, 2016). Adults with SAD are less likely to

marry and more likely to divorce (Stein & Kean, 2000; Wittchen et al., 1999). Therefore, effective and timely treatment offers an opportunity to adjust these trajectories.

Treatment

SAD is prevalent but underrecognised in adolescence and adulthood (Alves et al., 2022; Gross et al., 2005). Around 50% of people seek support, often in adulthood, typically after 15 to 20 years of active symptoms (NICE, 2013). Adolescents presenting for treatment within Child and Adolescent Mental Health Services (CAMHS) typically receive Cognitive Behavioural Therapy (CBT) developed to treat a range of anxiety disorders (Leigh, 2023) that incorporates components (related to theorised mechanisms of change) such as psychoeducation and exposure (James et al., 2020; NICE, 2013). However, the empirical evidence base is mixed. Adolescents with SAD are typically less likely to recover through CBT than adolescents with other anxiety disorders (Evans et al., 2021) and more likely to report symptoms at 10-year follow up (Beesdo-Baum et al., 2012).

There is a significant evidence base that underlines the efficacy of cognitive therapy for SAD in adults (Clark et al., 2022; NICE, 2013). Researchers have hypothesised that applying adult conceptualisations of SAD, e.g. developed from the Clark and Wells (1995) model, to adolescent SAD treatment might address possible maintenance factors sooner (Leigh et al., 2021) than other modalities (Rapee et al., 2023).

Clark & Wells Model (1995)

Recent empirical work has identified aspects of the Clark and Wells model (1995) related to maintenance processes (internal focus of attention, negative self-beliefs, safety-seeking behaviours, and post-event processing) in adolescent samples presenting for SAD treatment, compared to other anxiety disorders (Homer & Deeprose, 2017; Leigh et al.,

2023). Moves to adapt the use of cognitive therapy for SAD (CT-SAD) for adolescents has shown initial promise compared to standard CBT and control conditions (Leigh et al., 2023). However, larger samples are needed to consolidate this evidence base.

Phenomena of Interest

The under recognition of SAD (NICE, 2013), comparatively poorer treatment outcomes (Evans et al., 2021), and long lasting impacts create an impetus to better understand SAD in adolescence and emerging adulthood to support earlier recognition and improved treatment (Leigh et al., 2025). It is important to understand the direct lived experiences of adolescents and emerging young adults with SAD. Qualitative studies can provide a rich and in-depth understanding of lived experiences to inform clinical practice (Black et al., 2018). Qualitative appraisal can take us closer to the phenomenon through direct exploration and learning from those with first-hand knowledge (Neubauer et al., 2019) – with the hope of achieving closer proximity to notions of truth (Aromataris et al., 2024). There is an increasing recognition of the value of understanding lived experience within the research process (Gatera & Shuranjeet, 2023; Gray, 2022).

The period of adolescence into emerging adulthood is a phase of life underpinned by social, emotional, and cognitive maturation processes that are distinct to full adulthood (Icenogle et al., 2019). Therefore, understanding direct experiences of SAD would benefit from a bottom-up approach (in conjunction with top-down approaches applying adult models to adolescents) to appraise areas of fidelity and difference with the Clark and Wells (1995) model with consideration of stage/age.

Within this, the help-seeking position of those with SAD is somewhat unique, as the therapeutic process (a series of social interactions in of itself) can become a feared process (Clark, 2001). Help-seeking is often delayed into adulthood and associated with greater

impairment, despite the onset typically being much earlier (Kessler et al., 2010). This raises questions about what we can learn from the help-seeking position of young people with SAD that might inform earlier recognition. To the best of the authors' knowledge, no existing qualitative review of young people's lived experiences of SAD has been conducted.

Review Aims

Therefore, the current review aimed to:

1. Gain an in-depth understanding of adolescents and young people's lived experiences of SAD including, symptoms, causes, impact, and coping.
2. Understand adolescents and young people's experience of help-seeking and engagement with treatments, clinicians, and services.
3. Appraise how the experience of adolescents and young people compliment or differ to the Clark and Wells (1995) model in relation to maintenance processes.
4. Assess the quality of qualitative & mixed-methods studies investigating SAD.
5. Generate recommendations for clinical practice.

Materials & Method

Design

A qualitative systematic literature review was conducted using the principles of meta-aggregation from the Joanna Briggs Institute (JBI) to address these aims (Aromataris et al., 2024; Lockwood et al., 2015). Meta-aggregation was chosen to remain in proximity to the data (rather than re-interpret findings) to generate 'lines of action' (Hannes & Lockwood, 2011, p.1634) arising from synthesised findings of young people's lived experiences (Munn et al., 2021). Pragmatism underpins the JBI philosophical orientation (Hannes & Lockwood,

2011) which seeks to generate useful lines of enquiry and recommendations for clinical practice. The study was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement, a 27-item checklist to assess the quality of each element of the systematic review (Page et al., 2021). The protocol was prospectively registered in October 2024 on PROSPERO (CRD42024599883).

Study eligibility

Types of Participants

There is no universal definition of adolescence. This review included studies with an adolescent sample, defined by the World Health Organisation (2019) as ranging from ages 10 to 19 years. To incorporate the broadest conceptualisation of adolescence, in line with recent thinking around neurobiological development (Sawyer et al., 2018) and the UN definition of a young person (United Nations, 2013), a mean sample age of between 10 and 24 years was used to encapsulate adolescence into emerging adulthood. An additional criterion was added for samples with older participants (ages 18 to 24) to ensure that participants were in education to retain relevance for the developmental period of adolescence into emerging adulthood.

Participants were required to have either a diagnosis of social anxiety disorder (SAD) or social phobia (SP), have exceeded the cut-off for clinically significant symptoms of SAD on a validated measure or diagnostic interview/assessment tool, or have been referred to the research by a CAMHS clinician.

Studies that reviewed participants' treatment experiences were included if the sample met the clinical threshold for SAD pre-treatment but did not post-treatment (e.g. at the

point of interview), as it was felt this could yield important information related to experiences of treatment and help-seeking. Studies that reported an average SAD score for the sample were contacted and asked to provide supplementary information (scores per participant) to ascertain eligibility. As a minimum, all samples had to report a mean SAD score that reached or exceeded clinical significance. In studies where a minority of participants (within this) reported sub-clinical SAD scores, tracking exercises were completed to ascertain whether the findings were underpinned by the experiences of participants with clinical levels of SAD, where it was possible to do this (e.g. through clear reporting and participant numbering); and studies were excluded if this was not possible. SAD samples with other co-occurring disorders were permitted to reflect the high co-morbidity as seen in clinical practice (Halldorsson et al., 2023); however, mixed diagnostic samples (e.g. the inclusion of participants with depression and not SAD) were excluded so as not to dilute findings.

Phenomena of interest

The field notably struggles to reach a consensus around defining 'lived experience' (Roennfeldt & Byrne, 2020). For the purposes of this review, the definition of lived experiences reflected NHS England's definition that encompasses experiences of help-seeking, access and engagement with treatment, experiences of the therapeutic alliance and or services (NHS England, 2022). Within this, lived experiences were also understood as embodied cognitive, social, and emotional experiences of SAD (Casey, 2023). This included perspectives on symptoms (onset and maintenance), causes, impact, coping, peer and family support that can interact with help-seeking decisions. Help-seeking was understood as the use of formal or informal systems to gain support (as in Michelmore & Hindley, 2012). Studies that focussed on related, but adjacent, phenomena of interest (e.g. the impact of COVID-19 on SAD or SAD in the context of PTSD or another physical or mental health condition) were

excluded due to the review's aims to generate recommendations for clinical practice in treating primary SAD.

Context

The review included papers published in English and imposed no restriction on geographical location. Existing reviews, theoretical papers, or opinion pieces were excluded.

Types of studies

This review included studies published in a peer-reviewed journal that utilised a recognised qualitative methodology. This included (but was not limited to) designs such as phenomenology, grounded theory, ethnography, and action research (Aromataris et al., 2024). Studies that incorporated multi-informant perspectives (such as parents and clinicians) were included provided there was a self-report adolescent sample. This was to account for the key role that families and other support systems can play in obtaining help for young people (McDonagh & Hennessy, 2023). Mixed-methods studies were included provided that qualitative findings were reported separately. Quantitative studies were excluded.

Search Strategy

Searches were carried out using the main online databases for qualitative evidence synthesis and healthcare research (Booth, 2016): PsycINFO (via OVID), PubMed, MEDLINE (via OVID), CINAHL (via EBSCO), and EMBASE (via OVID). Search terms related to variants of (i) social anxiety or phobia (ii) adolescence and (iii) qualitative literature were developed from existing studies on SAD and literature on qualitative search strategies (Booth, 2016); then further refined/expanded through librarian consultation (see Appendix A). For included papers, backwards screening of reference lists, hand-searching, and forward

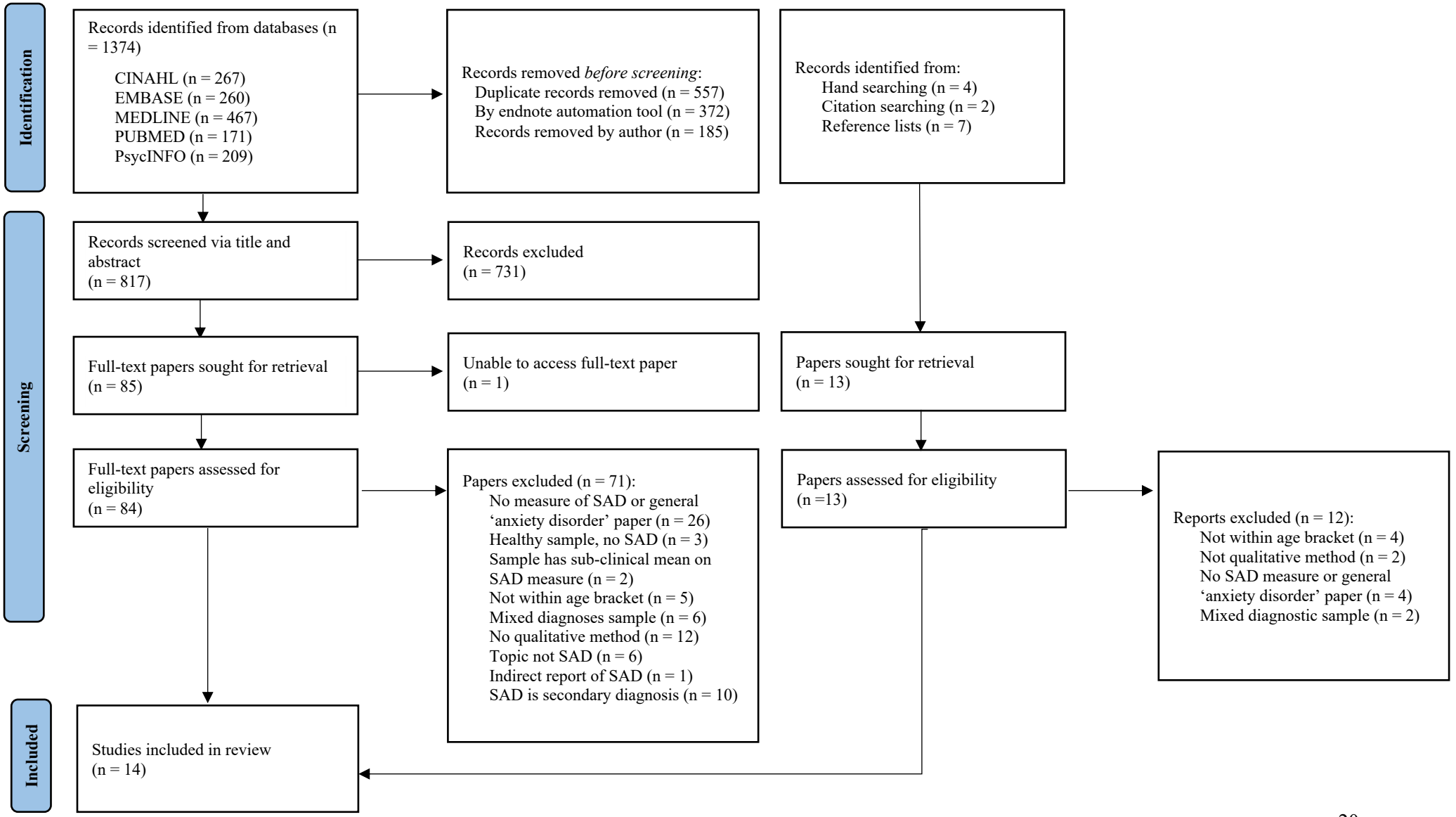
searching of citation lists were conducted to search for additional papers. There were no limitations on publication dates.

Study Selection

The selection process followed the PRISMA process, illustrated in Figure 1. Searches carried out in March 2025 yielded a total of 1374 references. References were uploaded to Endnote 20 and 557 duplicates were removed. Subsequently, 817 references were exported to Excel for title and abstract screening against the inclusion and exclusion criteria. Pilot screening was carried out to test the criteria on 30 references by two reviewers (FR and EI) and minor clarifications made. EI reviewed 20% of references and Cohen's kappa indicated good agreement, $k = .95$, for title and abstract (n = 163 references) and $k = .85$ (n = 17 papers) for full-text screening (McHugh, 2012). Inter-rater disagreement was discussed and (if not resolved) put forward for full-text screening or to a third/fourth reviewer (EK/ER). In total, 731 papers were excluded through title and abstract screening, resulting in 86 papers that were put forward for full text screening that yielded 14 papers that met the inclusion criteria.

Figure 1.

PRISMA Diagram of Study Selection Process



Quality Appraisal

The methodological quality of included studies was appraised using the JBI checklist, see Appendix B, from the JBI manual (Aromataris et al., 2024). The JBI checklist evaluates aspects of methodological rigour and has been noted for its favourable sensitivity to aspects of validity in comparison with other tools (Hannes et al., 2010). No study was excluded based on quality appraisal; due to wanting to ensure a comprehensive review (in a novel area) and a lack of obvious rationale for where a cut-off might be set. A second reviewer (EI) quality appraised four papers (20%). Cohen's kappa indicated excellent agreement, $k = .93$. Discrepancies were discussed and resolved, with an option of third/fourth review (EK or ER).

Data Extraction

Data extraction was informed by the JBI data extraction tool, see Appendix B, and details related to author, year, objectives, participants, concepts, and relevant contexts were extracted from each paper. Characteristics of included studies are presented in Table 1. Major findings and sub-themes with illustrations (participant quotes) were extracted from each study (Aromataris et al., 2024). Sub-themes were assessed for their ability to provide distinct meaning in discussion with the review team. Findings were identified through detailed reading of the papers which determined that findings (defined as major themes, sub-themes, categories and sub-categories) could be extracted from the results section. No studies used an ethnographic approach, wherein findings can be situated as authorial observations outside of the results section.

A second reviewer (EI) independently extracted data from 7 papers (50%) to check for human error and improve rigor. Each finding was given a credibility rating that assessed how well it was supported by participant quotes (Aromataris et al., 2024; Lockwood et al.,

2015). Findings where the accompanying participant quote explicitly supported the finding were rated unequivocal. Findings where the participant quote was either ambiguous or partially supported were rated credible. Findings with no supporting quote or where a quote did not support the theme were rated as being unsupported. Where multiple quotes supported a single finding, the one that most aligned with the finding was appraised (Hunter et al., 2019; Lockwood et al., 2015). A second reviewer (EI) quality appraised 21 findings (20%) and Cohen's kappa indicated perfect agreement $k = .1$. Discrepancies were discussed with an option of third/forth review (ER/EK).

Data Synthesis

Major themes, subthemes, or categories from included papers were synthesised using the JBI principles for meta-aggregation (Hannes & Lockwood, 2011). All findings were rated as unequivocal or credible and were saved to Microsoft Excel for synthesis. Findings were grouped into categories based on shared meaning (similarities in words and concepts) by a single reviewer (FR). Each category was underpinned by a minimum of two or more findings. Categories were aggregated into synthesised findings, representative of the overarching meanings across two or more categories (Lockwood et al., 2015). Categories and synthesised findings were appraised by the review team (EI/EK/ER) and finalised through consensus to develop a final analytic output that formed the foundation from which recommendations or 'indicatory' statements (Lockwood et al., 2015, p. 184) for clinical practice were made.

Results

Study Characteristics

The characteristics of the 14 included studies within this review are presented in Table 1.

Sample demographics

Studies were published between 2016 and 2025. Participants spanned 6 countries. Sample sizes varied from 6 to 70 participants, with mean ages of 11 to 23 years. Three studies included multi-informant samples that comprised parent and or clinician reports (n = 33) alongside adolescent reports. It was noted that Hjeltnes et al. (2016), Hjeltnes et al. (2018), and Hjeltnes et al. (2019) drew participants from the same wider sample (n = 53) of socially anxious young adults who participated in a university Mindfulness Based Stress Reduction (MBSR) programme. Each of these studies had different aims. There was no overlap in quotations. Therefore, findings from these papers were included. However, it was not possible to determine the number of unique participants.

Lived Experiences of SAD

All studies encompassed aspects of lived experiences of SAD. Ten studies focussed on experiences of SAD in the context of help-seeking and treatment. Four studies focussed on experiences of symptoms and coping.

Table 1.

Characteristics of Included Studies

Authors	Method/Analysis	Phenomena of interest	Setting, Geography & Culture	Participants	Author Conclusions
Clarke and Fox (2017)	Qualitative descriptive design using thematic analysis (Robson, 2011). Semi-structured interviews using The Occupational Circumstances Assessment Interview and Rating Scale (OCAIRS; Forsyth, 2006).	College participation of students with SAD.	Undergraduate students enrolled in a large Irish college.	<u>Demographics:</u> • 6 participants. • 19 to 22 years (*M* = 19.5; *SD* = 1.2). • 3 females, 3 males. • All undergraduates. <u>Clinical characteristics:</u> • All scored between 65 and 116 (*M* = 86.3; *SD* = 21.9) on the Liebowitz Social Anxiety Scale (LSAS; Liebowitz, 1987). • Some (an unspecified number) had sought professional help for SAD.	• Students with SAD experience significant functional impairment across academic and social activities.

Authors	Method/Analysis	Phenomena of interest	Setting, Geography & Culture	Participants	Author Conclusions
Fox et al. (2025)	Semi-structured focus groups and individual interviews. Thematic analysis (Braun & Clarke, 2006).	Perceptions and experiences of SAD in Black American adolescents and attitudes towards help-seeking and school-based mental health services.	Students attending an urban public high school in the United States classified as mid-high poverty status.	<u>Demographics:</u> • 15 participants. • 14 to 18 years (*M* = 16; *SD* = 1.2). • All identified as Black; two also identified as Latinx and two multi-racial. • 9 females, 5 males, & 1 undisclosed gender. <u>Clinical characteristics:</u> • Social anxiety subscale of the Screen for Child Anxiety Related Emotional Disorders (SCARED; Birmaher et al., 1997).	• Black students' experience of SAD aligns with current conceptualisations and links to aspects of discrimination and stigma.

Authors	Method/Analysis	Phenomena of interest	Setting, Geography & Culture	Participants	Author Conclusions
Halldorsson et al. (2023)	Qualitative study involving an 'in vivo social stress task' designed to simulate the effects of a live audience of peers during participant interviews. Semi-structured interviews; thematic analysis (Braun & Clarke, 2006).	Cognitive and behavioural factors that may play a role in maintaining SAD.	Children and adolescents referred to a specialist anxiety and depression clinic and research centre in the United Kingdom.	<u>Demographics:</u> • 12 children and adolescents. • 8 to 12 years (*M* = 10.9; *SD* =1.3). • 8 females, 4 males. • All white. <u>Clinical characteristics:</u> • SAD was diagnosed through semi-structured diagnostic interviews. • The Revised Children's Anxiety and Depression Scale (RCADS; Chorpita et al., 2000) was used with the Liebowitz Social Anxiety Scale for Children and Adolescents (LSAS; Liebowitz, 1987). LSAS scores ranged from 25 to 112 (*M* = 82.1; *SD* = 26.5). • Co-morbidities included: Generalised Anxiety Disorder, Specific Phobia, Separation Anxiety Disorder, Panic Disorder, Depression.	• There might be some developmental influences on the maintenance processes within SAD.

Authors	Method/Analysis	Phenomena of interest	Setting, Geography & Culture	Participants	Author Conclusions
Hjeltnes et al. (2016)	Phenomenological life-world study utilising hermeneutic-phenomenological epistemology. Semi-structured interviews. Team based approach to thematic analysis (Braun & Clarke, 2006).	The lived experiences of young adults with SAD in everyday life and reasons for seeking help.	Participants were recruited through a Norwegian University.	<u>Demographics:</u> • 29 undergraduate students. • 19 to 25 years (*M* = 22.9; *SD* = 1.44). • 15 females, 14 males. • 1 participant from an ethnic minority background, no other ethnicities reported. <u>Clinical characteristics:</u> • All met the criteria for SAD through a structured diagnostic interview, using the Mini-International Neuropsychiatric Interview (MINI; Lecrubier et al., 1997).	• Young people reported experiences of being characterised as shy as a precursor for SAD, as well as experiencing feelings as being uncontrollable, feeling lonely and hiding away, and experiences of deciding to face fears.

Authors	Method/Analysis	Phenomena of interest	Setting, Geography & Culture	Participants	Author Conclusions
Hjeltnes et al. (2018)	Mixed-methods appraisal of SAD symptom change. Semi-structured interviews; explorative reflective thematic analysis (Braun & Clarke, 2006). Informed by humanistic-existential perspectives.	To qualitatively compare the experiences of students who showed high and low symptomatic change in a trial of MBSR for SAD.	Participants were recruited through a Norwegian University.	<u>Demographics:</u> • 14 participants, taken from a sample of 24 high and low responders aged 21 to 25 (M = 23; SD = 1.23) that comprised 12 females, 12 males. • The sample was divided based on measures of treatment response. <u>Clinical characteristics:</u> • All met criteria for SAD through a structured diagnostic interview, using the Mini-International Neuropsychiatric Interview (MINI; Lecrubier et al., 1997).	• Students with SAD who responded less well to treatment felt less empowered and identified ambivalence and persistent experiential and behavioural avoidance.

Authors	Method/Analysis	Phenomena of interest	Setting, Geography & Culture	Participants	Author Conclusions
Hjeltnes et al. (2019)	Qualitative, phenomenological life-world study. Semi-structured interviews; thematic analysis (Braun & Clarke, 2006). from a hermeneutic phenomenological frame.	The change process for students with SAD whose symptoms improved after an 8-week MBSR program.	Participants were recruited through a Norwegian University.	<u>Demographics:</u> • 11 undergraduates. • 22 to 25 years (*M* = 23; *SD* = 1.07). • 5 females, 6 males. • All Caucasian. • Interviewed 2-weeks after treatment. <u>Clinical characteristics:</u> • All met criteria for SAD through a structured diagnostic interview, using the Mini-International Neuropsychiatric Interview (MINI; Lecrubier et al., 1997). • All reported clinically significant change in SAD symptoms on the Social Phobia Scale (SPS; Heimberg et al., 1992) or Global Severity Index (GSI; Schmitz et al., 2000).	• Young people described the benefits of using the MBSR programme to increase their capacity to attend to embodied experiences of SAD including sensations, thoughts, feelings and improved inter-personal relations.

Authors	Method/Analysis	Phenomena of interest	Setting, Geography & Culture	Participants	Author Conclusions
Kim et al. (2022)	Qualitative study. Semi-structured interviews; reflexive thematic analysis (Braun & Clarke, 2006).	To understand when young people with SAD experience social anxiety, how young people assess social interactions, and communication strategies used in uncertain social circumstances.	Californian College Students.	<u>Demographics:</u> • 26 college students. • 18 to 22 years (*M* = 20.41; *SD* = 2.95). • 15 females, 10 males, & 1 non-disclosed gender identity. • 10 East Asian/Asian American, 3 Non-Hispanic White Euro American, 2 South Asian/Indian American, 2 Latino/Hispanic American, 1 Black American, 1 Afro-Caribbean American, 1 Middle Eastern/Arab American, 1 Multi-Ethnic American, 2 other, and 3 declined to answer. <u>Clinical characteristics:</u> • Social anxiety was assessed via the Liebowitz Social Anxiety Scale (LSAS; Liebowitz, 1987). LSAS scores ranged from 30 to 135 (*M* = 68.19; *SD* = 26.56).	• Applying the Theory of Motivated Information Management (TMM) might help explain interactions in young adults with SAD.

Authors	Method/Analysis	Phenomena of interest	Setting, Geography & Culture	Participants	Author Conclusions
Lawrence et al. (2022)	Semi-structured individual interviews; thematic analysis (Braun & Clarke, 2006) from a experiential phenomenological perspective.	What families with children at prospective risk of anxiety disorders perceive to be the barriers to accessing targeted anxiety prevention programmes.	Participants were recruited from a longitudinal cohort study (Murray et al., 2007) in the United Kingdom.	<u>Demographics:</u> • 7 adolescents, 7 parents. • 14 to 17 years (*M* = 15.7; *SD* 1.1) • 6 females, 1 male. • White British sample. • All mothers. • 4 dyads reported a history of help-seeking for the adolescents' anxiety disorder, but none had been offered (or sought access to) an anxiety programme. <u>Clinical characteristics:</u> • Adolescent Diagnostic Interview Schedule IV Child and Parent Interviews (ADIS-IV C/P; Silverman & Albano, 1996) with some amendments made to align with DSM-V diagnoses.	• Young people and parents reported potential negative consequences of anxiety prevention programmes and potential facilitators of access.

Authors	Method/Analysis	Phenomena of interest	Setting, Geography & Culture	Participants	Author Conclusions
Leigh et al. (2023)	Semi-structured interviews. Treatment acceptability questionnaire. Thematic analysis (Boyatzis, 1998).	To understand young people's barriers to engagement and or reasons for sustained motivation and to appraise helpful treatment features of OSCA.	Participants were initially screened for the wider trial in four secondary schools in the United Kingdom, as reported in adjacent paper (Leigh & Clark, 2023).	<u>Demographics:</u> • 17 adolescents. • 15 to 18 years (*M* = 16.67; *SD* = .97). • All female (91% female in wider RCT). • Black British, White British, and Mixed Ethnic Group British. Specific numbers were not reported. <u>Clinical characteristics:</u> • SAD was assessed through a linked trial (Leigh & Clark, 2023) Liebowitz Social Anxiety Scale for Children and Adolescents Self-Report Version (LSAS; Liebowitz, 1987), Anxiety Disorders Interview Schedule IV for Children and Parents (ADIS-IV C/P; Silverman & Albano, 1996).	• OSCA is an appropriate and acceptable treatment for adolescents.

Authors	Method/Analysis	Phenomena of interest	Setting, Geography & Culture	Participants	Author Conclusions
Luan et al. (2022)	Phenomenological qualitative research. Semi-structured interviews; using Colaizzi 7-step analytic method (Colaizzi, 1978).	To understand the direct experiences and feelings of students with SAD in social situations.	Undergraduate college students in China.	<u>Demographics:</u> • 7 college students. • Aged 18 to 20 (*M* = 18.34; *SD* = 1.02). • 4 females, 3 males. • 5 were in school, 1 dropped out of education, and 1 had a temporary absence from school. <u>Clinical characteristics:</u> • A Structured Clinical Interview for DSM-IV diagnosed all participants with SAD. • 2 participants were hospitalised; 5 were not.	• Young people reported distorted self-awareness as a prominent feature of SAD; coupled with low self-esteem.

Authors	Method/Analysis	Phenomena of interest	Setting, Geography & Culture	Participants	Author Conclusions
McDonagh and Hennessy (2023)	Semi-structured interviews; analysed through thematic analysis (Braun & Clarke, 2006) using post-positivist epistemology.	To understand the help-seeking decisions and experiences of adolescents with SAD and their parents.	Irish adolescents in contact with CAMHS.	<u>Demographics:</u> • 12 adolescents & 13 parents. • 14 to 18 years (*M* = 16; *SD* = 1.16). • 9 females, 3 males and 13 mothers (incl. 9 dyads, 4 sole mothers, 3 sole adolescents). <u>Clinical characteristics:</u> • All were referred by an NHS CAMHS clinician who screened caseloads against criteria for SAD (NICE, 2013). • Co-morbidities included: suicidal ideation, low mood or depression, panic attacks, self-harm, body dysmorphia, eating disorder, general anxiety, history of selective mutism, OCD, Autism, general learning disability, post-traumatic stress disorder, and specific learning disabilities.	• Parents (namely mothers) can play an important role in noticing difficulties and help-seeking, young people help-seek for various reasons (not just SAD), and SAD can be viewed as shyness at first.

Authors	Method/Analysis	Phenomena of interest	Setting, Geography & Culture	Participants	Author Conclusions
Morrison et al. (2021)	Semi-structured interviews. Grounded theory analysis (Glaser & Strauss, 1968) and consensual qualitative research methods (Hill & Knox, 2021).	To develop an understanding from socially anxious students what determines their treatment expectations.	Participants were recruited from a larger sample of socially anxious undergraduates in the United States.	<u>Demographics:</u> • 11 undergraduates. • 18 to 21 years (*M* = 19.18; *SD* = 1.25). • All females. • 9 White/European, 1 White European and Hispanic/Latin American, 1 Asian. <u>Clinical characteristics:</u> • Participants scored above clinical cut-off for social anxiety on the Fear of Negative Evaluation-Brief Form (FNEB; Leary, 1983). • Participants scored between 10 to 90% (*M* = 56.36; *SD* = 22.03) on the Credibility/Expectancy Questionnaire (CEQ; Devilly & Borkovec, 2000). • Previous experience of psychotherapy was an exclusion criteria.	• Various determinants of therapy expectations (such as the views of peers and family, media, and undergraduate coursework that addresses psychotherapy) can influence positive or negative views.

Authors	Method/Analysis	Phenomena of interest	Setting, Geography & Culture	Participants	Author Conclusions
O'Bree et al. (2021)	Semi-structured interviews; Content analysis (Erlingsson & Brysiewicz, 2017)	The experiences of adolescents and young people with SAD using the digital intervention Entourage.	Participants were referred from four headspace youth early intervention centres in Melbourne, Australia.	<u>Demographics:</u> • 70 young people. • 14 to 25 years (*M* = 19.8). • 35 females, 30 males, 2 transmen, 2 gender non-conforming, & 1 non-disclosed. • 32 Australian, 8 White/Caucasian, 2 Filipino, 2 Sri Lankan, 1 Australian/ Italian, 1 Croatian, 1 English, 1 Italian/ Slovakian, 1 Lebanese, 1 Sinhalese, 1 Swiss, 1 Turkish, 1 Vietnamese, 17 Missing. <u>Clinical characteristics:</u> • Participants scored ≥30 on LSAS (Liebowitz, 1987). • Patient Health Questionnaire 9 (PHQ-9; Kroenke et al., 2001) indicated that 8.6% reported minimal symptoms, 15.7% mild depression, 32.9% moderate depression, 28.6% moderately severe depression, 14.3% severe depression.	• Young people with SAD experienced loneliness/isolation and found Entourage a helpful intervention. No overt gender differences were found in engagement with the intervention.

Authors	Method/Analysis	Phenomena of interest	Setting, Geography & Culture	Participants	Author Conclusions
Taylor et al. (2021)	Qualitative study within a wider feasibility study testing Cognitive Therapy for SAD in adolescents (CT for SAD-A; Creswell et al., 2021) Multi perspective design (Larkin et al., 2019) using interpretative phenomenological analysis (IPA; Smith et al., 2009).	The experiences of CT for SAD-A from adolescents, parents, and clinicians.	Participants were recruited through an NHS CAMHS Service in the United Kingdom.	<u>Demographics:</u> • 19 participants (6 adolescents, 6 parents, 7 clinicians). • 14 to 18 years old (*M* =15.7; *SD* = 1.4). • 5 females, 1 male. • Adolescent sample noted as predominantly White British. <u>Clinical characteristics:</u> • All adolescents were screened against the NICE (2013) criteria, then completed the Revised Children's Anxiety and Depression Scale (RCADS; Chorpita et al., 2000), and then completed structured diagnostic interviews against DSM-V criteria in CAMHS.	• Young people and parents spoke highly of CT for SAD-A and clinicians.

Clinical characteristics

All fourteen studies reported a sample mean that reached or exceeded clinically significant symptoms of SAD, a diagnosis of SAD, or referred young people to the study through a CAMHS professional. One strength was that most studies gave clear descriptions of the diagnostic and/or screening assessment of SAD, the psychometric properties of which are presented in Appendix C. Three studies specifically focussed on experiences post treatment, though participants met the criteria for probable SAD at the outset (Hjeltnes et al., 2018; Hjeltnes et al., 2019; Leigh et al., 2023).

In Lawrence et al. (2022), 6 out 7 participants scored for a probable SAD diagnosis and 1 scored for GAD with co-morbid SAD. In Fox et al. (2025) the mean sample SAD score exceeded clinical significance, though 4 out 15 participants reported sub-clinical scores. A tracking exercise was completed (enabled by clear participant reporting and numbered themes). No findings were solely supported by participants with sub-clinical SAD. Five studies screened for and reported co-morbidities.

Methodologies

Phenomenology was the most common reported approach (Luan et al., 2022; Taylor et al., 2021), including hermeneutic phenomenological epistemology (Hjeltnes et al., 2016; Hjeltnes et al., 2018; Hjeltnes et al., 2019) and experiential phenomenology (Lawrence et al., 2022). All studies used semi-structured interviews for data collection; one additionally used focus groups (Fox et al., 2025), one study interviewed participants during an in the moment live social stress task (Halldorsson et al., 2023), and another interviewed participants who had watched a SAD treatment rationale recording with or without persuasion techniques augmented (Morrison et al., 2021).

Methodological Quality

Table 2 gives the quality appraisal ratings of included studies. Questions (1-10) are taken from the JBI quality checklist (Aromataris et al., 2024), included in Appendix B. Detailed consideration of the appraisal criteria (Lockwood et al., 2015) was used to inform the approach taken to ratings. Studies ranged from meeting 20% to 100% of items. A collective strength was that all included studies received ethical approval. Almost all studies used two or more direct participant quotations to underpin each finding, except for a couple of instances where findings were supported by a single quote. Areas of incongruence included an example of purposeful sampling for a grounded theory study (Morrison et al., 2021) and attempts to ensure objectivity within thematic analysis (Clarke & Fox, 2017).

Within this, 50% of studies did not provide an overarching philosophical position. This represented a common area for development; although it should be acknowledged this continues to represent an area of debate and inconsistency within qualitative research (Bradbury-Jones et al., 2022). Thematic analysis (TA), for example, is a theoretically flexible approach; however, it is not atheoretical (Braun & Clarke, 2022). Therefore, in line with other meta-aggregations (as in, Twivy et al., 2023), items related to congruence of the research questions, methods, findings and interpretation (Q1 to Q5) were consequently rated as unclear for studies that did not outline an overarching philosophical stance. In respect of the 57.1% of studies that reported researcher reflexivity, statements were often limited to job role; though in some instances reflexivity was helpfully extended to the researcher's prior relationship with participants and assumptions (Lawrence et al., 2022), cultural stance (Fox et al., 2025), the philosophical stance of the researcher (Hjeltnes et al., 2016; Hjeltnes et al., 2018; Hjeltnes et al., 2019), process of 'bridling' and parental status (Taylor et al., 2021).

Table 2.

Quality Appraisal Ratings for Studies

Study	Q1 **Is there congruity between the stated philosophical perspective and the research methodology?**	Q2 **Is there congruity between the research methodology and the research question or objectives?**	Q3 **Is there congruity between the research methodology and the methods used to collect the data?**	Q4 **Is there congruity between the research methodology and the representation and analysis of the data?**	Q5 **Is there congruity between the research methodology and the interpretation of the results?**	Q6 **Is there a statement locating the researcher culturally or theoretically?**	Q7 **Is the influence of the researcher on the research and vice versa addressed?**	Q8* Are participants and their voices adequately represented?	Q9 Is the research ethical according to current criteria or recent studies, and there is evidence of ethical approval by an appropriate body?	Q10 **Do the conclusions drawn in the research report flow from the analysis or interpretation of the data?**	Total
Clarke and Fox (2017)	U	U	U	U	U	U	N	Y	Y	U	2
Fox et al. (2025)	U	U	U	U	U	Y	Y	N	Y	Y	4
Halldorsson et al. (2023)	U	U	U	U	U	U	Y	Y	Y	U	3
Hjeltnes et al. (2016)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Hjeltnes et al. (2018)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10

Study	Q1 **Is there congruity between the stated philosophical perspective and the research methodology?**	Q2 **Is there congruity between the research methodology and the research question or objectives?**	Q3 **Is there congruity between the research methodology and the methods used to collect the data?**	Q4 **Is there congruity between the research methodology and the representation and analysis of the data?**	Q5 **Is there congruity between the research methodology and the interpretation of the results?**	Q6 **Is there a statement locating the researcher culturally or theoretically?**	Q7 **Is the influence of the researcher on the research and vice versa addressed?**	Q8* Are participants and their voices adequately represented?	Q9 Is the research ethical according to current criteria or recent studies, and there is evidence of ethical approval by an appropriate body?	Q10 **Do the conclusions drawn in the research report flow from the analysis or interpretation of the data?**	Total
Hjeltnes et al. (2019)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Kim et al. (2022)	U	U	U	U	U	Y	N	Y	Y	U	3
Lawrence et al. (2022)	Y	Y	Y	Y	Y	U	Y	Y	Y	Y	9
Leigh et al. (2023)	U	U	U	U	U	N	U	Y	Y	U	2
Luan et al. (2022)	Y	Y	Y	Y	U	N	N	Y	Y	U	6
McDonagh and Hennessy (2023)	Y	Y	Y	Y	Y	Y	U	Y	Y	Y	9

Study	Q1 **Is there congruity between the stated philosophical perspective and the research methodology?**	Q2 **Is there congruity between the research methodology and the research question or objectives?**	Q3 **Is there congruity between the research methodology and the methods used to collect the data?**	Q4 **Is there congruity between the research methodology and the representation and analysis of the data?**	Q5 **Is there congruity between the research methodology and the interpretation of the results?**	Q6 **Is there a statement locating the researcher culturally or theoretically?**	Q7 **Is the influence of the researcher on the research and vice versa addressed?**	Q8* Are participants and their voices adequately represented?	Q9 Is the research ethical according to current criteria or recent studies, and there is evidence of ethical approval by an appropriate body?	Q10 **Do the conclusions drawn in the research report flow from the analysis or interpretation of the data?**	Total
Morrison et al. (2021)	U	U	N	U	U	Y	Y	U	Y	U	3
O'Bree et al. (2021)	U	U	U	U	U	Y	N	Y	Y	U	3
Taylor et al. (2021)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	10
Percentage Yes	50%	50%	50%	50%	42.9%	64.3%	57.1%	85.7%	100%	50%	

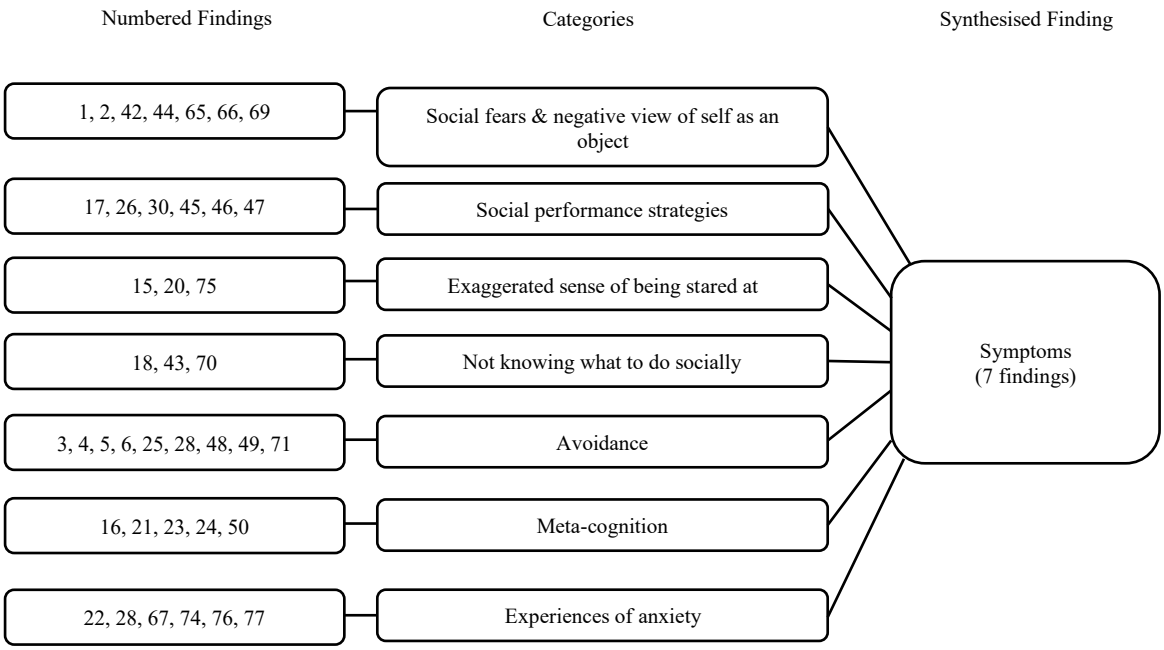
Y = Yes, N = No, U = Unclear and N/A = not applicable.

Q8* defined as two participant quotes per major theme, sub-theme, or category.

Synthesised Findings

Overall, 58 major themes or categories and 54 sub-themes or categories (n = 112) were extracted from 14 papers. All findings were rated as either credible or unequivocal. No findings were excluded due to credibility ratings. Given the aims of this review to examine lived experiences, a decision was taken to exclude 6 findings related to parent or clinician only views (e.g. systemic issues within CAMHS that were unsupported by adolescent quotation) from the final analysis with reviewer agreement (EI/ER/EK). Included findings (n = 106) with credibility ratings are presented in Appendix D. Findings were aggregated into 21 categories. Three findings encapsulated issues of access and barriers in relation to help-seeking and therefore were included in two categories. Categories were then grouped into 4 synthesised findings. An example is presented in Figure 2 and the full process in Appendix E.

Figure 2.
Example of the process meta-aggregation



Synthesised Finding 1: Symptoms (i.e. adolescents perceived cognitive, psychological, physiological, and behavioural features of SAD).

Overall, 40 findings and 7 categories contributed to the first synthesised finding. The category with the most findings (n = 9) was 'avoidance'. Examples of within-situation avoidance and escape behaviours were described across ages, including: phone use in young adolescence (Halldorsson et al., 2023), playing music or not talking in mid adolescence (Fox et al., 2025), and eating in quieter places off-campus or at home in young adulthood (Clarke & Fox, 2017). Participants from the global majority linked experiences of racism (actual and anticipatory) to use of avoidant strategies (Fox et al., 2025). Heightened physiological anxiety was associated with a feared loss of control that fuelled avoidance in order to manage (Hjeltnes et al., 2016).

Across age and stage, participants described a preoccupation with their own social performance (Clarke & Fox, 2017) and poor self-view: such as, 'I am stupid/inadequate' (in, Kim et al., 2022, p.1654). Younger adolescents reported greater challenges appraising these beliefs, categorised as 'meta-cognition', while some older students showed some (but limited) evidence of being able to re-evaluate negative appraisals (Kim et al., 2022). Young people, across age/stage, described social performance strategies to manage fears. Examples included hiding vulnerable aspects of themselves through censoring topics of conversation (Hjeltnes et al., 2016), over-talking to compensate, gravitating towards 'gentle' people (Kim et al., 2022), or trying to come across as likeable (Halldorsson et al., 2023).

Somatic and cognitive experiences of SAD arose through adolescents accounts of anticipatory and post event anxiety in relation to social situations, intense internal discomfort (Luan et al., 2022), and poor perceived social competency. Younger adolescents found it harder to describe cognitions (social anxiety was often conceived as an internal sensation)

while mid to later adolescents and students could describe fearing loss of control and extreme discomfort (Luan et al., 2022).

Synthesised Finding 2: Coping & help-seeking (i.e. making sense of how adolescents cope and what promotes help-seeking).

Six categories and 30 findings comprised this synthesised finding. Fear of negative social evaluation was the category with the most findings (n = 9). Across samples, adolescents described fears, such as 'they'll just think you are crazy' for help-seeking (Fox et al., 2025, p.16). Participants reported concerns about perceptions of anxiety prevention programmes (Lawrence et al., 2022) and concerns about peer responses (McDonagh & Hennessy, 2023). These fears were coupled with accounts of low tolerance for perceived discomfort in talking to a therapist (McDonagh & Hennessy, 2023) or accessing treatment (Fox et al., 2025).

Across samples, participants described not knowing when shyness (Hjeltnes et al., 2016; McDonagh & Hennessy, 2023) transitions into a significant issue (Lawrence et al., 2022). Long-term experiences of shyness were described as a precursor to SAD in almost all students who sought help while at university (in, Hjeltnes et al., 2016). Participants identified in a longitudinal cohort study as being at risk for anxiety disorders (now scoring for clinically significant SAD) noted that treatment might be more helpful when/if SAD symptoms have a functional impact– rather than the point where someone is identified as being at risk, e.g. 'I think I would rather have it [an intervention] while, or after, symptoms are showing cause beforehand I might think 'what's the point of doing this?' (Lawrence et al., 2022, p.570). Facilitators of access to early help were also noted in promoting awareness and making

programmes practical for parents to support adolescents to attend (e.g. online or shortened commutes).

Being unhappy and isolated were noted as drivers of help-seeking (Hjeltnes et al., 2016; Luan et al., 2022; McDonagh & Hennessy, 2023). Students seeking MBSR treatment described dissatisfaction and social estrangement as motivating them to seek treatment, which was similar to participants' predictions, in Lawrence et al. (2022), around the circumstances in which someone might be motivated to help-seek.

The role of parents and caregivers were noted to have helpful and hindering roles in shaping the likelihood of help-seeking. In McDonagh and Hennessy (2023), for example, nearly all adolescents reported they had not wished to seek help but were supported to do so by an adult around them. In Morrison et al. (2021), some participants attributed positive expectations to family narratives of helpful therapy experiences. However, in Fox et al. (2025), adolescents reported perceptions that families might minimise or ignore conversations about SAD due to cultural and generational differences.

Synthesised Finding 3: Promoting Change (i.e. understanding factors that promote positive therapy experiences and help to create change).

Four categories and 29 findings comprised this synthesised finding. The category with the most findings was 'appeal of treatment' (n = 12). Adolescents accessing the Entourage programme (of online resources and peer/therapist networks) outlined the importance of psychoeducation (O'Bree et al., 2021). Indeed, having a good treatment rationale was linked to more positive therapy expectations by students (Morrison et al., 2021). Ease of access was highlighted as being important; adolescents reported positive experiences of online platforms (O'Bree et al., 2021) and modalities (Leigh et al., 2023). Over

half of students (in, Morrison et al., 2021) were more likely to form positive expectations if their friends had also had therapy. This was also reflected in the appeal of the Entourage platform to males (in, O'Bree et al., 2021) who described an increased likelihood of help-seeking and engagement if a trusted contact had recommended the intervention.

Moreover, students who were classified as high responders to the MBSR programme (Hjeltnes et al., 2018) reported making an active decision to engage with group participants when compared to qualitative accounts of low responders, who reported continuing to make similarly avoidant social decisions during treatment. Participants described greater connection to peers, groups, and therapists (Hjeltnes et al., 2019; O'Bree et al., 2021; Taylor et al., 2021) and a process of re-connection with themselves (Hjeltnes et al., 2019); all of which appeared to reverse some of the impacts of social avoidance.

Adolescents (in, Taylor et al., 2021, p.405) reported they 'hated' doing behavioural experiments – but reported this as a helpful component. The majority of students (in, Morrison et al., 2021) felt that coursework (psychotherapy materials) helped shape positive expectations. Moreover, students in the MBSR programme described wanting to change and having an active belief about change through treatment (Hjeltnes et al., 2018). Adolescents who had sought and responded to help for SAD noted active engagement with tools to change their experiences of symptoms, such as developing greater meta-cognitive abilities, e.g. to 'see negative thoughts for what they are' (Hjeltnes et al., 2019, p.39) and tolerating greater internal discomfort (Hjeltnes et al., 2018).

Synthesised Finding 4: Barriers (i.e. making sense of adolescents understanding of non-treatment response or barriers).

Two categories and 8 findings comprised this final synthesised finding. The category of 'poor expectations and practical challenges' had 6 findings. A minority of college students

listed coursework (psychotherapy material) and media views as negative influencers of expectations (in, Morrison et al., 2021) and adolescents who received CT for SAD noted practical challenges, such as staying focussed and the amount of reading (Leigh et al., 2023), although it should be acknowledged the treatment was rated highly across interviews. Furthermore, high anxiety (Hjeltnes et al., 2018; O'Bree et al., 2021) was noted for its impact on some adolescents ability to engage.

Discussion

This systematic literature review aimed to understand the lived experiences and help-seeking position of young people with SAD. Meta-aggregation of 106 findings from 14 studies resulted in 4 synthesised findings. These represent adolescents' perspectives on (1) symptoms (2) coping and help-seeking (3) promoting change and (4) barriers. There was no cut-off for quality appraisal of studies in this review. Studies comprised mixed methodological quality, though all findings were rated as credible or unequivocal which enhances the credibility of synthesised findings (Hannes et al., 2018). What follows is a discussion of each synthesised finding in the context of existing literature and implications for practice in line with the JBI guidance for meta-aggregation.

Symptoms

Across studies of higher and lower methodological quality, adolescents' lived accounts of SAD shared similarities with the Clark and Wells (1995) model, with some variations related to stage and age. This lends support for the application of cognitive and behavioural models to younger populations; though sits in contrast to another recent review that concluded that current diagnostic criteria for depression do not capture adolescents' experiences fully (Twivy et al., 2023).

Across samples in this review, adolescents reported a range of social performance strategies and heightened self-consciousness. There was no explicit support for Clark and Wells (1995)'s observer perspective, but adolescents described extremely negative self-perceptions (Kim et al., 2022) and preoccupation with social performance that resonated with ideas of internal focus of attention/self as a social object. There was evidence of similar markers of distorted self-images, such as: flushing, blushing, and sweating (Luan et al., 2022) also described in adult populations (Warnock-Parkes et al., 2016). Young adolescents were less able to identify cognitions, in line with developmental expectations (Halldorsson et al., 2023). Avoidance was the most consistent and prevalent behavioural response noted in this review and was associated with distress, as noted in other research (Evans et al., 2021). Taken together, this builds on evidence that suggests adolescents with SAD might benefit from treatments based on the theorised maintenance processes outlined by Clark and Wells (1995), with some evidence in favour of greater scaffolding around cognitive work for younger adolescents.

Most adolescents' reported experiences of symptoms of SAD aligned with the symptom profile outlined in the ICD-11 (World Health Organisation, 2022), with a potential additional influence of racism on symptoms reported by participants in one mixed-methodological quality study (Fox et al., 2025). This finding is further contextualised by accounts of UK young adults who self-identified with SAD, who reported an interaction-effect between cultural norms and social interactions on social anxieties (Zegrean, 2024). Experiences of racial discrimination can increase the odds of lifetime prevalence of anxiety disorders, including SAD (Nguyen et al., 2023). It follows that practitioners should formulate for the specific interrelationship between experiences of racism (actual and anticipatory) on safety-seeking efforts through avoidance in adolescents with SAD from the global majority.

This is pertinent as negative beliefs within social anxiety can be rooted in meanings associated with memories of actual distress, such as discrimination (Wild et al., 2007).

Coping & Help-Seeking

Long term shyness was described as a forerunner of SAD across accounts of young adult help-seekers in studies assessed as having robust methodological quality in this review. SAD remains underrecognised in adolescence (NICE, 2013). The concept of not knowing when to seek help has similarly arisen in adult's accounts of SAD (Goetter et al., 2020). Therefore, building on guidance laid out in the ICD-11, it is important that practitioners are able to recognise non-transient periods of shyness; defined as longer than several months (World Health Organisation, 2022). Given the significance of avoidant coping identified across age/stages in this review, it is possible that screening for socially avoidant coping could offer a potential indicator of behavioural responses implicated in the development of SAD.

There was additional evidence in favour of practitioners being aware that functional impact and negative outcomes might act as drivers of help-seeking (Hjeltnes et al., 2016; Lawrence et al., 2022). This is an interesting finding in the context of research into potential harms associated with prevention or universal anxiety programmes (Foulkes et al., 2024; Guzman-Holst et al., 2025) as it might suggest help-seeking for SAD is better placed when indicated rather than preventatively identified. This review supports the timely access to intervention at the point of presentation for services.

Research suggests a minority of young people with anxiety or depression seek help (Gulliver et al., 2010; Huff et al., 2024) and attempt to manage for years into adulthood (Patel et al., 2022). Adolescents' in this review reported intense physiological anxiety, fear of negative evaluation, and stigma as barriers to help-seeking, which has been supported in

other qualitative and quantitative research (Lundkvist-Houndoumadi & Thastum, 2017; McDonagh et al., 2022). Practitioners should be aware of (and account for) how SAD symptoms might interact with the process of help-seeking. As with other treatment approaches for anxiogenic difficulties (e.g. PTSD described in, Smith, 2010), practitioners might wish to address the idea that adolescents may not want to engage with the treatment or therapist from the beginning and plan with the young person for this – discussing how intended solutions might unintentionally have become part of the problem.

Furthermore, peers have been described as central in accounts of help-seeking adolescents (Lynch et al., 2023). Some support for peers was found, however, the role of parents and caregivers as being potentially helpful and hindering was more prominently centred in adolescents' accounts. It follows that practitioners should be mindful to sensitively engage families in assessment and treatment. Negative familial narratives of treatment could offer a potential treatment target within a holistic intervention for families already known to services. This is also supported by adjacent experimental studies assessing the value of strong rationales in enhancing treatment expectation (Ametrano, 2017). For families not known to services, there is some evidence underlining the role of (non-familial) adults, such as teachers, having potentially helpful roles in supporting adolescents to help-seek in other areas, such as psychosomatic symptoms (Kjellström et al., 2017).

Promoting Change

Across modalities, adolescents' noted that reducing avoidance was helpful in alleviating symptoms and promoting change. Adolescents who engaged in CT for SAD commended the use of behavioural experiments to test beliefs, and the development of meta-cognitive abilities, which has been upheld in empirical studies (Creswell et al., 2021). Ease of access was highlighted by adolescents as being integral to the appeal of treatment that aligns

with the reported successes of flexible models of adolescent treatment in different areas (Broersen et al., 2024).

Barriers

Beyond individual differences, there was some evidence of higher barriers to accessing treatment for adolescents who reported increased physiological symptoms and higher avoidance, also supported in adult literature (Chartier-Otis et al., 2010). Practitioners should consider ways to support adolescents with more severe SAD symptoms manage (or habituate) physiological responses to reduce the potential for treatment disengagement.

Limitations

Studies included in this meta-aggregation reported some (but limited) reflexivity and philosophical orientation. While this is a somewhat common dilemma in qualitative studies (Bradbury-Jones et al., 2022), it prevents appraising the findings from the lens from which the themes/categories were constructed. Furthermore, the process of meta-aggregation does not allow for findings to be extracted at a participant level; thus, a more nuanced appraisal of individual differences and demographics was not possible. This review found fewer studies conducted in younger adolescence, closer to the estimated age of SAD onset (e.g. 10-13 years). This stage of development might hold greater influence in understanding the onset and experience of SAD symptoms. Moreover, adolescent SAD is also highly co-morbid (Halldorsson et al., 2023). Five studies in this review used screening tools that accounted for a range of difficulties. The nine studies that used SAD-specific measures (unsurprisingly) did not report co-morbidities. Thus, co-morbidity rates might have been higher than reported across samples. Common co-morbidities might have more of an intersecting influence on adolescents' experiences of SAD than it was possible to account for in this review. Taken

together, these reflections suggest findings from this review might not generalise to all adolescents with SAD. As such, the aforementioned practical recommendations offer a resource to assist (not replace) clinical judgement in the context of the rising complexities seen within CAMHS (Edwards et al., 2024).

Moreover, to ensure this review was helpful for the identification and treatment of SAD, clinical cut-offs guided the eligibility criteria. However, it should be noted that early warning signs of SAD might be more present in pre-clinical samples that could yield information helpful to the earlier recognition in adolescence that could guide future reviews.

Conclusions

This review highlighted similarities between young people's reported lived experiences of SAD and the Clark and Wells (1995) model, with some variance related to age/stage and cultural experiences. Practitioners should assess and formulate for the interrelationship between racism and safety-seeking behaviours. To progress the recognition of SAD, practitioners should be explicit about the differences between episodic and/or developmentally appropriate shyness and SAD and consider screening for socially avoidant coping as a potential marker of vulnerability for SAD development. Parents/carers likely have a role in shaping adolescent help-seeking attitudes, which offers a potential holistic intervention target for families known to services to increase belief in treatment. This also highlights a potential role for non-familial adults in supporting adolescents to help-seek. Practitioners should be aware young people might present for help at the point where SAD symptoms are having a functional impact and consider addressing within-treatment avoidance from the beginning. Participants' experiences of treatment changes were clustered around reducing avoidance, connection, flexible engagement, online options, and guided therapist and or peer support.

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Service Improvement Project (SIP)

Title: Perspectives on Barriers and Facilitators to 'Babies 1st' Video Interaction Guidance Based Community Bonding Groups.

Word count: 4995

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Proposed Journal: The Journal of Reproductive and Infant Psychology.

Rationale: This journal was chosen for its focus on publishing original work to interdisciplinary audiences, including psychological aspects of health visiting and nursing (as per the referrers and staff in this project) and interest in aspects of service organisation. It has a 6.8 CiteScore and 2.1 Impact Factor. Author guidelines can be found here and are presented in Appendix P.

Abstract

Background: Access to parent-infant services in the UK is variable. This service improvement project aimed to identify the facilitators and barriers to access and engagement with community-based parent-infant bonding groups to inform meaningful recommendations for development. 'Babies 1st' commissioned the study based on hypotheses that only a small percentage of potentially eligible parents were attending their video-interaction guidance (VIG) based bonding groups.

Methods: A mixed-methods study was conducted between July 2023 and June 2024. Ten participants from parent, facilitator, and referrer groups participated in semi-structured interviews. Reflexive thematic analysis from a realist stance was conducted. Qualitative data was supplemented by an evaluation of attendance records to better understand engagement.

Results: Four themes were constructed from the data, with twelve sub-themes: (1) landscape of parent-infant services (2) generating referrals (3) from referral to attendance and (4) experiences in the group.

Discussion: Findings outlined multiple positive benefits from group attendance and highlighted the value of familiarity and consistency for promoting access, alongside barriers of parental stigma, anxiety, and different perspectives on bonding. Ten service recommendations were developed from the findings.

Key words: bonding groups, parent-infant intervention, video interactive guidance, VIG, reflexive thematic analysis.

Perspectives on Barriers and Facilitators to 'Babies 1st' Video Interaction Guidance Based Community Bonding Groups.

There is a growing evidence base, underlined by theories of child development, that highlights the importance of our earliest relational experiences in the perinatal period (from conception to age two) in laying the foundations for outcomes across the lifespan (Samson et al., 2024). Warm, attuned experiences of caregiving can support the development of infants' emotion regulation abilities, secure attachments (or internal working model) and neural and social-emotional development (Celebi, 2017; Opie et al., 2023). New parents must navigate a multitude of challenges during the perinatal period. These can include shifts in personal and social identities as well as negotiating societal norms and parenting discourses (Lévesque et al., 2020). This period can be especially challenging for parents with mental health difficulties which might, at times, present barriers to providing good-enough care (Bigelow et al., 2018; Chamberlain et al., 2019; Samson et al., 2024).

Mental ill-health impacts an estimated one in four women during pregnancy and the perinatal period (NHS England, 2019). Maternal depression has been linked to insecure infant attachment styles (Khan et al., 2020) and increased lifespan vulnerabilities, such as anti-social behaviour (Gajos & Beaver, 2017) and adolescent depression (Stein et al., 2014). However, these outcomes are not inevitable. Preliminary evidence suggests interventions aiming to develop the sensitivity of parent-infant interactions using video-interaction guidance (VIG) may moderate the risk of negative outcomes (Chakkalackal et al., 2021; O'Hara et al., 2019; Stein et al., 2014).

Access

Given the wide-ranging impacts, improving access to services in the perinatal period is a health and social care priority (NHS England, 2019). Of parents surveyed in 2022, 23% reported being unable to access a parenting support service (Action for Children, 2022). However, there is limited evidence pertaining to parent-infant services. What we do know relates to perinatal care and speaks to the complexity of access; with issues arising from stigma, socio-cultural differences, structural (Lovell et al., 2023; Sambrook Smith et al., 2019) and racial disparities (Lovell et al., 2023).

There is considerable local variation in the availability of parent-infant interventions in the UK (Parent-Infant Foundation, 2023). In England, 42% of clinical commissioning groups (CCGs) had no provision for under twos in 2020 through Child and Adolescent Mental Health Services (Hogg, 2020). The number of parent-infant teams has grown post-pandemic: from 26 teams in 2020 to 46 in 2024. The government is piloting the Start for Life programme (2021-2025) integrating perinatal and parent-infant support through family hubs. However, funding decisions remain the choice of individual CCGs.

Service context

This service improvement project was commissioned by 'Babies 1st' (https://babies1st.net/), a not-for-profit community interest company (CIC), that runs free community baby bonding groups across the Thames Valley. The engagement process is based on principles of targeted universalism, aiming to recruit parents whose difficulties can confer parenting vulnerabilities, such as uncertain asylum status, mental ill-health, or unstable living conditions, through referrals from NHS and Social Care as well as self-referral from local parents interested in improving their parent-infant bond.

The groups are based on two combined approaches: Video Interaction Guidance (VIG) is the main intervention augmented with Wait Watch and Wonder approaches. The groups are delivered by VIG accredited practitioners. VIG is a parent-infant intervention used to enhance inter-subjectivity (shared understanding), sensitivity, and attunement between parents and infants (Kennedy et al., 2017). Wait Watch and Wonder is an attachment intervention that supports parents to appraise how they can interpret their infants' cues to promote securer and more organised attachment relationships (Cohen et al., 1999). The theorised mechanisms of change for both interventions centre on increasing parent-infant attunement and parental reflective functioning to strengthen the quality of parent-infant attachment relationships, which is considered to have a protective role across developmental, cognitive, emotional and social domains for outcomes into adulthood (Chakkalackal et al., 2021).

With consent, parents and infants are photographed or filmed during the groups using facilitators' smart phones to support the process of VIG in identifying moments of success or exception. Group facilitators spend time with parents reviewing the photos using a strengths-based approach to feedback. Parents are asked to reflect on what they see within the photographs and are asked to review the photographs of other parents in the group. Within this, parents are sensitively invited to consider their own attachment blueprints, experience of parenting, and experiences of being parented. Parents are given video clips and photographs to take away as a reminder. During each group, facilitators will also invite parents to pause (wait) and observe their infants for a 5-minute window (watch) and then ask questions such as *'what do you think your baby is feeling?'* or *'what do you see when you look at him/her?'*(wonder).

One such group in Buckinghamshire offers weekly 1.5-hour groups on a year-round basis. Attendance is open-ended: parents can attend for as long as they find the provision helpful while their infant is aged 0 to 2. Facilitators also offer 1-1 sessions to (approximately one third of) parents who find the group setting more challenging. The 1-1 referral process is based on facilitator observation and has no formalised criteria.

Senior leaders identified generating referrals and sustaining engagement as key service challenges. The Buckinghamshire group had 4 dyads registered in June 2023 (n = 8), but facilitators observed irregular attendance. The service-related need underpinning the project was to better understand facilitators and barriers to access and engagement with groups to inform meaningful recommendations to develop practice.

Aims

The aims were agreed with 'Babies 1st' leaders as follows:

(1) Map current referral sources, processes & engagement (defined as repeat attendance).

(2) Understand parents' experiences of accessing and engaging with 'Babies 1st'.

(3) Understand perspectives of group facilitators and referrers.

(4) Make recommendations for changes in these processes to promote referrals and support engagement.

(5) Outline learning around engaging parents in service evaluation.

Materials & Method

Design

A mixed methods design was used. An exploration of attendance records (n = 118 entries) was conducted to explore engagement. Attendance data was used to contextualise

qualitative interviews (n = 10) undertaken with parent, facilitator, and professional referrer stakeholder groups. The trainee attended bonding groups (n = 3) and facilitator supervision (n = 1), adopting a position aligned with participant-observer approaches (DeWalt & DeWalt, 2011) to familiarise potential participants with the project aims and increase trust, in line with recommendations for overcoming racial and ethnic disparities in healthcare designs (Lovell et al., 2023). Careful consideration was given to the benefits and constraints of taking a participant observer role, adopting a second-order position that to observe a system is to influence it (Dallos & Draper, 2005). Issues of power and difference were attended to through reflexive logs kept to appraise the construction of meaning at intersections of the Social GRRAACCEESS (Burnham, 2012).

Participants

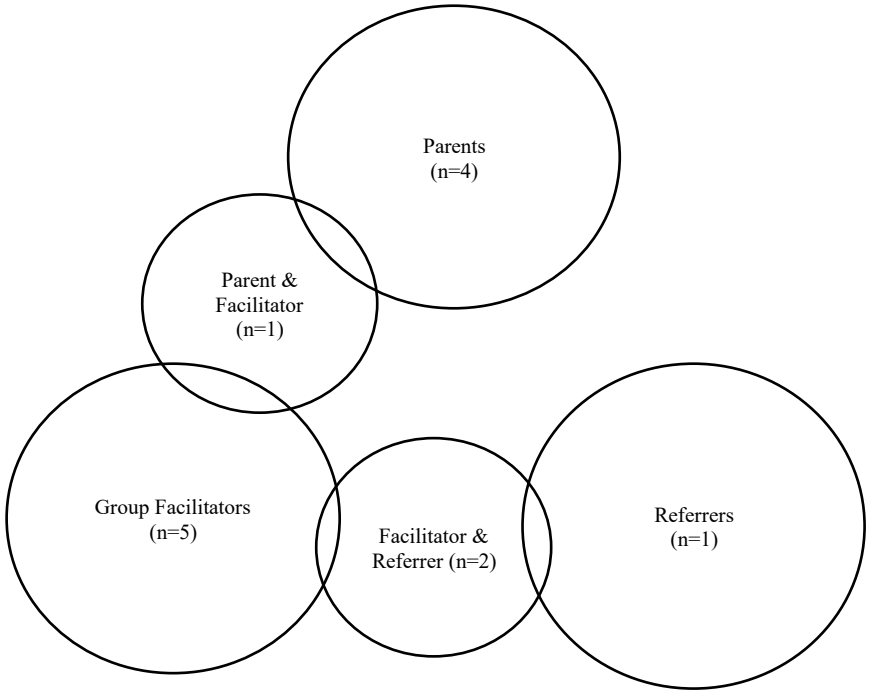
Participants (see Figure 1) were parents (n = 4), group facilitators (n = 5), and referring professionals (n = 1). Purposive sampling was used to achieve the project aims to make recommendations around access and barriers. All participants identified as women. Parents were recruited from the Buckinghamshire group and had attended at least one session. All parents were in heterosexual relationships. Further details related to age and ethnicity were not available through 'Babies 1st' records.

One facilitator was a 'Babies 1st' leader, two facilitated the Buckinghamshire groups, and two facilitated other 'Babies 1st' groups and supported the Buckinghamshire group. All facilitators attended a group supervision space where groups, parents, and referrals were discussed and felt able to comment on areas of similarity/difference between groups in relation to access to enrich the dataset. Facilitators' professional backgrounds included nursing, health visiting, perinatal peer support, psychodynamic counselling, paediatrics, and early years childcare. One facilitator had former experience of attending groups as a parent.

Some facilitators (n = 2) had additional part-time roles and referred parents into groups from their respective professional settings. The external professional was a health visitor and had not yet referred into the groups.

Figure 1.

Diagram of Participant Groups



Measures

Attendance records

An exploration of attendance data was undertaken to understand engagement between January and November 2023.

Qualitative interviews

A semi-structured interview schedule (in Appendix G) was developed in consultation with 'Babies 1st' leaders and an expert by experience (EbE). Areas explored included participants' motivation to engage, the referral process, barriers to engagement, suggested improvements, and cultural and disability arrangements.

Data Collection

Recruitment was conducted between July and October 2023. Across groups, 17 people were invited to participate (see Appendix H for inclusion criteria) and 7 declined: parents (n = 1) and referrers (n = 6). Of these, some referrers (n = 2) gave the rationale of feeling unable to comment on access and barriers due to their roles (e.g. management). A sub-section of parents (n = 1) and referrers (n = 4) did not respond to the invitation and no reason was provided.

Individual interviews (n=10) with the trainee were scheduled over the phone or Microsoft Teams. Interview length averaged 29 minutes (ranging 21 to 54 minutes). Participants were interviewed once. Nine participants gave consent to be recorded; one declined and contemporaneous field notes were used in lieu of recording (Halcomb & Davidson, 2006). The first interview acted as a pilot, which indicated that the schedule was acceptable. As revisions were not needed, data from this interview was included in the analysis. Recordings were listened to twice. Once, to enable manual transcription and pseudonymisation and a second time, to support immersion and check for accuracy.

Ethics

Ethical approval was granted through the Oxford Institute for Psychology Training and Research in June 2023 (presented in Appendix I). Participants were provided with an

information sheet and gave informed consent (in Appendix J). Time was ringfenced to debrief each participant to contain the interview process and ensure they were not distressed.

Analysis

Attendance records

A service evaluation was initially planned to track referrals and sources. This proved unfeasible when appraising 'Babies 1st' monitoring systems. Therefore, attendance records were explored using descriptive statistics.

Qualitative analysis

Qualitative data from the interview transcripts (n = 9) and field notes (n = 1) taken by the researcher were uploaded to NVivo (Version 14, 1.7.2) for Mac to create a single dataset. Inductive thematic analysis was performed using the six phases outlined by Braun and Clarke (2006) as a recursive process (Appendix K). Reflexive thematic analysis (TA) was chosen to allow for inductive and flexible theme construction across different participant groups. The analysis was conducted from a realist stance with themes identified at a primarily semantic level, with latent meanings noted. This approach was adopted to support the pragmatic objective of the service evaluation in providing recommendations around access and barriers. Reflexive TA from a realist lens allowed us to embrace subjectivity and encompass multiple meanings and contradictions of participants' real experiences to inductively develop the analysis and critically appraise the output, acknowledging the reciprocal influence of findings on our perspectives.

Transcripts (n = 10) were reviewed twice by a single coder, a white British female trainee clinical psychologist, a reflexive statement is presented in Appendix L. In total, 143

initial codes were developed and organised into a provisional theme structure, which was then reviewed with 'Babies 1st' to consider the process of meaning-making at the intersection of the data, team, and analytic contexts. This led to codes being collapsed (133) and re-constructed into 12 sub-themes clustered around 4 overarching themes, which were then appraised by an EbE in relation to resonance, salience, and relevance. The Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist (Tong et al., 2007) was completed to support transparent and comprehensive reporting (Appendix M).

Patient and Public, and Service Involvement

'Babies 1st' leaders (n = 2) and EbEs, one former parent and one current parent (who did not participate in interviews), provided consultation. EbE support was enlisted to develop the interview schedule and then again to appraise the later theme structure. EbE reflections noted that the themes resonated with their own lived experiences and helped to highlight areas of salience (such as experiences of VIG). This led the trainee to review and prioritise recommendations and develop an infographic for dissemination (Appendix N).

Results

Evaluation of attendance records

Pseudonymised attendance records (n = 118) from 41 groups run between January and November 2023 were explored using descriptive statistics.

Infants were aged between 9-days and 21-months at the point of first attendance. A total of 118 engagements were recorded which comprised 19 individual parent-infant dyads (n = 38 group participants). The *did not attend* (DNA) rate was 49.5%, consisting of 53 instances where parents gave apologies and 63 instances where facilitators were unaware of the reasons for non-attendance. However, crucially, there was no agreed point at which

facilitators stopped recording consecutive non-attendance and recorded that the parent had withdrawn from the intervention. Seven parent-infant dyads attended one group but did not attend again. One parent-infant dyad attended 36 groups. Eleven sessions of parallel 1-1 intervention across 7 dyads were offered during this period.

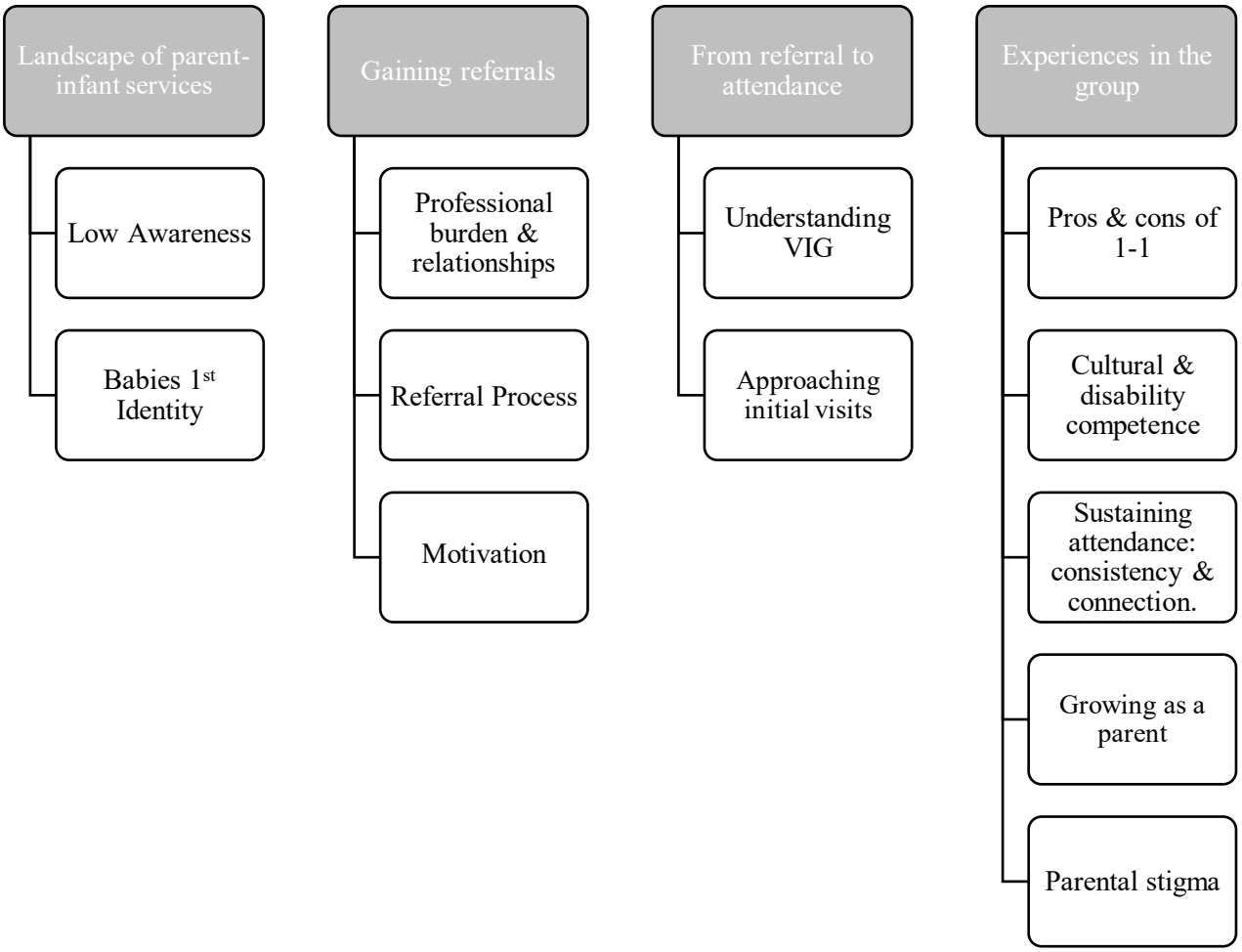
Where a parent-infant dyad was recorded as attending but arrived late, this was included in the analysis. Where it was determined the data had been mis-coded (for example, attendance for one group had been inputted as 1-1 attendance with times/figures that matched the group) this was clarified and included. The name/referral pathway, parent age, or ethnicity were not recorded on the records the trainee accessed so it was not possible to appraise possible trends in non-attendance related to these variables. Baseline and repeat data for the Mothers' Objective Relation Scale (MORs) was not available for the analysis.

Thematic Analysis

Four themes and twelve sub-themes were developed from 133 codes (Figure 2). Brief illustrative quotes are provided (Appendix O includes a longer list with a thematic map) coded as P=participant, F=facilitator, and R=referrer with a corresponding participant number.

Figure 2.

Overview of Themes and Sub-Themes



Theme 1: Landscape of Parent-Infant Services

This theme encapsulated differing understandings of how ‘Babies 1st’ is positioned within the landscape of parent-infant services and facilitators and barriers arising from this.

Low Awareness

In line with national data around parenting support services (Action for Children, 2022), low awareness was noted as a central barrier to accessing groups. Developing strong relationships with health visitors (F09, F10, R05, F08, P01, P03, P04) was highlighted as a way of 'catching everyone' eligible to attend (P04). Suggestions were provided around working with health visitors to embed information into pre-natal information packs (P01, F06) and considering how professionals can signpost to ‘Babies 1st’ in antenatal appointments (P03). Ideas for targeted advertising (F08) and social media use (P01) were provided to overcome barriers around awareness.

The newness of post-pandemic bonding groups (F06) contextualised how participants understood awareness. Facilitators and referrers recognised that few professionals ‘understand what video interactive guidance is’ (F10) and identified a need to explain more clearly what it means to be filmed within groups to build awareness and trust.

Identity of ‘Babies 1st’

‘Babies 1st’ unique identity – as ‘not a normal baby group’ (F10) - was highlighted as an enabler of access. Local gaps in the parent-infant provision (between universal baby groups and specialist teams) was acknowledged in interviews (R05, P03, P02) and supported in the literature (Parent-Infant Foundation, 2023). Participants reflected on the somewhat unique benefits of spaces where social and cultural constructs, such as the idea that bonding ‘should just come naturally’ (R05) can be dismantled. Narratives around ‘unfit parenting’

(Breheny & Stephens, 2007) and gendered concepts of ‘good mothering’ are somewhat ubiquitous within our current discourse (Capdevila et al., 2022). Challenging these norms and supporting infant mental health also appealed to facilitators' motivations to run groups (F06 & F08) that set apart ‘Babies 1st’ from other services.

However, participants questioned whether ‘groups are the right option for everyone’ (R05, P04 & F07). Multiple perspectives were expressed related to the purpose of groups. Some parents queried whether groups are a specialist intervention or open to anyone (P02, P04 & F10) and one facilitator highlighted the universalism of ‘Babies 1st’ intended audience (F06). Two parents (P04 & P02) wished for more structured teaching/learning opportunities about parenting. However, the same parents reflected on whether these suggestions were appropriate, questioning their understanding of the group’s purpose. Parents and facilitators noted a smaller group size felt more 'contained' for 'therapeutic work' (F10), reduced 'overwhelm' (P01), and helped to promote engagement (P02). However, facilitators acknowledged ‘bums on seats’ can open commissioning doors (F10).

The contradictions within these perspectives could be organised around three main questions: (1) who is ‘Babies 1st’ targeting and how can this be communicated? (2) what is an optimal group size (with lower and upper limits) for intervention and funding? (3) how does parent-infant acuity of difficulty impact group size?

Table 1.

Landscape of Parent-Infant Services	**Supporting Quotes**
Low awareness	'Maybe it is professionals not understanding what it is - I guess that is what it boils down to' (F10).
Identity of ‘Babies 1st’	'I go to other groups with him…but with a lot of mum’s it’s all happy and “this is a great time”

Landscape of Parent-Infant Services	Supporting Quotes
	and you don't feel that you can really open up about stuff like that [bonding]...' (P03).

Theme 2: Gaining Referrals

Professional burden & relationships

Developing a good knowledge of local referrers was highlighted as a key factor in promoting access (F07, P02 & R05). This finding was supported by insufficient data to track referrals within 'Babies 1st' records. Facilitators attributed a lack of referrals, despite efforts to engage referrers (F08 & F10), to professional burden (F06, F08 & F09). This is reflected in wider calls for greater workforce planning to join up parent-infant services, NHS, and Social Care eco-systems (Parent-Infant Foundation, 2023).

A strong consensus was formed around the benefits of familiarity and taking a relational approach to support parents to attend for the first time (F09, F10, P01, R05, F08) despite the time burden this brings. Suggestions to grow this approach to access included: inviting parents to bring a friend (F09) or supporting referrers to attend with a parent for the first time (R05). Prior relationships with facilitators (in alternate roles) were noted as having both helpful and hindering aspects. These relationships scaffolded parents 'through the door' (F10) but also could complicate group dynamics (F08).

Referral process

Experiences of the referral process were constructed as a sub-theme. Parents spoke highly of what they perceived to be a proactive and positive response from 'Babies 1st' in relation to referrals (F10, P01, P02, P03, P04). This included 'really encouraging' calls with

the team who were 'very non-judgemental, really open, and re-assured me that everyone is in the same boat' (P03). All parents received calls within 7-9 days of the initial referral (P03). Supporting referrers to refer into groups with ease was highlighted as an important enabling factor needed to offset professional burden (F08).

Motivation

Understanding motivation for involvement was constructed as a sub-theme. Some parents and referrers noted that issues with 'bonding' motivated them to first attend or refer into groups (P03, R05, P04) with the aim of improving relationships and being more emotionally present. Other parents had been referred by a 'Babies 1st' facilitator also working in a perinatal team or self-referred through researching infant socialising opportunities. For facilitators, motivation was linked to 'Babies 1st' identity and dyadic working.

Table 2.

Gaining Referrals	**Supporting Quotes**
Professional burden & relationships	'I think it is professional overwhelm, everyone is so busy and they have such high caseloads and it [referrals] goes out of their minds…' (F08).
Motivation	'I guess what makes it easy is if they [parents] can come with someone else... it doesn't make it easier but it does make it more possible' (F09).
Referral Process	'I found the initial call…really encouraging to sort of first get me there. I was very nervous' (P03).

Theme 3: From referral to attendance

Understanding VIG

Helping parents and referrers understand VIG was constructed as a sub-theme. Facilitators valued the role of VIG highlighting: the evidence base (F07), its cultural suitability (F08), the speed at which therapeutic outcomes can be attained (F07 & F09), positive outcomes (F06, F07, F09 & R05) such as improved parental self-view (F09) and attachment (F10). Facilitators highlighted a seeing is believing benefit of VIG so that parents do not have to trust professional perspectives and can use the medium as a platform to see change for themselves (F08 & F09). One facilitator of a different 'Babies 1st' group suggested that sending parents weekly photos motivated them to return to the group and offered a 'visual reminder' of groups at home (F06).

However, despite strong facilitator support, overwhelm with initial experiences of VIG was noted as a barrier. One parent described overcoming initial 'dread', another struggled to understand the 'point' (P04), and almost all facilitators noted parents can initially feel 'self-conscious' (F07). Discrete use of media recording helped one parent to feel 'comfortable' and overcome this barrier (P03 & R05).

Approaching initial visits

Across participants, the time between the referral and first attendance was a period of 'heightened parental anxiety' (P01, R05, F10, F09, F08). Considering a stepped approach to care (Richards, 2012), referrals from healthcare may represent higher acuity and greater risk of drop-off between the referral and groups (F08 & R05). Parents noted that having familiarity with the group location, knowing the parking options (P01, P02, P03) and knowing 'who is running the group' (R05, F10, F09, F08) helped ameliorate a sense of threat (F07, P01) and supported attendance.

Participants also identified idiosyncratic barriers (such as clashes with nap times) that were regarded as barriers intrinsic to running baby groups. Participants' noted there was no right answer to overcoming these, only answers of best fit, with consistency being preferred.

Table 3.

From referral to attendance	**Supporting Quotes**
Understanding VIG	'The video thing...I am not that keen on' (P02). '…they get used to being [a] little self-conscious' (F07).
Approaching initial visits	'It [knowing the location and venue] could also help potentially people like me that if I did not know the place that would be a real off-putter' (P01).

Theme 4: Experiences in the group

Pros & cons of 1-1

Considering the benefits and barriers of 1-1 dyadic work was constructed as a sub-theme. Facilitators and parents noted this could be a helpful intervention to complement groups for parents who might otherwise struggle (F07, F08, F09, P01, P03). 1-1 may be useful for parents who find groups 'too exposing' (F08), parents who might struggle to hear and 'act on' feedback (F08 & P01), parents who might benefit from the focussed attention of a facilitator (F09) and parents with multiple acute emotional/physical difficulties (P03). However, one parent noted they would 'never' consider 1-1, raising a question around how 'Babies 1st' can identify parents best suited to this (P04).

Cultural & Disability Competence

Cultural and disability competence was constructed as a sub-theme that participants noted as an essential factor for sustained engagement. Facilitators noted the flexibility of VIG for promoting cultural and disability competent approaches through individually tailoring feedback in groups (F08, F09). Facilitators noted enthusiasm for continued learning around cultural difference (F07) and use of supervision to problem-solve and attend to white privilege. Facilitator knowledge (flexibly applied to group members) was noted to promote inclusion (P04, R05, P03, P01, F08, F07, F06). However, resource challenges were acknowledged, such as the difficulties of doing VIG through an interpreter and the financial implications of resource translation (F10). A lack of visible physical difference was noted (in contrast to invisible differences discussed), but confidence in the venue and accessibility was expressed (F08, P03).

Sustaining attendance: consistency & connection

Consistency and connection were factors linked to ongoing attendance (F06, F07, P03). Participants' linked consistency to enabling greater connection and safeness within groups. Non-intrusive approaches to facilitator-parent interactions were noted as ways to help parents feel safe (F07) alongside ideas for promoting group connection outside of the space (F08).

It was also noted that parents cited positive reasons for non-attendance, such as increased social opportunities (F08 & P03). Indeed, social support can be an indicator of increased parenting resilience (Herbers et al., 2023). This raises the paradox inherent to any therapeutic intervention: that it is designed to become superfluous and poses a question for 'Babies 1st' around the natural point of ending. Ideas for open-door policies for non-engagement were offered (P01). These aligned with attachment ideas around enabling parents to use groups as a secure base and return when needed (Silver, 2013).

Growing as a parent

Outcomes from the groups were constructed as a sub-theme. These outcomes included: increased connections, parent-to-parent, infant-to-parent, parent-to-infant, and parent-to-facilitator (F06, F08, F10, P02, P03, P04, R05), feeling less alone (F06, P03), increased belonging (F07, F09, F10 & P02), improved parenting confidence (F07, F08, P01, P02, P03), reframing parental difficulties (F06, F08, P01, P03), shared experiences and learning (F07, F06, F08, F09, F10, P01, P02, P03, R05), opportunities to find enjoyment in the parent-infant relationship (F09, P01, P03, P04), better understanding of self as a parent (F09, P01, P02, P03), infant socialising (F06, F07, P01, P04), and mental health benefits (F07, F08, F09, R05). Attending groups normalised help-seeking and feelings of ambivalence within parenting (F07, F08, F07, P01, R05) that aligns with findings around ambivalence arising in other studies (Raneberg & MacCallum, 2024).

Parental Stigma

Despite clear positive experiences, fear about being judged (F07, F08, F09, P01, P02, P03) was patterned across the dataset. Fear of judgement acted as a barrier to disclosure (P02, P03) and engagement. Crying infants can elicit strong responses (Fairbrother et al., 2019). Parents expressed feelings of stigma within groups as a pressure to answer facilitator questions with 'good' or 'deep' answers (P02 & P01), a perceived pressure to visually demonstrate a connection with their baby who may be distressed (F08, P02), and partial or censored disclosure of feelings (P01). One parent described her fear that social services would be called if she did not attend weekly (P02). This aligned with findings that 30% of women in a community survey did not disclose mental ill-health to professionals due to concerns about child removal (Boots Family Trust, 2013).

Ways to reduce stigma included: facilitators being more aware of the 'public nature' of VIG feedback (F08), the importance of non-judgemental and non-correcting approaches (F08, P03) to build feelings of safeness, and the need to highlight confidentiality to allay stigma and concerns (R05).

Table 4.

Experiences in the group	**Supporting Quotes**
Pros & cons of 1-1	'I was at the group, and they said it wasn't having as much impact as they had hoped so then I had some 1-1 for a while' (P01).
Cultural & Disability Competence	'I am from a different culture/country. I feel supported through my cultural differences' (P04).
Sustaining engagement: consistency & connection	'Food would be great too… that would help them [parents] connect socially as well…and things like mum's meet ups so it becomes like a real little community' (F08).
Growing as a parent	'I mean it has been kind of comforting to know that like I am doing the right things for [name of child]' (P01). 'You can see it feels very meaningful, because you can see those lightbulb moments in mums and they suddenly realise that things are not as bad as they think' (F08).
Parental Stigma	'…people get paranoid that social services will come round' (P02).

Discussion

Implications

The findings of this service improvement project were consistent with calls for a national/local engagement strategy for parent-infant care that joins the dots between parent-

infant interventions and wider NHS and Social Care services (Parent Infant Foundation, 2023).

Multiple positive impacts were reported in relation to attending VIG-based parent-infant groups, noted as spaces where parents could take off 'the mask' that motherhood is brilliant all the time. A strong consensus formed around the benefits of familiarity and relationships in mitigating anxiety and promoting access. Barriers centred on reduced awareness, parental stigma, differing perspectives on the purpose of groups, and professional burden.

Recommendations

Ten recommendations for improving access and reducing barriers were derived from the findings, see Table 5. Adopting relationship-centred approaches to increase familiarity through advertisement, pre-group information, and the referral process were highlighted as potential mechanisms to improve access and help parents understand VIG. Non-correcting approaches to facilitation and outlining attendance expectations were linked to reducing stigma.

Table 5.

Recommendations of areas for service development

Area	Recommendations	Arising from
1. Raising the local profile of 'Babies 1st'.	To raise the profile of 'Babies 1st' and increase familiarity with the groups, suggestions include (i) develop further relationships with local health visitors to embed 'Babies 1st' information into pre-natal information packs and support professionals to signpost to 'Babies 1st' in antenatal appointments. (ii) Schedule regular email contact with referrers with reminders of the referral process and criteria (iii) Attend or schedule community events or drop-ins to support families and professionals gain a greater understanding of the work 'Babies 1st' does (iv) Make a short video for social media to introduce facilitators to humanise the process (v) Consider targeted media advertisements (paid for or free) in local parenting and social media group and/or baby events.	1.1 Low Awareness & 1.2 'Babies 1st' Identity
2. Information provision.	(i) Information provided to parents should include facilitator profiles and aim to demonstrate what VIG entails and the benefits, showing the process from beginning to end, and overview expectations around group attendance. Ways to communicate the concept of 'targeted universalism' should be considered and inform approaches to advertisement and information. For example, (ii) confirming whether parents can invite friends and or share information about the groups would be valued (iii)	1.2 'Babies 1st' Identity, 3.1 Understanding VIG & 4.4

Area	Recommendations	Arising from
	Information provided to referrers should overview the process and benefits of VIG (iv) Positive outcomes identified by participants in this project could be shared in information related to the group.	Growing as Parent
3. Record-keeping.	Record-keeping could be developed in the following ways: (i) Record and hold centrally the details of local professional referrers. This may enable the time burden of engaging referrers to be shared across the team and enable regular blind-copied email contact (ii) Record the referral source for each new parent to gain more data on who is and who is not referring into 'Babies 1st' (iii) Agreements for reporting attendance should be made: such as the point at which facilitators cease to record consecutive periods of non-attendance without a reason and note the parent has withdrawn from the intervention (iv) Record parents age, gender, sexuality and ethnicity to support understanding drop-out rates.	1.2 'Babies 1st' Identity, 2.1 Professional Burden & Evaluation of Records.
4. Supporting referrals.	New guidance issued in March 2024 outlined a three-step process to support professionals to initiate conversations around parent-infant relationships (Department of Health & Social Care, 2024). The third step is appropriate signposting. 'Babies 1st' should appraise what is the minimum relevant and safe level of information required from referrers to balance professional burden with aims of increasing access. One idea was for 'Babies 1st' to consider enabling referrers to gain consent from	2.1 Professional Burden, 2.3 Referral Process, 3.1 Understanding

Area	Recommendations	Arising from
	parents on their caseload to share their contact details. 'Babies 1st' could then complete the referral form during initial phone contact.	VIG & Evaluation of Records
5. Supporting parents from referral to the groups.	A particular strength of 'Babies 1st' was the introductory phone calls offered to parents. Pre-group information should continue to grow this and include (i) Guidance about what to expect at groups in relation to VIG (ii) Pictures and profiles of facilitators (iii) Pictures of the setting with directions, transport, and parking (iv) 'Babies 1st' should make explicit how the groups manage confidentiality and non-attendance and (v) consider other ideas suggested such as whether parents can bring a friend or family member to their first group or enable referrers to attend for part of a session (in cases where it is felt a parent may not be able to attend without this).	3.1 Understanding VIG & 3.2 Approaching Initial Visits.
6. Working with parents less able to attend groups.	Further work should continue to build a picture of parents who are at most risk of dropping-out and formalise the process of referral for 1-1 intervention. Some initial evidence was found in respect of parents who might benefit most from 1-1, such as parents who (i) feel more self-conscious in groups (ii) who might struggle to hear and act on feedback (iii) or would benefit from focussed facilitator	4.1 Pros & cons of 1-1 work & 4.4 Growing as a parent.

Area	Recommendations	Arising from
	attention due to acuity of difficulties. An open-door policy for re-engagement was preferred. 'Babies 1st' should also consider ways of celebrating endings.	
7. Peer support & strengthening engagement.	To continue to strengthen parent connections based on the expressed value of consistency: with a similar time, location, and facilitators where possible. Consider suggestions such as (i) having a community lunch (ii) develop the WhatsApp group (iii) consider what constitutes an optimal group size (with upper and lower limits) for intervention balancing acuity of needs and commissioning pressures (iv) Support parents to receive the media generated through VIG (v) and note that non-intrusive approaches were essential to establishing psychological safeness within groups.	4.3 Sustaining attendance: consistency and connection & 4.5 Parental Stigma
8. Outcomes & monitoring.	Consider ways to capture the multi-varied outcomes of groups and measure impact (such as recording of the MORs).	4.4 Growing as a Parent & Evaluation of Records.

Area	Recommendations	Arising from
9. Parent feedback and involvement.	Based on accounts of stigma, develop mechanisms to capture ongoing service user feedback and experiences (such as the development of a service user group or provision of an anonymous feedback link).	4.5 Parental Stigma
10. Future service improvement & or research opportunities.	Qualitative interviews proved acceptable and effective. However, only one external referrer viewpoint was captured (i) Given the role of referrers in growing attendance; interviews with referrers or anonymous questionnaires to gather further data around the referral process would provide helpful information to inform proposed changes. (ii) Recording consent to contact parents would enable future evaluation around the reasons for drop-out.	Method & Reflexive account of the project

Service Response

Findings and recommendations were presented at 'Babies 1st' service away day in August 2024 with ongoing discussion related to implementation. 'Babies 1st' has identified a named person to triage referrals, are developing a checklist for practitioners recording attendance and referrals and have begun creating a new parent information pack that outlines attendance expectations, confidentiality, and the process of VIG. Continued efforts from practitioners throughout the project timeline to engage referrers has supported an uptake in group attendance.

Strengths & Limitations

This service improvement project benefited from a mixed methods approach. Using a participant-observer style approach to familiarise potential participants to the aims of the study and build trust was successful in engaging participants already attending groups. Participants noted enthusiasm for parent-infant groups and a readiness to speak about their experiences. Practical recommendations were produced to improve access and reduce barriers.

Despite efforts to invite all eligible participants to the study, just one referrer (external to 'Babies 1st') participated. Moreover, only parents who had opted into the service were recruited. While all parents engaged in the group at the point of data collection were recruited; parental voices were a minority within the sample compared to a majority professional group. Efforts were made to invite parents who had declined or left the group; but none were recruited. The experiences of these parents are likely to yield valuable information related to access and barriers not captured within the current data. Parents were all women in heterosexual relationships, some in professional roles, and no fathers or males were accessing the groups or had accessed the groups in the past year. In line with findings of

other service evaluations (Department for Health and Social Care, 2024), some types of parents may not be consistently reaching groups and their voices and perspectives are not captured within these findings. 'Babies 1st' reporting processes meant that it was not possible to consider drop-out rates in relation to age, socioeconomic status, neurodiversity, disability, or ethnicity. There was no consistent end date for recording consecutive non-attendance which may have biased attendance rates.

Pragmatic considerations guided decisions around data collection, as opposed to data saturation. The analysis represents the trainee's meaning making of the data and other interpretations are possible (if not encouraged in reflexive TA).

Future Directions

The design of this cross-sectional service evaluation negates broader generalisation of these findings to UK-based parent-infant groups. However, as noted in Braun and Clarke (2022), qualitative findings can offer situated knowledge, such as rich contextualised understandings of specific experiences and meanings that might offer helpful reflection to other parent-infant provisions considering issues of access. The recommendations arising from this project have been developed to support future and ongoing evaluation of the service model used by 'Babies 1st'. Future evaluation should appraise access in relation to the aforementioned factors associated with barriers to parent-infant groups and (where feasible) consider opportunities to strengthen the voice of parents accessing 'Babies 1st' as well as those who have disengaged and opted out.

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Theory-Driven Research Project (TDRP)

Title: Exploring the Impact of Childhood Memories of Warmth & Safeness and Self-Compassion on Trauma-Related Shame in Adults with Complex Post Traumatic Stress Disorder.

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Word count: 4998

Proposed Journal: The Journal of Traumatic Stress.

Rationale: This is an open access journal that welcomes a range of original research designs for an interdisciplinary audience. It acts as a primary reference for professionals who study and treat people exposed to highly stressful and traumatic events. The journal has an impact factor of 2.4 and CiteScore of 5.8. Author guidelines can be found here and are presented in Appendix X.

Abstract

Background: Some adults with Complex Post Traumatic Stress Disorder (CPTSD) experience significant trauma-related shame that carries a high allostatic load. Childhood experiences of warmth and safeness are considered to guide adjustment to traumatic events: helping us feel safe, respond to ourselves with kindness, and reach to others for support during times of difficulty. However, many survivors have not had the opportunity to experience early relational safeness or develop self-compassionate abilities. *Aims:* to extend our understanding of trauma-related shame in adults with CPTSD.

Method: Participants (n = 192) with a probable diagnosis of CPTSD completed 5-measures: The International Trauma Questionnaire (ITQ), Trauma Related Shame Inventory (TRSI), Early Memories of Warmth and Safeness Scale (EMWSS), The Compassionate Engagement and Action Scale, Self-Compassion Subscale (CEAS-SC) & The Patient Health Questionnaire 8 (PHQ-8).

Results: Hierarchical regression showed the full model (age, gender, ethnicity, depression, CPTSD symptoms, early memories of warmth and safeness, and self-compassion) explained 18.3% of the variance in trauma-related shame. Self-compassion and CPTSD symptoms were significant predictors of trauma-related shame. Adults with CPTSD who reported lower than average self-compassionate abilities (relative to the UK general population) reported higher trauma-related shame compared to those with higher self-compassionate abilities.

Discussion: These findings suggest that self-compassion is a worthwhile therapeutic target to address trauma-related shame in CPTSD. Limitations and future research directions are discussed.

Key words: warmth and safeness, self-compassion, trauma-related shame, complex post-traumatic stress, CPTSD.

Exploring the Impact of Childhood Memories of Warmth & Safeness and Self-Compassion on Trauma-Related Shame in Adults with Complex Post Traumatic Stress Disorder.

Post Traumatic Stress Disorder (PTSD) and Complex Post Traumatic Stress Disorder (CPTSD) are debilitating disorders characterised by elevated and ongoing psychological distress following threat to life, whether actual or threatened (DSM-5; American Psychiatric Association, 2013; ICD-11; World Health Organisation, 2022), significant injury or sexual assault, or more broadly a significant threat to psychological integrity (Gradus & Galea, 2022). The past two decades have given rise to a broader understanding of the affective components of PTSD such as guilt and shame, in addition to fear, and the concomitant impact on identity and relationships (Maercker et al., 2022).

CPTSD was introduced as a distinct sibling diagnosis to PTSD in the ICD-11 in 2018 (World Health Organisation, 2022). CPTSD is characterised by six symptom clusters that incorporates the PTSD symptom triad: re-experiencing traumatic memories in the present (e.g. flashbacks or nightmares), a persistent heightened sense of threat, and avoidance; alongside three additional clusters that account for the impact on self (commonly called 'disturbance in self-organisation' or DSO) that includes: severe and pervasive negative self-concept, emotion dysregulation, and difficulties with relationships (ICD-11; World Health Organisation, 2022). The estimated prevalence of CPTSD in the UK is 12.9% (Karatzias et al., 2019). Estimates can rise to 21.4% in survivors of abuse (Knefel & Lueger-Schuster, 2013) and 16 to 38% in asylum seeking populations who help-seek (de Silva et al., 2021). PTSD and CPTSD are highly co-morbid with other mental health difficulties, such as depression (Fung et al., 2022; Öst et al., 2023).

Trauma-Related Shame

Trauma-related shame is understood as a deep pervasive experience that can arise from traumatic experiences and is often conceptualised as an integral feature of CPTSD (Salter & Hall, 2022; Stubley et al., 2025). Shame, guilt, or failure form part of the diagnostic criteria for CPTSD DSO symptoms (World Health Organisation, 2022). Shame is conceptualised as a 'self-conscious' state of mind that interweaves cognitive, affective, and physiological responses to perceived social threats or humiliation (Lee et al., 2001). Shame is often conceptualised as relating to the perception of inherent defect in one's own mind and others' minds, while guilt is thought to relate to remorse/culpability in relation to behaviour (Budden, 2009; DeCou et al., 2023). Shame may have evolutionary roots in signalling social warning, based in a need for social acceptance to maximise the chances of survival through group membership and maintaining social status (Gilbert & Simos, 2022). Shame comprises internal and external states which can globally degrade a person's self-concept and give rise to feelings of worthlessness or disempowerment (Gilbert & Simos, 2022; Lee et al., 2001).

Trauma-related shame has been associated with the development and maintenance of CPTSD (Pai & Vella, 2024). A positive relationship between shame and negative self-concept has been identified (Laughlin, 2025); however, correlational and qualitative designs impede robust interpretation. Evidence underlines shame as a predictor of PTSD symptom severity (Matloub et al., 2024), distress (DeCou et al., 2023), and attests to the complex relationships between shame and traumatic stress (Flynn et al., 2024).

Childhood Experiences of Warmth & Safeness

Understanding trauma-related shame in CPTSD is nuanced and debated. The literature consistently points towards adverse early experiences in compromising key tasks of

childhood (such as developing secure attachments or emotion regulation skills) that can have neurobiological and interpersonal implications into adulthood (Karatzias et al., 2020; Maercker et al., 2022). Early memories of warmth and safeness (EMWS) encompass our emotional memories of feeling loved, valued, and emotionally safe in childhood (Gilbert et al., 2017). Children need caregivers who are emotionally available, (sufficiently) responsive, and able to model healthy coping and emotion regulation (Ainsworth et al., 1978). Our earliest caregiving experiences provide a foundation for the formation of secure attachments, internalised as relational blueprints (or working models) that guide our expectations of how others will relate to us (Bowlby, 1969).

Early life experiences (such as absence or invalidation) may influence the development of shame states. Lee et al. (2001) offer a theoretical illustration for how latent shame states may be activated following later trauma. A person's appraisal of traumatic experiences may be *congruently* situated within their earlier experiences– i.e. trauma appraisals match their self-view (e.g. 'I am bad') or perception of how others view them (e.g. 'others blame me') and reinforce these beliefs. Trauma appraisals alternately may be *incongruently* situated and a person may blame others and/or experience humiliation (Lee et al., 2001).

Clinical Implications

Trauma-related shame can influence how a person attributes meaning to traumatic events (Stubley et al., 2025) and organise help-seeking behaviour (Gilbert & Simos, 2022; Grass et al., 2025). Early shame memories have been associated with trauma memory characteristics in terms of intrusion, avoidance (of recall), and arousal (Matos et al, 2010). Cognitive models point towards the role of high arousal during traumatic experiences that impedes cognitive processing and contributes towards poor elaboration of trauma memories

(Ehlers & Clark, 2000). Shame might be responsive to corrective information introduced to update trauma sequalae (Ehlers & Clark, 2000), but it is thought shame might not respond as well to habituation through exposure (as shame is relational and comprises a state of social threat) and has been associated with increased dysregulation (Mirabile et al., 2024) which might disrupt optimal levels of emotional arousal needed for memory based processing. There is an impetus to improve our understanding of how to address trauma-related shame.

Self-Compassion

Self-compassion is understood as a sensitivity to suffering and a motivation to take preventative action (Gilbert, 2014). Compassion-focussed therapy (CFT) was borne out of clinical observations that clients presenting with high shame and self-criticism struggled with tasks of cognitive behavioural therapy (CBT) due to difficulties generating soothing self-talk (Gilbert, 2010). CFT is showing an emerging promise in targeting trauma-related shame in qualitative studies (Ashfield et al., 2021), improving negative mental health outcomes in meta-analyses (Petrocchi et al., 2024), and mediating symptoms of CPTSD in cross-cultural samples (Peng & Ishak, 2025). Training self-compassionate tendencies aims to activate a person's soothe-system alongside other compassionate abilities: receiving compassion and compassion towards others (Gilbert, 2010). These flows of compassion (self, towards others, and from others) are considered an antidote to shame (CPTSD Foundation, 2022).

Rationale for the present study

Interpersonal traumatic experiences (such as intimate partner violence or sexual assault) carry a higher risk of trauma-related shame and the development of CPTSD (Hyland et al., 2017). Psychological theories predict that EMWS and self-compassion might be protective against trauma-related shame. Therefore, this paper aimed to test theoretical

predictions related to the impact of EMWS and self-compassion on trauma-related shame, extend the literature, and provide future directions.

Research Questions

The study sought to answer the following research questions:

Primary Research Question and Hypothesis

(1) Do self-compassion and EMWS account for significant variance in levels of trauma-related shame in adults with CPTSD?

H1: Self-compassion and EMWS will account for significant variance in trauma-related shame in adults with CPTSD.

Secondary Research Question and Hypothesis

(2) Are there significant differences in trauma-related shame in adults with CPTSD who report higher or lower self-compassionate abilities than average levels in the UK general population?

H1: Adults with CPTSD who report lower than average self-compassionate abilities (relative to the UK general population) will report significantly higher levels of trauma-related shame than those who report higher self-compassionate abilities.

Materials & Method

Design and Participants

This cross-sectional design comprised two empirical components. Self-compassion and EMWS were independent variables. Trauma-related shame was the dependent variable.

Inclusion Criteria

Participants were aged ≥ 18 years old and scored for a probable diagnosis of CPTSD on the International Trauma Questionnaire (ITQ). Participants were required to have not commenced a trauma-focused psychological therapy (such as trauma-focused Cognitive Behavioural Therapy or EMDR) to account for the potentially confounding influence of treatment on measures of trait-based self-compassion. Sufficient English was required to complete measures. Participants were asked to confirm residence in the United Kingdom and confirm they had taken part once. No additional exclusion criteria were applied.

Participant Recruitment

The study made use of four recruitment avenues. Participants were recruited through a Thames Valley NHS traumatic stress (outpatient) service between November 2024 and April 2025. The study made use of a pre-collected dataset of routine measures within the same service, collected from November 2022 to October 2024 when the study received sponsor confirmation of capacity and capability. A London-based NHS traumatic stress service was set up as a Participant Identification Centre (PIC). A community sample was recruited in parallel through social media (e.g. Instagram), charities (e.g. Oxford Recovery College, the Survivor's Trust, and Out of the Storm), organisations (e.g. UK Psychological Trauma Society) and online social media peer groups (e.g. Recovery Code X). No financial or material incentives for participation were offered. An example recruitment poster is presented in Appendix R.

Measures

The ITQ is the main validated and most widely used measure of CPTSD (Seiler et al., 2023) and was used to screen for eligibility and measure symptoms. Participants were eligible if they scored for a probable diagnosis of CPTSD on the ITQ. Following screening, eligible participants were invited to complete measures of trauma-related shame, EMWS, self-compassion and depression in addition to demographics. An overview and psychometric properties of measures is presented in Table 1.

Table 1.

Overview of measures & psychometric properties

Domain	**Measure**
CPTSD symptoms & impairment	**International Trauma Questionnaire (ITQ; Cloitre et al., 2018).** The ITQ is an 18-item measure of probable CPTSD and PTSD diagnosis. The measure asks raters to briefly describe the traumatic experience that troubles them the most and records the time elapsed since this experience. The measure is scored on a 5-point Likert scale from 0 (not at all) to 4 (extremely) in relation to PTSD and DSO symptom clusters, and functional impairment. A total symptom score and an overall symptom severity and impairment score is generated. Within this study, the total score (symptom severity and impairment) was used to screen for probable CPTSD; and the dimensional symptom score used in analyses. Scoring for a probable diagnosis of CPTSD is defined as endorsing (scores of ≥2 on) one symptom associated with each of the three PTSD symptom clusters and one indicator of PTSD

Domain	Measure
	impairment, as well as one symptom from each of the DSO symptom clusters and one indicator of DSO impairment (Cloitre et al., 2018). The measure has shown acceptable internal reliability (α = .77) for PTSD and DSO subscales in community samples (Cloitre et al., 2018) and composite reliability estimates of .81 for PTSD and .84 for DSO subscales in clinical samples of survivors of sexual violence (Frost et al., 2022).
Trauma-Related Shame	**Trauma-Related Shame Inventory (TRSI; Øktedalen et al., 2014).** The TRSI is a 24-item questionnaire that measures trauma-related shame, with internal and external shame subscales. The measure is scored on a 4-point Likert scale (0 = not true of me to 3 = completely true of me). A total score is generated from 0 to 72. It has generalisability and dependability coefficients of .874 and .868 within a clinical PTSD sample (Øktedalen et al., 2014) and demonstrated strong internal consistency (α = .96) in a community sample of sexual assault survivors (DeCou et al., 2019). The measure has shown acceptable discriminant validity when compared with trauma-related guilt (Øktedalen et al., 2014).
Early Memories of Warmth & Safeness	**Early Memories of Warmth & Safeness Scale (EMWSS; Richter et al., 2009).** The EMWSS is a 21-item questionnaire that assesses childhood memories of emotional safeness and containment. The measure is scored on a 5-point Likert scale (0 = no, never to 4 = yes, most of the time). A total score is generated between 0 and 84. The

Domain	Measure
	EMWSS has shown good internal consistency (α = .77) and test-retest reliability (*r* = .91) in community samples (Richter et al., 2009) that has been replicated (*α* = .96) in large samples (Capinha et al., 2021). The measure has not been validated in C/PTSD populations but has shown good psychometric properties (α = .89) in adolescent and young adult populations accessing residential or criminal justice facilities (Vagos et al., 2017).
Self-Compassionate Abilities (Engagement & Action)	**The Compassionate Engagement and Action Scale, Self Compassion Subscale (CEAS-SC; Gilbert et al., 2017)**. The CEAS-SC is a 13-item subscale that measures two aspects of self-compassion: (i) engagement, the ability to engage sensitively with suffering and (ii) action, the ability to focus on helpful action. The CEAS-SC is part of a longer questionnaire measuring compassionate engagement and action for the three flows of compassion. The measure is scored on a 10-point Likert scale (1 = never to 10 = always). The CEAS-SC has shown good internal consistency (α = .88) and test re-test reliability (*r* = .82) in general population samples (Lindsey et al., 2022).
Depressive Symptoms	**Patient Health Questionnaire (Kroenke et al., 2009).** The PHQ-8 is an 8-item measure of the presence and severity of depressive symptoms. The measure is scored on a 4-point scale, from 0 = not at all to 3 = nearly every day, from which a total score out of 24 is generated. Good psychometric properties have been shown for the PHQ-8 with good internal consistency (α = .88) in samples of survivors of intimate partner violence (Arias de la Torre et al., 2023) and PTSD (α = .91)

Domain	Measure
	samples (Jaramillo et al., 2019). The PHQ-8 was included within this set of measures to account for the common co-occurrence of CPTSD and depression (Hyland et al., 2017).
Demographics	Participants provided their age, ethnicity, and gender. One idiosyncratic question was asked of the community sample: *'To the best of your ability, can you tell us how many adults in your childhood you experienced as safe and loving? This could be parents, carers, mentors, aunts/uncles, grandparents, siblings, foster carers etc'*. This question was developed with experts by experience (EbE) for exploratory analyses, based on literature suggesting that having one safe and loving childhood attachment might be protective in experiences of trauma-related shame.

Procedure

Participants completed measures online via Qualtrics or at an NHS service. NHS participants at the main site completed measures as part of routine clinical care; they were given an information sheet and provided consent for scores from the EMWSS, completed at assessment, and ITQ, CEAS-SC, TRSI and PHQ-8, completed at the start of therapy, to be used in the research; alongside pseudonymised demographics. PIC and community participants used an URL or QR code to access the information sheet, provide consent (Appendix S), complete eligibility screening, and undertake measures online. Safeguards against online bots were put in place, as per guidance on managing bots in community sampling (Lawrence et al., 2023). A support page, that mirrored the debrief, offered signposting and grounding exercises (Appendix T).

Ethics

Ethical approval was granted from Tyne and Wear South Research Ethics Committee (24/NE/0166), the NHS Health Research Authority (HRA), and all Research and Development departments (Appendix Q). REC approval was given to use pseudonymised pre-collected data from an NHS traumatic stress service. Informed consent was sought from prospectively recruited participants through NHS and community sampling.

Patient and Public, and Service Involvement

Experts by experience who had received treatment for CPTSD (n = 2) provided paid consultation. Recommendations were incorporated into the study materials, including enhancing accessible language, scaffolding instructions for online questionnaires, and the decision to screen participants using the ITQ rather than self-reported diagnosis.

Data Analytic Plan

The data analytic plan was registered with Open Science Framework (OSF) in December 2024. At the end of recruitment, the community dataset was downloaded from Qualtrics and combined with pseudonymised data from the NHS service in Microsoft Excel collected in parallel; before being uploaded to SPSS (v.30 for Mac) for analysis.

Power

A priori power calculations using G*Power 3.1 software (Faul et al., 2007) indicated 128 to 210 participants were required for an ANCOVA and 107 to 153 participants for regression analyses at $p = \leq .05$ for 80 to 95% power. Given the novel area of research, medium effect sizes were used.

Data cleansing

There was no missing data in the community sample. Within the clinical sample, two items of functional impairment (ITQ: P8 and C8) were pro-rated for two participants, by calculating the participant's mean item score on the subscale. Both participants scored for a probable diagnosis without these items; a decision was taken to pro-rate to accurately describe the sample.

A data collection error was identified in the administration of the CEAS-SC that impacted participants from one of four recruitment streams: through use of a 0-10 scale instead of a 1-10 scale. This was identified mid-recruitment and rectified. An analysis was completed to assess affected data-items per impacted participant (defined as scores of either 0, 1, or 2). A decision was taken to include participants with ≤1 affected item (out of 10 items) and adjust the item from either 0 to 1, 1 to 2, or 2 to 3. Participants (n = 62) with >1 affected item were excluded from the final analyses due to self-compassion being a main predictor. These participants were re-recruited. Within the final sample, 17 participants were included who had 1 affected CEAS-SC item.

Data checks & assumptions

Data checks were conducted to support accuracy and appraise whether the dataset met statistical assumptions. Shapiro Wilk tests alongside visual inspection of Q-Q plots and histograms were used to evaluate normality for each variable. Checks were carried out to assess that the main statistical assumptions for t-tests, ANCOVA, and regression analyses were met. These included a review of tolerance and variance inflation factors to assess issues with multi-collinearity, visual inspection of scatterplots of residuals to assess for homoscedasticity, use of Levene's test to assess for homogeneity of variance, the Durbin-

Watson test to assess for independence of residuals, and an assessment of homogeneity of regression slopes to support ANCOVA assumptions. The full details of all assumptions are presented in Appendix V. Due to small sample sizes; demographic categories were condensed for analyses. The EMWS variable was positively skewed (e.g. most values were clustered at the lower end of the measure with a skewness value of 1.31). As such, the variable was transformed using a square root transformation.

Self-Compassion Groups

To the authors knowledge, no current publications have examined the CEAS-SC within a C/PTSD population. Therefore, the sample was split into higher than average and lower than average self-compassionate abilities using a mean CEAS-SC score (±58.2 to 1dp) from the original validation paper using a UK population sample (Gilbert et al., 2017). During data checks, differences were found between high and lower self-compassion groups on variables of CPTSD symptoms and depression symptoms with small to medium estimated effect sizes (Appendix V). An ANCOVA is sufficiently robust to account for small differences between groups and other assumptions (e.g. homogeneity of regression slopes) were met, so a decision was taken to proceed with the analysis (Leppink, 2018).

Results

Overall, 192 participants met the eligibility criteria. Participants were recruited from one NHS service (n = 89 pre-collected and 18 prospectively consented) and an online sample (n = 85). Signposting from an NHS PIC did not yield further participants.

Demographic Characteristics

Of the sample, 85.4% (n = 164) were female, 7.8% were male (n = 15), 6.8% (n = 13) were non-binary or other gender denominations. Participants were aged from 18 to 75 years old (M = 40.9; SD = 12.8). Ethnicity data was collected and benchmarked in line with the census (National Office for Statistics, 2021). The sample was broadly representative of the population demographics for England and Wales with notable exceptions from White Gypsy or Roma Traveller, Black British African, or Asian Chinese backgrounds. A breakdown of participant ethnicities is presented in Appendix U.

Clinical Characteristics

Trauma Type & Length

Participants cumulatively reported a total of 448 traumatic events, experiences, or categories of abuse via the ITQ, presented in Appendix U. Most participants (n = 185) reported multiple traumatic experiences and or prolonged experiences of abuse. Seven participants reported a single discrete traumatic event. Reporting of traumatic experiences varied: participants reported categories, e.g. 'sexual abuse' or general statements, e.g. 'trauma'. Therefore, it was not possible to meaningfully report findings related to when index trauma experiences occurred.

Descriptive Statistics

Descriptive statistics for each of the main variables are presented in Table 2. Good internal consistency was found across measures: ITQ (α = .82), TRSI (α = .96), EMWSS (α = .97), CEAS-SC total (α = .88) and PHQ-8 (α = .84).

Table 2.

Descriptive statistics for participants.

	Community Sample		NHS Sample		Total	
N	85		107		192	
Outcome Variables	**M**	**SD**	**M**	**SD**	**M**	**SD**
ITQ Symptoms	37.0	5.3	40.3	4.6	38.8	5.2
ITQ Total (Symptoms & Impairment)	54.4	8.6	59.8	7.1	57.4	8.3
Internal Shame	24.6	7.5	26.5	8.9	25.6	8.3
External Shame	18.3	9.2	23.3	10.0	21.1	9.9
Trauma-Related Shame Total	42.9	15.7	49.8	17.9	46.7	17.3
Early Memories of Warmth & Safeness	17.3	16.3	18.9	17.6	18.2	17.0
Self-Compassion, Engagement	33.4	9.5	28.7	10.2	30.8	10.2
Self-Compassion, Action	19.3	8.0	16.0	8.0	17.5	8.2
Self-Compassion Total	52.7	16.2	44.7	16.6	48.2	16.9
PHQ-8	16.4	5.5	20.0	3.4	18.4	4.8

Symptom Severity

The recent publication of ITQ symptom percentiles (Baker et al., 2025) from a large diagnostic sample (n = 18,972) enabled the present sample to be contextualised in terms of clinical severity: 4 participants reported minimal clinical symptoms, 1 reported mild symptoms, 5 reported moderate symptoms, 4 reported severe symptoms, and 178 (92.7%) reported very severe clinical symptoms of CPTSD. Most participants (n = 185) scored ≥10 on the PHQ-8 (Kroenke et al., 2009) indicating clinically significant symptoms.

Do self-compassion and early memories of warmth & safeness account for significant variance in levels of trauma-related shame in adults with CPTSD?

Hierarchical Linear Regression

A hierarchical linear regression, presented in Table 3, was run to see if EMWS and then self-compassion improved the prediction of trauma-related shame over and above age, gender, ethnicity, CPTSD symptoms, and depression. The final model (demographics, CPTSD symptoms, depression, EMWS and self-compassion) was statistically significant, R^2 = .213, $F(7, 184) = 7.103$, p = <.001, adjusted R^2 = .183. The addition of CPTSD symptoms (model 2) led to a statistically significant increase in R^2 of .111, $F(1, 187) = 24.34$, p = <.001. The addition of depression (model 3) did not lead to a statistically significant increase, R^2 = .013, $F(1, 186) = 2.82$, p = .095. The addition of EMWS (model 4) did not lead to a statistically significant increase, R^2 = .00, $F(1, 185) = .007$, p = .93. The addition of self-compassion (model 5) led to a statistically significant increase in R^2 of .054, $F(1, 184) = 12.52$, p = <.001. CPTSD symptoms (t = 2.87, p = .005) and self-compassion (t = -3.54, p = <.001) emerged as statistically significant predictors of trauma-related shame in the final model.[1]

[1] These findings were run without 17 participants with an affected CEAS-SC data item and the results replicated.

Table 3.

Hierarchical regression predicting trauma-related shame from demographic variables, CPTSD symptoms, depression, EMWS, self-compassion.

	B	95% CI		SE B	β	R^2	AR^2	*F*	R^2 change	*F* change
		LL	UL							
Model 1	46.37	37.91	54.83	4.29		.035	.02	2.29		
Age	-0.03	-0.22	0.17	0.10	-0.02					
Gender	-2.81	-9.75	4.14	3.52	-0.06					
Ethnicity	6.91	1.43	12.40	2.78	0.18					
Model 2	3.76	-15.05	22.57	3.76		.146	.128	8.016	.111	24.34**
Age	-0.04	-0.23	0.14	0.09	-0.03					
Gender	-2.68	-9.23	3.87	3.32	-0.06					
Ethnicity	4.48	-0.78	9.75	2.67	0.12					
ITQ Symptoms	1.13	0.68	1.59	0.23	0.34					
Model 3	4.32	-14.42	23.05	9.50		.159	.137	7.039	.013	2.82
Age	-0.04	-0.22	0.14	0.09	-0.03					
Gender	-2.17	-8.71	4.38	3.32	-0.04					
Ethnicity	4.26	-0.99	9.50	2.66	0.11					
ITQ Symptoms	0.88	0.33	1.42	0.28	0.26					
PHQ-8	0.50	-0.09	1.09	0.30	0.14					

	B	95% CI		SE B	β	R^2	AR^2	*F*	R^2 change	*F* change
Model 4	4.68	-16.01	25.37	10.49		.159	.132	5.836	.00	.007
Age	-0.04	-0.23	0.15	0.09	-0.03					
Gender	-2.17	-8.73	4.40	3.33	-0.04					
Ethnicity	4.25	-1.01	9.51	2.67	0.11					
ITQ Symptoms	0.87	0.32	1.42	0.28	0.26					
PHQ-8	0.50	-0.09	1.09	0.30	0.14					
EMWS	-0.05	-1.21	1.11	0.59	-0.01					
Model 5	20.62	-1.331	42.58	11.13		.213	.183	7.103	.054	12.522**
Age	0.03	-0.154	0.22	0.09	0.02					
Gender	-1.65	-8.029	4.72	3.23	-0.03					
Ethnicity	5.12	-0.012	10.25	2.60	0.13					
ITQ Symptoms	0.78	0.245	1.32	0.27	0.24					
PHQ-8	0.26	-0.325	0.85	0.30	0.07					
EMWS	0.26	-0.882	1.39	0.58	0.03					
CEAS-SC	-0.26	-0.403	-0.11	0.07	-0.25					

B = unstandardised regression co-efficient, CI = confidence interval, LL = lower limit, UL = upper limit, SE B = standard error, β = standardised co-efficient, R^2 = coefficient of determination, AR^2 = adjusted R^2, p = ≤ .05*, p = ≤ .01**.

Are there significant differences in levels of trauma-related shame in adults with CPTSD who have higher and lower than average self-compassionate abilities?

Tests of difference

Chi-squared tests, presented in Table 4, were run to see if there were statistically significant differences between self-compassion groups on dichotomous variables hypothesised to link to trauma-related shame. Recruitment source was the only statistically significant finding ($\chi^2 = 8.64$, $p = .003$, Cramer's V/Phi = -.21/.21), suggesting a small association (Kim, 2017). Independent samples t-tests were run to test for differences between continuous variables and self-compassion groups, presented in Table 4. Assumptions were met and are presented in Appendix V. Prior regression analyses suggested that age did not predict trauma-related shame; therefore, despite a small significant difference, it was determined age was unlikely to have a confounding influence on the main outcome variable.

Independent samples t-tests were also run to test for statistically significant differences between clinical and community participants on the main study variables. The clinical sample scored significantly higher on measures of CPTSD symptoms, $M = 2.79$, 95% CI [1.20, 4.39], and depression, $M = 2.51$, 95% CI [1.04, 3.97]. Statistically significant differences, with small to medium effect sizes, were found, presented in Appendix W.

Table 4.

Demographic and clinical characteristics of lower than average and higher than average self-compassion groups.

	Total (N = 192)		Higher self-compassion group (n = 54)		Lower self-compassion group (n = 138)		Chi-squared	
Variable	N	%	N	%	N	%	χ^2	*p*
Gender							.26	.61
Female	164	85.42	45	83.3	119	86.2		
Male/Other	28	14.58	9	16.7	19	13.8		
Ethnicity							1.49	.22
Asian, Black, Other	52	27.08	18	33.3	34	24.6		
White	140	72.92	36	66.7	104	75.4		
Recruitment Source							8.64	.003*
Clinical (NHS)	107	55.7	21	38.9	86	62.3		
Community	85	44.3	33	61.1	52	37.7		
	M	SD	M	SD	M	SD	*t*	*p*
Age	40.9	12.8	39.2	12.6	45.1	12.4	-2.9	.002*
ITQ Symptom	38.8	5.2	36.8	5.58	39.59	4.808	3.45	<.001**
PHQ-8	18.4	4.8	16.61	5.73	19.12	4.14	3.37	<.001*
EMWS	18.2	17	3.514	2.17	3.82	2.03	0.91	.363

*p= ≤.05, ** p = ≤.001.

Analysis of Covariance (ANCOVA)

An ANCOVA was run to answer the secondary research question. After adjustment for CPTSD symptoms and depression, there was a statistically significant difference in trauma-related shame in high/lower self-compassion groups, $F(1, 188) = 5.89$, $p = .016$, $\eta^2 = .03$. Post hoc analysis was performed with a Bonferroni adjustment. Trauma-related shame

was (statistically) significantly higher in the lower-than-average self-compassion group (M = 48.54; SE = 1.37) compared to the higher self-compassion group (M = 42.12; SE = 2.2), with an adjusted mean difference of 6.42, 95% CI [1.20, 11.63], p = .016.[2]

Discussion

This study sought to assess the relationship between self-compassion and early memories of warmth and safeness (EMWS) on experiences of trauma-related shame in adults with CPTSD. CPTSD is often associated with interpersonal and prolonged traumatic experiences (Karatzias et al., 2017) that carries an increased vulnerability for experiencing trauma-related shame. In line with this, 3.6% (n = 7) of the present sample reported a single discrete traumatic experience and 96.4% (n = 185) reported multiple prolonged experiences or categories of abuse. Trauma-related shame was approximately normally distributed, ranging from 2 to 72, which supports its inclusion in the routine clinical assessment of CPTSD.

The full regression model (demographics, CPTSD symptoms, depression, EMWS, and self-compassion) explained 18.3% of the variance in trauma-related shame. Self-compassion contributed towards 5.4% of the variance in trauma-related shame over and above other variables. This finding in many ways reflects the process of psychological formulation: wherein the onset and maintenance of difficulties are often represented through the cumulative impact of various contributing factors. Thus, these findings suggest that self-compassionate abilities might have a protective function in mitigating against some trauma-related shame. The mechanism(s) for change remains unclear; however, the ability to tolerate rather than avoid shame might allow for greater meta-cognitive appraisal through a self-

[2] These findings were run without 17 participants with one affected CEAS-SC data item and the results replicated.

compassionate lens (e.g. ‘what happened to me was wrong’ rather than ‘there is something wrong with me’) and/or activate CFT’s soothing system to promote emotion regulation (Gilbert, 2010). These findings suggest self-compassionate abilities should be screened for and targeted in addressing trauma-related shame; extending adjacent research concluding that self-compassion is a worthwhile therapeutic target for DSO symptoms (Karatzias et al., 2019).

Interestingly, EMWS did not emerge as a statistically significant predictor of trauma-related shame. These findings might suggest current self-compassionate abilities (alongside CPTSD symptoms) are more influential in shaping trauma-related shame than early relational experiences. However, EMWS might have a role in ways not measured by this design. There was no real range or comparison (e.g. people with higher EMWS). It is possible that adults with higher EMWS might experience less shame and/or CPTSD symptomology and thus were perhaps not eligible for this study. Therefore, EMWS might retain some clinical relevance to trauma-related shame.

An ANCOVA suggested that adults with CPTSD who report below average self-compassionate abilities (relative to the UK general population) show higher levels of trauma-related shame compared to those with higher self-compassionate abilities. Within this study, 72.5% of participants’ self-compassion scores were lower than the average in the UK population (Gilbert et al., 2017; Lindsey et al., 2022); suggesting that some adults within this population struggle with self-compassion.

As with many designs, this study needed to make careful decisions related to balancing participant burden with generating data for meaningful enquiry. Other variables, such as perceived and actual social support or other compassionate flows (receiving and giving) were not tested. The ability to receive compassion from others, for example, might hold weight in predicting trauma-related shame, as this might presume the mind of another is

perceived as less threatening. Receiving or giving compassion might also enable greater receipt of social support, reduce social isolation, and or potentially allow for more opportunities for corrective relational experiences that might support shame reduction.

Furthermore, research highlights the steep social and economic impacts of CPTSD relative to other conditions: such as unemployment, addiction, homelessness (Davis et al., 2022) and a comparably worse cognitive profile (Schöndorf et al., 2025). One study of 5,756 Kenyan adults found financial support had a greater impact on psychological well-being than individual therapy in improving quality of life through lifting people out of poverty (Haushofer et al., 2021). There might be other determinants of trauma-related shame beyond intrinsic factors such as self-compassion.

Strengths & Limitations

The present study benefitted from a large sample that enabled 90-95% power for medium effect sizes, reducing the likelihood of Type II error (Collins & Watt, 2021). However, small to medium effect sizes were observed; therefore, caution should be applied in respect of interpretation without further replication in larger samples. Furthermore, regression models can estimate causal relationships, but controlled designs have stronger abilities to make causal claims about relationships between variables.

While there was a range of self-compassion scores within the sample, the ANCOVA finding should be contextualised within some of the acknowledged limitations of using a mean split to determine the higher and lower self-compassion groups. This includes a lack of nuance related to scores around the mean (e.g. scores of 57 and 59 can be assigned to low and high self-compassion groups despite there being minimal actual difference) and there is a negative impact of dichotomising variables in relation to statistical power. Taken together, this suggests some caution is warranted in interpreting and generalising this finding.

All measures used showed good internal consistency (Tavakol & Dennick, 2011). The sample was predominantly female, reflecting trends in CPTSD diagnosis (Stubley et al., 2025), and broadly aligned with population data (National Office for Statistics, 2021); with notable exceptions from White Gypsy or Roma Traveller, Black British African, or Asian Chinese backgrounds.

It should be acknowledged digital literacy, sufficient English, and electronic device possession are likely pre-requisites for online recruitment. Adverse experiences can disproportionately impact people for whom these might represent barriers: such asylum seeking communities (Jowett et al., 2021) or those in lower socio-economic circumstances (Misiak et al., 2022). This may have been offset by NHS recruitment (where support to complete measures could be provided if needed) although no formal measures to assess access were taken. Furthermore, one important limitation is the small (but statistically significant) differences between clinical and community participants. This finding aligns with research suggesting (within PTSD populations) those who experience greater symptoms or co-morbidities are more likely to help-seek (Koenen et al., 2003). The sample scored for more severe DSO symptoms and co-occurring depression. Therefore, it is possible these findings do not generalise fully to the CPTSD population and caution should be applied before generalising.

Future Directions

These findings suggest self-compassion is a worthwhile therapeutic target in addressing trauma-related shame in CPTSD that would benefit from replication in larger samples. Future studies could test the other flows of compassion (giving and receiving) to develop a broader perspective on how compassion (across three flows) influences trauma-related shame. There might also be value investigating sub-clinical CPTSD samples to see if

there are earlier indicators related to the role of EMWS prior to the onset of diagnosable symptoms.

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TDRP Executive Summary

Why did we do this study?

Around 70% of people will encounter a traumatic experience in their lives. Our experiences in childhood are thought to shape our responses to traumatic events; helping us feel safe, respond to ourselves with kindness, and reach to others for support during times of difficulty. However, some people have not had the opportunity to experience relational safeness or develop self-compassionate abilities. If you experience multiple traumatic experiences over a long period of time (especially interpersonal trauma) the risk of experiencing trauma-related shame and developing a traumatic stress condition called Complex Post Traumatic Stress Disorder (CPTSD) can rise.

Trauma-related shame is a social state of threat that can involve beliefs (e.g. 'I am defective' or 'I am to blame for what happened to me'), emotions (e.g. fear, embarrassment, dysregulation, worthlessness), body sensations (e.g. fight-flight-freeze, dissociation or numbness) and behaviours (e.g. avoidance, concealment, or blame). It is thought that experiencing high shame might make it harder to access support for CPTSD. Theories and research suggest shame can make accessing trauma-focussed treatments harder, such as building a strong therapeutic alliance with a therapist or accessing emotions to process trauma memories. So far, there is not a huge amount of research exploring trauma-related shame, what we can do to reduce trauma-related shame, or how these ideas relate to one another beyond theories. We set out to investigate trauma-related shame in adults with CPTSD.

How was the study carried out?

A sample of adults (aged 18 years and older) with CPTSD were recruited in partnership with an NHS traumatic stress service and online (through social media and

peer support charities). Participants either completed a one-off online questionnaire or gave us consent for us to use their scores from questionnaires completed within the service. This was combined with data the service had already collected using the same questionnaires. The questionnaires asked about experiences of trauma symptoms and impairment, trauma-related shame, self-compassionate abilities, childhood memories of warmth and safeness, and depression.

Analyses were taken to consider whether self-compassionate abilities and childhood memories of warmth and safeness could predict trauma-related shame when we controlled for CPTSD symptoms, depression, and demographics such as age, gender, and ethnicity. We used a study that looked at self-compassion in the UK general population to establish a cut-off for higher and lower self-compassion in our sample and divided participants into two groups: (1) above average self-compassionate abilities and (2) lower than average self-compassionate abilities. We compared trauma-related shame between these groups and controlled for depression and CPTSD symptoms.

What did the study find out?

In total, 192 adults with CPTSD participated. Participants ranged from 18 to 75 years old. The average age was 41 years. In total, 85.4% were female, 7.8% were male and 6.8% identified as other gender denominations. The sample shared similarities to the ethnicities of people living in England and Wales at the time of the last census in 2021, but no one responded who was from a White Gypsy, Roma Traveller, Black British African, or Asian Chinese background. Of the people who participated, 185 reported multiple or long-lasting experiences of trauma. Participants reported a range of levels of trauma-related shame.

Our analyses suggested that adults with CPTSD who report below average self-compassionate abilities (relative to the UK general population) showed higher levels of trauma-related shame compared to those with higher self-compassionate abilities. When we added age, gender, ethnicity, CPTSD symptoms, depression, early memories of warmth and safeness and self-compassion to a statistical model of trauma-related shame, the model estimated that these factors together predict 18.3% of trauma-related shame. Of these factors, CPTSD and self-compassion were significant predictors of trauma-related shame. Self-compassion contributed towards 5.4% of the prediction over and above other factors. Early memories of warmth and safeness did not predict trauma-related shame.

What did we conclude?

We concluded that our findings suggest self-compassion is a worthwhile therapeutic target in helping people experiencing trauma-related shame in CPTSD; but this finding should be replicated in larger samples and in a controlled experimental design to feel more confident in its reliability and accuracy. We concluded there is value in screening for self-compassionate abilities within NHS traumatic stress services; those who fall below average might experience higher trauma-related shame. We also wondered about other factors that might influence trauma-related shame, such as social support or other types of compassion (such as receiving compassion from others or giving compassion) in explaining more about trauma-related shame in adults with CPTSD.

We had a few hypotheses about why childhood memories of warmth and safeness did not predict trauma-related shame in our study. Most people in our study reported few childhood memories of warmth and safeness. While this aligned with our

theoretical ideas, it meant the scores were clustered at the lower end of values. This meant there was little comparison or range within the sample (e.g. people with higher memories of warmth and safeness). We wondered if childhood memories of warmth and safeness might be protective in the development of CPTSD and subsequent trauma-related shame. It is possible that perhaps people who have increased experiences of childhood warmth and safeness might be less likely to develop CPTSD and therefore maybe did not meet our study criteria. Therefore, it was not possible to rule in or completely rule out the role of childhood memories of warmth and safeness in predicting trauma-related shame.

What next?

We wondered about exploring this idea further in future research with people who do not meet the diagnostic criteria for CPTSD (or whose scores fall just below). Moving forward, we concluded that future research should try and replicate our results (with larger samples and in experimental designs). We concluded that it would be helpful to test the other types of compassion (such as receiving compassion from others or giving compassion) to build up a broader picture of the role of compassion and trauma-related shame in CPTSD.

Word count – 979

Connecting Narrative

Background and Overview

Before psychology, I completed my undergraduate in English Literature and worked in youth engagement and safeguarding roles for charities. Working in the third sector showed me some of the social, physical, and economic inequalities that can underpin service access. Developing more accessible service models was one motivation for me in applying for the doctorate; alongside a desire to apply psychological learning and contribute towards the evidence-bases that underpin care. I knew I wanted to pursue research relevant to services and clinical practice, consider issues of access across the lifespan, and draw on expertise through experience, which are threads that run throughout these projects.

Service Improvement Project

For my service improvement project, I was drawn to the idea of working with a grass-roots community organisation running parent-infant bonding groups. The needs of 'Babies 1st' in thinking about access/barriers aligned with the values that underlined my pre-doctorate experiences. The project gave me opportunities to attend groups and take on a participant observer style role. This was a highlight of my first year of training. This enabled me to informally shape the design with parents through gentle and informal conversations– it was a personable approach to service evaluation (e.g. putting a face to a name) and enabled me to consider non-intrusive times/dates for interviews and resolve participation barriers in-situ. This process helped me reflect on the dual need to improve access to services as well as the need for accessibility within study designs.

I found it helpful to keep a reflexive log to appraise my own thoughts as a qualitative researcher. Parents attending groups were often described as 'vulnerable'; however, I also

observed these women to be highly resilient, tenacious, and strong. It made me reflect on the importance of language use – the choices I made had some ability to empower and or fragilise. I found expert by experience input invaluable in shaping the interview questions and considering dissemination. The paper is currently under peer review at the Journal of Reproductive and Infant Psychology. I look forward to seeing it published on behalf of the parents who kindly gave their valuable time to speak to me (often with babies in tow) and the organisation who is acting on the recommendations arising from this.

Theory Driven Research Project

Ideas for my TDRP developed in discussion with supervisors and appraising the literature. Lived experiences in my own family has given me some personal insight into how shame might organise behaviour and disrupt patterns of help-seeking and care. As a researcher and clinician, I am conceptually drawn to ideas of compassion, as enacted values (and something that can be practiced, modelled, and developed) when considering trauma-related shame. I wanted to test theoretical predictions in relation to this.

One hope was to integrate these ideas into a research design that would enable me to develop my research skills, having had some (but limited and mainly transferable) experiences of research pre-training. I found each phase: sponsorship, NHS ethics, setting up a PIC, coordinating between two R&D teams in different NHS trusts, and working with online and NHS recruitment in-parallel, gave me a really good base of skills and an idea of some of the challenges of balancing clinical time with research. I quickly learned (unsurprisingly) that I could not do my best thinking about research in between home visits on placement and instead found helpful ways to manage the project. This included building in reflective time to ‘think’ as well as ‘do’ – I realise I valued reflexivity within empirical work to think conceptually about theories and ideas, the impact of the work, and subsequent

decisions. One area of interest for me was about the ethics of administering questionnaires about potentially emotive topics online (e.g. trauma, shame, and childhood warmth); however, I was heartened to receive pro-active and positive communications from a range of people who had seen the advertisement and through PPI (who noted the EMWS scale got to the 'nub' of their experiences). Participants inevitably expressed feelings (as expected), but this was a helpful reminder as a researcher not to shy away from this form of recruitment. One area of interest and challenge was interpreting the findings (without clear precedents). Initially, I had wondered if the findings fell short of our theoretical expectations; but further appraisal helped me consider various angles, debates, and the nuances of operationalising and measuring these variables. I realised I enjoy the collaborative working aspects of research and do my best thinking bouncing ideas around with others –which (inevitably) provided more ideas for further research.

Systematic Review of the Literature

The idea for my SRL arose from clinical work on placement. I was intrigued by the paradox: that treatment for SAD (comprising a series of therapeutic but ultimately social interactions) could become a feared process so much so that help-seeking and engagement could be avoided or forestalled. I was saddened to read about the delay between typical onset in adolescence and help-seeking for adults with SAD; having witnessed first-hand how successful CT for SAD could be in the progress my client made. I wanted to take a lifespan approach across my thesis portfolio and was curious to explore whether adult models could be applied well to adolescents. I hoped to use the review as an opportunity to add to the knowledge base through amplifying participants' lived experiences of SAD.

Thesis Portfolio

Overall, I felt privileged to conduct three original projects of my choosing. The opportunity to work with knowledgeable and compassionate supervisors (in particular, at the traumatic stress service) helped me nurture skills, aim for progress not perfection, and energised my interests. At the beginning, I quietly expressed some reservations about my abilities in conducting research – my psychology conversion course felt brief and, in many ways, so different to my English degree. However, I have reached the end with a renewed appreciation for how well these experiences integrate. I am a far more confident and knowledgeable researcher and actively wish to be research active in clinical roles moving forward.

Word count – 998

Acknowledgements

My genuine thanks go to all the participants, experts by experience, charities and organisations who have so generously provided their time and valued experiences to support these projects and taught me so much about my values as clinician and researcher.

Thank you to all my research supervisors Fiona, Moni, Becca, Emma, and Deborah, alongside the guidance of Matt, Dani and Myra, but a particular thank you Dot and Emily for being so compassionate and generous to me, I feel very lucky to have worked together and hope our paths cross again. Thank you to Maria and Devanshi for supporting data collection.

To Christy, thank you for welcoming me into the profession – and for showing me a great many things about the kind of psychologist I would like to be. Thank you to Jo, Sarah, Hannah and Simon for helping me continue to build this in clinical supervision and to Sue for being such a lovely supervisor to me during my thesis write up.

Special thanks to Jana; I am grateful to have navigated this journey together in ways I don't quite have the words to describe; and to Tasha, Abi, Rachel, and Amber it has been such a privilege to train together. I am excited to step into the next phase of life with you all and see all the interesting and wonderful things that come next.

Thank you to everyone who has personally supported me in recent years (there are too many to name), but I am especially grateful for L, E, A, S and C for your unwavering friendship, care packages in the post, and most of all keeping me grounded, laughing, and able to find balance. Thank you to H & F, your insistence there is always time to a build dinosaur zoo or play spiderman has provided so much respite.

And last, but by no means least, to S, your love and kindness has always seen me through the best and the most difficult of times. No words of thanks are enough.

Appendices

Appendix A: SRL - Search Terms by Database

PsycINFO

1. (‘Social phobia’ or ‘social anxiety’ or 'social anxiety disorder*' or ‘SAD’ or 'socially anxious' or ‘socially phobic’ or ‘social fear*’).ab,ti.
2. (adolescen* or ‘late adolescence’ or ‘early adolescence’ or teen* or 'young person’ or youth or 'secondary school student' or ‘middle school student’ or 'high school student' or student* or pupil* or juvenile* or 'older child*' or 'young adult' or 'young people').ab,ti.
3. ('Qualitative method*' or ‘qualitative stud*’ or qualitative or 'focus group*' or 'interpretative phenomenological analysis' or ‘IPA’ or 'narrative analysis' or 'semi-structured interview*' or 'thematic analysis' or 'TA' or 'Braun-and-Clarke' or ‘theme*’ or 'grounded theor*’ or phenomenol* or 'framework analys*' or 'content analys*' or ethnograph* or 'constant-compar*' or 'conversation analysis' or hermeneutic* or heuristic* or discourse analys*).ab,ti.
4. Exp *social anxiety / or *social phobia /
5. Exp *adolescent development /
6. Exp *qualitative methods / or *qualitative measures /
7. 1 or 4
8. 2 or 5
9. 3 or 6
10. 7 and 8 and 9
11. Limit 10 to peer reviewed journal

EMBASE

1. (‘Social phobia’ or ‘social anxiety’ or 'social anxiety disorder*' or ‘SAD’ or 'socially anxious' or ‘socially phobic’ or ‘social fear*’).ab,ti.
2. (adolescen* or ‘late adolescence’ or ‘early adolescence’ or teen* or 'young person’ or youth or 'secondary school student' or ‘middle school student’ or 'high school student' or student* or pupil* or juvenile* or 'older child*' or 'young adult' or 'young people').ab,ti.
3. ('Qualitative method*' or ‘qualitative stud*’ or qualitative or 'focus group*' or 'interpretative phenomenological analysis' or ‘IPA’ or 'narrative analysis' or 'semi-structured interview*' or 'thematic analysis' or 'TA' or 'Braun-and-Clarke' or ‘theme*’ or 'grounded theor*’ or phenomenol* or 'framework analys*' or 'content analys*' or ethnograph* or 'constant-compar*' or 'conversation analysis' or hermeneutic* or heuristic* or discourse analys*).ab,ti.
4. Exp *social anxiety / or *social phobia /
5. Exp *adolescent development /
6. Exp *qualitative research /
7. 1 or 4
8. 2 or 5
9. 3 or 6
10. 7 and 8 and 9

CINHAHL

1. TI ('social phobia' or 'social anxiety' or 'social anxiety disorder*' or 'SAD' or 'socially anxious' or 'social fear*') **OR AB** ('social phobia' or 'social anxiety' or 'social anxiety disorder*' or 'SAD' or 'socially anxious' or 'social fear*')

2. TI (adolescen* or ‘late adolescence’ or ‘early adolescence’ or teen* or 'young person’ or youth or 'secondary school student' or ‘middle school student’ or 'high school student' or student* or pupil* or juvenile* or 'older child*' or 'young adult' or 'young people') **OR AB** (adolescen* or ‘late adolescence’ or ‘early adolescence’ or teen* or 'young person’ or youth or 'secondary school student' or ‘middle school student’ or 'high school student' or student* or pupil* or juvenile* or 'older child*' or 'young adult' or 'young people').
3. TI ('Qualitative method*' or ‘qualitative stud*’ or qualitative or 'focus group*' or 'interpretative phenomenological analysis' or ‘IPA’ or 'narrative analysis' or 'semi-structured interview*' or 'thematic analysis' or 'TA' or 'Braun-and-Clarke' or ‘theme*’ or 'grounded theor*’ or phenomenol* or 'framework analys*' or 'content analys*' or ethnograph* or 'constant-compar*' or 'conversation analysis' or hermeneutic* or heuristic* or discourse analys*) **OR AB** ('Qualitative method*' or ‘qualitative stud*’ or qualitative or 'focus group*' or 'interpretative phenomenological analysis' or ‘IPA’ or 'narrative analysis' or 'semi-structured interview*' or 'thematic analysis' or 'TA' or 'Braun-and-Clarke' or ‘theme*’ or 'grounded theor*’ or phenomenol* or 'framework analys*' or 'content analys*' or ethnograph* or 'constant-compar*' or 'conversation analysis' or hermeneutic* or heuristic* or discourse analys*).
4. (MM ‘social anxiety’ or ‘social phobia’)
5. (MM ‘adolescence’)
6. (MM ‘qualitative studies’)
7. S1 or S4
8. S2 or S5
9. S3 or S6
10. S7 and S8 and S9

11. Limiter – Peer Reviewed

MEDLINE

1. (‘Social phobia’ or ‘social anxiety’ or 'social anxiety disorder*' or ‘SAD’ or 'socially anxious' or ‘socially phobic’ or ‘social fear*’).ab,ti.
2. (adolescen* or ‘late adolescence’ or ‘early adolescence’ or teen* or 'young person’ or youth or 'secondary school student' or ‘middle school student’ or 'high school student' or student* or pupil* or juvenile* or 'older child*' or 'young adult' or 'young people').ab,ti.
3. ('Qualitative method*' or ‘qualitative stud*’ or qualitative or 'focus group*' or 'interpretative phenomenological analysis' or ‘IPA’ or 'narrative analysis' or 'semi-structured interview*' or 'thematic analysis' or 'TA' or 'Braun-and-Clarke' or ‘theme*’ or 'grounded theor*’ or phenomenol* or 'framework analys*' or 'content analys*' or ethnograph* or 'constant-compar*' or 'conversation analysis' or hermeneutic* or heuristic* or discourse analys*).ab,ti.
4. Exp *social anxiety / or *social phobia /
5. Exp *adolescent development /
6. Exp *qualitative research
7. 1 or 4
8. 2 or 5
9. 3 or 6
10. 7 and 8 and 9

PUBMED

Title and abstract (‘Social phobia’ or ‘social anxiety’ or 'social anxiety disorder*' or ‘SAD’ or 'socially anxious' or ‘socially phobic’ or ‘social fear*’) AND (adolescen* or ‘late adolescence’ or ‘early adolescence’ or teen* or 'young person’ or youth or 'secondary school student' or ‘middle school student’ or 'high school student' or student* or pupil* or juvenile* or 'older child*' or 'young adult' or 'young people') AND ('Qualitative method*' or ‘qualitative stud*’ or qualitative or 'focus group*' or 'interpretative phenomenological analysis' or ‘IPA’ or 'narrative analysis' or 'semi-structured interview*' or 'thematic analysis' or 'TA' or 'Braun-and-Clarke' or ‘theme*’ or 'grounded theor*’ or phenomenol* or 'framework analys*' or 'content analys*' or ethnograph* or 'constant-compar*' or 'conversation analysis' or hermeneutic* or heuristic* or discourse analys*).

Appendix B: SRL - Joanna Briggs Institute (JBI) Tools

JBI Quality Appraisal Tool

JBI Critical Appraisal Checklist for Qualitative Research

Reviewer_____Date_____

Author _____Year_____Record Number_____

	Yes	No	Unclear	Not applicable
1. Is there congruity between the stated philosophical perspective and the research methodology?	☐	☐	☐	☐
2. Is there congruity between the research methodology and the research question or objectives?	☐	☐	☐	☐
3. Is there congruity between the research methodology and the methods used to collect data?	☐	☐	☐	☐
4. Is there congruity between the research methodology and the representation and analysis of data?	☐	☐	☐	☐
5. Is there congruity between the research methodology and the interpretation of results?	☐	☐	☐	☐
6. Is there a statement locating the researcher culturally or theoretically?	☐	☐	☐	☐
7. Is the influence of the researcher on the research, and vice- versa, addressed?	☐	☐	☐	☐
8. Are participants, and their voices, adequately represented?	☐	☐	☐	☐
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?	☐	☐	☐	☐
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?	☐	☐	☐	☐

Overall appraisal: Include ☐ Exclude ☐ Seek further info ☐

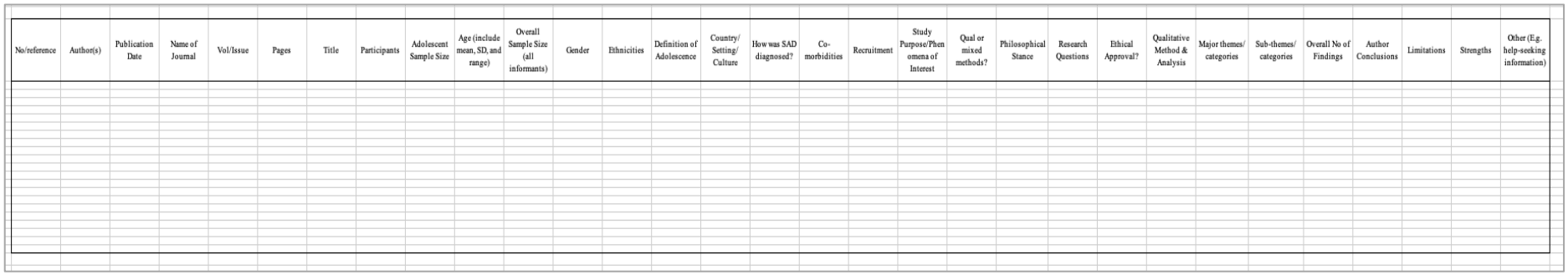
Comments (Including reason for exclusion)

_____

_____

_____

Data Extraction Tool (informed by the Joanna Briggs Institute Extraction Tool)



No/reference	Author(s)	Publication Date	Name of Journal	Vol/Issue	Pages	Title	Participants	Adolescent Sample Size	Age (include mean, SD, and range)	Overall Sample Size (all informants)	Gender	Ethnicities	Definition of Adolescence	Country/ Setting/ Culture	How was SAD diagnosed?	Co-morbidities	Recruitment	Study Purpose/Phenomena of Interest	Qual or mixed methods?	Philosophical Stance	Research Questions	Ethical Approval?	Qualitative Method & Analysis	Major themes/ categories	Sub-themes/ categories	Overall No of Findings	Author Conclusions	Limitations	Strengths	Other (E.g. help-seeking information)

The extraction categories are as follows: number/reference, authors, publication date, journal, volume/issue, pages, paper title, participants, sample size, age (include mean, standard deviation, and range), gender, ethnicities, definition of adolescence, country, setting and culture, how SAD was diagnosed/assessed, co-morbidities, study purpose/phenomena of interest, qualitative or mixed-methods, philosophical stance, research questions, ethical approval, qualitative method and analysis, major themes or categories (list), sub-themes or sub-categories (list), overall number of findings, author conclusions, limitations, strengths, and other (e.g. help-seeking information).

Appendix C: SRL - Overview & Psychometric Properties of Measures

An overview and psychometric properties of the measures used in included studies are reported as follows. Good test-retest reliability is typically considered to be $r = \geq.70$ (Terwee et al., 2007) and $k = .6$ to $.8$ can indicate substantial agreement, $k = .8$ to $.9$ is often considered good agreement and ≥.95 excellent agreement (McHugh, 2012). Intraclass coefficients between .5 to .75 suggests moderate reliability, .75 to .9 is good reliability, and ≥.9 is suggestive of excellent reliability (Koo & Li, 2016). Good internal consistency is often conceptualised as an $\alpha = .70$-$.95$ (Terwee et al., 2007).

The Liebowitz Social Anxiety Scale (LSAS; Liebowitz, 1987)

A 24-item measure of social anxiety range and severity of impact. Adults are asked to rate items (related to aspects of daily living) from 0 = none to 3 = severe, in relation to fear, and from 0 = never and 3 = usually, in relation to avoidance that can be combined score of 0 to 144. In adults, it has been suggested that scores of <30 suggest that SAD is unlikely, scores of 30 to 60 might indicate probable SAD or non-generalised forms (e.g. performance anxieties), and scores from 60 to 90 indicate very probable and generalised SAD symptoms that warrant intervention (Mennin et al., 2002). The measure has shown to have good psychometric properties. Test-retest reliability for the LSAS self-report over a 12-week time frame was $r = 0.83$, $p \leq .01$ (Baker et al., 2002). Internal consistency has been shown to be high $\alpha = .95$ (Baker et al., 2002). The clinician reported and self-report measures have been shown to have comparable psychometric properties in adult samples (Fresco et al., 2001).

Paper	LSAS SAD scores

Clarke and Fox (2017)	Used 65 and over as the cut off for eligibility in the study. Participant scores ranged from 65 to 116.
Kim et al. (2022)	Participant scores ranged from 30 to 135 (*M* = 68.19; *SD* = 26.5).
O'Bree et al. (2021)	Participants were eligible if they scored ≥30. Authors reported that the sample had 9.9% had mild SAD symptoms, 12.3% had moderate symptoms, 21.0% had marked symptoms, 56.8% had severe or very severe symptoms in an adjacent paper for the wider study (Rice et al., 2020).

The Liebowitz Social Anxiety Scale for Children and Adolescents (LSAS-CA; Liebowitz, 1987)

Similar findings have been demonstrated when the LSAS has been tested with a sample of children and adolescents. Like the adult LSAS, children and adolescents are asked to rate 24-items from 0 = none to 3 = severe (in relation to fear) and 0 = never to 3 = usually (in relation to avoidance) that can be combined to determine a score from 0 to 144. In adolescents, a cut-off of 22.5 has been suggested as a way of differentiating between SAD and health controls and 29.5 for differentiating between SAD and other anxiety disorders (Masia-Warner et al., 2003). with reports of high internal consistency α = .90-.97 (α = .83-.95 for the subscales) and good test-retest reliability, with an intraclass correlation coefficient of .89-.94 (Masia-Warner et al., 2003).

Paper	LSAS-CA Score
Halldorsson et al. (2023)	Reported participant scores of 25 to 112 (*M* = 82.1; *SD* = 26.5).

Leigh et al. (2023)	Reported baseline participant scores (*M* = 93.29; *SD* = 22.43 for the waitlist group and *M* = 86.59; *SD* = 25.43) for the intervention group) in a wider paper reporting the trial of OSCA Leigh et al. (2023) in conjunction with the ADIS-C/P diagnostic interview by an assessor blind to the randomised groups. Post-treatment scores were *M* = 86.52; *SD* = 35.37 for the waitlist and *M* = 15.11; *SD* = 15.15 for the intervention group.
Taylor et al. (2021)	Report participant baseline scores of 97.41 and then 36.18 at follow up post-treatment in an adjacent paper describing the full trial (Creswell et al., 2021).

The Screen for Child Anxiety Related Emotional Disorders (SCARED; Birmaher et al., 1997).

This is widely used 41-item measure based on child and parent reports that assesses for anxiety disorder in childhood and adolescents. Children and adolescents are asked to rate items from 0 = not true to 2 = very true creating a total score of 82 for the full measure or a maximum score of 14 for the 7-item social phobia subscale. The measure has shown high internal consistency (α = .74 to .93), good discriminant validity, and test-retest reliability with intraclass coefficients ranging from .70-.90 (Birmaher et al., 1997). Use of social phobia subscale has shown to demonstrate good psychometric properties in African-American student samples with high internal consistency, α = .89, and moderate test-retest reliability, *r* = 0.47 over 6-months (Boyd et al., 2003). A score of ≥8 on the social phobia subscale or ≥25 overall is indicative of probable SAD (subscale) or a probable anxiety disorder (total score).

Paper	SCARED Score
Fox et al. (2025)	Reported participant scores from 4 to 13 (*M* = 8.9; *SD* = 3.2). Eleven participants exceeded the clinical cut-off for probable SAD. Four participants reported sub-clinical SCARED scores, 3 of these participants did not participant in interviews: all 4 joined focus groups. None of the individual findings in this paper was supported solely by a quote by a sub-clinical participant; therefore, a decision was taken to include the paper.

The Anxiety Disorder Interview Schedule for DSM-IV, Child & Child and Parent versions (ADIS-C/P; Silverman & Albano, 1996).

A semi-structured diagnostic interview (Silverman & Albano, 1996) that assesses for anxiety and mood disorders (including social anxiety disorder/social phobia) based on criteria laid out in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-4; American Psychiatric Association, 1994). Later versions are based on the 5th edition (DSM-5; American Psychiatric Association, 2013). Clinicians use a Clinical Severity Rating (CSR) from 0 to 8 for each anxiety disorder; a score of ≥4 suggests that a child or adolescent meets the full diagnostic criteria for a DSM-IV (or later editions DSM-V) anxiety disorder (Silverman & Albano, 1996). A score of 0 indicates no psychopathology, a score of 4 indicates moderate psychopathology, and a score of 8 indicates severe psychopathology. The ADIS-C/P has shown excellent intraclass correlation coefficients of .71 (Silverman et al., 2001), good inter-rater reliability k = .92 for individual and co-morbid disorders (Lyneham et al., 2007).

Paper	ADIS-C/P Outcome
Halldorsson et al. (2023)	Reported CSR ratings of 4-7 for all participants.
Lawrence et al. (2022)	Reported all participants received a diagnosis of SAD; 6 of whom received a diagnosis of primary SAD and one of whom received a diagnosis of GAD with secondary SAD. CSRs not reported.
Leigh et al. (2023)	Reported that all participants received a diagnosis of SAD via an assessor blind to the allocation of intervention/control groups in adjacent paper reporting the full trial (Leigh et al., 2023).
Taylor et al. (2021)	Reported that all participants received a diagnosis pre-treatment in an adjacent paper reporting the full trial (Creswell et al., 2021).

The Revised Children's Anxiety and Depression Scale (RCADS; Chorpita et al., 2000)

The RCADS comprise a 47-item measure that assesses for probable major depressive disorder (MDD), panic disorder (PD), social phobia (SP), generalised anxiety disorder (GAD), separation anxiety disorder (SAD), and obsessive-compulsive disorder (OCD). Adolescents are asked to rate items from 0 = never to 3 = always. Good internal consistency has been demonstrated (α =.87 for the SAD subscale) in a clinical sample (Chorpita et al., 2005) and good test-retest reliability (Chorpita et al., 2000).

Paper	RCADS Score

Halldorsson et al. (2023)	Reported overall child report scores ranging from 36 to 76 and parent report scores ranging from 58 to >80.
Taylor et al. (2021)	Reported social anxiety t-scores of 74.26 pre-treatment and 44.00 at follow up in adjacent linked paper reporting the full trial (Creswell et al., 2021).

The Mini International Neuropsychiatric Interview (MINI; Lecrubier et al., 1997).

A structured diagnostic interview to assess for a range of disorders including social phobia based on DSM criteria. It has demonstrated good (.93) specificity (Lecrubier et al., 1997) excellent inter-rater reliability (k = .94), and moderate (k = .65) re-test reliability (Sheehan et al., 1998). There are no recognised clinical cut-offs as the interview assesses for the presence of symptoms and represents a decision tree format of yes/no questions against DSM criteria, and the clinician decides whether sufficient diagnostic criteria are met in conjunction with the DSM-IV and or DSM-V.

Paper	MINI Outcome
Hjeltnes et al. (2016)	Reported that 28 participants were determined to meet MINI criteria for SAD and 26 met the criteria for generalised SAD.
Hjeltnes et al. (2018)	Reported that 23 met criteria for generalised SAD and 1 for specific SAD.
Hjeltnes et al. (2019)	Reported all 11 students meet the criteria for generalised SAD at the outset of treatment.

The Fear of Negative Evaluation Brief Form (FNEB; Leary, 1983)

The FNEB is a 12-item measure of fear of negative evaluation (a central feature of social anxiety disorder). Participants rate items from 0 = not at all characteristic of me to 4 = very characteristic of me to generate an overall score out of 60. It is commonly used as a measure of social anxiety disorder (Bailey et al., 2006; Collins et al., 2005) and has been shown to demonstrate good (r = .94) test retest reliability (Collins et al., 2005) and excellent (α =.95) internal consistency (Carleton et al., 2011). A score of 38 has been suggested as a cut-off (that balances sensitivity with specificity) to identify between those showing clinical signs of SAD (Carleton et al., 2011).

Paper	FNEB Score
Morrison et al. (2021)	Reported eligibility for inclusion was FNEB scores one standard deviation above the non-clinical population (48.8 in Leary, 1983). All participant scores exceeded this, a second cut-off of 38 has been proposed to identify those with clinical features. Participants all confirmed they believe SAD was an issue for them.

CAMHS Clinicians

Additional less formalised measures were used to identify participants. McDonagh and Hennessy (2023), for example, asked CAMHS clinicians to reviewed their caseload against the NICE guidance (NICE, 2013). This methods of determining eligibility was included to reflect clinical realities within CAMHS, wherein clinicians will often not repeat diagnoses if children transition between teams, there can be a reluctance to give professional diagnoses (Appleton et al., 2021), and a minority of diagnoses are reviewed adjusted once given in light of new information (O'Connor et al., 2020).

Appendix D: SRL - Numbered Findings and Credibility Ratings

Paper	Major Theme or Category	Credibility Rating	Linked major theme or category if applicable.
Clarke and Fox (2017)	(1) "The influence of perception of self and perception of others" (Clarke & Fox, 2017, p. 36).	Credible	
	(2) "Perception of self and others participation in daily life activities" (Clarke & Fox, 2017, p. 36).	Credible	"The influence of perception of self and perception of others" (Clarke & Fox, 2017, p. 36).
	(3) "Perception of self and others influences interaction with the environment" (Clarke & Fox, 2017, p. 38).	Credible	"The influence of perception of self and perception of others" (Clarke & Fox, 2017, p. 36).
Fox et al. (2025)	(4) "Social Anxiety Symptoms" (Fox et al., 2025, p. 7).	Unequivocal	
	(5) "Experiences of Black Students Related to Social Anxiety" (Fox et al., 2025, p. 7).	Credible	
	(6) "Social Isolation/Behavioural Avoidance" (Fox et al., 2025, p. 7).	Unequivocal	
	(7) "Stigma/fear of judgment" (Fox et al., 2025, p.7).	Unequivocal	
	(8) "Barriers to help-seeking" (Fox et al., 2025, p. 7)	Unequivocal	
	(9) "Parent/important adult factors related to help-seeking" (Fox et al., 2025, p. 8).	Unequivocal	

Paper	Major Theme or Category	Credibility Rating	Linked major theme or category if applicable.
	(10) "Preference to Handle Problems on Own" (Fox et al., 2025, p. 9).	Unequivocal	"Barriers to help-seeking" (Fox et al., 2025, p. 7)
	(11) "Lack of Perceived Treatment Effectiveness" " (Fox et al., 2025, p. 9).	Credible	"Barriers to help-seeking" (Fox et al., 2025, p. 7)
	(12) "Confidentiality Concerns" (Fox et al., 2025, pp. 9-10).	Unequivocal	"Barriers to help-seeking" (Fox et al., 2025, p. 7)
	(13) "Concerns about Negative Outcomes" (Fox et al., 2025, p. 10).	Credible	"Barriers to help-seeking" (Fox et al., 2025, p. 7) "Barriers to help-seeking" (Fox et al., 2025, p. 7)
	(14) "Fear of Appearing Weak" (Fox et al., 2025, p. 10).	Unequivocal	"Barriers to help-seeking" (Fox et al., 2025, p. 7) "Barriers to help-seeking" (Fox et al., 2025, p. 7)
Halldorsson et al. (2023)	(15) "Discomfort being the centre of attention" (Halldorsson et al., 2023, pp. 7-8).	Credible	
	(16) "(Lack of) awareness of cognitions" (Halldorsson et al., 2023).	Unequivocal	
	(17) "Managing social fears" (Halldorsson et al., 2023).	Credible	
	(18) "I will do something wrong" (Halldorsson et al., 2023, p. 7).	Unequivocal	"Discomfort being the centre of attention" (Halldorsson et al., 2023, pp. 7-8).
	(19) "I am being judged" (Halldorsson et al., 2023, p. 7).	Unequivocal	"Discomfort being the centre of attention" (Halldorsson et al., 2023, pp. 7-8).

Paper	Major Theme or Category	Credibility Rating	Linked major theme or category if applicable.
	(20) "Sense of being stared at" (Halldorsson et al., 2023, p. 8).	Unequivocal	"Discomfort being the centre of attention" (Halldorsson et al., 2023, pp. 7-8).
	(21) "Knowing what I and others are thinking" (Halldorsson et al., 2023, p. 9).	Credible	"(Lack of) awareness of cognitions" (Halldorsson et al., 2023).
	(22) "It is just a feeling" (Halldorsson et al., 2023, p. 9).	Unequivocal	"(Lack of) awareness of cognitions" (Halldorsson et al., 2023).
	(23) "Finding it hard to explain" (Halldorsson et al., 2023, p. 9).	Unequivocal	"(Lack of) awareness of cognitions" (Halldorsson et al., 2023).
	(24) "Not knowing" (Halldorsson et al., 2023, p. 10).	Unequivocal	"(Lack of) awareness of cognitions" (Halldorsson et al., 2023).
	(25) "Wanting to get out of here" (Halldorsson et al., 2023, p. 10).	Unequivocal	"Managing social fears" (Halldorsson et al., 2023).
	(26) "Trying to come over as likeable" (Halldorsson et al., 2023, p. 10)	Unequivocal	"Managing social fears" (Halldorsson et al., 2023).
Hjeltnes et al. (2016)	(27) "From Being Shy to Interpreting Anxiety as a Mental Health Problem" (Hjeltnes et al., 2016, pp. 1708-1709).	Credible	
	(28) "Experiencing Emotions as Threatening and Uncontrollable" (Hjeltnes et al., 2016, p. 1710).	Unequivocal	
	(29) "Encountering Loneliness as Relationships Fall Away" (Hjeltnes et al., 2016, p. 1711).	Unequivocal	

Paper	Major Theme or Category	Credibility Rating	Linked major theme or category if applicable.
	(30) "Hiding the Vulnerable Self From Others" (Hjeltnes et al., 2016, p. 1712).	Credible	
	(31) "Deciding to Face Social Fears in the Future" (Hjeltnes et al., 2016, p. 1713).	Credible	
Hjeltnes et al. (2018)	(32) "Discovering the agency to change or not feeling empowered by the MBSR program" (Hjeltnes et al., 2018).	Credible	
	(33) "Forming an Active Commitment or Feeling Ambivalent Toward Learning Mindfulness" (Hjeltnes et al., 2018, p. 113).	Unequivocal	"Discovering the agency to change or not feeling empowered by the MBSR program" (Hjeltnes et al., 2018).
	(34) "Engaging with Others or Avoiding Contact with the Group" (Hjeltnes et al., 2018, p. 114).	Unequivocal	"Discovering the agency to change or not feeling empowered by the MBSR program" (Hjeltnes et al., 2018).
	(35) "Using the Mindfulness Practice to Approach or Resigning when Faced with Unpleasant Experience" (Hjeltnes et al., 2018, p. 115).	Credible	"Discovering the agency to change or not feeling empowered by the MBSR program" (Hjeltnes et al., 2018).
	(36) "Using the Course to Break Interpersonal Patterns or Remaining Stuck in Everyday Life" (Hjeltnes et al., 2018, p. 116).	Credible	"Discovering the agency to change or not feeling empowered by the MBSR program" (Hjeltnes et al., 2018).
Hjeltnes et al. (2019)	(37) "Using Awareness of the Body to Sense that you are	Credible	

Paper	Major Theme or Category	Credibility Rating	Linked major theme or category if applicable.
	Actually Here Right Now" (Hjeltnes et al., 2019, p. 38).		
	(38) "Establishing a Space that Enables You to See Negative Thoughts for What They Are" (Hjeltnes et al., 2019, p. 39).	Unequivocal	
	(39) "Allowing Fear and Shyness Through Sustained Awareness of Physical Sensations" (Hjeltnes et al., 2019, p. 40).	Unequivocal	
	(40) "Transforming an Experience of Being Inferior with Kindness and Self-Acceptance" (Hjeltnes et al., 2019, p. 40).	Credible	
	(41) "Discovering New Ways of Engaging with People" (Hjeltnes et al., 2019, p. 41).	Unequivocal	
Kim et al. (2022)	(42) "Perceived discrepancy in mutual goals" (Kim et al., 2022, p. 1653).	Credible	
	(43) "Perceived discrepancy in common ground" (Kim et al., 2022, p. 1654).	Credible	
	(44) "Perceived discrepancy in self-image" (Kim et al., 2022, p. 1654).	Credible	
	(45) "Assessments about the benefits of socializing" (Kim et al., 2022, p. 1654).	Credible	

Paper	Major Theme or Category	Credibility Rating	Linked major theme or category if applicable.
	(46)"Assessments about communication competency" (Kim et al., 2022, p. 1655).	Credible	
	(47) "Assessments about amiability of the information provider" (Kim et al., 2022, p. 1655).	Credible	
	(48) "Decision to avoid social interactions" (Kim et al., 2022, p. 1655).	Credible	
	(49)"Decision to pursue social interactions" (Kim et al., 2022)	Credible	
	(50) "Decision to re-appraise social interactions" (Kim et al., 2022)	Credible	
Lawrence et al. (2022)	(51) "Desirability of Targeted Prevention" (Lawrence et al., 2022, p. 569).	Credible	
	(52) "When and Whether to Act" (Lawrence et al., 2022, p. 570).	Credible	
	(53) "Facilitators of Access" (Lawrence et al., 2022, p. 571).	Credible	
	(54) "The right thing to do?" (Lawrence et al., 2022, p. 569).	Unequivocal	"Desirability of Targeted Prevention" (Lawrence et al., 2022, p. 569).
	(55) "Negative consequences of targeted prevention" (Lawrence et al., 2022, p. 569).	Credible	"Desirability of Targeted Prevention" (Lawrence et al., 2022, p. 569).
	(56) "When to intervene" (Lawrence et al., 2022, p. 570).	Unequivocal	"When and Whether to Act" (Lawrence et al., 2022, p. 570).

Paper	Major Theme or Category	Credibility Rating	Linked major theme or category if applicable.
	(57) "Identifying anxiety as a problem" (Lawrence et al., 2022, p. 570).	Unequivocal	"When and Whether to Act" (Lawrence et al., 2022, p. 570).
	(58) "Responding to risk concerns" (Lawrence et al., 2022, pp. 570-571).	Credible	"When and Whether to Act" (Lawrence et al., 2022, p. 570).
	(59) "Promoting awareness" (Lawrence et al., 2022, p. 571).	Unequivocal	"Facilitators of Access" (Lawrence et al., 2022, p. 571).
	(60) "Practicalities of implementation" (Lawrence et al., 2022, p. 569).	Unequivocal	"Facilitators of Access" (Lawrence et al., 2022, p. 571).
Leigh et al. (2023)	(61) "Satisfaction with online delivery of treatment" (Leigh et al., 2023, p. 3).	Credible	
	(62) "Flexible communication supports encouragement to remain motivated" (Leigh et al., 2023, pp. 3-4).	Credible	
	(63) "Helpful content of the treatment programme" (Leigh et al., 2023, p. 4).	Unequivocal	
	(64) "Challenges" (Leigh et al., 2023, p. 5).	Credible	
Luan et al. (2022)	(65) "Distorted Self-Consciousness" (Luan et al., 2022, p. 1731).	Unequivocal	
	(66) "Fear of Negative Reactions from Others" (Luan et al., 2022, p. 1732).	Unequivocal	
	(67) "Negative Psychosomatic Experience" (Luan et al., 2022, p. 1732).	Credible	

Paper	Major Theme or Category	Credibility Rating	Linked major theme or category if applicable.
	(68) "A Strong Desire to Seek Treatment" (Luan et al., 2022, p. 1733).	Credible	
	(69) "Low self-evaluation" (Luan et al., 2022, p. 1731).	Credible	"Distorted Self-Consciousness" (Luan et al., 2022, p. 1731).
	(70) "Self-Experience Lacking Self-Confidence" (Luan et al., 2022, p. 1731).	Credible	"Distorted Self-Consciousness" (Luan et al., 2022, p. 1731).
	(71) "Attitude and Avoidance Behavior" (Luan et al., 2022, p. 1732).	Unequivocal	"Distorted Self-Consciousness" (Luan et al., 2022, p. 1731).
	(72) "Excessive Concern About Other People's Evaluation" (Luan et al., 2022, p. 1732).	Unequivocal	"Fear of Negative Reactions from Others" (Luan et al., 2022, p. 1732).
	(73) "Worry About Making a Bad Impression" (Luan et al., 2022, p. 1732).	Unequivocal	"Fear of Negative Reactions from Others" (Luan et al., 2022, p. 1732).
	(74) "Feelings of Pain and Helplessness" (Luan et al., 2022, p. 1732).	Credible	"Negative Psychosomatic Experience" (Luan et al., 2022, p. 1732).
	(75) "Ambivalence" (Luan et al., 2022, p. 1733).	Credible	"Negative Psychosomatic Experience" (Luan et al., 2022, p. 1732).
	(76) "Anticipatory and Persistent Anxiety Experience" (Luan et al., 2022, p. 1733).	Credible	"Negative Psychosomatic Experience" (Luan et al., 2022, p. 1732).
	(77) "Physiological Reaction" (Luan et al., 2022, p. 1733).	Unequivocal	"Negative Psychosomatic Experience" (Luan et al., 2022, p. 1732).
McDonagh and	(78) "Coming to View Anxiety as More than Just 'Shyness'"	Unequivocal	

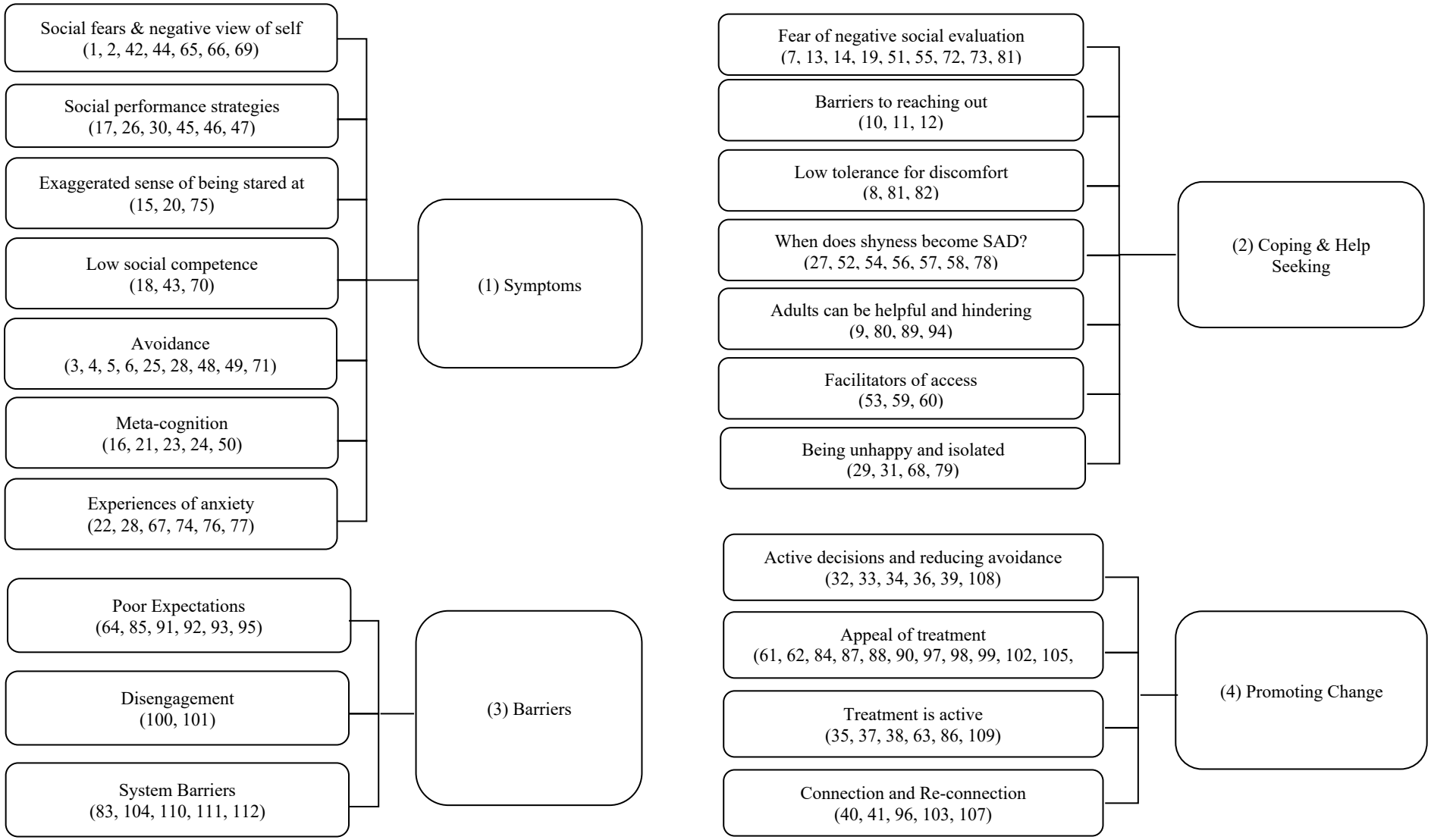
Paper	Major Theme or Category	Credibility Rating	Linked major theme or category if applicable.
Hennessy (2023)	(McDonagh & Hennessy, 2023, p. 2715).		
	(79) "Help-seeking because of unhappiness, not just anxiety" (McDonagh & Hennessy, 2023, p. 2717).	Credible	
	(80) "Help-seeking as a result of adult intervention" (McDonagh & Hennessy, 2023, p. 2719).	Unequivocal	
	(81) "Help-seeking as embarrassing and shameful" (Mc Donagh & Hennessy, 2023, p. 2720).	Unequivocal	
	(82) "Help-seeking as a feared social situation" (Mc Donagh & Hennessy, 2023, p. 2722).	Credible	
	(83) "Help-seeking hindered by institutional barriers" (Mc Donagh & Hennessy, 2023, p. 2723).	Credible – excluded (parent/clinician only finding)	
Morrison et al. (2021)	(84) "Determinants of positive psychotherapy expectations" (Morrison et al., 2021, pp. 785-787).	Credible	
	(85) "Determinants of negative psychotherapy expectations" (Morrison et al., 2021, pp. 787-788).	Unequivocal	
	(86) "Coursework"(Morrison et al., 2021, p. 785).	Credible	"Determinants of positive psychotherapy expectations" (Morrison et al., 2021, pp. 785-787).

Paper	Major Theme or Category	Credibility Rating	Linked major theme or category if applicable.
	(87) "Media" (Morrison et al., 2021, p. 786).	Unequivocal	"Determinants of positive psychotherapy expectations" (Morrison et al., 2021, pp. 785-787).
	(88) "Friends" (Morrison et al., 2021, p. 786).	Unequivocal	"Determinants of positive psychotherapy expectations" (Morrison et al., 2021, pp. 785-787).
	(89) "Family" (Morrison et al., 2021, p. 786).	Unequivocal	"Determinants of positive psychotherapy expectations" (Morrison et al., 2021, pp. 785-787).
	(90) "Social Environment" (Morrison et al., 2021, pp. 786-787).	Unequivocal	"Determinants of positive psychotherapy expectations" (Morrison et al., 2021, pp. 785-787).
	(91) "Coursework" (Morrison et al., 2021, p. 787).	Credible	"Determinants of negative psychotherapy expectations" (Morrison et al., 2021, pp. 787-788).
	(92) "Media"(Morrison et al., 2021, p. 787).	Unequivocal	"Determinants of negative psychotherapy expectations" (Morrison et al., 2021, pp. 787-788).
	(93) "Important people and their experience of psychotherapy" (Morrison et al., 2021, p. 787).	Unequivocal	"Determinants of negative psychotherapy expectations" (Morrison et al., 2021, pp. 787-788).
	(94) "Family beliefs" (Morrison et al., 2021, p. 787).	Unequivocal	"Determinants of negative psychotherapy expectations" (Morrison et al., 2021, pp. 787-788).
	(95) "Sociocultural Environment" (Morrison et al., 2021, p. 788).	Credible	"Determinants of negative psychotherapy expectations" (Morrison et al., 2021, pp. 787-788).
O'Bree et al. (2021)	(96) "Connection" (O'Bree et al., 2021, p. 9).	Unequivocal	
	(97) "Anxiety Management" (O'Bree et al., 2021, p. 9).	Unequivocal	

Paper	Major Theme or Category	Credibility Rating	Linked major theme or category if applicable.
	(98) "Appeal" (O'Bree et al., 2021, p. 10).	Unequivocal	
	(99) "Appeal to Young Males" "Connection" (O'Bree et al., 2021, p.10).	Credible	
	(100) "Disengagement" (O'Bree et al., 2021, p. 10).	Credible	
	(101) "System Improvement" (O'Bree et al., 2021, p. 11).	Credible	
Taylor et al. (2021)	(102) "Endorsing the treatment" (Taylor et al., 2021, pp. 402-403).	Unequivocal	
	(103) "Finding therapy to be collaborative and active; challenging but helpful" (Taylor et al., 2021, pp. 404-405).	Credible	
	(104) "Navigating change in a complex setting" (Taylor et al., 2021, p. 407).	Unequivocal - excluded (parent/clinician only finding)	
	(105) "Hopeful and positive about therapy and its outcomes" (Taylor et al., 2021, pp. 402-403).	Unequivocal	"Endorsing the treatment" (Taylor et al., 2021, pp. 402-403).
	(106)"Clinicians Affinity with the Treatment"(Taylor et al., 2021, p. 404).	Unequivocal - excluded (parent/clinician only finding)	"Endorsing the treatment" (Taylor et al., 2021, pp. 402-403).
	(107) "Therapy is a collaborative effort" (Taylor et al., 2021, p. 404).	Credible	"Finding therapy to be collaborative and active; challenging but helpful"

Paper	Major Theme or Category	Credibility Rating	Linked major theme or category if applicable.
			(Taylor et al., 2021, pp. 404-405).
	(108) "An active process is challenging, but helpful" (Taylor et al., 2021, p. 405).	Credible	"Finding therapy to be collaborative and active; challenging but helpful" (Taylor et al., 2021, pp. 404-405).
	(109) "Measuring progress is difficult, but support guidance and learning" (Taylor et al., 2021, p. 406).	Unequivocal	"Finding therapy to be collaborative and active; challenging but helpful" (Taylor et al., 2021, pp. 404-405).
	(110) "The typical structure of CAMHS priorities crises over therapies" (Taylor et al., 2021, p. 408).	Credible - excluded (parent/clinician only finding)	"Navigating change in a complex setting" (Taylor et al., 2021, p. 407).
	(111)"Complex cases require flexible responses" (Taylor et al., 2021, p. 408).	Unequivocal - excluded (parent/clinician only finding)	"Navigating change in a complex setting" (Taylor et al., 2021, p. 407).
	(112) "Practical problems impede implementation" (Taylor et al., 2021, p. 408).	Unequivocal - excluded (parent/clinician only finding)	"Navigating change in a complex setting" (Taylor et al., 2021, p. 407).

Appendix E: SRL - Meta-Aggregation Process



Appendix F: SRL - Journal Author Guidelines

Author guidelines can be found here for the target journal CAMH: https://acamh.onlinelibrary.wiley.com/hub/journal/14753588/forauthors.html. CAMH is an international journal with a growing reputation for publishing work of clinical relevance to multidisciplinary practitioners in child and adolescent mental health. The journal is referenced using APA style formatting, requires manuscripts to be double-spaced, and review articles must conform to the PRISMA statement. Articles must be no more than 6000 words (excluding tables, figures, and references; and no more than 8000, including quotes and figures but excluding references). The abstract must not exceed 250 words and be structured under the subheadings of background, method, results, conclusion. A key practitioner message is required for all articles. Additional requirements specified by the journal for authors are included below:

Key Practitioner Message

- **What is known?** The onset of SAD is typically estimated to be within adolescence to emerging adulthood. SAD is underrecognised and is associated with poor outcomes across the lifespan. Help-seeking for SAD represents a paradox; as even in the most active therapies, therapy involves a series of social interactions that can become feared. Evidence highlights the benefits of applying the Clark and Wells (1995) model of SAD to adults to adolescent treatment.
- **What is new?** It remains unclear whether adolescents' lived experiences of SAD and help-seeking align with the Clark and Wells (1995) model and current conceptualisations of SAD.
- **What is significant for clinical practice?** Young people's reported lived experiences of SAD were analogous with the Clark and Wells (1995) formulation of SAD, with

some variance related to age/stage. Practitioners should formulate for the interrelationship between experiences of racism on safety-seeking for adolescents from the global majority. Practitioners should be explicit about the differences between episodic and/or developmentally appropriate shyness and SAD and consider screening for socially avoidant coping as a potential indicator of vulnerability for SAD development. Parents/carers can be helpful/hindering for adolescents and attitude towards treatment can be a helpful treatment target and/or wider networks of support utilised. Participants mostly showed support for indicated intervention: having treatment when SAD symptoms are having a negative impact, as this can drive motivation to help-seek and engage. Targeting avoidance was reported as a driver of change with participants' experiences of treatment. Participants reported satisfaction with a range of modalities and reported benefit of flexible engagement, online options, and opportunities for guided therapist support and or peer involvement.

Study Funding & Conflicts of Interest

All authors are based at Oxford Institute for Clinical Psychology Research and Training. FR and EI are trainee clinical psychologists; and ER and EK are clinical psychologists. None of the authors have any competing interests to declare.

Contributions

FR conducted the systematic review, including running searches, PROSPERO registration, completing title and abstract and full-text screenings, quality appraisal of studies and credibility ratings of findings, and was responsible for the meta-aggregation and analytic output. EI acted as a second reviewer for screenings and quality appraisals. ER/EK acted as a third and fourth reviewer for points of discussion/disagreement and finalised the synthesis

and recommendations through consensus. FR drafted the manuscript, and all reviewers were involved in revisions.

Appendix G: SIP - Semi-Structured Interview Schedule

Semi-Structured Interview Questions

- Intro & thank for volunteering to take part.
- Explain format: about 30 minutes, questions about experience of Babies 1st.
- Recap info sheet (audio recording, confidentiality, data).
- Check access needs for the interview – e.g., repeat questions, take breaks if needed.
- Give permission not to answer questions if uncomfortable.
- Opportunity for questions.

[Start interview – begin audio recording]

Warm up

1. **How did you first get involved/hear about Babies 1st?**

Access

2. **Can you tell us about your motivation to come along /refer into/run baby bonding groups?**

   Prompts parents: *what prompted you to first get involved? What makes you want to keep coming back?*
   Prompts facilitators/referrers: *what motivates you to run the groups or refer parents in? Why do you keep doing this? [If never referred, what has motivated you to find out more about the groups?].*

3. **What do you think parents & babies gain from coming to these groups?**

   Prompts parents: *how does attending the groups impact your everyday life – what have you noticed? Has it affected how you see yourself or your baby? Has there been any unintended outcomes or surprises? How have you found VIG (video interactive guidance) during the groups?*
   Prompts facilitators/referrers*: What have you noticed about the parents and babies you have worked with or have referred in? How does attending the groups impact the*

way parents see themselves/their relationship with their baby? Has there been any unintended outcomes or surprises? What is your experience of how parents find VIG?

4. **What makes it easy for parents to come along/be referred into the groups?**

   Prompts parents: *What does Babies 1st do that helps you attend? How do you find attending a group as opposed to a 1-1 session?*

   Prompts facilitators/referrers: *What does Babies 1st do that helps you refer parents in? What do you think about referring into groups as opposed to a 1-1 session? What do you notice for Hampden Way?*

5. **Can you tell us a little bit about your experience of self-referring or referring into the groups?**

   Prompts all: *how did you find the referral process? How long did it take? How supported did you feel? How easy or hard was it to contact the team? Who in your support network of people knew about Babies 1st?*

Barriers

6. **What do you think makes it harder for parents to come to groups (a) for the first time (b) keep coming back each week?**

   Prompts parents: *what do you think are the barriers? What has been difficult for you? What gets in the way of you coming every week? What is your experience of VIG? How do you find attending a group as opposed to a 1-1 session?*

   Prompts facilitators/referrers: *What do you notice is hard for parents? What do you think are the barriers? What is your experience of how parents find VIG? How do you find referring into groups as opposed to a 1-1 session?*

7. **What do you think Babies 1st could do to overcome or get past some of these challenges?**

   Prompts parents: *if you were put in charge of Babies 1st what would you do/change? How do you think Babies 1st could increase awareness of the groups? Is there anything Babies 1st or a different service could offer that might help you to come more often (e.g., a meal or help planning transport)?*

   Prompts facilitators/referrers: *if you were put in charge of Babies 1st what would you do/change? How do you think Babies 1st could increase awareness of the groups? Is there anything Babies 1st or a different service could offer that might help parents come more often (e.g. a meal or help planning transport)?*

8. **How do the groups support parents from diverse backgrounds and/or disabilities?**

   Prompts parents: *how are differences supported? Is there anything you would like to see changed or done differently?*

   Prompts facilitators/referrers: *how are differences supported? Is there anything you would like to see changed or done differently? How can Babies 1st best meet the needs of the local community?*

Wrap-up

9. **Is there anything we haven't discussed related to helping more parents attend the groups that feels important to mention?**

[End of interview]

Debrief

- Thank for time – incredibly helpful and appreciated.
- Recap aims (to help more parents come to groups).
- Revisit what to do if concerns/wish to withdraw.
- Give opportunity for questions.
- Explain timeframe for write up and outcomes.

Appendix H: SIP - Inclusion Criteria

The inclusion criteria were kept deliberately broad to maximise accessibility within the design. There was no prerequisite for parents to have attended bonding groups (only that they should have been referred or self-referred). This attempted to widen the pool of potential participants to include parents who had not attended as well as potential referrers who had not referred (to help answer questions around access and barriers). 'Babies 1st' leaders indicated they wanted the project to focus on one group location (Buckinghamshire) in relation to improving access and reducing barriers. The inclusion criteria were as follows:

- Parents with an infant (aged up to 2 years old) who had attended or been referred to 'Babies 1st' Buckinghamshire group.
- Group facilitators and referral partners associated with 'Babies 1st' Buckinghamshire group able to comment on access and barriers.

Appendix I: SIP - NHRA Tool & Ethics

Go straight to content.

Medical Research Council

NHS Health Research Authority

Is my study research?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

Understanding facilitators and barriers to access and engagement in community-based parent-infant groups run by Babies 1st.

IRAS Project ID (if available):

You selected:

- **'No'** - Are the participants in your study randomised to different groups?
- **'No'** - Does your study protocol demand changing treatment/ patient care from accepted standards for any of the patients involved?
- **'No'** - Are your findings going to be generalisable?

Your study would NOT be considered Research by the NHS.

You may still need other approvals.

Researchers requiring further advice (e.g. those not confident with the outcome of this tool) should contact their R&D office or sponsor in the first instance, or the **HRA** to discuss your study. If contacting the HRA for advice, do this by sending an outline of the project (maximum one page), summarising its purpose, methodology, type of participant and planned location as well as a copy of this results page and a summary of the aspects of the decision(s) that you need further advice on to the HRA Queries Line at **Queries@hra.nhs.uk**.

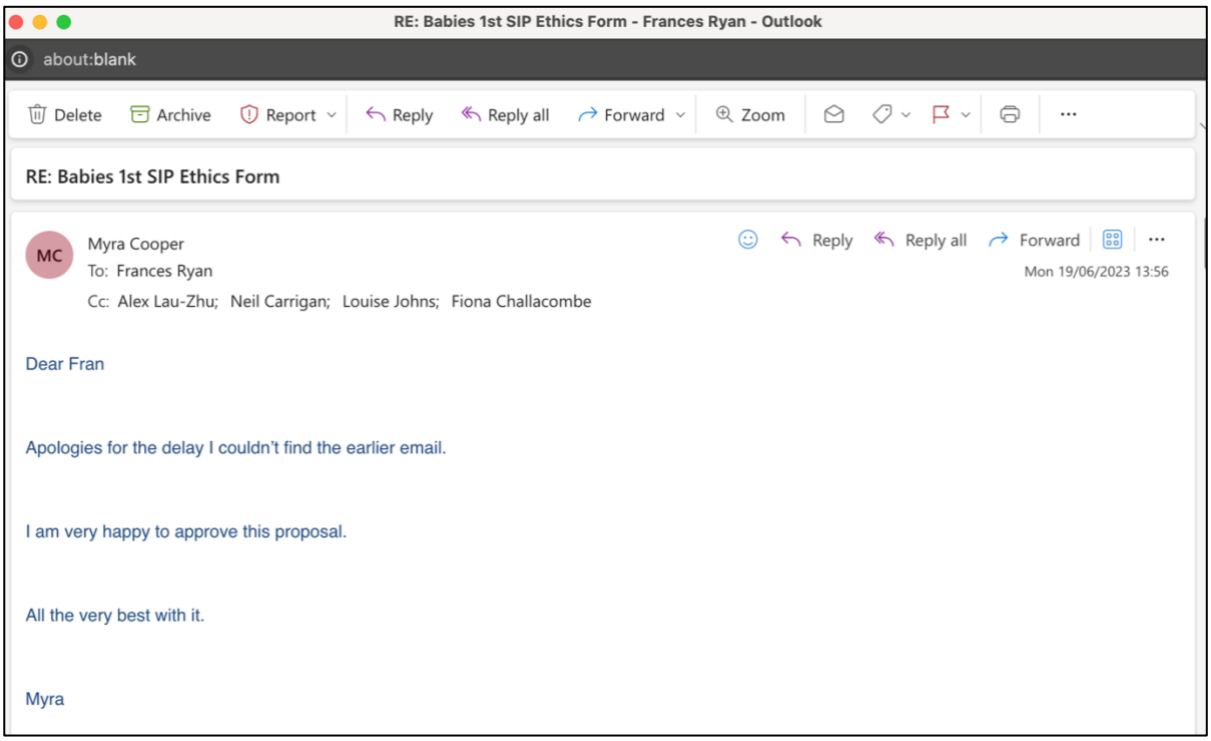
For more information please visit the **Defining Research** table.

Follow this link to start again.

Print This Page

NOTE: If using Internet Explorer please use browser print function.

About this tool **Feedback** **Contact** **Glossary** **Accessibility**


RE: Babies 1st SIP Ethics Form - Frances Ryan - Outlook
about:blank
Delete
Archive
Report
Reply
Reply all
Forward
Zoom
RE: Babies 1st SIP Ethics Form
MC
Myra Cooper
To: Frances Ryan
Cc: Alex Lau-Zhu; Neil Carrigan; Louise Johns; Fiona Challacombe
Reply
Reply all
Forward
Mon 19/06/2023 13:56
Dear Fran
Apologies for the delay I couldn't find the earlier email.
I am very happy to approve this proposal.
All the very best with it.
Myra

Appendix J: SIP – Participant Information & Consent

UNIVERSITY OF OXFORD

babies 1st

Babies 1st Improvement Project Information Sheet

We'd like to invite you to take part in our improvement project to help understand more about Babies 1st groups & referrals. We think more people could benefit from coming to the groups & would like to understand how to improve engagement. Taking part in the project is voluntary! You're receiving information because you are either involved (or have been involved) in the groups or are someone who can refer into the groups. We'd like to know what you think is good, what can be improved, and what makes it difficult for parents come & keep coming?

What's involved?

- A conversation on the phone or online taking about 30-mins.
- We'll ask you questions about your experiences of the service & audio record your answers (to help us remember what you say) & then delete the audio recording later.
- You can be honest and say whatever you like – its confidential & will not impact on your experience of the groups. It is helpful to know if you have taken part in the groups, we will not be asking about your personal experiences of therapy.
- The only time we may ever need to share information is if you tell us something that makes us concerned about you or someone else and we would discuss this with you. We'll make sure you cannot be personally identified in our write up.
- We'll keep your contact details safely in a separate place until after the project is completed. If you change your mind about taking part in this, you can contact us to withdraw up until the point we publish.
- We plan to write up our findings for Babies 1st and publish in a journal.

Who is running the project?

- My name is Fran Ryan & I'm a Trainee Clinical Psychologist (frances.ryan@stx.ox.ac.uk). I've been asked by Babies 1st Director (Moni Celebi) to review and help improve people's experiences of the groups to help more parents come along. I'm not involved in Babies 1st directly and will be conducting calls with people who volunteer to take part.
- My supervisor is Dr Fiona Challacombe based at the Oxford Institute of Clinical Psychology Training and Research. If you have any concerns about the project, you can contact Fiona via the OXICPT phone number: 01865 226431.





Babies 1st Improvement Project: Consent Form

I've had a chance to read/or talk about the information sheet and ask questions.	☐
I know taking part is voluntary and I can withdraw (without a reason and without any consequences).	☐
I know the conversation will be audio recorded (either on the phone or online) & later deleted.	☐
I know how this project will be written up, published, and how my data will be stored.	☐
I give permission for the use of specific anonymous quotations to be used in the final write up and possible publication.	☐
I know how to raise a concern if I have one.	☐
I'm happy for Babies 1st to share my contact details to take part in the project and to set up a phone/online call.	☐
I agree to take part.	☐

Name: **Signature:**

Date:

Appendix K: SIP – Process of Thematic Analysis (Braun & Clarke, 2006)

	Stage*	Summary
1	Familiarisation.	The trainee conducted 10 semi-structured interviews between July and November 2023. 9 out of 10 audio recordings were transcribed manually by the trainee in January 2024 and contemporaneous field notes were used in place of audio recording for 1 participant who declined consent to be recorded. Following transcription, each transcript was read through twice (once while listening to the concurrent audio recording) to support immersion across the data set and reduce human error through transcription. Hesitation or clear repetition were removed (Braun & Clarke, 2022) and identifying details pseudonymised. Reflexive discussions were undertaken between the trainee and wider team throughout this phase to discuss initial thoughts and positioning. Transcripts were not returned to participants for comment or correction. Audio recordings were deleted following transcription.
2	Generating initial codes.	Initial codes were generated across the entire data set (143) in February 2024 assessing features of potential relevancy in answering the service evaluation questions. This process was inductive and took place on NVivo Version 14 for Mac. Word-clouds were used to support visually mapping out codes and exploring patterns of meaning.
3	Generating themes.	Codes were arranged into preliminary themes (4) and sub-themes (7) in March 2024 based on areas of sameness/difference and places of overlap noted.

	Stage*	Summary
4	Reviewing themes.	Initial themes were reviewed with ‘Babies 1st’ and refined to determine a structure of 'best fit' for the data set and discuss areas of omission/'thinness' in March 2024. The meeting was audio recorded and reflected on as part of the analytic process to account for the reciprocal influence of the data on the team and vice versa. This led to some codes being collapsed (133) and sub-themes being re-constructed into a final structure of sub-themes (12) clustered around overarching themes (4). Expert by experience consultation was sought on this theme structure. The 15-point checklist described in Braun & Clarke (2006) was reviewed to appraise quality in the analytic process.
5	Defining and naming themes.	Initial descriptions (that laid out the scope and central organising concept) of each theme and sub-theme were developed. An overarching name was decided for each.
6	Producing the report.	The analysis was reported with pseudonymous data extracts (quotes) used to illustrate each theme. The Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines (Tong et al., 2007) were followed. Themes were appraised in the discussion section using the current literature to offer brief context.

*Reflexive logs were kept throughout all six stages & the stages treated as recursive rather than linear.

Appendix L: SIP - Researcher's Reflexive Statement

It is important to consider the trainee's Social GRRAACCEESS (Burnham, 2012), background, and training across all areas of the design to consider the impact on the process of meaning-making, approach taken, and appraisal of subsequent findings. The first author (FR), a white female in her early 30s, was (at the time of writing) a trainee clinical psychologist. Having a background in English led the trainee to be curious about the use of language in parenting discourses, what 'successful' parent-infant bonding means, and how attending a group is interpreted and integrated into people's experiences of being a parent. Stress and pressure is known to be commonplace in discourses around parenting (Fang et al., 2024). This raised the core question around who decides a parent (and which parents) would benefit from a parent-infant intervention and where the 'problem' is located in relation to bonding.

The trainee had no previous experience of parent-infant services; but was conscious of wider lived experiences of postnatal difficulties and traumatic birth stories within her own family and social network (and concurrent narratives around help-seeking) and had an interest in working with children and families that prompted interest in the topic. FR conducted the interviews, transcription, and subsequent thematic analysis. The trainee adopted a participant observer style role through attending parent-infant groups (n=3) and group facilitator supervision (n=1) during the recruitment phase of the project.

Careful thought was given to the benefits and constraints of taking a participant observer role, considering the second-order position that to observe a system is to influence it (Dallos & Draper, 2005). Benefits included the opportunity to take time to familiarise potential participants to the aims of the service evaluation, answer questions, develop an accessible and relevant interview schedule, and build trust (all components that supported a

more inclusive/accessible design). This retrospectively felt pertinent considering findings related to fear and stigma and parental experiences of marginalisation. Challenges included positioning the service improvement project as being external (but also connected) to 'Babies 1st' to enable honest feedback from participants. FR had no prior relationship with any of the participants.

The trainee made use of a reflexive journal (logs kept for one year throughout the process) and research supervision to consider areas of inadvertent biases/assumptions and how they might have shaped the interviews– for example, considering how parents might have perceived a trainee wearing an NHS lanyard/ID badge in 'Babies 1st' parent-infant groups (a non-NHS service) and considering how/where different professions might locate the 'problem' within parent-infant relationships given the diversity of the 'Babies 1st' MDT and how this is similar/different to clinical psychology. Areas of visible difference were considered (such as the power associated with consent forms branded with the Oxford University logo) and areas of invisible sameness.

Reflexive thematic analysis allowed us to fully embrace the subjectivity of the process while trying to access participants' real meaning. Meeting with the project team (including 'Babies 1st' leaders) throughout the analytic phase allowed for a deeper exploration of patterns of meaning, consideration of whether each had a distinct organising influence, and appraisal of gaps through discussion. Within this were opportunities for expectations and assumptions around bonding groups, targeted universalism, and parenting to be explored and different perspectives generated. This was especially helpful in the period between developing initial themes and finalising them.

Appendix M: SIP - COREQ Checklist for Reporting Qualitative Studies

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist. If you have not included this information, either revise your manuscript accordingly before submitting or note N/A.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	8, 46-47
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	9, 46-47
Occupation	3	What was their occupation at the time of the study?	9, 46-47
Gender	4	Was the researcher male or female?	9, 46-47
Experience and training	5	What experience or training did the researcher have?	46-47
Relationship with participants			
Relationship established	6	Was a relationship established prior to study commencement?	6
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	6
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	46-47
Domain 2: Study design			
Theoretical framework			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	9
Participant selection			
Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	6-8
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	6-8
Sample size	12	How many participants were in the study?	6 & 8
Non-participation	13	How many people refused to participate or dropped out? Reasons?	8
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	8
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	8
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	6-7
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	8, 40-42
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	8
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	8
Field notes	20	Were field notes made during and/or after the inter view or focus group?	8 & 9
Duration	21	What was the duration of the inter views or focus group?	8
Data saturation	22	Was data saturation discussed?	30
Transcripts returned	23	Were transcripts returned to participants for comment and/or	44

Topic	Item No.	Guide Questions/Description	Reported on Page No.
		correction?	
Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	8, 46-47
Description of the coding tree	25	Did authors provide a description of the coding tree?	13, thematic m
Derivation of themes	26	Were themes identified in advance or derived from the data?	9
Software	27	What software, if applicable, was used to manage the data?	9
Participant checking	28	Did participants provide feedback on the findings?	10
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	48-54
Data and findings consistent	30	Was there consistency between the data presented and the findings?	23
Clarity of major themes	31	Were major themes clearly presented in the findings?	12-13
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	No

Developed from: Tong A, Sainsbury P, Craig J. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. 2007. Volume 19, Number 6: pp. 349 – 357

Once you have completed this checklist, please save a copy and upload it as part of your submission. DO NOT include this checklist as part of the main manuscript document. It must be uploaded as a separate file.

*Please note page numbers correspond to the draft manuscript submitted for publication.

Appendix N: SIP - Participant Infographic

babies 1st

Service Improvement Project Summary

UNIVERSITY OF OXFORD

Background

Babies 1st run free bonding groups for parents and babies up to 2 years old. Babies 1st use video feedback (VIG) to support parents to develop their emotional relationship with their baby. The team noticed that a small number of parents were coming to baby bonding groups at Hampden Way Family Centre in High Wycombe and their was space for more....

What was this study about?

We know that accessing parenting support in the first 1001 days of a baby's life can have a long-term positive impact - for parents and babies! Babies 1st wanted to make sure their bonding groups are as accessible as possible and support more parents to attend. We hoped to answer a few questions: (1) What makes it easy for parents to attend Babies 1st bonding groups (2) What are the barriers? (3) What can Babies 1st do to make it easier for parents to attend?



Findings

We learned:

- Lots of people do not know about Babies 1st, bonding groups, or video-interactive guidance (VIG).
- Babies 1st is 'not a normal baby group' and offers a place for parents to take off the 'mask that motherhood is brilliant' all the time.
- Parents told us about positive experiences of attending groups including increased connections, confidence, and support.
- There are lots of perspectives about why someone might attend a bonding group!
- Parents told us that familiarity (e.g. knowing the people, facilitators, time & location) supported them to come.
- Being culturally and disability confident is important in supporting all parents to come.
- Sadly some parents still experience stigma and fears related to parenting and bonding.
- Non-judgemental approaches help create safer spaces within bonding groups.
- Doing 1-1 sessions might help parents who feel more self-conscious in groups, who might need more time to process feedback, or who have specific difficulties that make accessing groups harder.
- VIG can be daunting to begin with but has a positive impact.
- Babies 1st are developing the way they collect data around who does and does not attend or refer into groups.



What did we do?

To answer these questions, 10 people kindly gave us their time and took part in interviews. Of these, 4 were parents attending Babies 1st groups in Hampden Way, 5 were group facilitators, and 1 was a professional referrer. We also reviewed (non-identifiable) attendance records from the bonding groups between January to November 2023. This was a service improvement project.

Next steps

Babies 1st are pleased that the number of parents are increasing in 2024 & are working hard work to advertise the bonding groups. We made 10 recommendations for Babies 1st to continue developing their bonding groups in relation to these findings. For example, the team are designing a new parent information pack, are looking at how they record attendance, and have named someone within the team who will look at all referrals. Babies 1st are developing their recording systems so they can better understand who is and is not coming to the groups and referring in.



A big THANK YOU to the people who kindly volunteered their time to take part in this study. If you'd like to find out more about Babies 1st, you can do so here: https://babies1st.net/

Appendix O: SIP – Supporting Quotes & Thematic Map

Theme 1: Landscape of parent-infant services	**Supporting Quotes**
Low Awareness	'...knowing what is available and how to access it' (R05). 'Maybe it is professionals not understanding what it is I guess that is what it boils down to' (F10). 'My health visitor didn't bring it up at 6-weeks so I hadn't sort of raised that I was having issues, but maybe if they [health visitors] were being sort of proactive they already could put out that there is groups like this' (P03).
Identity of 'Babies 1st'	'I go to other groups with him, but with a lot of mum's it's all happy and "this is a great time" and you don't feel that you can really open up about stuff like that [bonding] to a lot of other people...It is hard to talk to your family about things like that because everyone thinks you must be having the best time of your life' (P03). 'You might need bums on seats but actually the therapeutic work is better in smaller groups' (F10). 'I think it is a lack of understanding about what video interactive guidance is because it is not a normal baby group' (F10). 'It would be lovely if there were more (groups) and we could refer in more families and get more people to realise because I think it's just so valuable' (R05). 'To get referrals, I think it is something we have to chip away

	at we constantly have to remind health visitors that we are here' (F08). 'I come across a lot of families who could benefit from VIG who are not under Perinatal Mental Health or Reconnect and there is that gap, isn't there you know' (R05). 'I think a lot of Mum's in that initial period put everything down to baby blues because that is what everyone say's' (P03).
Theme 2: Gaining Referrals	**Supporting Quotations**
Professional burden & relationships	'I already had relationships with [some parents] so that could get them through the door' (F10). 'I know them [the facilitators] from other things...I guess it is knowing that the people are friendly...the thing that made me to turn up first was that I knew I knew two of people there' (P01). 'I think it is professional overwhelm, everyone is so busy and they have such high caseloads and it goes out of their minds it just because when you talk to them they say "oh my god that is amazing somewhere to refer these women to" but then the referrals don't come' (F08).
Motivation	"My initial motivation was just wanting to improve my relationship with my child, I knew I was struggling with bonding' (P03).
Referral Process	'I guess what makes it easy is if they [parents] can come with someone else so you know whether it is one of us going to

	hold them by the hand and bring them or whether they can come with a friend... it doesn't make it easier but it does make it more possible' (F09). "I do think we do a little more handholding than the universal sessions, so we are more likely to call, more likely to do an initial appointment some of those ladies' (F10). 'That is why I am grateful for them [the facilitators] because I feel like that [phone call] is nice... I liked that someone reached out to me and actually did that. So, you do feel like a sense that you are important and self-worth by doing that' (P02). 'I sort of explained my situation and it just felt very non-judgemental, really open, and sort of re-assured me everyone is in the same boat' (P03). 'I think to be honest people see the [referral] form and think I will do it later. I think if people could just ping us an email with a name and a number and say this woman has given consent we would get a lot more referrals' (F08).
Theme 3: From referral to attendance	**Supporting Quotations**
Understanding VIG	'…once they get used to being [a] little self-conscious and we talk about that as well when we are reviewing the photographs, what does this look like? What does this feel like? You know very quickly they are managing sort of to be absorbed with what is going on with the children' (F07). 'The video thing...I am not that keen on' (P02).

	'The core values of VIG are empathy, compassion and kindness and so once you demonstrate that and you receive the mum's initiative, and you hear them and they feel supported and all that goes out of the window and look past all that and just really start to understand see the positives in the VIG' (F08). 'We don't have to explain the process to them we just have to show them the picture and get them to notice all the lovely things that they can see' (F09). 'I have felt perfectly comfortable and it [VIG] has not really bothered me' (P03).
Approaching initial visits	'People with anxiety... getting there and back can be quite a big deal if you've got a woman who is experiencing intrusive thoughts and thinks she is going to get run over on the way or thinks that a car is going to mount the pavement and you know crush the pushchair' (F08). 'It [knowing the location and venue] could also help potentially people like me that if I did not know the place that would be a real off-putter' (P01). 'I can't think of anything that would make it a lot more accessible – even just being in the same room, it is nice just being in same environment so I don't think moving locations would help' (P03). 'Coming along to a group could feel quite threatening' (F07). 'The thought of going to a group is I suspect is very hard, I am a mum myself and I remember…it was making that first

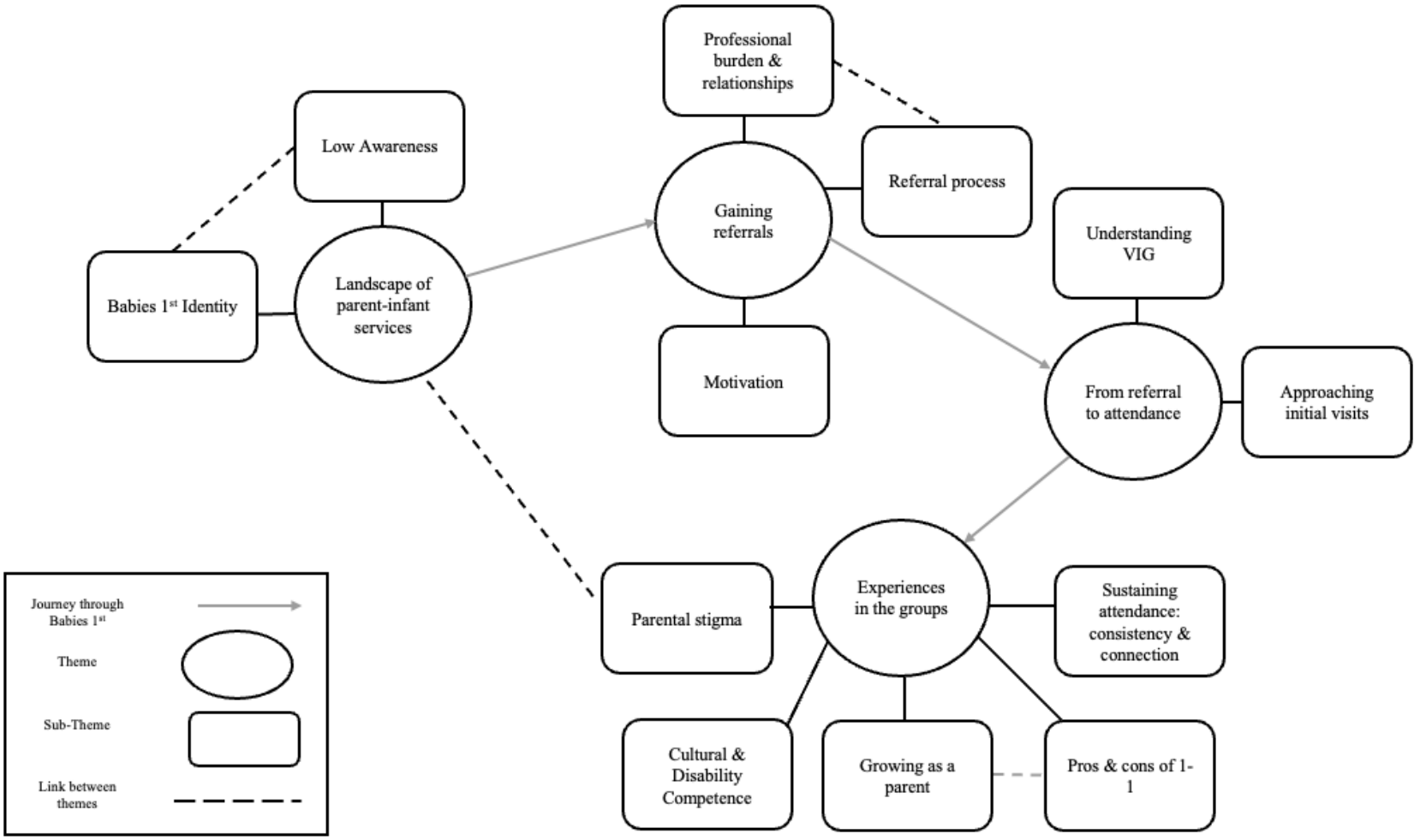
	step to going it can be really daunting but then I think it's about trying to break that barrier down' (R05).
Theme 4: Experiences in the group	**Supporting Quotations**
Pros & cons of 1-1	'The work is really crucial but I think it needs to be done 1-1 with [name of parent] and it's too exposing in the group and god bless her [name of parent] stands up there and says that she feels nothing for her baby and that is tough' (F08). 'I was at the group and they [facilitators] said it wasn't been having as much impact as they had hoped so then I had some 1-1 for a while' (P01). 'I think we are in a time where time is money and we do not have a lot of either. When you look at a ratio of practitioner to client numbers a group is better, sometimes it is not always suitable and sometimes you do have to do 1-1s because that is so intense' (R05).
Cultural & Disability Competence	"I think it is trying to break down that barrier what that certain cultures expect and what they think and what is their experience and viewpoint and then trying to work through that' (R05). 'I am from a different culture/country. I feel supported through my cultural differences' (P04). 'I think obviously making groups accessible for everybody but still being able for the facilitators to cater for individual needs' (F06).

Sustaining engagement: consistency & connection	"If you were doing the opposite of changing times and days all the time it would be really difficult for everyone as you would not have a set schedule' (P03). 'Food would be great too, if they [parents] could all stay and have a lunch that would help them connect socially as well wouldn't it you know yeah and things like mum's meet ups so it becomes like a real little community' (F08).
Growing as a parent	'It is nice to hear how other people's experiences are because a lot of the time you can relate so you do not feel so alone' (P03). '…[parents] watching each other's [photos and videos] they can all probably feedback what they have noticed and give support to the mum saying this is what you could do and take bits back for themselves' (R05). 'I mean it has been kind of comforting to know that like I am doing the right things for [my child]' (P01). 'Slowly I have learned that I can find ways to deal with it [parenting difficulties] without going to that baby group, so I have grown out of it a little bit and I do think people grow out of that group' (P02). 'It has made me more confident that I am sort of doing my best by [my child]' (P03). 'You can see it feels very meaningful, because you can see those lightbulb moments in mums and they suddenly realise that things are not as bad as they think' (F08).

	'We get a lot of mums with very low self-esteem or no confidence really or just feeling totally overwhelmed and they put a lot of blame on themselves and feel a lot of guilt and shame. It is so nice to reinforce what they experience is normal, they are doing a much better job, they have bonded with their babies, but they don't see or feel that they have at that point' (F08).
Parental Stigma	'[Facilitator] definitely does not seem to understand me sometimes' (P01). 'You will be asked questions in front of other people, if you don't really know them or don't feel comfortable with them then ... then you might not come back straight away' (P02). 'You are not going to open up are you about these things, about issues about bonding, you don't want to be judged again as I said people get paranoid that social services will come round' (P02). '[Facilitator] can come across a little pushy to people who are already doubting themselves all the time as a parent, it can be a little intimidating even if when they don't mean to be. So it is just really making sure anyone sort of running the groups...takes a very laid-back approach... to how they look at our parenting so no one feels judged…I think that would be the biggest thing for me would be who is running it as that can change the whole atmosphere' (P03). '…because you feel like someone is always saying something about your parenting or correcting you on something so you then don't want to open up about something you think is even worse' (P03).

	'I have come across some mums who won’t go to groups because they are scared of seeing someone that they know but it’s about making sure they know its confidential you know no one needs to be told’ (R05).

Thematic Map



Appendix P: SIP – Journal Author Guidelines

The Journal of Reproductive and Infant Psychology authors guidance is found here: https://www.tandfonline.com/action/authorSubmission?show=instructions&journalCode=cjri20. A manuscript was submitted in November 2024 and is under peer review as of May 2025. The journal is open access and accepts original pieces of work. It has a word limit of 5000 words for qualitative methods and authors must conform to APA style referencing. Additional requirements of the journal are included below, as follows:

Acknowledgements

With thanks to our experts by experience, our valued participants, and the 'Babies 1st' team who generously gave their time to speak with us and develop the project.

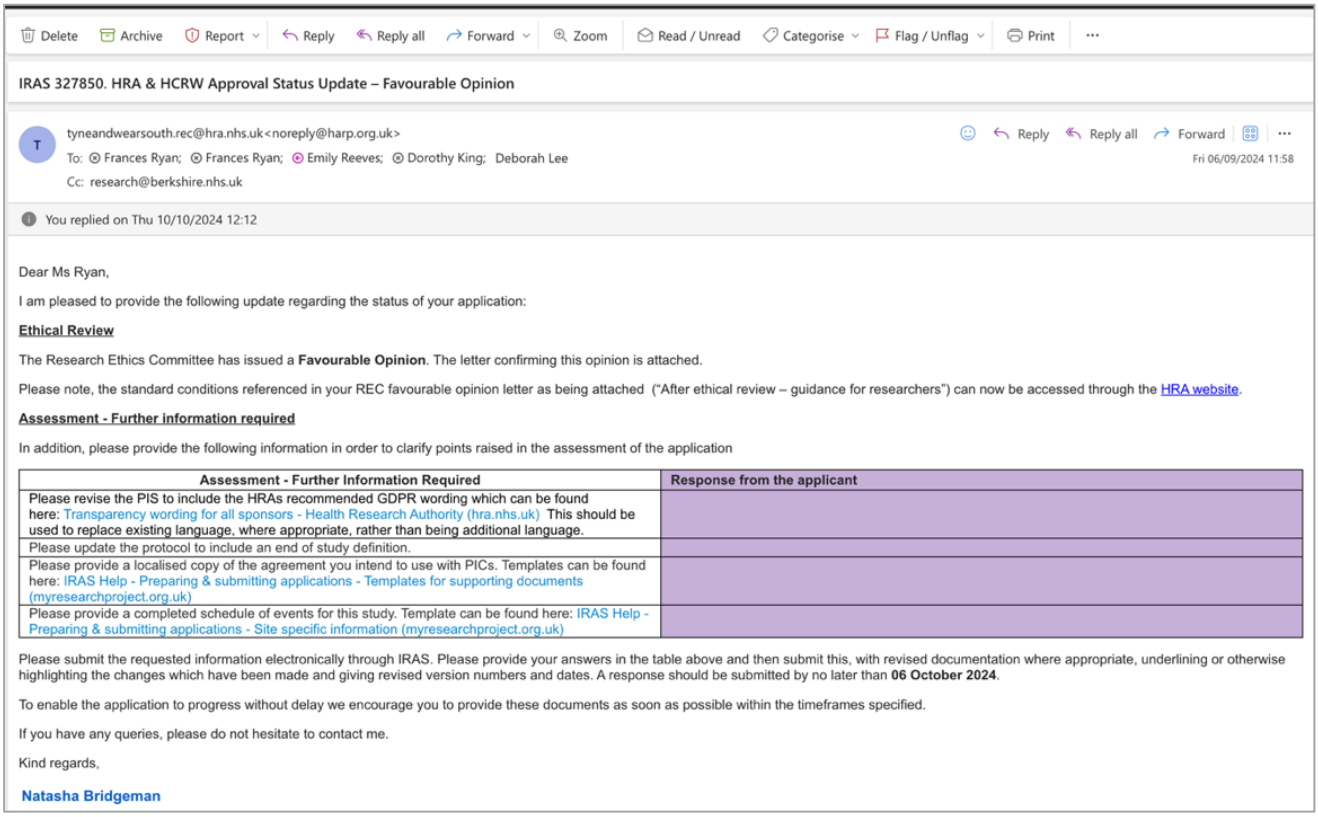
Declaration of Interest Statement

Authors Frances Ryan and Dr Fiona Challacombe declare no conflict of interest. Frances Ryan is a Trainee Clinical Psychologist and Dr Fiona Challacombe is a Research Clinical Psychologist. The project is part of a doctoral thesis funded by the Oxford Institute of Clinical Psychology Training and Research. Authors Dr Rebecca Knowles Bevis and Monika Celebi work within 'Babies 1st'. Neither was directly involved in data collection nor interviews. Their perspectives were embraced and valued as part of the reflexive analytic process and in considering the implementation of recommendations.

Appendix Q: TDRP – Ethics and Sponsorship Arrangements

The Chief Investigator (CI) for the project was the trainee (Fran Ryan) and Dr Dorothy King acted as the Principal Investigator (PI). A favourable opinion was issued from REC on 6th September 2024. Three minor recommendations were made following helpful peer review and additional information supplied. HRA and HCRW approval was granted on 11th October 2024. Confirmation of capacity and capability was issued by the Sponsor on 30th October 2024 and from the PIC (following application) on 19th November 2024. On 13th January 2025, an amendment was submitted to enable the use of Microsoft Forms to collect consent in the NHS service (as well as paper-based recording of consent), update the community information sheet to centre the eligibility criteria (upon some guidance from charities advertising the study), and update the link for PIC recruitment. These changes were deemed to be non-substantial in discussion with the Sponsor. Example documents (from a much larger set of documents produced) at each stage of the process are provided as follows:

REC Favourable Opinion, Email (1 of 1)



Delete Archive Report Reply Reply all Forward Zoom Read / Unread Categorise Flag / Unflag Print ...

IRAS 327850. HRA & HCRW Approval Status Update – Favourable Opinion

tyneandwearsouth.rec@hra.nhs.uk<noreply@harp.org.uk>
To: Frances Ryan; Frances Ryan; Emily Reeves; Dorothy King; Deborah Lee
Cc: research@berkshire.nhs.uk

Reply Reply all Forward ...
Fri 06/09/2024 11:58

You replied on Thu 10/10/2024 12:12

Dear Ms Ryan,

I am pleased to provide the following update regarding the status of your application:

Ethical Review

The Research Ethics Committee has issued a **Favourable Opinion**. The letter confirming this opinion is attached.

Please note, the standard conditions referenced in your REC favourable opinion letter as being attached ("After ethical review – guidance for researchers") can now be accessed through the HRA website.

Assessment - Further information required

In addition, please provide the following information in order to clarify points raised in the assessment of the application

Assessment - Further Information Required	Response from the applicant
Please revise the PIS to include the HRAs recommended GDPR wording which can be found here: Transparency wording for all sponsors - Health Research Authority (hra.nhs.uk) This should be used to replace existing language, where appropriate, rather than being additional language.	
Please update the protocol to include an end of study definition.	
Please provide a localised copy of the agreement you intend to use with PICs. Templates can be found here: IRAS Help - Preparing & submitting applications - Templates for supporting documents (myresearchproject.org.uk)	
Please provide a completed schedule of events for this study. Template can be found here: IRAS Help - Preparing & submitting applications - Site specific information (myresearchproject.org.uk)	

Please submit the requested information electronically through IRAS. Please provide your answers in the table above and then submit this, with revised documentation where appropriate, underlining or otherwise highlighting the changes which have been made and giving revised version numbers and dates. A response should be submitted by no later than **06 October 2024**.

To enable the application to progress without delay we encourage you to provide these documents as soon as possible within the timeframes specified.

If you have any queries, please do not hesitate to contact me.

Kind regards,

Natasha Bridgeman

REC Favourable Opinion Letter Sample (1 of 2)

NHS
Health Research Authority

North East - Tyne & Wear South Research Ethics Committee
NHSBT Newcastle Blood Donor Centre
Holland Drive
Newcastle upon Tyne
NE2 4NQ

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

06 September 2024

Ms Frances Ryan
The Oxford Institute of Clinical Psychology Training and Research
Isis Education Centre
Warneford Hospital
OX3 7JX

Dear Ms Ryan

Study title:	**Exploring the effects of childhood memories of warmth & safeness and self-compassion on trauma-related shame in adults with Complex Post Traumatic Stress Disorder (CPTSD).**
REC reference:	**24/NE/0166**
IRAS project ID:	**327850**

The Research Ethics Committee (REC) reviewed the above application at the meeting held on 02 September 2024. Thank you for attending to discuss the application.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies

REC Favourable Opinion Letter Sample (2 of 2)

2. reporting results
3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Number	Recommendations
1)	The Committee recommends that the summary of the study states that the data that is being analysed is anonymised.
2)	The Committee recommends that it be made clear in the online consent section that participants can only complete the questionnaire once.
3)	The Committee recommends that the applicants state on the trauma free text section what the procedure will be if a participant is to name a perpetrator and highlight that it is unlikely to be investigated due to the anonymity of the study.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations.

Registration of Clinical Trials

All research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a public registry before the first participant is recruited and no later than six weeks after. For this purpose, 'clinical trials' are defined as:

- clinical trial of an investigational medicinal product
- clinical investigation or other study of a medical device
- combined trial of an investigational medicinal product and an investigational medical device
- other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.

A 'public registry' means any registry on the WHO list of primary registries or the ICMJE list of registries provided the registry facilitates public access to information about the UK trial.

HRA Approval Letter Sample (1 of 1)

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Ms Frances Ryan
The Oxford Institute of Clinical Psychology Training and Research
Isis Education Centre
Warneford Hospital
OX3 7JX

Email: approvals@hra.nhs.uk

11 October 2024

Dear Ms Ryan

HRA and Health and Care

Study title:	**Exploring the effects of childhood memories of warmth & safeness and self-compassion on trauma-related shame in adults with Complex Post Traumatic Stress Disorder (CPTSD).**
IRAS project ID:	**327850**
REC reference:	**24/NE/0166**
Sponsor	**Berkshire Healthcare NHS Foundation Trust**

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation.

Confirmation of Capacity & Capability from Sponsor Sample (1 of 2)

NHS
Berkshire Healthcare
NHS Foundation Trust

From: Research@berkshire.nhs.uk

To: PI, Co-I, Site Clinical team, Research Delivery team, Sponsor, Divisional Head (for info only)

Copy in: R&D Ops manager, Lead Research Nurse

Subject: Confirmation of Capacity and Capability at Berkshire Healthcare

Dear Dot King,

Full Study Title: Exploring the effects of childhood memories of warmth & safeness and self-compassion on trauma-related shame in adults with Complex Post Traumatic Stress Disorder (CPTSD).

IRAS number: 327850 **R&D Reference:** 24MHSN327850 **Portfolio Status:** Non Portfolio

This email confirms that following a full review, Berkshire Healthcare NHS Foundation Trust has the capacity and capability to deliver the above-mentioned study.

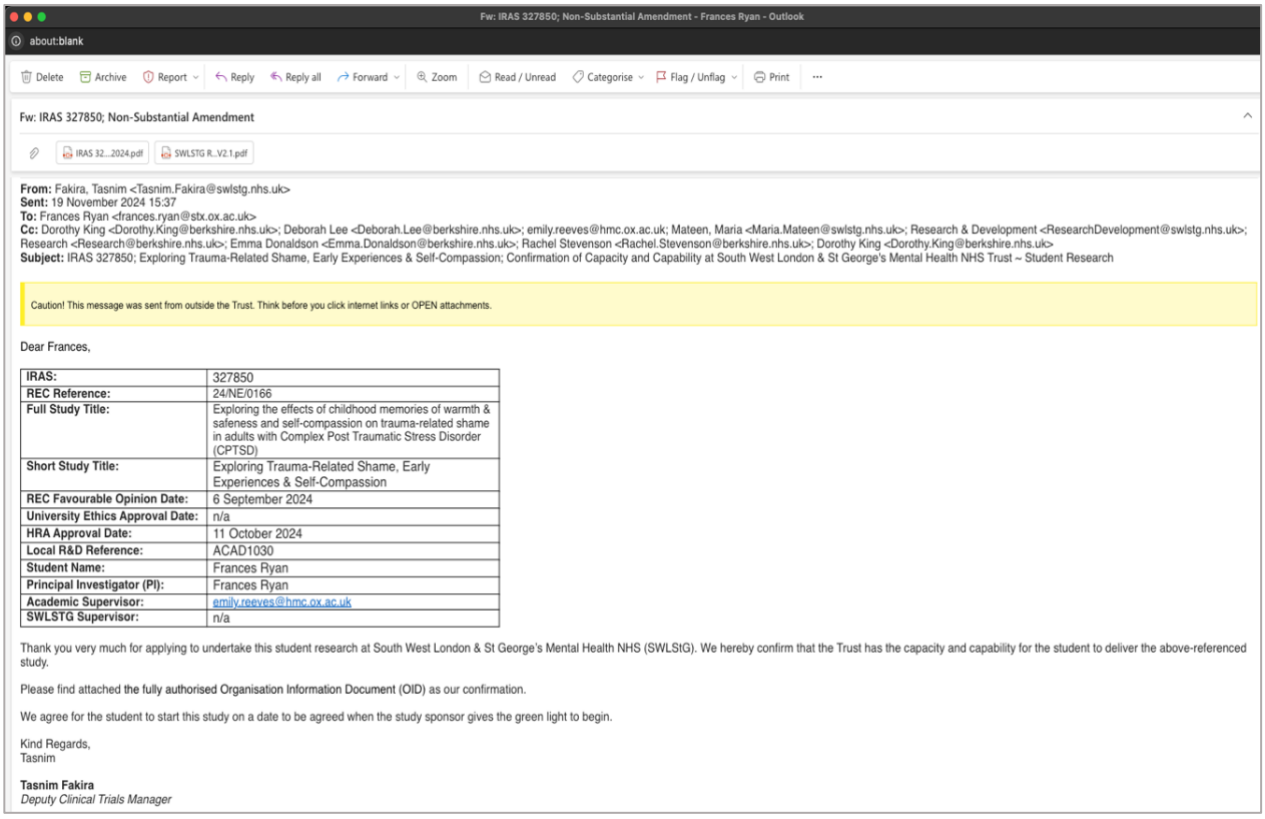
The current documents approved by the HRA and agreed for use at our site are:

Document	Version	Date
TDRP Protocol CPTSD	V4.4	4 October 2024
BTSS Information Sheet	V2.2	2 October 2024
Community & PIC Information Sheet	V2.1	2 October 2024
BTSS Consent Form	V2.1	6 May 2024
Community & PIC consent form	V2.1	4 October 2024
BTSS Template Clinical Note for Consent	V1	6 May 2024
Community & PIC debrief & further support page A	V2.1	2 October 2024
Community & PIC debrief & further support page B	V2.1	2 October 2024
Getting Support Page	V2.1	2 October 2024
SWLSTG PIC Team Information Sheet	V2	28 May 2024
BTSS Recruitment Poster	V2	6 May 2024

Confirmation of Capacity & Capability from Sponsor Sample (2 of 2)

Community Recruitment Poster (with PPI)	V4	6 May 2024
Instagram Formatted Community Recruitment Poster	V1	6 May 2024
SWLSTG Recruitment Poster	V2	6 May 2024
BHFT Organisation Information Document	V1	24 June 2024
SWLSTG BHFT Signed Organisation Information Document	V1	3 October 2024
BTSS & Community Schedule of Events	V1	27 August 2024
PIC Schedule of Events	V1	27 August 2024

Confirmation of Capacity & Capability from PIC email (1 of 1)



Fw: IRAS 327850; Non-Substantial Amendment - Frances Ryan - Outlook

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Fw: IRAS 327850; Non-Substantial Amendment

IRAS 32...2024.pdf | SWLSTG R...V2.1.pdf

From: Fakira, Tasnim <Tasnim.Fakira@swlstg.nhs.uk>
Sent: 19 November 2024 15:37
To: Frances Ryan <frances.ryan@stx.ox.ac.uk>
Cc: Dorothy King <Dorothy.King@berkshire.nhs.uk>; Deborah Lee <Deborah.Lee@berkshire.nhs.uk>; emily.reeves@hmc.ox.ac.uk; Mateen, Maria <Maria.Mateen@swlstg.nhs.uk>; Research & Development <ResearchDevelopment@swlstg.nhs.uk>; Research <Research@berkshire.nhs.uk>; Emma Donaldson <Emma.Donaldson@berkshire.nhs.uk>; Rachel Stevenson <Rachel.Stevenson@berkshire.nhs.uk>; Dorothy King <Dorothy.King@berkshire.nhs.uk>
Subject: IRAS 327850; Exploring Trauma-Related Shame, Early Experiences & Self-Compassion; Confirmation of Capacity and Capability at South West London & St George's Mental Health NHS Trust ~ Student Research

Caution! This message was sent from outside the Trust. Think before you click internet links or OPEN attachments.

Dear Frances,

IRAS:	327850
REC Reference:	24/NE/0166
Full Study Title:	Exploring the effects of childhood memories of warmth & safeness and self-compassion on trauma-related shame in adults with Complex Post Traumatic Stress Disorder (CPTSD)
Short Study Title:	Exploring Trauma-Related Shame, Early Experiences & Self-Compassion
REC Favourable Opinion Date:	6 September 2024
University Ethics Approval Date:	n/a
HRA Approval Date:	11 October 2024
Local R&D Reference:	ACAD1030
Student Name:	Frances Ryan
Principal Investigator (PI):	Frances Ryan
Academic Supervisor:	emily.reeves@hmc.ox.ac.uk
SWLSTG Supervisor:	n/a

Thank you very much for applying to undertake this student research at South West London & St George's Mental Health NHS (SWLStG). We hereby confirm that the Trust has the capacity and capability for the student to deliver the above-referenced study.

Please find attached the fully authorised Organisation Information Document (OID) as our confirmation.

We agree for the student to start this study on a date to be agreed when the study sponsor gives the green light to begin.

Kind Regards,
Tasnim

Tasnim Fakira
Deputy Clinical Trials Manager

Non-Substantial Amendment Tool Frontpage Summary, 13th January 2025 (1 of 1)

Amendment Tool

v1.6 05 December 2021

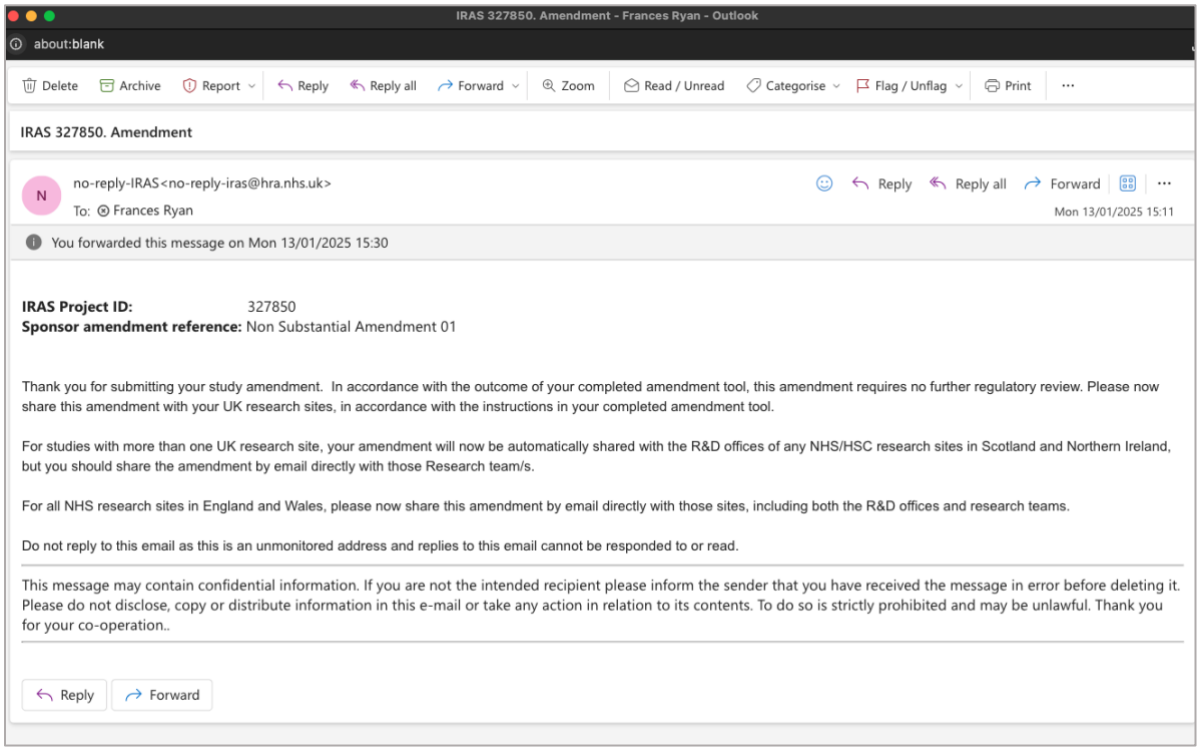
For office use
QC: No

Section 1: Project information

Short project title*:	Exploring Trauma-Related Shame, Early Experiences & Self-Compassion
IRAS project ID* (or REC reference if no IRAS project ID is available):	IRAS no: 327850 | REC reference: 24/NE/0166
Sponsor amendment reference number*:	Non Substantial Amendment 01
Sponsor amendment date* (enter as DD/MM/YY):	03 December 2024
Briefly summarise in lay language the main changes proposed in this amendment. Explain the purpose of the changes and their significance for the study. If the amendment significantly alters the research design or methodology, or could otherwise affect the scientific value of the study, supporting scientific information should be given (or enclosed separately). Indicate whether or not additional scientific critique has been obtained (note: this field will adapt to the amount of text entered)*:	Summary of three non-substantial amendments proposed: (1) To upload the BTSS consent form (V2.1) from Microsoft Word to Microsoft Forms and ask BTSS participants to complete the consent form electronically. All of the consent clauses remain the same; we wish to amend the delivery of the consent form. This is for ease of access for BTSS participants and aligns with the process used in the service to collect measures electronically through Microsoft Forms. (2) To amend the SWLSTG recruitment poster (V2) & change the SWLSTG Qualtrics link. The link will continue to carry SWLSTG participants to the same online questionnaire that was approved by REC. There is no change to the process/procedure for these participants. We wish to offer SWLSTG participants a different Qualtrics link so as to more accurately describe our community and clinical sample (as using the same Qualtrics link would mean the community and PIC data will be merged and we will not be able to differentiate, this change means that the community sample and PIC will have a different link leading to the same set of measures). (3) To make a minor amendment the Community and PIC Information Sheet (V2.2) to reiterate our eligibility critiera at the top of the information sheet. This is with the aim of being much clearer for participants who we are looking to recruit (ahead of the screening questions) and is based on feedback from charities advertising the study around what would be helpful. No change to process/procedure.

Project type (select):	**Specific study**			
	Research tissue bank			
	Research database			
Has the study been reviewed by a UKECA-recognised Research Ethics Committee (REC) prior to this amendment?:	**Yes**		No	
What type of UKECA-recognised Research Ethics Committee (REC) review is applicable? (select):	**NHS/HSC REC**			
	Ministry of Defence (MoDREC)			
Is all or part of this amendment being resubmitted to the Research Ethics Committee (REC) as a **modified amendment** (i.e. a substantial amendment previously given an unfavourable opinion)?	Yes		**No**	
Where is the NHS/HSC Research Ethics Committee (REC) that reviewed the study based?:	England	Wales	Scotland	Northern Ireland
	Yes	No	No	No
Was the study a clinical trial of an investigational medicinal product (CTIMP) OR does the amendment make it one?:	Yes		**No**	
Was the study a clinical investigation or other study of a medical device OR does the amendment make it one?:	Yes		**No**	
Did the study involve the administration of radioactive substances, therefore requiring ARSAC review, OR does the amendment introduce this?:	Yes		**No**	
Did the study involve the use of research exposures to ionising radiation (not involving the administration of radioactive substances) OR does the amendment introduce this?:	Yes		**No**	
Did the study involve adults lacking capacity OR does the amendment introduce this?:	Yes		**No**	
Did the study involve access to confidential patient information outside the direct care team without consent OR does the amendment introduce this?:	Yes		**No**	
Did the study involve prisoners or young offenders who are in custody or supervised by the probation service OR does the amendment introduce this?:	Yes		**No**	
Did the study involve children OR does the amendment introduce this?:	Yes		**No**	
Did the study involve NHS/HSC organisations prior to this amendment?:	**Yes**		No	
Did the study involve non-NHS/HSC organisations OR does the amendment introduce them?:	**Yes**		No	
	England	Wales	Scotland	Northern Ireland

Non-Substantial Amendment Email, no further review, 13th January 2025 (1 of 1)



IRAS 327850. Amendment - Frances Ryan - Outlook

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IRAS 327850. Amendment

N no-reply-IRAS<no-reply-iras@hra.nhs.uk>
To: Frances Ryan
Reply | Reply all | Forward
Mon 13/01/2025 15:11

You forwarded this message on Mon 13/01/2025 15:30

IRAS Project ID: 327850
Sponsor amendment reference: Non Substantial Amendment 01

Thank you for submitting your study amendment. In accordance with the outcome of your completed amendment tool, this amendment requires no further regulatory review. Please now share this amendment with your UK research sites, in accordance with the instructions in your completed amendment tool.

For studies with more than one UK research site, your amendment will now be automatically shared with the R&D offices of any NHS/HSC research sites in Scotland and Northern Ireland, but you should share the amendment by email directly with those Research team/s.

For all NHS research sites in England and Wales, please now share this amendment by email directly with those sites, including both the R&D offices and research teams.

Do not reply to this email as this is an unmonitored address and replies to this email cannot be responded to or read.

This message may contain confidential information. If you are not the intended recipient please inform the sender that you have received the message in error before deleting it. Please do not disclose, copy or distribute information in this e-mail or take any action in relation to its contents. To do so is strictly prohibited and may be unlawful. Thank you for your co-operation..

Reply | Forward

Both the Sponsor and PIC R&D teams re-confirmed continuing confirmation of capacity and capability following the submission of this non-substantial amendment.

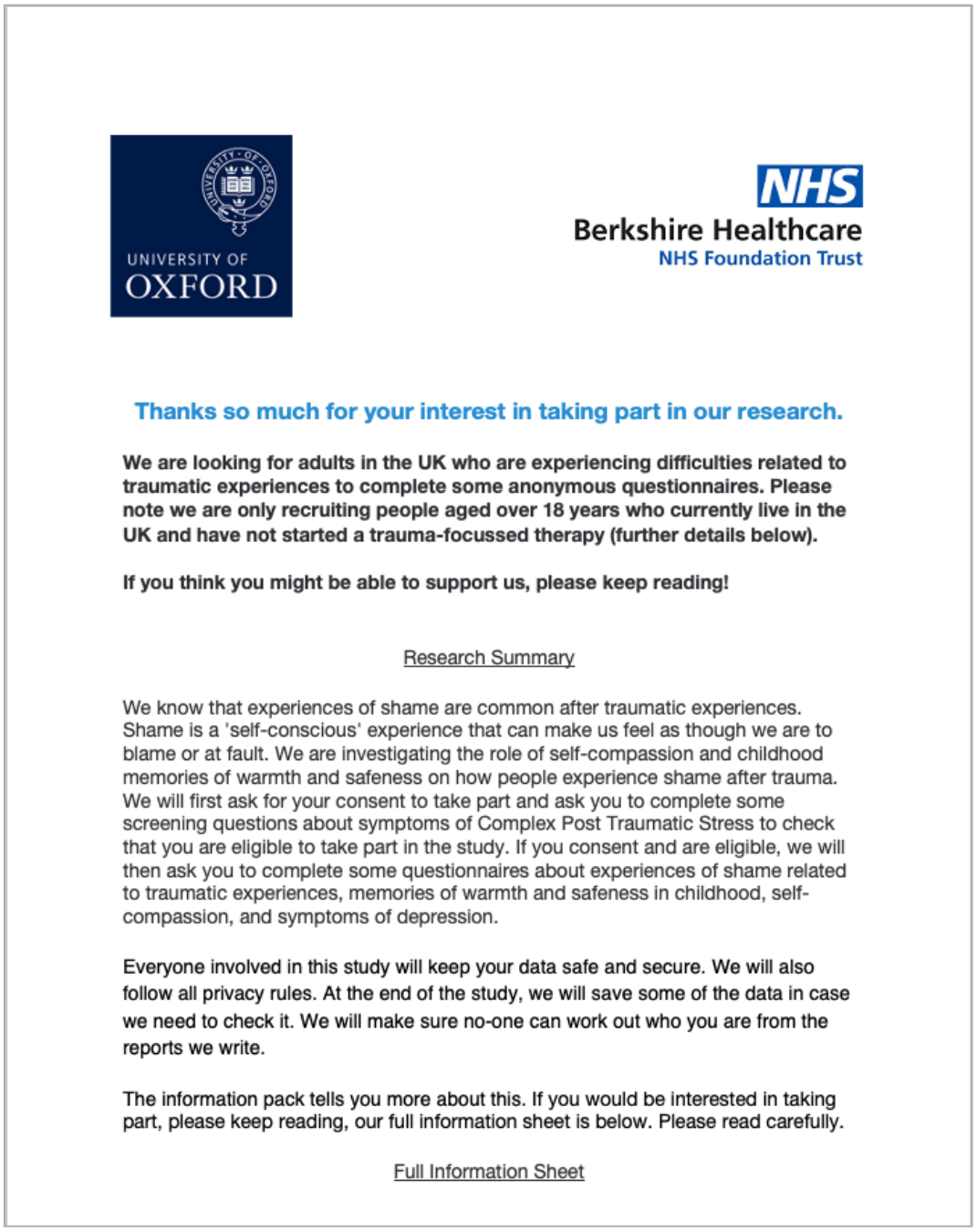
Appendix R: TDRP - Example Community Recruitment Poster Sample (1 of 1)



Note: variations of this poster were made for NHS and PIC participants.

Appendix S: TDRP - Participant Information & Consent Sheets

Community Participant Information Sheet (1 of 6)



UNIVERSITY OF OXFORD

NHS
Berkshire Healthcare
NHS Foundation Trust

Thanks so much for your interest in taking part in our research.

We are looking for adults in the UK who are experiencing difficulties related to traumatic experiences to complete some anonymous questionnaires. Please note we are only recruiting people aged over 18 years who currently live in the UK and have not started a trauma-focussed therapy (further details below).

If you think you might be able to support us, please keep reading!

Research Summary

We know that experiences of shame are common after traumatic experiences. Shame is a 'self-conscious' experience that can make us feel as though we are to blame or at fault. We are investigating the role of self-compassion and childhood memories of warmth and safeness on how people experience shame after trauma. We will first ask for your consent to take part and ask you to complete some screening questions about symptoms of Complex Post Traumatic Stress to check that you are eligible to take part in the study. If you consent and are eligible, we will then ask you to complete some questionnaires about experiences of shame related to traumatic experiences, memories of warmth and safeness in childhood, self-compassion, and symptoms of depression.

Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules. At the end of the study, we will save some of the data in case we need to check it. We will make sure no-one can work out who you are from the reports we write.

The information pack tells you more about this. If you would be interested in taking part, please keep reading, our full information sheet is below. Please read carefully.

Full Information Sheet

Community Information Sheet (2 of 6)

Who are we?

We are a team of researchers based at either Oxford University or Berkshire Healthcare NHS Foundation Trust.

The project is being completed by Fran Ryan, Trainee Clinical Psychologist (Oxford Institute for Clinical Psychology Training & Research) supervised by Dr Dorothy King, Clinical Psychologist (Berkshire Traumatic Stress Service) Dr Emily Reeves, Clinical Psychologist (Oxford Institute for Clinical Psychology Training & Research) and Dr Deborah Lee, Consultant Clinical Psychologist (Berkshire Traumatic Stress Service).

Dorothy King is the Principal Investigator.
Fran Ryan is the Chief Investigator.

Berkshire Healthcare NHS Foundation Trust has kindly sponsored this study. Use of the word 'we' refers to the sponsor and research team.

What is the purpose of our study?

We know some people experience shame after traumatic events or experiences. Shame is often thought of as a 'self-conscious' experience that can attack our sense of self-worth and can make us feel as though we are to blame, worthless, or helpless. Shame can be a barrier to reaching out for help, talking to a therapist, or accessing feelings to process trauma memories. We don't fully know what leads some people to experience more shame than others. Theories suggest our childhood experiences of warmth and safeness and self-compassion (how compassionate we can be towards ourselves in times of difficulty) are connected to how much shame people experience following trauma. This study has been reviewed by expert by experience advisors from Berkshire Traumatic Stress Service & aims to help us begin to fill this gap and better understand how to support people who experience shame after traumatic events.

What is involved?

The questionnaires should take no more than 10-15 minutes to complete. No background knowledge is needed & there are no right or wrong answers.

We will first ask you about symptoms of Complex PTSD using The International Trauma Questionnaire. If you are eligible, we will then ask you to complete questionnaires about:

- Experiences of shame related to traumatic events (The Trauma Related Shame Inventory)

- Memories of warmth and safeness in childhood (The Early Memories of Warmth and Safeness Scale)
- Self-compassion (The Compassionate Engagement & Action Scale)
- Symptoms of depression (The Patient Health Questionnaire 8).

We will also ask some basic questions about yourself, including your age, gender, and ethnicity. We will not collect any information that could personally identify you and have designed this study to be anonymous. This means we cannot personally identify you through your responses. Please note that deciding to take part in this study will not impact how or if you receive care from an NHS service if this is applicable to you. Please only participate in this study once.

How do I take part?

You can click yes (or no) below to give your consent to take part. If you consent, we'll invite to complete some screening questions. Only people experiencing current symptoms of complex post-traumatic stress will be invited to participate. You will then be asked to complete some questions related to experiences of shame, memories of warmth and safeness, self-compassion, and mood.

If you're not eligible to take part in this study, the questionnaire will end and your answers will not be stored. All studies have criteria for participation so please note that not being eligible is not a reflection on the nature of your experiences.

Who can take part?

We are looking for adults who are currently experiencing symptoms of Complex Post Traumatic Stress Disorder (CPTSD). You don't have to have been given a formal diagnosis to take part. We are asking everyone to complete some screening questions at the beginning to check that you are eligible to participate. You will need to:

- To be aged 18 years or older
- Live in the UK
- Not currently be receiving a trauma-focussed therapy. It is absolutely ok to be thinking about therapy or be on a waitlist, but please note we are only recruiting people who have **not begun** therapy at present. Examples of therapies might include trauma-focussed cognitive-behavioural therapy (CBT), eye movement desensitisation and reprocessing (EMDR), Narrative Exposure Therapy (NET) or other trauma-focussed therapies. Please note that if you access other support, such as attending an online or in-person survivor group or receive peer-support or mentoring, you are eligible to participate.

Community Information Sheet (4 of 6)

Do I have to take part?

No. Taking part is completely voluntary. You may withdraw (without giving a reason & with no consequence) up until the point where you submit your responses. You can withdraw by pressing the exit button or closing your browser before submitting your answers and your data will not be stored. If you are accessing NHS service, withdrawing your consent will not impact your care in any way.

As the study is completely anonymous, we cannot withdraw your data after you submit your responses as we will not be able identify you in our research.

What are the risks and benefits of taking part?

Some questionnaires will ask you about memories in childhood and symptoms and difficulties you may be experiencing following traumatic events. Some questions may be more difficult to think about or bring up unexpected emotions.

We have put together a support page (getting support) with links to some helpful grounding exercises and signposting to places where you can get further advice or support. You can download the page if you would find it helpful. Support information will also be available at the end of the questionnaire. If you choose to exit the questionnaire early, you can still return here (to this information sheet) to access the getting support link if you would find it helpful.

Experts with lived experiences of traumatic stress have supported us to review our study materials. If you are accessing an NHS service, choosing to participate will not impact your care in the service. One future benefit of the research is that it will help us, as researchers and clinicians in the field, to better understand how to support people who experience shame after traumatic events.

What personal data is collected?

No identifiable personal data will be collected.

We're collecting limited demographic data to help understand if certain factors (e.g. age or gender) impact on how people answer questions. This information is commonly collected and is important for describing our sample, and assessing how representative it is of the broader population. Your IP address will not be stored. We'll take steps to ensure data remains confidential, such as password protection.

Your responses to this study are anonymous. This means we cannot identify you personally through your responses. There is one free-text question (Question 6), which asks you to briefly describe the experience that troubles you the most. Please do **not** provide us with identifiable information on this question. If you do provide us with identifying information (for example, the name of someone who abused you)

and go onto complete the full questionnaire, we will be obliged to pass this information onto the relevant authorities - even though we will not know who you are. Details and links to further support are provided on the getting support and debrief pages.

Who will have access to my data & how will it be stored?

The research team involved in this study will have access to the research data, which is anonymous. Responsible members of the University of Oxford may be given access to data for monitoring and/or audit. The responses you provide will be stored in a password-protected electronic file on a secure server. Research data will be stored for 3 years after completion.

You can find out more about how we use your information at

- Visiting www.hra.nhs.uk/information-about-patients
- By asking one of the research team using the contact details at the bottom of this page.
- Contact Berkshire Healthcare NHS Foundation Trust Data Protection Officer at research@berkshire.nhs.uk or https://www.berkshirehealthcare.nhs.uk/get-involved/our-research-and-development/

Will the research be published?

The findings will be shared on the media channels used to advertise our study. The findings will be submitted for publication to an academic journal and may be presented at conferences. The results will be written up for a Doctorate in Clinical Psychology. On submission of the thesis, it will be deposited both in print and online in the University of Oxford archives to facilitate open-access use for future research.

Who has reviewed the study?

The project has been reviewed by experts by experience from Berkshire Traumatic Stress Service, Berkshire Healthcare NHS Foundation Trust Research & Development Team, and received ethical approval through IRAS (Project Number 327850), REC reference number 24/NE/0166. It has been funded by Oxford Institute for Psychology Training and Research.

Who do I contact if I have a concern?

If you have a concern or question, please see the contacts below. If you wish to raise a compliant, we will acknowledge your complaint within 10 working days and give you an indication of how long it will take to be dealt with.

Contact details

Fran Ryan - Trainee Clinical Psychologist
Oxford Institute of Clinical Psychology Training & Research, Isis Education Centre, Warneford Hospital, Oxford OX3 7JX.
Email: frances.ryan@stx.ox.ac.uk

Dr Dorothy King - Clinical Psychologist
Berkshire Traumatic Stress Service, Erlegh House, Whiteknights Campus, University of Reading, RG6 6BZ.
Email: traumaandveterans@berkshire.nhs.uk.

Project title: Exploring the effects of childhood memories of warmth & safeness and self-compassion on trauma-related shame in adults with CPTSD | IRAS Project: 327850 | REC Reference 24/NE/0166 | Community and PIC Information Sheet V2.2 | 3 December 2024.

Thank you for taking the time to read this information sheet.

NHS Participant Information Sheet (1 of 6)



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NHS
Berkshire Healthcare
NHS Foundation Trust

Berkshire Traumatic Stress Service Information Sheet

Research Summary

We know that experiences of shame are common after traumatic experiences. Shame is a 'self-conscious' experience that can make us feel as though we are to blame or at fault.

We are investigating the role of self-compassion and childhood memories of warmth and safeness on how people experience shame following trauma. As part of your assessment and treatment with Berkshire Traumatic Stress Service, you will be asked to complete some questionnaires asking about symptoms of Complex Post Traumatic Stress Disorder, experiences of shame related to traumatic experiences, memories of warmth and safeness in childhood, self-compassion, and symptoms of depression.

In this research study we will use information from questionnaires you have completed. We will only use information that we need for the research study. We will let very few people know your name or contact details, and only if they really need it for this study.

We are asking for your consent to use the scores from these questionnaires in our research project. We will ask you to complete a consent form. If you give your consent, any personally identifying details from your data will be removed and then passed with some basic demographic information about you (age, gender, & ethnicity) to the research team to use as part of the wider data set. This means that the research team will not be able to identify who you are, and your data will be pseudonymised. Deciding whether to give consent for your data to be used for this research will not impact your care with Berkshire Traumatic Stress Service in any way.

Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules.

At the end of the study, we will save some of the data in case we need to check it. We will make sure no-one can work out who you are from the reports we write.

The information pack tells you more about this. If you would be interested in giving consent, please keep reading.

NHS Participant Information Sheet (2 of 6)

Full Study Information Sheet

Before deciding whether to take part in this research, it is important to understand what is involved. Please read this information sheet carefully.

Who are we?

We are a team of researchers based at either University of Oxford or Berkshire Healthcare NHS Foundation Trust. The project is being completed by Fran Ryan, Trainee Clinical Psychologist (Oxford Institute for Clinical Psychology Training & Research) supervised by Dr Dorothy King, Clinical Psychologist (Berkshire Traumatic Stress Service), Dr Emily Reeves, Clinical Psychologist (Oxford Institute for Clinical Psychology Training & Research) and Dr Deborah Lee, Consultant Clinical Psychologist (Berkshire Traumatic Stress Service).

Dorothy King is the Principal Investigator.
Fran Ryan is the Chief Investigator.

Berkshire Healthcare NHS Foundation Trust has kindly sponsored this study. Use of the word 'we' refers to the sponsor and research team.

What is the purpose of our study?

We know some people experience shame after traumatic events. Shame is often thought of as a 'self-conscious' experience that can attack our sense of self-worth and can make us feel as though we are to blame, worthless, or helpless. Shame can be a barrier to reaching out for help, talking to a therapist, or accessing feelings to process traumatic memories. We don't fully know what leads some people to experience more shame than others. Theories suggest our childhood experiences of warmth and safeness and self-compassion (how compassionate we can be towards ourselves in times of difficulty) are connected to how much shame people experience following trauma. This study has been reviewed by expert by experience advisors from Berkshire Traumatic Stress Service & aims to help us begin to fill this gap and better understand how to support people who experience shame after traumatic events.

What is involved?

As a routine part of your assessment and treatment at Berkshire Traumatic Stress Service, you will be asked to complete questionnaires looking at:

- Symptoms of Complex PTSD (The International Trauma Questionnaire)
- Experiences of shame related to traumatic events (The Trauma Related Shame Inventory)
- Memories of warmth and safeness in childhood (The Early Memories of Warmth and Safeness Scale)
- Self-compassion (The Compassionate Engagement & Action Scale)
- Symptoms of depression (The Patient Health Questionnaire 8).

These are standard questionnaires that you will be asked to complete as part of your assessment and treatment in the service. You will be asked whether you give consent for us to use the data as part of the research project.

We are asking for your consent to use your scores from these questionnaires and some demographic information about you (age, gender, and ethnicity) as part of our research project.

When all the data has been collected for this study, a member of staff in Berkshire Traumatic Stress Service will remove all personally identifiable information before sending the data to the research team. This means that all data used for this research study will be pseudonymised, so that you cannot be personally identified by anyone in the research team or within our data.

It is important to know that it is your choice whether you take part in this research study and deciding whether to take part will not impact how or if you receive care from Berkshire Traumatic Stress Service or another NHS service.

How do I take part?

If you are willing for us to use your scores from these questionnaires in our research, please let us know using the contact details below or let your therapist know. We will then get in touch with you to ask you to complete a consent form. If you give your consent, clinicians within the team will pass your pseudonymised scores from these questionnaires and some basic demographic information about you (age, gender, & ethnicity) to the research team to use as part of the wider data set.

You may see this study advertised on media channels, please only participate in this study once.

Do I need a diagnosis to take part?

No. It is ok if you do have a diagnosis (such as Post Traumatic Stress Disorder or Complex Post Traumatic Stress Disorder), but we understand that not everyone will.

Do I have to take part?

No. Taking part is completely voluntary. Choosing whether to take part will not affect the care and treatment you receive in Berkshire Traumatic Stress Service. Once you have given your consent, your data will be pseudonymised ready to give to the research team, so we cannot withdraw your data as we will not be able identify you in our research!

What are the risks and benefits of taking part?

Some questionnaires you complete ask about memories in childhood and symptoms and difficulties you may be experiencing following traumatic events. Some questions may be more difficult to think about or bring up unexpected emotions. Completing these

questionnaires is part of routine practice in Berkshire Traumatic Stress Service and part of your assessment and treatment in the service. You will therefore have an allocated clinician that you can speak to if you would like help or support when completing the questionnaires. Experts with lived experiences of traumatic stress have supported us to review our study materials too.

There are no additional requirements for you in taking part in the study – we will ask for your consent to use scores from questionnaires that you will be asked to complete as a standard part of your assessment and first therapy appointment in the service. We will not ask you to complete anything in addition to this. Choosing to participate will not impact your care in the service. One (indirect) benefit is that it will help us (researchers and clinicians in the field) to better understand how to support people who experience shame after traumatic events.

What personal data is collected?

When completing the questionnaires as part of routine practice in Berkshire Traumatic Stress Service, you will be asked for your name on the consent form. The consent form will be stored on your clinical records, which are separate to the research study. When questionnaire scores are used for research purposes, any personally identifiable information will have been removed.

We're collecting limited demographic data to help understand if certain factors (e.g. age or gender) impact on how people answer questions. This information is commonly collected and is important for describing our sample, and assessing how representative it is of the broader population. We'll take reasonable measures to ensure data remains confidential, including using secure servers and password protection.

How will we use information about you?

We will need to use information from you from your questionnaires and records at Berkshire Traumatic Stress Service.

The research team involved in this study will have access to the research data, which is pseudonymised. Responsible members of the University of Oxford may be given access to data for monitoring and/or audit. Your responses will be pseudonymised at Berkshire Traumatic Stress Service and the raw scores shared with the research team. The data will be stored in a password-protected electronic file on a secure server at the University of Oxford. Research data will be stored for 3 years after completion.

This information will include you're your raw scores from the above questionnaires and your age, your gender and your ethnicity. People will use this information to do the research or to check your records to make sure that the research is being done properly.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

You can stop being part of the study at any time, without giving a reason, but we will keep the information about you that we already have. We need to manage your records in specific ways for research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

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

You can find out more about how we use your information at

- At https://www.hra.nhs.uk/information-about-patients/
- By asking one of the research team using the contact details at the bottom of this page.
- Contact Berkshire Healthcare NHS Foundation Trust Data Protection Officer at research@berkshire.nhs.uk or visit https://www.berkshirehealthcare.nhs.uk/get-involved/our-research-and-development/

Will the research be published?

The findings will be shared on the media channels used to advertise our study and Berkshire Traumatic Stress Service. The findings will be submitted for publication to an academic journal and may be presented at conferences. The results will be written up for a Doctorate in Clinical Psychology. On submission of the thesis, it will be deposited both in print and online in the University of Oxford archives to facilitate open-access use for future research.

Who has reviewed the study?

The project has been reviewed by experts by experience from Berkshire Traumatic Stress Service, Berkshire Healthcare Foundation Trust Research & Development Team, and received ethical approval through Tyne and Wear South Research Ethics Committee (IRAS Project Number 327850, REC reference number **24/NE/0166**. It has been funded by Oxford Institute for Psychology Training and Research.

Who do I contact if I have a concern?

If you have a concern or question, please see the contacts below. If you wish to raise a complaint, we will acknowledge your complaint within 10 working days and give you an indication of how long it will take to be dealt with.

You can also contact Patient Advice & Liaison Service (PALS) by:

- Calling 0118 904 34 67
- Email: PALS@berkshire.nhs.uk
- Or visit https://www.berkshirehealthcare.nhs.uk/contact-us/our-patient-advice-and-liaison-service-pals/

Contact details

Frances Ryan - Trainee Clinical Psychologist
Oxford Institute of Clinical Psychology Training & Research, Isis Education Centre, Warneford Hospital, Oxford OX3 7JX.
Email: frances.ryan@stx.ox.ac.uk

NHS Participant Information Sheet (6 of 6)

Dr Dorothy King - Clinical Psychologist
Berkshire Traumatic Stress Service, Erlegh House, Whiteknights Campus, University of Reading, RG6 6BZ.
Email: traumaandveterans@berkshire.nhs.uk

Thank you for taking the time to read this information sheet.

Community and PIC Participant Consent Form (1 of 2)

Community & PIC Consent Form V2

Q1. Please confirm the following to give your **consent** to take part.

I have read the information sheet & know where I can go to ask questions or access further support or signposting.

I understand I will be invited to complete some screening questions about symptoms of Complex Post-Traumatic Stress Disorder and, if eligible, be asked to complete some further questions that should not take more than 10-15 minutes to complete.

I understand if I am not eligible for this research study, none of my responses will be saved.

I know I can withdraw (for any reason & without consequence) up until I submit my responses at the end, after which I cannot withdraw as my responses are anonymous cannot be identified in the research.

I understand my responses are anonymous and I will not be personally identified in the write up or publication.

- ◯ Yes, I consent to take part.
- ◯ No, I do not consent to take part.

Q2. I confirm I'm aged 18 years old or older.

- ◯ Yes
- ◯ No

Q3. I live in the United Kingdom.

- ◯ Yes

○ No

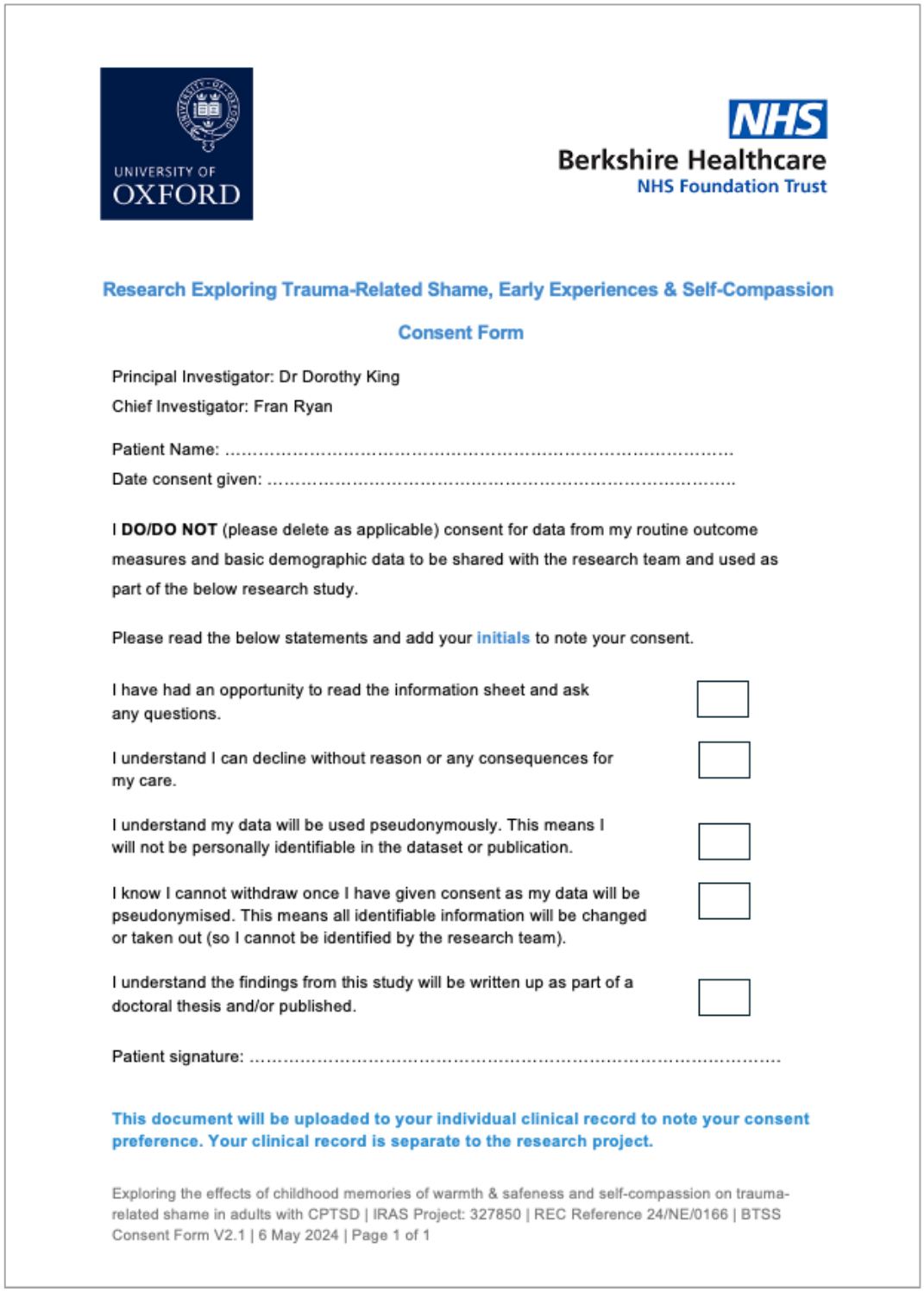
Q4. I am not currently accessing a trauma-focussed psychological therapy (including through the NHS, privately, or a charity).

○ No, I am not accessing trauma-focussed psychological therapy.
○ Yes, I am having trauma therapy.

Q5. We are recruiting for this study through lots of different places (including the NHS, charities, and social media). Please confirm that you have participated once.

○ Yes - I am taking part for the first time.
○ No - I have already completed this study.

NHS Participant Consent (1 of 1)



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NHS
Berkshire Healthcare
NHS Foundation Trust

Research Exploring Trauma-Related Shame, Early Experiences & Self-Compassion

Consent Form

Principal Investigator: Dr Dorothy King
Chief Investigator: Fran Ryan

Patient Name: .....
Date consent given: .....

I **DO/DO NOT** (please delete as applicable) consent for data from my routine outcome measures and basic demographic data to be shared with the research team and used as part of the below research study.

Please read the below statements and add your **initials** to note your consent.

I have had an opportunity to read the information sheet and ask any questions. ☐

I understand I can decline without reason or any consequences for my care. ☐

I understand my data will be used pseudonymously. This means I will not be personally identifiable in the dataset or publication. ☐

I know I cannot withdraw once I have given consent as my data will be pseudonymised. This means all identifiable information will be changed or taken out (so I cannot be identified by the research team). ☐

I understand the findings from this study will be written up as part of a doctoral thesis and/or published. ☐

Patient signature: .....

This document will be uploaded to your individual clinical record to note your consent preference. Your clinical record is separate to the research project.

Exploring the effects of childhood memories of warmth & safeness and self-compassion on trauma-related shame in adults with CPTSD | IRAS Project: 327850 | REC Reference 24/NE/0166 | BTSS Consent Form V2.1 | 6 May 2024 | Page 1 of 1

Note: following submission of a non-substantial amendment in January 2025 this form was uploaded to Microsoft Forms to enable electronic submission as well as paper based for participants at the NHS service.

Appendix T: TDRP – Example Debrief Sheet & Getting Support Page

All eligible participants scored for a probable diagnosis of CPTSD. The online study forked at the end based on PHQ-8 scores; those scoring above the threshold for clinical significance were taken to the below debrief sheet. Participants scoring below significance were taken to an identical debrief sheet without signposting related to depression.

Community and PIC Example Debrief (1 of 3)



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NHS
Berkshire Healthcare
NHS Foundation Trust

Thank you so much for taking part in our research study, we really appreciate your help.

This study will help us understand more about how self-compassion and early memories of warmth and safeness influence experiences of shame in adults who experience symptoms of Complex Post-Traumatic Stress Disorder.

We understand that some of the questions may be difficult to think about, so we really appreciate your time in helping us better understand trauma-related shame. We hope, through this work, we are better able to tailor the interventions and support that are offered in NHS services.

To remind you, your responses are anonymous. We store the results on a password-protected server, which can only be accessed by the research team.

Your responses suggest that you might be experiencing current difficulties with symptoms of Complex Post-Traumatic Stress Disorder and symptoms of depression. If you are not already accessing help, the NHS can help if you are experiencing difficulties with your mental health.

Grounding strategies

If you would benefit from some grounding strategies to help bring yourself into the present moment, you can find some ideas below:

Paced breathing calm exercise

Community and PIC Example Debrief (2 of 3)

https://www.youtube.com/watch?v=aNXKjGFUlMs

5-4-3-2-1 grounding technique
https://www.youtube.com/watch?v=30VMIEmA114

Further advice and support

If you are concerned about your mental health, we encourage you to speak to your GP who can then refer you for further help. If you are concerned about keeping yourself safe or are worried about risk to others, emergency assistance can be provided by calling 999 or attending your local Accident and Emergency Department (A&E). You can also call NHS 111 for help with urgent but non-life threatening difficulties.

Charities and other support

There are also many charities who can provide advice, emotional and practical support.

The Samaritans provide a 24-hour helpline and/or email service.
Free phone - 116 123
Email - jo@samaritans.org

Shout provides a free 24-hour mental-health text service.
Text SHOUT to 85258.

You may also want to look at the Mind website (www.mind.org.uk) which has information about different mental health difficulties, to see if this sounds like what you are experiencing and to find out more about getting support. Some people find it useful to have an idea of what to tell their GP or mental health clinician.

Please take a screenshot of this page if you would find it useful.

A note on confidentiality

Community and PIC Example Debrief (3 of 3)

Your responses to this study are anonymous - this means we cannot identify you personally through your responses. Question 6 asked you to describe the experience that troubles you the most. We asked you **not** to provide us with identifiable information. Please note that (if accidentally or intentionally) you have provided us with identifiable information (for example, the name of someone who hurt or abused you) we are obliged to pass this information onto the relevant authorities by way of duty of care around reporting, even though we will not know who you are.

If you have experienced a crime, you can access support through: https://www.victimsupport.org.uk/

If you have experienced a crime and would like to report this to the authorities anonymously, you can do so here: https://crimestoppers-uk.org/

If you have experienced a crime and would like to report this to the authorities, you can call 101.

Further questions or concerns

If you have questions about any aspect of this project, you can contact:

Fran Ryan - frances.ryan@stx.ox.ac.uk
Dr Dorothy King - traumaandveterans@berkshire.nhs.uk

If you know anyone else who may be eligible to participate in this study, you are welcome to provide them with the link to the questionnaire.

Title: Exploring the effects of childhood memories of warmth & safeness and self-compassion on trauma-related shame in adults with CPTSD | IRAS Project: 327850 | REC Reference 24/NE/0166 | Community and PIC Debrief & Support Page A V2.1 | 2 October 2024

Getting Support Page (1 of 3)

The below getting support page was embedded into the information sheet so all participants irrespective of eligibility could access the grounding strategies, signposting, and information.



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NHS
Berkshire Healthcare
NHS Foundation Trust

Getting Support

Thank you for your time. We understand that some of the questions may be difficult to think about, so we really appreciate your time in helping us better understand trauma-related shame. To remind you, your responses are anonymous. If you choose to exit the questionnaire after visiting this page, your responses will not be stored. If you choose to complete the questionnaire, we will store the results on a password-protected server, which can only be accessed by the research team.

Grounding strategies

If you would benefit from some grounding strategies to help bring yourself into the present moment, you can find some ideas below:

Paced breathing calm exercise
https://www.youtube.com/watch?v=aNXKjGFUlMs

5-4-3-2-1 grounding technique
https://www.youtube.com/watch?v=30VMIEmA114

Accessing mental health support

If you are not already accessing help, the NHS can help if you are experiencing difficulties with your mental health. There are also many charities who can provide advice, emotional and practical support.

If you are concerned about your mental health, we encourage you to speak to your GP who can then refer you for further help. If you are concerned about keeping yourself safe or are worried about risk to others, emergency assistance can be

Exploring the effects of childhood memories of warmth & safeness and self-compassion on trauma-related shame in adults with CPTSD | IRAS Project: 327850 | REC Reference 24/NE/0166 | Getting Support Page V2.1 | 2 October 2024 | Page 1 of 3

Getting Support Page (2 of 3)

provided by calling 999 or attending your local Accident and Emergency Department (A&E). You can also call NHS 111 for help with urgent but non-life threatening difficulties.

Charities

The Samaritans provide a 24-hour listening helpline and/or email service.
Free phone - 116 123
Email - jo@samaritans.org

Shout provide a 24-hour free mental-health text service.
Text SHOUT to 85258.

You may also want to look at the Mind website (www.mind.org.uk) which has information about different mental health difficulties, to see if this sounds like what you are experiencing and to find out more about getting support. Some people find it useful to have an idea of what to tell their GP or mental health clinician.

Please take a screenshot of this page if you would find it useful. It is also available at the end of the questionnaire.

A note on confidentiality

Your responses to this study are anonymous. This means we cannot identify you personally through your responses. Question 6 of our screening questions asked you to describe the experience that troubles you the most. We asked you not to provide us with identifiable information. Please continue to read if you (accidentally or intentionally) did provide us with identifiable information (for example, the name of someone who abused you). If you did not complete the study or were not eligible, it is important to know this data will not be stored and we will have no record of this. You can find ways to anonymously report crimes and/or abuse below. If you did provide us with identifiable information on Question 6 AND went onto complete the full questionnaire, please note we are obliged to pass any identifiable information (for example the name of an abuser) onto the relevant authorities by way of duty of care around reporting, even though we will not know who you are.

If you have experienced a crime, you can access support through: https://www.victimsupport.org.uk/

If you have experienced a crime and would like to report this to the authorities

Getting Support Page (3 of 3)

anonymously, you can do so here: https://crimestoppers-uk.org/

If you have experienced a crime and would like to report this to the authorities, you can call 101.

Further questions or concerns

If you have any more questions about any aspect of this project, please contact:
Fran Ryan - frances.ryan@stx.ox.ac.uk
Dr Dorothy King - traumaandveterans@berkshire.nhs.uk

Appendix U: TDRP – Additional Sample Demographic & Clinical Characteristics

Participant Ethnicities Relative to England and Wales Population Figures

	N	% sample	% England & Wales*
Asian, Asian British or Asian Welsh: Bangladeshi	2	1.04	1.1
Asian, Asian British or Asian Welsh: Chinese	0	0	0.7
Asian, Asian British or Asian Welsh: Indian	5	2.6	3.1
Asian, Asian British or Asian Welsh: Pakistani	3	1.56	2.7
Asian, Asian British or Asian Welsh: Other Asian	1	0.52	1.6
Black, Black British, Black Welsh, Caribbean or African: African	0	0	2.5
Black, Black British, Black Welsh, Caribbean or African: Caribbean	2	1.04	1
Black, Black British, Black Welsh, Caribbean or African: Other Black	0	0	0.5
Mixed or Multiple ethnic groups: White and Asian	6	3.13	0.8
Mixed or Multiple ethnic groups: White and Black African	4	2.1	0.4
Mixed or Multiple ethnic groups: White and Black Caribbean	2	1.04	0.9
Mixed or Multiple ethnic groups: Other Mixed or Multiple ethnic groups	5	2.6	0.8
White: English, Welsh, Scottish, Northern Irish or British	142	73.96	74.4
White: Irish	1	0.52	0.9
White: Gypsy or Irish Traveller	0	0	0.1
White: Roma	0	0	0.2
White: Other White	17	8.85	6.2
Other ethnic group: Any other ethnic group	2	1.04	1.6

*Data taken from the census (National Office for Statistics, 2021).

Trauma types reported in the sample.

ITQ Trauma Type	**Reported Frequency**	
	Community	NHS
Physical Abuse		
Physical Abuse (childhood)	8	41
Physical Abuse (adulthood)	0	3
Physical Abuse (age not specified)	2	9
Female Genital Mutilation (FGM)	0	2
Domestic Abuse and Violence		
Domestic Abuse/Violence (childhood)	3	21
Domestic Abuse/Violence (adulthood)	1	4
Domestic Abuse/Violence (age not specified)	10	12
Forced Marriage	0	1
Forced Abortion	0	1
Sexual Assault and Abuse		
Sexual Assault/Abuse (childhood)	19	57
Sexual Assault/Abuse (adulthood)	0	20
Sexual Assault/Abuse (age not specified)	19	12
Grooming	0	2
Emotional Abuse		
Emotional Abuse (childhood)	8	32
Emotional Abuse (adulthood)	0	1
Emotional Abuse (age not specified)	3	11
Verbal Abuse/Assault	0	2
Childhood spiritual abuse	0	1
Traumatic Bereavement/Loss	7	13

ITQ Trauma Type	**Reported Frequency**	
	Community	NHS
Childhood Neglect	2	16
War		
Torture	0	2
War/genocide	0	1
Witnessing torture & death of loved ones	0	1
Other Traumatic Events or Experiences		
Stalking	0	1
Racial trauma	0	1
Physical health issue/surgery	2	5
Forced feeding	0	2
Witnessing suicidal attempts (childhood)	0	1
Suicidal attempts (at any age)	0	1
Workplace trauma	0	2
Single Event (e.g. car accident)	2	4
Hospital/Psychiatric Iatrogenic Harm	0	4
Bullying	2	13
Adult Homelessness	0	1
Drug/alcohol addiction (Parental, Spouse)	2	1
Traumatic birth	1	3
Domestic Homicide Attempt	1	0
General (unspecified "abuse" or "difficulty")	20	32

Appendix V: TDRP - Statistical Checks & Assumptions

Early Memories of Warmth and Safeness (EMWS)

Observation of histograms and descriptive statistics for each variable indicated that the EMWS variable was significantly positively skewed (skewness = 1.31). Therefore, the variable was transformed using a square root transformation via SPSS. Subsequent inspection of normality and residual plots indicated improvement towards normal distribution, with a revised skewness value of .172 and -.433 kurtosis. The transformed value was used in subsequent analyses.

Hierarchical Regression

There was independence of residuals, as assessed by a Durbin-Watson statistic of 1.931. There was a linear relationship between the dependent variable and each independent variable; and dependent variable and independent variables collectively, as assessed through scatterplots of studentised residuals against unstandardised predicted residuals and partial regression plots. There was homoscedasticity, as assessed by visual inspection of plot of residuals. There was no evidence of multicollinearity, as assessed by tolerance and variance inflation factors (above 0.1 and below 10 respectively). There were no residuals greater than ±3 SD. There were no high leverage values, assessed as values over 0.2. There were no cases with influential values, as assessed through inspection of Cook's Distance values above 1. The residuals were approximately normally distributed, as assessed through a histogram with a superimposed line and inspection of P-P plots.

ANCOVA

Participants were asked to confirm they had only taken part in the study once during online screening to mitigate against participants completing measures in an NHS clinic and then again online or vice versa. While it is not possible to prove with accuracy that all participants represented unique entries, 4 participants were excluded from the online sample for selecting 'I have already participated in this study' which suggests some helpfulness in the screening question. Different participants were assigned to one of two groups: higher than average self-compassion (n = 54) and lower than average self-compassion (n = 138) ensuring independence of observations. There was a linear relationship between each covariate (trauma-symptoms and depression) on each level of the independent variable (high and low self-compassion) as assessed through visual inspection of a scatterplot. Standardised residuals for the high self-compassion group were normally distributed, as assessed by Shapiro Wilk's test (p >.05). The standardised residuals for the low self-compassion group (n = 138) were not normally distributed, as assessed by Shapiro Wilk's test (<.05). As Shapiro Wilk's test works better for smaller samples (< 30) and in larger samples can report minor deviations as being significant, Q-Q plots and a histogram were inspected. This indicated an approximately normal distribution and a decision taken to proceed. There was homoscedasticity and homogeneity of variances, as assessed by visual inspection of a scatterplot and Levene's test of homogeneity of variance (p = 0.85) respectively. There were no cases with standardised residuals ±3SD.

It was worth noting that statistically significant differences between ITQ symptoms, PHQ-8 scores, and participant ages between self-compassion groups were highlighted through independent samples t-tests, in Table 4. These were calculated to have small to medium effect sizes, e.g. ITQ symptoms (d = .53, r = .25), PHQ-8 (d = .50, r = .24), and participant age (d = -.47, r = -.23), There was homogeneity of regression slopes for covariates included in the model, and the interaction terms were not statistically significant: CPTSD

symptoms = $F(1, 186) = 1.33$, $p = .25$ and PHQ-8= $F(1, 186) = 2.88$, $p = .091$. An ANCOVA was assessed to be sufficiently robust to account for the impact of small statistical differences between groups, so a decision to proceed was made with some caution (as with most statistical tests) considered in respect of the reliability of interpretation (Leppink, 2018). Age was not controlled for as the regression suggested that demographic variables did not predict trauma-related shame.

Independent Samples T-Tests

Independent samples t-tests were run to appraise differences between self-compassion groups on continuous variables and to test the recruitment strategy by checking for differences between clinical and community participants scores on main study variables. As previously, it was presumed there were different participants in the clinical and community samples and different participants were allocated to each self-compassion groups that supported independence of observations. Inspection of box plots identified no ±3SD outliers. Inspection of Q-Q plots and histograms indicated approximately normal distribution on each group of the independent variable: community and clinical samples and each self-compassion groups. There was homogeneity of variances, as assessed by Levene's test for equality of variances (all $p > .05$), except when reviewing PHQ-8 scores between the clinical and community samples. which violated this assumption ($p = <.001$) and thus a Welch's test was used.

Appendix W: TDRP – Additional & Exploratory Analyses

Independent Samples T-Tests

Independent samples t-tests were run to appraise whether there were significant differences on each of the main variables (CPTSD, depression, self-compassion, EMWS and trauma-related shame) between the clinical (n =107) and community samples (n = 85). Statistically significant differences were found between ITQ symptoms, $t(190) = -4.5$, $p = <.001$, with clinical participants scoring higher than community participants, $M = 3.45$, 95% CI [1.96, 4.39], $p = <.001$. Statistically significant differences were found between CEAS-SC self-compassion scores, $t(190) = 3.3$, $p = <.001$, with the community sample scoring higher than the clinical sample, $M = 8.01$, 95% CI [3.3, 12.7], $p = <.001$. Statistically significant differences were between levels of reported trauma-related shame, $t(190) = -2.8$, $p = .003$, with the community sample reporting lower trauma-related shame, $M = -6.86$, 95% CI [-11.72, -2.0] than the clinical sample. No significant differences were found in relation to EMWS between samples. Significant differences in PHQ-8 scores were found, $t(190) = -5.3$, $p = <.001$, with the community sample reporting lower levels of depression, $M = -3.6$, 95% CI [-4.9, -2.3] than the clinical sample. Small to medium effect sizes were estimated: ITQ symptoms ($d = -0.66$, $r = -.31$), Trauma-Related Shame ($d = -0.42$, $r = -0.20$), Self-Compassion ($d = 0.47$, $r = -0.23$) and PHQ-8 ($d = -0.79$, $r = 0.36$).

Furthermore, both analyses were re-run without 17 community participants identified to have one affected data item on the CEAS-SC due to a data collection error:

Hierarchical Regression

A hierarchical regression (n = 175) was run to see if EMWS and self-compassion accounted for significant variance in trauma-related shame accounting for age, gender,

ethnicity, CPTSD symptoms, depression. The full model of age, gender, ethnicity, trauma symptoms, depression, EMWS and self-compassion was statistically significant, $R^2 = 0.184$, $F(7, 167) = 5.38$, $p < .001$, adjusted $R^2 = 0.150$. The addition of self-compassion to the final model led to an increase in R^2 of 4.5%, $F(1, 167) = 9.19$, $p = .03$. Full models in both analyses (with and without 17 participants with 1 affected data item) were statistically significant to $p < .001$ and trauma symptoms and self-compassion continued to emerge as significant predictors of trauma-related shame. Therefore, the findings were deemed to have been replicated.

ANCOVA

An ANCOVA was run without the 17 participants with 1 affected data item. After adjustment for CPTSD symptoms and depression, there was a statistically significant difference in trauma-related shame between high/lower self-compassion groups, $F(1, 171) = 4.11$, $p = .044$, $\eta^2 = .024$. Post hoc analysis was performed with a Bonferroni adjustment. Trauma related shame was statistically significantly lower in the high self-compassion group ($M = 43.04$; $SE = 2.41$) compared those in the higher-than-average self-compassion group ($M = 48.81$; $SE = 1.44$) with a mean difference of -5.76, 95% CI [-11.36, -0.16], $p = .044$. Both ANCOVA models were statistically significant with comparable adjusted mean differences. Therefore, the findings were deemed to have been replicated.

Exploratory analysis: attachment as a predictor

The number of self-reported safe and loving attachment figures was added as an additional block to the hierarchical linear regression model. The full model of demographics (age, gender, ethnicity), CPTSD symptoms, depression, EMWS, self-compassion, and attachments was statistically significant, $R^2 = .258$, $F(8, 84) = 3.30$, $p = .003$, adjusted $R^2 =$

.18. The addition of attachments (block 6) did not lead to a statistically significant increase of $R^2 = .002$, $p = .625$ in the prediction trauma-related shame. Only the community sample (n = 85) completed this exploratory question. As such, the analysis was underpowered.

Appendix X: TDRP - Author Guidelines for Journal

Author guidelines for the target journal can be found here: https://onlinelibrary.wiley.com/page/journal/15736598/homepage/forauthors.html. The Journal of Traumatic Stress is an interdisciplinary journal that focuses on publishing original work on biopsychosocial aspects of trauma. Papers focus on theoretical formulations, research, treatment, prevention education/training, and legal and policy concerns. The journal acts a primary reference for professionals who study and treat people exposed to highly stressful and traumatic events (directly or through their occupational roles). Research papers must be formatted to APA standards, be no longer than 7500 words (inclusive of abstract, references, tables, and figures) and include a data availability statement. Additional requirements specified by the journal for authors are included below:

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Declaration of Interest & Funding Statement

FR is a trainee clinical psychologist, and ER a clinical psychologist, affiliated with the Oxford Institute for Clinical Psychology Training and Research (OXIPTR) and declare no competing interests. DK and DL are Clinical Psychologists and DS an Assistant Psychologist who work at the NHS traumatic stress service associated with this study and declare no competing interests. MM is a Clinical Psychologist and works at the NHS traumatic stress service that acted as a PIC. The authors have no funding interests to declare.

Author Contributions

FR conceived and designed the study under the supervision of DK, ER and DL. FR completed the statistical analysis and were responsible for the interpretation of the data. FR acted as the Chief Investigator and DK as the Principal Investigator. DS and DK consented clinical participants at main NHS research site. FR and MM coordinated recruitment efforts at a second NHS service acting as a PIC. FR drafted the manuscript, and all authors were involved in revisions.