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Doctoral Thesis

What is the relationship between self harm and self compassion, in the context of voice hearing?

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Word count

Section	Main text	Appendices, including References, Figures and Tables	Total
Abstract	283	-	283
Literature Review	7723	9760	17483
Research Paper	7218	8948	16166
Critical Review	3946	1509	5455
Ethics Section	3717	7138	10855
Total	22887	27355	50242

Thesis abstract

This thesis focuses on the role of self-compassion in two types of mental health problem; eating disorders and self-harm in people with auditory hallucinations. The systematic review included 20 quantitative studies investigating the relationships between eating pathology and self-compassion. Findings suggest that self compassion may play an important role in mitigating the effects of eating behaviours consistent with an eating disorder diagnosis. High self compassion was associated with higher ratings of body satisfaction, body appreciation and lower ratings of shame. Moreover, the literature review indicated that in clinical samples, it is fear of self compassion that predicted eating disorder symptomology. Recommendations were made for those providing psychological therapy to those who present with eating disorders, including the role of self compassion in assessment and treatment.

The second paper reports on a study of the potential moderating role of self-compassion in self harm in people who hear voices. Results indicate that ratings of positive self compassion significantly moderate the association between omnipotence and self injury. Furthermore, positive self compassion had a moderating effect on the relationship between interpersonal trauma and self injury. The study lends support for use of Compassion Focused Therapy protocols in voice hearers. Future research should examine more closely the function of self injury in voice hearers, which may provide insights into the specific role of positive self compassion in ameliorating self harming behaviours.

The critical appraisal contains reflections on the research process and discusses challenges to considering self compassion from an individualised perspective. The paper presents an argument that self compassion can be socially determined and factors that influence its development. It also explores personal challenges in the application of psychiatric terminology in the ethics and write up processes.

Declaration

This thesis documents research undertaken for the Doctorate in Clinical Psychology at the Division for Health Research, Lancaster University. The work presented here is the author's own, except where due reference is made. The work has not been submitted for the award of a higher degree elsewhere.

Name: Kelly Price

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Date: 1st July 2016

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Firstly I would like to thank those who took the time to participate in this research and took the time to contact me to tell me about their experiences of voice hearing. I am immensely grateful to the numerous websites, charities and self-help organisations who generously and enthusiastically helped me to advertise my study.

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Section One: Literature Review

Eating pathology and self compassion: a systematic review

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Prepared in accordance with notes for contributors for European Eating Disorders Review[1]

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[1] see Appendix 1 for notes for authors

Abstract

Self compassion has been implicated as a protective factor in an array of mental health problems. There are however few studies of this factor with regard to eating pathology. A systematic review was conducted using PsychInfo, MedLine and CINAHL (1984–2016) databases. Twenty quantitative studies met inclusion criteria. Self-compassion appears to play an important role in contributing towards positive changes in disordered eating. Furthermore, within both clinical and non-clinical samples, self compassion has a strong association with body preoccupation, body surveillance and acceptance of body image. Self compassion is also reported to act as a moderator, decreasing potential emotional regulation/distress related to body surveillance. However, in clinical samples, it is fear of self compassion that was found to be the strongest predictor of eating pathology. There is a lack of studies examining eating pathology in males and varied eating disorders, including obesity.

Key words: eating disorders, body image, self compassion

Introduction

Eating disorders (ED) are defined as a disturbance of eating habits or weight-control behaviours that result in significant impairment in physical and psychosocial functioning (Diagnostic and Statistical Manual of Mental Disorders, Version Five [DSM-V], 2013). According to the American Psychiatric Association, DSM-V criteria stipulate that bulimia nervosa (BN) is a series of recurrent episodes of binge eating, marked by lack of control and distress, characterised by "inappropriate behaviours such as self induced vomiting to avoid weight", over at least a three month period (p.1). Anorexia nervosa (AN) is characterised by "distorted body image and excessive dieting that leads to severe weight loss with a pathological fear of becoming fat". According to the DSM-V criteria, Unspecified Feeding or Eating Disorder (UFED) applies to individuals where behaviours cause clinically significant distress/impairment of functioning, but do not meet the full criteria of any of the Feeding or Eating Disorder criteria. This appears to supersede the previous diagnosis of Eating Disorder Not Otherwise Specified (EDNOS) described in DSM-IV.

Eating disorders are characterised by excessive concerns about body image, weight and distorted body image. Those living with an ED experience significant distress and a negative impact upon their quality of life (Kristellar, Baer, & Qullian-Wolever, 2006). According to a review by Hoek and van Hoeken (2003), the prevalence rate for AN is between 0.1 and 1% while BN is 0.3%. Further, they suggest that due to the stringent diagnostic criteria, many people who have substantially disordered eating go unrecognised. Additionally, Strother, Lemberg, Stanford and Turberville (2012) argue that ED in males is currently under-diagnosed, undertreated, and misunderstood by many clinicians who encounter them. Within the LGBT population, ED symptoms were 10 times more prevalent in gay and bisexual men compared with heterosexual men (Strong, Williamson, Netemeyer, & Geer, 2000) but were similarly underreported.

Concerns about body image and restrictive eating behaviours are also common in individuals who are considered sub threshold for a formal diagnosis of ED (Kurth, Krahn, Nairn, & Drewnowski, 1995). Body dissatisfaction is present in the majority of women in developed countries throughout their lives (Matthiasdottir, Jonsson, & Krustjansson, 2012) and body weight dissatisfaction occurs in women with and without EDs (Coker & Abraham, 2014). Shaw, Ramirez, Trost, Randall, and Stice (2004) report that as a result of societal pressure, women in the general population are concerned with their weight and report unhappiness with their weight, and that these similarities exist across ethnic groups. Accordingly, Cash, Phillips, Santos, and Hrabosky (2004) suggest that body image disturbance and body dissatisfaction are best understood on a continuum, rather than as dichotomous concepts.

Risk factors

A meta-analytic review by Stice (2002) identifies a number of risk factors in the development and maintenance of eating pathology including perfectionism and impulsivity. Perceived pressure to be thin and thin-ideal were regarded as causal risk factors in negative affect, dieting, body dissatisfaction and eating pathology. Notably, body dissatisfaction emerged as one of the most consistent and robust risk and maintenance factors for eating pathology. Fairburn (1997) hypothesised that the primary maintenance of bulimic pathology was appearance over-evaluation. Fairburn posits that ‘inflexible thinking’ maintains severe dieting in individuals who regard their body shape as the most important aspect of self evaluation. Consequently, it is argued that beliefs overvaluing thinness result in maintenance of bulimic pathology, as this is fuelled by the belief that a range of interpersonal and emotional benefits arise from improvement in one’s appearance, promoting restrictive dieting and maintains binge eating.

Stice (2002) proposes that body dissatisfaction may lead to excessive dieting as a means of controlling one's weight, whilst also fostering negative affect due to the over-evaluation of one's appearance. Body dissatisfaction may also directly promote compensatory behaviours that characterize some eating disorders (e.g., vomiting).

Shame

A key aspect of eating psychopathology not examined in Stice's (2002) review is shame. According to Tagney and Dearing (2002), shame is a self evaluating experience that is inextricably linked to our relationship with self and others. Shame encompasses external experiences that influence one's sense of self (Goss & Allan, 2010) and is considered an important contributor to eating pathology (McKinley & Hyde, 1996). In eating psychopathology, levels of internal and external shame have been found to be higher than in other clinical groups (Cook, 1994; Masheb, Grilo, & Brondolo,1999). Further, feelings of shame have been found to predict eating disorder pathology in both community and clinical samples, even when guilt, global negative affect, body mass index (BMI) and depression are controlled for (Burnley & Irwin, 2000; Hayaki, Friedman, & Brownell, 2002; Kelly & Carter, 2013).

Within ED populations, shame, self-criticism and pride operate crucial roles in the maintenance of ED pathology (Goss & Gilbert, 2002). For example, Goss and Gilbert suggest that individuals may be critical of themselves and their body, increasing feelings of shame which, in turn, triggers behaviours that focus on weight and appearance, which further increases feelings of shame. Moreover, Allan and Goss (2009) argue that feelings of pride and the ability to control size, shape and affect is central to eating disorder psychopathology (p.310).

Shame has also been linked to vulnerability and severity of eating psychopathology (Goss and Allan, 2009). Kelly, Carter and Borairi (2013) proposed that 'symptoms' of EDs

can be understood as attempts to protect oneself against underlying feelings of shame. For example, Gilbert (2002) suggested that individuals can attempt to overcompensate for feelings of shame through overachieving or through attempts to make reparations to others. According to Gilbert (1998), internal shame refers to self evaluations relating to different aspects of the self (e.g. inadequacy, ugly) while external shame refers to sense of self and its relationship to how we perceive we exist negatively in the mind of others. Bauer, Winn, Schmidt, and Kordy (2005) found higher levels of external shame in individuals with AN, which appeared to be positively related to the degree to which they were underweight. By contrast, individuals with BN, experienced an over-concern about body weight and shape, indicated in higher scores in internal shame. Moreover, they report that individuals 'in remission' continued to struggle with elevated levels of external shame when compared to non-clinical samples.

Goss and Allan (2009) noted that shame experiences can be dynamic and variable for ED patients, and that these fluctuations are often linked to the regulation of negative emotional experiences (p. 306-307). The affect regulation model (Hawkins & Clement, 1984; McCarthy, 1990) postulates that binge eating acts as a comfort and distraction from adverse emotions and that behaviours such as vomiting can be understood as emotional catharsis. Stice's meta-analysis revealed that negative affect is a risk factor for eating pathology and a causal risk factor for body dissatisfaction for ED and that these effects were most potent for general negative affect, rather than anxiety. While, the directionality of this link was not confirmed in this meta-analysis, a subsequent review and meta-analysis confirms a reciprocal link between depression and obesity (Luppino et al., 2010). That is, obesity increases the risk of depression and depression increases the risk of developing obesity.

Gilbert (1998) suggests that shame hinges on self criticism. In patients with ED, trait self criticism was associated with more severe eating symptomatology and shame

experiences (Kelly & Carter, 2013). Barrow (2007) found that in an ED sample, individuals scored higher on self criticism and suggested that post binge shame and self criticism may occur.

Gilbert and Procter (2006) suggest links between shame, self criticism and compassion. They propose that when an individual experiences shame and perceives the external world as critical, their evaluations of self may also be critical and hostile. Under this threat, the ability to self soothe and be self compassionate may be compromised. In Compassion Focused Therapy (CFT), the aim is to increase one's ability to be self compassionate in order to reduce this feeling of shame and threat so as to increase feelings of safety.

Self compassion

Self compassion involves being caring and compassionate towards oneself, in the face of hardship or perceived inadequacy (Neff, 2003). More specifically, it is described as the interaction between kindness towards onself, a sense of common humanity and the ability to face painful thoughts and feelings in the moment, without judgement. This, it is proposed, facilitates recognition and acceptance of reality and allows individuals to respond more effectively in challenging situations. Neff (2003) found that higher ratings of self compassion were negatively associated with self criticism. The implication is that self compassion can reduce shame and self criticism, leading to improvement in mental health.

Self compassion is inversely related to psychopathology (Barnard & Curry, 2011) and offers a 'buffering effect' against depression and anxiety (Raes, 2011). More specifically, self compassion appears to have a potential protective component, as a recent meta-analysis found self compassion to have a large effect size ($r = -0.54$) when examining stress, anxiety and depression (MacBeth & Gumley, 2012; Muris & Petrocchi, 2016).

Self compassion acts to weaken the impact of negative experiences (Zessin, Dickhauser, Garbade, 2015) and is a strong predictor of psychological health among younger and older adults (Barnard & Curry, 2011; Philips & Ferguson, 2013) and adolescents.

The promotion of self compassion has been linked to reductions in anxiety and depression in long term mental health problems (Gilbert & Procter, 2006), as well as depression and shame in high security psychiatric settings (Laithwaite, O'Hanlon, Collins, Doyle, Abraham, Porter, & Gumley, 2009). Moreover, self compassion can help to protect against self evaluative anxiety when considering personal weaknesses (Neff, Kirkpatrick, & Rude, 2007), facilitate resilience (Leary, Tate, Adams, Allen & Hancock, 2007) and has a positive effect on happiness and optimism (Neff, 2009). Gilbert (2010) has identified that self compassion, in some people, is feared. Gilbert posits that fear and resistance to self compassion is linked to concerns about whether compassion was deserved and unfamiliarity with compassion.

Within eating pathology, Neff (2003) postulates that a higher level of self compassion results in reduced levels of rumination and an increase in positive emotions. Individuals may be kinder to themselves and less self critical when diet regimes are broken, thus reducing the emotional impact and the perceived need for compensatory behaviours. It is proposed that self compassion leads to forgiveness for 'diet breaking', whilst maintaining sight of goals to regulate eating behaviour. Adams and Leary (2007) argue that the induction of self compassion can also result in a lower tendency to use eating as a way of coping with negative emotions, alleviating distress for individuals who had broken dietary rules in a non clinical sample. They suggest that self compassion leads individuals to forgive themselves for their actions and enables them not to feel overwhelmed by a mistake, which may ordinarily lead to rumination and negative emotions. This links to issues of perfectionism and control, factors that are important in the development and maintenance of eating pathology (Stice, 2002).

Gilbert (2005) suggests that the most effective way to regulate shame is to elicit support and compassion (Carter & Kelly, 2013). Consequently, CFT aims to increase self compassion, which in turn is aimed at reducing shame in ED populations.

To date, there has been no attempt to systematically review the literature that examines the relationship between self compassion and eating pathology, despite the growing body of literature. The aims of this review were to a) examine and synthesise the evidence for the relationship between self compassion and eating pathology, b) examine whether self compassion was associated with less severe eating pathology, and to c) examine the evidence for self compassion as a mediating/moderating factor for eating pathology.

Method

The systematic review was conducted according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher, Liberati, Tetzlaff & Altman, 2009).

Search procedure

Studies were identified by searching electronic databases and scanning reference lists of articles. No time limits were set for the searching of articles. To examine whether higher scores of self compassion reduced eating pathology, cross sectional and prospective studies were reviewed that assessed the relationship between self compassion, body image disturbance, BMI and/or body appreciation, in individuals from clinical and non-clinical samples. The search was applied to PsycINFO (2002-Present), CINAHL (1987-Present) and MedLine (1984-Present). The final search was run on 15th January, 2016. Databases were systematically searched using two search strings (eating disorder and self compassion). These were: DE "Eating Disorders" OR DE "Anorexia Nervosa" OR DE "Binge Eating Disorder" OR DE "Bulimia" OR DE "Hyperphagia" OR DE "Purging (Eating Disorders)" OR "body" AND "self-compassion" OR "self compassion" OR compassion*. Fig. 1 details the systematic search and eligibility of screening for this review. Eligibility was established by initially reviewing the titles and the abstracts. Studies potentially meeting the inclusion criteria were then reviewed in their entirety to establish whether they should be included. The research team established whether studies met the inclusion/exclusion criteria through regular meetings. Reference lists of the eligible papers were scanned in an attempt to identify further literature not found in the database search. No further studies were identified.

[INSERT FIGURE 1]

Inclusion and exclusion criteria

Studies meeting the following criteria were included: 1) use of a self report measure of self compassion; 2) use of a validated measure to assess eating pathology; 3) quantitative methodology; 4) published in a peer review journal; and 5) written in English. Studies were excluded if: 1) the study was presented in a conference abstract, dissertation, or single case study format. No restrictions were placed on the age or diagnostic status of the study participants.

Quality assessment

Eligible studies were quality assessed using the Effective Public Health Practice Project Quality Assessment Tool (EPHPP; National Collaborating Centre for Methods and Tools, 2008). The EPHPP is a guide to systematically appraise study quality across seven areas: selection bias, study design, confounders, blinding, data collection methods, withdrawal and dropouts, and intervention integrity and analyses. The tool can be used to review the quality of observational, cross-sectional, before and after studies and randomized controlled trials and has good content and construct validity and adequate test–retest reliability (Armijo-Olivo, Stiles, Hagen, Biondo, & Cummings, 2012; Thomas, Ciliska, Dobbins, & Micucci, 2004). All the papers were rated by the lead author. A selection of the papers were independently rated by a colleague. Any differences in ratings were discussed and resolved.

Data extraction

After evaluating the methodological design of the studies, the main research findings were considered and summarised. The data extracted from each study included sample characteristics (i.e. country, population, sampling methods, gender of participants and sample size), details of the research measures used to assess self compassion and eating pathology,

the statistical analytic methods used to examine the associations between self compassion and eating pathology and a narrative description of the main, relevant findings.

Results

Overall summary of studies

In total, 674 titles and abstracts were reviewed. 18 studies were included, across 20 papers. Participants in the papers by Schoenefeld and Webb (2013) and Daye, Webb, and Jafari (2014) were taken from the same sample. Similarly, Carter and Kelly (2015) and Kelly, Carter, and Borairi (2013) utilised the same sample. The 18 studies included in this review were all published within the last 3 years, in 12 different journals. Table 1 provides a summary of each study, including a brief overview of relevant study characteristics. Table 2 outlines a summary of the main research findings.

[INSERT TABLE 1]

[INSERT TABLE 2]

Demographic characteristics

A total of 4308 participants took part in the included studies. The female to male ratio was 4125:179 (however, one study included unidentified gender for four participants). The age of participants ranged from 14–76 years with a mean of 24.26 years. Most studies involved non clinical samples (n= 3863, 89.7%). Seven studies involved clinical samples (n = 445, 10.3%). Non-clinical control participants (n=278) were recruited within two clinical studies for comparison purposes (Kelly, Vimalakathan, & Carter, 2014; Ferreira, Pinto-Gouveia, & Duarte, 2013). The participants considered in these clinical studies had diagnoses of Anorexia Nervosa (n = 168, 37.8%), Bulimia Nervosa (n = 125, 28.1%), Binge Eating Disorder (n = 41, 9.2%) and Eating Disorder Not Otherwise Specified (n = 111, 24.9%). Studies recruited across a range of domains, including hospital and day centre

settings (n = 404, 9.4%), online (n = 926, 21.5%), education and corporate settings (n = 123, 2.9%) and universities (n = 2814, 65.3%). One paper (Kelly & Carter, 2015) reported that participants were recruited through hospital, eating disorder community services and online (n = 41, 1 %). Within the clinical sample, participants were recruited from outpatient mental health services, Eating Disorder care units, eating disorder community centres and day hospitals.

The majority of studies included in the review were conducted in North America (n = 15). Of the remaining studies, three were conducted in Portugal (Duarte, Ferreira, Trindade, & Pinto-Gouveia, 2015; Ferreira, Matos, Duarte, & Pinto-Gouveia, 2014; Ferreira, Pinto-Gouveia, & Duarte, 2013), one in Thailand (Pisitsungkagarn, Taephant, & Attasaranya, 2013) and one in Australia (Prowse, Bore, & Dyer, 2013).

Study quality assessment

The results of the assessment of study quality are shown in Table 1. Each item was rated as weak, moderate or strong, according to the guidelines of the tool. The studies were quality assessed by KP. Additionally, a proportion of these studies (10) were rated and agreed upon by an independent reviewer. Any disagreements were discussed and resolved. A summary of the ratings are shown in Table 3.

Overall, the quality of the papers was mixed. Most of the studies were cross-sectional (n = 13). Papers that were ‘strong’ utilised a robust study design in which groups were balanced with respect to important variables prior to a randomised intervention or control group for clinical samples. When comparing clinical and non clinical samples, papers rated as strong considered confounders. Many of the papers included college students and utilised self report measures, where validity and reliability ratings were provided by authors.

No studies were excluded from the review based on quality rating since the aim was to evaluate study design and quality in relation to the research question. However, the results of the quality assessment were taken into account when interpreting findings.

[INSERT TABLE 2]

Design characteristics

Thirteen studies used a cross-sectional design and two used prospective designs. The studies included in this review employed a number of similar research designs to examine the relationship between eating pathology and self compassion, including between-group (k = 2), correlational (k = 16) and cohort (k = 2) designs. Specifically, the studies employing between-group designs compared participants with a diagnosis of eating disorder with comparable non eating disordered participants (i.e., a non-clinical sample who did not have a formal diagnosis of eating disorder) on measures of self compassion, fear of self compassion, self esteem, and eating disorder symptomology. The studies employing correlational designs examined the relationship between eating pathology and self compassion in a single group of participants.

Measures

Details regarding measures employed in the eligible studies are displayed in Table 2. All studies used the Self Compassion Scale (SCS), in short or long form. Fourteen studies assessed self compassion with the original SCS, six study relied on the SCS-SF. In terms of eating pathology and body image, 10 different measures were used. The two most commonly administered measures were the Eating Disorder Examination Questionnaire (EDE-Q, Fairburn & Beglin, 1994; Fairburn, Cooper & O'Connor, 2008; k = 10) and the Body Appreciation Scale (BAS, Avalos, Tylka & Wood-Barcalow, 2005; k = 4). While BMI was reported in 11 studies, this was only used as a measure for analysis in two studies (Liss &

Erchull, 2015; Kelly, Vimalakathan & Miller, 2014). All measures used in the studies were self report.

Eating disorder symptomatology

Participants with higher eating disorder symptomology (as measured by EDE-Q, EDE-16D and Eating Attitudes Test [EAT-26]) scored lower on self compassion in five studies (Prowse, Bore, & Dyer, 2013; Kelly, Vimalakanthan, & Miller, 2014; Taylor, Daiss, & Kreitsch, 2015; Tylka, Russell & Neal, 2015; Ferreira, Pinto-Gouveia, & Duarte, 2013). In non-clinical samples (n=2), self compassion was reported as the strongest predictor of EQE-Q Global *(B*= -.50, p = < .01 (Prowse et al., 2013; Kelly et al., 2014).

Participants scoring higher on self compassion were also found to have higher levels of unconditional permission to eat when hungry (intuitive eating) (r = .39, p < .01), and body image flexibility (r = .49, p < .01 (Schoenefeld & Webb, 2013). Moreover, women with higher levels of self compassion were reported to have healthier attitudes towards food F(1, 201) = 40.31, p < .001 (Liss & Erchull, 2015). Further, in examining binge eating disorder and self compassion scores, a significant negative association was found (r = .25, p < .01) (Webb & Forman, 2013).

By contrast, within clinical samples, self compassion alone was not a significant predictor of EDE-Q. Rather, fear of self compassion emerged as the strongest predictor of EDE-Q global *(B* = .74, p = < .01) (Vimalakanthan, & Carter, 2014). Similarly, lower self compassion was associated with greater fear of self compassion, greater pathology on the EDE-Q (Kelly, Carter, Zuroff, & Borairi, 2013; Kelly & Carter, 2015). Shame and eating disorder pathology were more severe the higher patients' fear of self compassion and the lower their dispositional self compassion (Kelly, Carter, Zuroff, & Borairi, 2013). A moderating effect of self compassion was reported on the relationship between shame memory variables and eating psychopathology (Ferreira, Matos, Duarte, & Pinto-Gouveia,

2014). Early changes in self compassion are reported as being a significant predictor of change in eating disorder symptoms as a result of treatment, $F(1, 195) = 4.74$, $p < .05$, effect size $r = .15$ (Kelly, Carter, & Borairi, 2013).

A significant negative association was between self compassion and bulimia in an ED sample (Ferreira, Pinto-Gouveia, & Duarte 2013). In terms of dietary restraint, self compassion emerged as a significant negative predictor within a clinical sample (Kelly, Vimalakanthan, & Miller, 2014). Self compassion was negatively correlated with ED behaviour and was the best predictor of eating psychopathology in a clinical sample. Further, self compassion emerged as a significant predictor of ED pathology ($B = -.84$, $p < .001$) with the model explaining 37.6% of eating psychopathology severity variance (Ferreira, Matos, Duarte, & Pinto-Gouveia, 2014).

Effect of self compassion on BMI

Four studies examined the relationship between BMI and self compassion (Webb & Forman, 2013; Duarte, Ferreira, Trindade, & Pinto-Gouveia, 2015; Liss & Erchull, 2015; Kelly, Vimalakanthan, & Miller, 2014). While these revealed a positive association, none were reported to be significant. Positive relationships between BMI and global eating pathology were weaker, the higher women's level of self compassion. This was also evident for eating and weight concerns, suggesting that the relationship between eating pathology and BMI were not attenuated in women with higher levels of self compassion (Kelly, Vimalakanthan, & Miller, 2014). By contrast, self compassion, in conjunction with mindful eating, significantly predicted BMI, $F(2, 147) = 3.83$, $p = .02$ (Taylor, Daiss, & Kreitsch, 2015). This was the only study in the review to consider mindful eating in the context of BMI and self compassion.

Body image acceptance

Self compassion was found to predict body image acceptance in two studies

(Pisitsungkagarn et al., 2014; Prowse, Bore, & Dyer, 2013). Self compassion was negatively correlated with global eating pathology, and positively correlated with body image flexibility, (r = 0.41, p = < .001) (Kelly, Vimalakanthan, & Miller, 2014). Similarly, in non clinical samples, self compassion was negatively and significantly associated with body surveillance (Daye, Webb, & Jafari, 2014; Liss & Erchull, 2015) and increased when body preoccupation decreased, when controlling for self esteem (Wasylkiw, MacKinnon, & MacLellan, 2012).

Body preoccupation was reported to significantly and negatively predict self compassion $F(1, 186) = 34.31$, $p < .01$, adj $R^2 = .15$ (Wasylkiw, MacKinnon, & MacLellan, 2012) while self compassion was associated with lower ratings in relation to thin-ideal internalization (Tylka, Russell & Neal, 2015). When self compassion was low, media thinness-related pressure predicted thin-ideal internalization, B= .588, t(434) = 6.40, $p <$ .001. This effect was not apparent when self-compassion was high. Between group comparisons revealed that self compassion was negatively associated with drive for thinness, (r = -.32, p < .001) in non clinical samples. In the ED sample, this association was stronger, r = -.47, p < .05 (Ferreira, Pinto-Gouveia, & Duarte, 2013).

Body satisfaction

Six studies examined the relationship between body satisfaction and self compassion. Self compassion was negatively correlated with body dissatisfaction (r = -.62, p < .01) (Albertson, Neff, & Dill-Shackleford, 2015) and body image dissatisfaction had an effect on self compassion, Z = -3.00; p = .003 (Duarte, Ferreira, Trindade, & Pinto-Gouveia, 2015). Self compassion was linked to lower levels of body image dissatisfaction in both clinical and non clinical sample (Ferreira, Pinto-Gouveia, & Duarte, 2013). Self compassion had a partial mediating effect and only in ED sample when examining body dissatisfaction and drive for thinness. Self esteem was found to be predicted by body image satisfaction and self compassion ($F(3, 298) = 35.48$, $p < .001$) (Pisitsungkagarn et al., 2014) and was strongest in

participants with low self compassion ($B = 0.39$, $p < .001$).

Body appreciation

Positive dimensions of body images were examined in three studies. All reported a positive correlation between self compassion and body appreciation, ranging from .62, $p < .001$ (Homan & Tylka, 2015) to $r = .72$, $p < .01$ (Albertson, Neff, & Dill-Shackleford, 2015; Wasylkiw, MacKinnon, & MacLellan, 2012). When body comparison was the predictor in a moderation analysis, self compassion showed a significant positive relationship with body appreciation, B=.37 (95% CI=.30, .45), SE= .04, $t(252) = 9.47$, $p < .001$) (Homan & Tylka, 2015) . With regards to ED symptomology, moderation analysis revealed that, body comparison was strongly related to poorer body appreciation B = -.22 (95% CI =.29, -.15), SE= .03, $t(252) = -6.47$, $p < .001$) when self compassion scores were low, but not when these were high. Self compassion reduced the significance of self esteem, negatively predicting scores on the BSQ (including body appreciation and body self esteem) (Wasylkiw, MacKinnon, & MacLellan, 2012).

Shame

Shame was examined in seven studies. Women with higher levels of self compassion had significantly lower shame $F(1, 201)$ 80.55, $p < .001$ (Liss & Erchull, 2015; Albertson, Neff, & Dill-Shackleford, 2015). External shame was found to predict drive for thinness and self compassion, accounting for 19.8% of the drive for thinness in non clinical samples (Ferreira, Pinto-Gouveia, & Duarte, 2013) while the frequency of recollecting restrictive/critical caregiver eating messages and body shame was strongest when self compassion was low, $t(269) = 5.580$, $p < .001$ (Daye, Webb, & Jafari, 2014).

Correspondingly, lower self compassion was associated with higher ratings of shame in clinical samples (Kelly, Carter, Zuroff, & Borairi, 2013; Ferreira, Pinto-Gouveia, & Duarte, 2013) and self compassion was shown to have a moderating effect on relationship

between shame memory variables and eating psychopathology (Ferreira, Matos, Duarte, & Pinto-Gouveia, 2014). In CFT intervention groups, significant changes in body shame ratings were observed and participants were more compassionate as shame lessened (Albertson, Neff, & Dill-Shackleford, 2015). Further, when examining the unique predictors of controlled motivation at baseline in an ED sample, only shame was identified as having an effect $F(1,60) = 6.48$, $B = .55$ ($SE = .26$), $p = .01$ (Carter & Kelly, 2015).

Self esteem and self worth

Two studies examined the relationship between self compassion and self esteem. A positive relationship was found between self compassion and self –esteem ($r = 0.62$, $p < .001$) (Kelly, Vimalakanthan, & Miller, 2014) and self compassion was also found to predict self esteem, $B = 0.30$ (SE = 0.05) $B = 0.34$ $p < .001$ (Pisitsungkagarn, Taephant, & Attasaranya, 2014). Further, higher ratings of self compassion were found to have a moderating positive effect on self esteem, related to physical appearance.

Two studies reported on self worth. Self compassion was inversely related to appearance self worth ($r = -.42$, $p < .001$) (Homan & Tylka, 2015) was negatively associated with contingent self-worth-appearance ($r = -.48$, $p < .01$) (Albertson, Neff, & Dill-Shackleford, 2015). Further, when self compassion was low, self worth had the strongest impact upon body appreciation, in a positive direction (Homan & Tylka, 2015).

Effect of self compassion on depression

Self compassion and depression was examined in five studies. In non clinical samples, self compassion (B = -11.26, SE =1.15, t= -9.77, $p < .01$) was a significant predictor of depressive symptoms, $F(1,186) = 95.36$, $p < .01$, adj. $R^2 = .34$ (Wasylkiw, MacKinnon, & MacLellan, 2012). More specifically, for females with higher self compassion scores, depression scores were much lower, $F(1, 201) = 104.25$, $p < .001$ (Liss & Erchull, 2015). It is noteworthy that negative eating attitudes only significantly positively correlated with

depression for those low in self compassion (Liss & Erchull, 2015) suggesting that those with lower ratings of self compassion experience more symptoms of depression and are more likely to hold attitudes that relate to negative body image and weight concerns. Participants scoring higher on self compassion were found to have higher levels of distress tolerance (r = .53, $p < .01$), although this had only a negligible impact on intuitive eating (Schoenefeld & Webb, 2013).

In a study comparing non clinical and clinical samples, self compassion was negatively associated with depression ratings (r = -.51, $p < .001$) and (r = -.57, $p < .05$) respectively (Ferreira, Pinto-Gouveia, & Duarte, 2013). Moreover, when comparing CFT, a behavioural intervention and control group in a clinical sample, participants in the CFT condition who were lower in fear of self compassion were the only participants to experience significant decreases in depressive symptoms over time, B = -4.5 (SE = 1.05), $p < .001$ (Kelly & Carter, 2015).

Self compassion intervention

Five studies examined the effectiveness of a self compassion intervention. All but one (Albertson, Neff, & Dill-Shackleford, 2015) were with clinical samples. Intervention length varied from three weeks (Kelly & Carter, 2015; Albertson, et al., 2015) to 12 weeks (Kelly, Carter, Zuroff, & Borairi, 2013; Kelly, Carter, & Borairi, 2013; Carter & Kelly, 2015). Participants exposed to self compassion meditation (Albertson et al., 2015) and CFT demonstrated significantly higher gains in self compassion compared to the control groups (Kelly & Carter, 2015). Albertson et al. (2015) reported a large effect size (Cohen's d = .82) (F=37.37, $p < .001$) while Kelly and Carter (2015) reported that the estimated rate of self compassion improvement in the CFT condition was greater than the average estimated rate across the behavioural and control conditions $F(1,90) = 5.93$, $p < .05$, effect size r = .25. Moreover, positive self compassion improved in the CFT condition only, and contrasts

revealed that this improvement was greater than the other conditions $F(1,90) = 4.98$, $p < .05$, effect size $r = .23$.

Post intervention follow up showed that scores three months after the intervention showed differences in body dissatisfaction, levels of self compassion, body shame, body appreciation and contingent self worth for appearance that were significantly different than pre test but not post-tests, suggesting that gains in the outcomes were maintained after the intervention (Albertson et al., 2015).

The estimated rate of change was examined in participants with low and high self compassion. Contrary to the study hypotheses, patients with high self compassion and low fear of self compassion did not differ significantly from that of other patients (Kelly, Carter, Zuroff, & Borairi, 2013). When examining changes in eating disordered symptoms after 12 weeks, patients with combinations of low self compassion and high fear of self compassion did not change over time (12 weeks). By contrast, all other combinations had significant reductions in ED symptoms (Kelly, Carter, Zuroff, & Borairi, 2013) suggesting low-self compassion combined with high fear of self-compassion may form a barrier to successful CFT for ED. For ED patients with higher self compassion, significant decreases were observed in eating psychopathology across all fear of self compassion levels.

Changes early in treatment were important since estimates revealed that patients who had relatively larger increases in self compassion early in treatment had significant decreases in eating disorder symptoms over 12 weeks, $B = -0.20$ ($SE = 0.06$), $p < .001$, and to a lesser degree, so too did patients who had relatively smaller increases in self compassion, $B = -0.13$, ($SE = 0.06$), $p < .05$ (Kelly, Carter, & Borairi, 2013). When controlling for EDE-Q change X time, there was a significant effect of early self compassion change X time, $F(1, 175) = 6.77$, $p = .01$, effect size $r = .19$. Importantly, only larger *early* improvements in self compassion

showed significant decreases in shame, over time B = -0.10 (SE = 0.04), $p < .05$ (Kelly, Carter, & Borairi, 2013).

Compliance was measured in one study (Kelly & Carter, 2015) and indicated that self reported compliance with food planning were highest across the self compassion group. Self compassion was positively correlated with autonomous motivation ($r = .27$, $p < .001$), but not controlled motivation. Thus, those who had higher scores on the self compassionate measure and experienced more social support at the start of treatment were more intrinsically motivated for treatment (Carter & Kelly, 2015).

Discussion

Self compassion involves being caring and compassionate towards oneself, in the face of hardship or perceived inadequacy (Neff, 2003) and is a topic of increasing research in eating psychopathology. This review shows accumulating evidence that self compassion may be a protective factor against disordered eating (Ferreira, Pinto-Gouveia & Duarte, 2013). Findings suggest that within both clinical and non clinical samples, that self compassion has a strong association with body preoccupation, body surveillance and acceptance of body image. This supports previous findings that body image flexibility and a self compassion attitude towards the body, mediate cognitions about eating and ED (Wendell, Masuda, & Le, 2012).

Self compassion appears to be crucial in diet breaking. Studies within this review revealed that increased self compassion was related to healthier eating behaviours and more intuitive eating (Schoenefeld & Webb, 2013; Webb & Forman, 2013; Liss & Erchull, 2015). This is consistent with Adams and Leary's (2007) finding that for highly restrictive individuals, the induction of self compassion alleviates self criticism and negative affect.

Self compassion is also reported to act as a moderator, decreasing potential emotional regulation/distress related to body surveillance. Studies that examined the role of depression reported that higher levels of self compassion were positively associated with distress tolerance (Wasylkiw, MacKinnon, & MacLellan, 2012; Liss & Erchull, 2015; Ferreira, Pinto-Gouveia, & Duarte, 2013). Although self compassion may be protective in the realm of eating and body image, receiving compassion from others or oneself, appears to be a frightening experience for certain individuals (Gilbert, McEwan, Matos & Rivis, 2011). This was echoed in this review, with findings suggesting that in clinical samples, it was fear of self compassion that was found to be the strongest predictor of eating pathology. For individuals with high self criticism, the development of self compassion can be most difficult and can be

associated with concerns about weakness, deservedness and unresolved grief (Gilbert & Procter, 2006; Mayhew & Gilbert, 2008).

When examining the relationship between self compassion and specific measures of disordered eating (including EDE-Q), higher ratings of self compassion were only found to be a predictor of reduced symptomology in non clinical samples. This might be an important consideration in the development of any intervention strategies in clinical samples.

Although not the primary aim, this review revealed a relationship between shame and eating pathology in both clinical and non clinical samples. This is consistent with studies specifically focussing on shame which confirm it as a risk factor for disorder eating (McKinley & Hyde, 1996; Cook, 1994; Masheb, Grilo, & Brondolo, 1999). Thus, self compassion may be an important component in the successful prevention and treatment of disturbances in body image and related eating disordered behaviours (Breines, Toole, Tu, & Chen, 2014). While the association between shame and self compassion has been found, to some degree within this review, in women with and without eating disorders, the direction of causality is not known. It may be that individuals with less severe eating disordered pathology are more self compassionate, as influenced by lower levels of self criticism.

Self compassion interventions appear promising for both clinical and non clinical samples (Albertson, Neff, & Dill-Shackleford, 2015; Kelly & Carter, 2015; Kelly, Carter, Zuroff, & Borairi, 2013; Kelly, Carter, & Borairi, 2013; Carter & Kelly, 2015). Results suggest that improvements in body dissatisfaction, levels of self compassion, body shame, body appreciation and contingent self worth for appearance were maintained post intervention (Albertson et al., 2015). Importantly, fear of self compassion appears crucial when examining changes in eating disordered symptoms, following CFT intervention as patients low in self compassion and high in fear of self compassion did not change over time, suggesting that fear of self compassion may impair patients' response to treatment if they

have low self compassion. Similarly, early changes in self compassion ratings during the course of an intervention appeared crucial to changes in ED symptomology (Kelly, Carter, Zuroff, & Borairi, 2013; Kelly, Carter, & Borairi, 2013). Gilbert and Procter (2006) suggest that individuals who are highly self critical can particularly struggle with developing self compassion, which acts to maintain ED pathology (Goss & Gilbert, 2002). Consequently, interventions designed to promote self compassion in ED patients should consider fear of self compassion, alongside self criticism. Moreover, careful consideration ought to be given to the formation and maintenance of the therapeutic relationship since individuals may actively resist engaging in compassionate experiences (Gilbert, McEwan, Matos & Rivis, 2011).

It is noteworthy that the findings of this review echo previous research, identifying the positive impact of self compassion in other disorders (Raes, 2011; Barnard & Curry, 2011; MacBeth & Gumley, 2012; Muris & Petrocchi, 2016). Previous studies have found little difference in the self compassion ratings between anxiety and ED groups, which is reported to be lower than those in the general population (Costa, Maroco, Pinto-Gouveia, Ferreira, & Castihlo, 2015). Thus, whilst it does not appear that low self compassion is specific to ED, understanding the role of self compassion in ED is important for treatment and prevention. Goss and Allan (2010) report that ED patients share trans-diagnostic psychological process (including anxiety, depression, social withdraw and obsessional features, which may predate the onset of ED or evolve during the course of the disorder. Similarly, there is high co-morbidity across DSM-IV categories and that many ‘symptoms’ are inter-connected (Borsbroom, Cramer, Schmittmann, Epskamp & Waldorp, 2011). Consequently, focusing on self compassion in ED appears beneficial, either directly, due to the potential direct impact on ED pathology or indirectly as EDs appear related to other relevant mental health issues.

Limitations and future research

As with any review, we cannot disregard the known bias towards publishing significant effects (Chan, Hrobjartsson, Haahr, Gotzsche, & Altman (2004) and the possibility that studies examining the links between self compassion and eating pathology that were non significant were left unpublished. Consequently, we cannot rule out the possibility that this review overemphasises the positive association between self compassion and body image satisfaction, acceptance and healthy eating behaviours.

It is important to consider the methodological limitations of this body of literature. Many of the papers were cross sectional in design and used convenience sampling, with no control groups. Most importantly, prospective designs have been under-utilized. This area of research is still relatively new and is thus limited by a lack of active comparison conditions and small sample sizes. A second major methodological limitation is that there has been an under-utilisation of randomized experiments as the use of cross sectional studies do not permit investigators to rule out third-variable explanations. Moreover, cross sectional studies preclude any inferences of causality. Thirdly, many investigations used unrepresentative samples, such as college students or patients from a clinical setting. While it is more convenient to recruit participants from these sources, the generalisability of the findings is constrained. Nevertheless, Mintz and Kashubek (1999) estimate that 20% of college women engage in disordered eating practices, suggesting that recruitment from this population is appropriate when considering ED pathology. Despite this, greater use should be made of community-recruited samples. Table 2 outlines the quality appraisal for each paper that was included in this review.

It was notable that the majority of participants across the studies were female, suggesting that caution should be utilised in generalising the findings to males. Some research proposes that there may be gender differences in application self compassion, as women may be socialised to be more self sacrificing, prioritising the needs of others over

their own, impacting their ability to be self compassionate (Baker-Miller, 1986; Raffaelli & Ontai, 2004). Similarly, women were reported to be more self critical than males and demonstrate a tendency to judge themselves more negatively (DeVore, 2013). A recent meta-analysis suggests women's self esteem is lower than men's which may also impact on self compassion (Gentile et al. 2009). Self compassion involves soothing and comforting self when suffering is experienced, which may be a quality emphasised more in women. However, a recent meta-analysis suggests that despite finding a small but meaningful difference ($d = .18$, $SE = .02$, $p < .0001$) in levels of self compassion between men and women, these gender differences should not be overemphasised (Yarnell, Stafford, Neff, Reilly, Knox, Mullarkey, 2015). It was reported that women did appear to adopt a role of nurturing and self sacrifice and were more compassionate to others, and this did not always translate to self, as they engaged in more negative self talk.

There may also be differences in the ways in which the 'symptoms' of ED present in males as Strother, Lemberg, Stanford and Turberville (2012) suggest that body image distortion and ED in males are significantly neglected in both diagnosis and treatment. They propose that males do not generally have a firm drive for thinness and are prone to have as much desire to *gain* weight as they are to *lose* it. Further, it is argued that the function and type of compensatory strategies employed by women with an ED are different to men (Weltzin, 2005). Accordingly, Grossbard, Lee, Neighbors & Larimer, 2008) propose that an alternative body image dissatisfaction assessment tool be utilised in men, which places emphasis on compensatory behaviours, binge habits, attitudes about food, and emotional triggers, leading to the development of appropriate interventions.

It is noteworthy that within the studies recruiting clinical samples, participants with other eating disordered behaviours were neglected (including obesity). In addition, the diagnostic categories within the studies do not refer to the new DSM-V criteria. The

limitations of the research reviewed here mean it is not possible to distinguish if there are differences in the role of self compassion across different EDs. Future research should examine this to establish if current CFT interventions may add to the overall effectiveness of current psychological interventions for EDs and whether these require adaption for different ED practices. In addition, further examination of the effectiveness of mindfulness in increasing self compassion in EDs should be assessed, following the work of Taylor, Daiss, and Kreitsch (2015) who found that self compassion, in conjunction with mindful eating, significantly predicted BMI in a positive manner.

A potential limitation in this review is that most of the participants included in the studies in this review were White females, limiting the ethnic diversity and potential generalisability of the findings. While this is consistent with much of the research examining EDs across different ethnic groups, finding that white women revealed more body image disturbance relative to African American women (Celio, Zabinski & Wilfley, 2002), one cannot discount the potential role of shame and stigma in the reporting of ED behaviours. That is, what impact does shame have in the disclosure of ED practices across different ethnic groups?

Other issues not covered by the literature might include body dissatisfaction and physical disability. Chrisler, Golden and Rozee (2012) suggest that women with physical disabilities may be particularly vulnerable to body dissatisfaction, given the pressure to be attractive and attractiveness being based on body image. Similarly, Taleporos and McCabe (2001) reported that many of the women in their study concluded that their disabilities made them feel physically and sexually unattractive.

It is important to note that none of the studies in this review provided analysis of the positive and negative indicators of self compassion. One meta-analysis (Muris, 2009) exploring the properties of the SCS suggests that the use of a total self compassion score of

the SCS or SCS-SF, is likely to result in an inflated relationship with symptoms of psychopathology. Moreover, use of the SCS-SF, may not be optimal instruments for measuring the true protective nature of self compassion, mainly because these scales include negative items that tap toxic mechanisms which may inflate the relationship with psychopathology. Thus, future research should include analysis of both positive and negative subscales of the SCS or the SCS-SF to examine predictors of mental health problems.

Conclusion

All studies reported a significant positive association between self compassion and reduced eating pathology (including body satisfaction, healthy eating habits, body acceptance and appreciation of body). However, the studies lacked representative samples and included few clinical samples, across a range of eating disorders. In particular, the studies suggest that for clinical samples, it is fear of self compassion that predicted ED symptomology. As a result, this review lends support for the assertion that further attention is required regarding the role of self compassion in eating disorders as well as their assessment and treatment.

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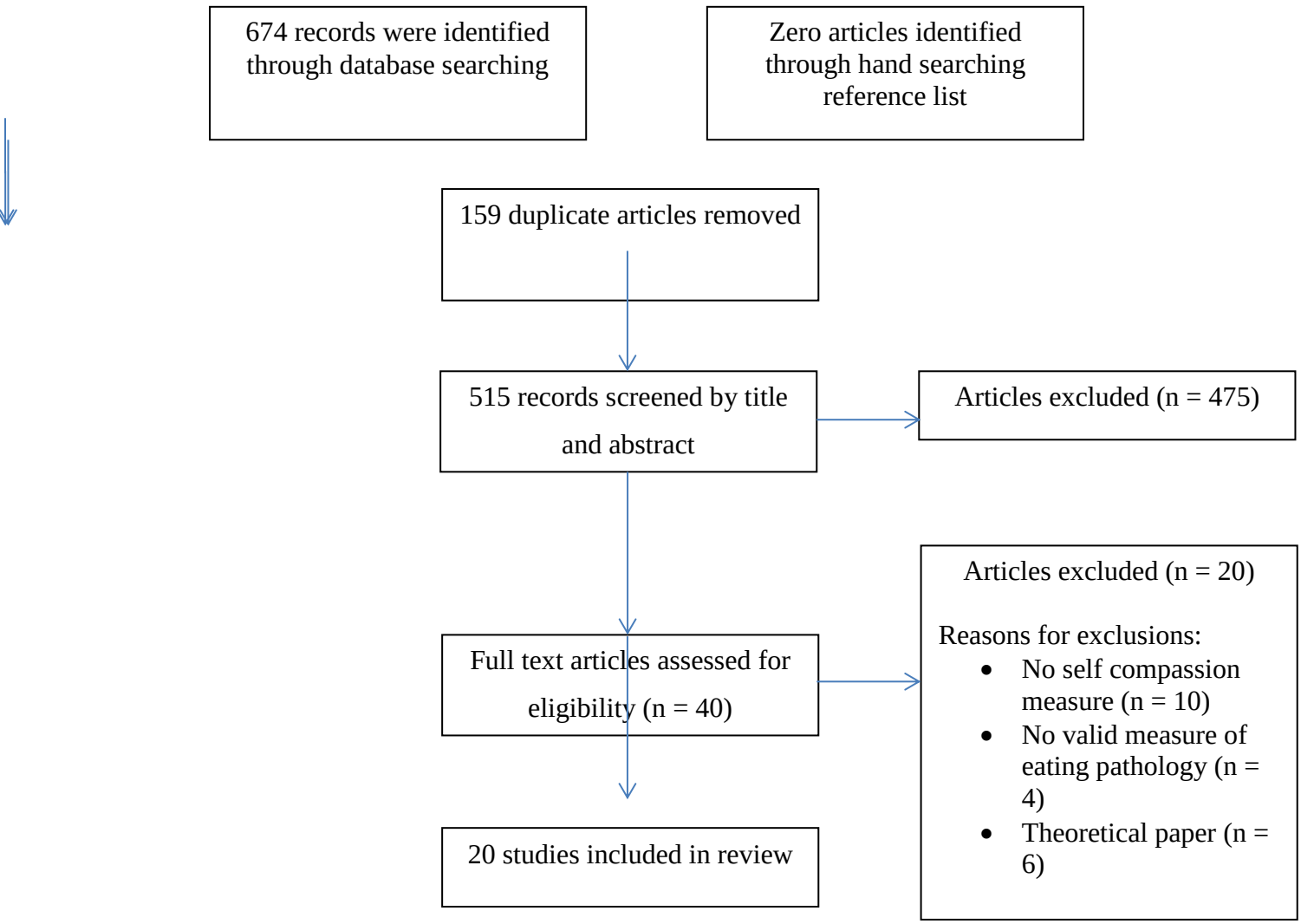

Figure 1. Flow chart for inclusion of studies in the review.

Table 1

Demographics of studies included in the review

Author, date, country of recruitment	Research design	Gender		Mean age	Ethnicity	Sample type/ diagnosis
		Male	Female			
Albertson et al. (2015), USA	Randomised Control Trial	0	228	Intervention group: 36.42 (SD = 1.31) Control group: 38.42 (SD = 1.42)	White (95%)	Non clinical
Carter et al. (2015),** Canada	Cross sectional	3	94	28 (SD = 9.6)	Caucasian (79.2%) East Asian (4.5%) South Asian (1.4%) African-Canadian (2.8%) Latino (10.8%) Mixed Race (1.5%)	Clinical Mean BMI Anorexia Nervosa = 16.6 (SD = 1.8) Mean BMI Bulimia Nervosa = 24.5 (SD = 6) Mean BMI Eating Disorder Not Otherwise Specified = 22.6 (SD = 4.4) Anorexia Nervosa Restricting type (27.1%) Anorexia Nervosa Binge Purge Type (17.3%)

						Bulimia Nervosa (30.9%) Eating Disorder Not Otherwise Specified (24.7%)
Daye et al. (2014),* USA	Cross sectional	0	322	19.48 (SD = 1.46)	White or European American (65.3%) African American (20.4%) Hispanic or Latino (5.6%) Asian or Asian American (3.1%) American Indian or Alaska Native (1.5%) Hawaiian or other Pacific Island (0.9%)	Non clinical Mean BMI = 22.78 (SD = 4.95) Underweight (14%) Normal weight (62%) Overweight (16%) Obese (8%)
Duarte et al. (2015), Portugal	Cross Sectional	0	662	20.33 (SD = 1.76)		Non clinical Mean BMI = 21.86kgs (SD = 3.12kg/m2) Underweight (10.72%) Normal weight (75.23%) Overweight (14.05%)
Ferreira et al. (2013),	Between group	0	225	Clinical: 23.62		Clinical (n = 102) Mean BMI = 21.15 (SD = 6.93)

Portugal				(SD = 7.42) Non clinical: 23.54 (SD = 6.89)		Bulimia Nervosa (30.4%) Anorexia Nervosa (32.4%) Eating disorder not otherwise specified (37.2%) Non clinical (n = 123) Mean BMI = 21.95 (SD = 3.19)
Ferreira et al. (2014) Portugal	Cohort	0	34	24.56 (SD = 7.61)		Clinical Mean BMI = 22.60 (SD = 8.31) Anorexia Nervosa (29.4%) Bulimia Nervosa (44.1%) Eating Disorder Not otherwise Specified (26.5%)
Homan et al. (2015) USA	Cross sectional	0	263	35.26 (SD = 12.42)	White (77.9%) African American (10.6%) Asian American (5.3%) Native American (1.5%)	Non clinical Mean BMI = 26.23 (SD = 6.45) Underweight (3.4%) Normal weight (54.6%) Overweight (20.5%) Obese (25.5%)
Kelly et al. (2013a) Canada	Prospective	2	74	27.5 (SD = 9.3)	Caucasian (79.1%) East Asian (4.5%) South Asian (1.5%) African-Canadian (2.9%)	Clinical Anorexia Nervosa Restricting type (29.2%) Anorexia Nervosa Binge Purge Type (18.5%) Bulimia Nervosa (29.2%)

					Latino (10.5%) Mixed Race (1.5%)	Eating Disorder Not Otherwise Specified (23.1%)
Kelly et al. (2013b)** Canada	Prospective	3	N = 97	28 (SD = 9.6)	Caucasian (79.2%) East Asian (4.5%) South Asian (1.4%) African-Canadian (2.8%) Latino (10.8%) Mixed Race (1.5%)	Clinical Mean BMI = 21 (SD = 5.5) Anorexia Nervosa Restricting type (27.2%) Anorexia Nervosa Binge Purge Type (18.5%) Bulimia Nervosa (29.6%) Eating Disorder Not Otherwise Specified (24.7%)
Kelly et al. (2014a) Canada	Cross Sectional	0	153	20.2 (SD = 3.49)	Caucasian (48.3%) South Asian (19.4%) East Asian (12.9%) Southeast Asian (6.5%) Black/African (3.2%) Bi-racial (3.2%) West Indian/Caribbean (2.6%) Hispanic (1.3%) Middle Eastern (1.3%)	Non clinical

					Aboriginal (first nations) (0.7%) Other (0.7%)	
Kelly et al. (2014b) Canada	Case Control	0	252	Clinical: 28 (SD = 9.6) Non clinical: 20 (SD = 5.0)	Clinical: Caucasian (79.2%) Hispanic (10.8%) East Asian (4.5%) African-Canadian (2.8%) Other (2.9%) Non clinical: Caucasian (48.3%) South Asian (19.4%) East Asian (12.9%) Southeast Asian (6.5%) Black/African (3.2%) Bi-racial (3.2%) West Indian/ Caribbean (2.6%) Other (5%)	Clinical (n = 97 Mean BMI = 20.99 (SD = 5.57) Bulimia Nervosa (29.6%) Anorexia Nervosa restricting type (27.2%) Anorexia Nervosa binge-purge type (18.5%) Eating disorder not otherwise specified (24.7%) Non clinical (n = 155) Mean BMI = 23.08 (SD = 4.99)

Liss et al. (2015) USA	Cross sectional	0	210	Low compassion: 19.28 (SD = 1.85) High compassion: 19.23 (SD = 1.82)	Low compassion: White/Caucasian (88.5%) Black/African American (1.9%) Asian/Pacific Islander (2.9%) Latina (1.0%) Multiracial (4.8%) Other (1.0%) High compassion: White/Caucasian (87.7%) Black/African American (3.8%) Asian/Pacific Islander (2.8%) Latina (3.8%) Not disclosed (0.9%) Other (0.9%)	Low compassion (n = 104) High compassion (n = 106)
Pisitsungkagarn et al. (2014) Thailand	Cross Sectional	0	302	20.36 (SD = 1.25)	-	Non clinical Mean BMI = 19.87 (SD = 2.83)
Prowse et al. (2013)	Cross Sectional	98	309	22.5	Anglo-Saxon (86%)	Non clinical

Australia					Aboriginal or Torres Strait Islander (2%) Other cultural background (12%)	
Schoenefeld et al. (2013)* USA	Cross sectional	0	322	19.48 (SD = 1.46)	European American (67.4%) African American (21.1%) Latina (5.8%) Asian (3.2%) American Indian (1.6%) Hawaiian or other Pacific Island (1.0%)	Non clinical Mean BMI = 23.55 (SD = 5.11)
Taylor et al. (2015) USA	Cross Sectional	22	128	19.23 (SD = 3.69)	Non Hispanic White (74%) Hispanic American (12%) Another ethical or racial category (14%)	Non clinical Mean BMI = 23.02 (SD=3.69) Overweight or obese (26%)
Tylka et al. (2015) USA	Cross sectional	0	435	28.14 (SD = 5.45)	White (73.3%) Asian American (8.7%)	Non clinical

					African American (8.5%) Latina (4.8%) Multiracial (4.6%)	
Wasylkiw et al. (2012) Canada Study 1	Cross sectional	0	142	19 (SD = 1.13)		Non clinical
Wasylkiw et al. (2012) Canada Study 2	Cross sectional	0	189	18.41 (SD = 1.04)		
Webb et al. (2013) USA	Cross sectional	47	168	19.81 (SD = 1.48)	European American (45.2%) Latino American (23.5%) African American (6.9%) Other (4.6%)	Non clinical

Table 2

Summary of the main findings of studies included in the review

Author, date	Measures		Main (relevant) findings
Albertson et al. (2015)	**SCS** **BSQ** **OBCS (body shame subscale)** **BAS** CSW	1. 2. 3. 4.	Self-compassion was negatively correlated with body dissatisfaction (*(r* = -.62, *p* < .01) and body shame *(r* = -.67, *p* < .01) Self compassion was positively correlated with body appreciation *(r* = .72, *p* < .01). Self compassion was negatively associated with contingent self-worth-appearance (*r* = -.48, *p* < .01) The intervention group demonstrated significantly higher gains in self compassion compared to the control group, Cohen's *d,* indicating a large effect size (0.82) (*F*=37.37, *p* < .001). post intervention scores were significantly different (p < .05) to pre-test scores
Carter et al. (2015)**	**EDE-Q** ACMTQ BDI RSE **SCS-SF** ESS SPS	1. 2. 3.	Patients who reported more received social support and higher levels of self compassion at admission, also reported higher levels of autonomous motivation for treatment. Self compassion was positively correlated with autonomous motivation (*r* = .27, *p* < .001), but not controlled motivation. Thus, those who were more self compassionate and experienced more social support at the start of treatment were more intrinsically motivated for treatment. When examining the unique predictors of controlled motivation at baseline, only shame was identified as having an effect *F*(1,60) = 6.48, *B* = .55 (*SE* = .26), *p* = .01.
Daye et al. (2014)*	CEMS **OBCS** **SCS**	1. 2. 3. 4.	Self compassion as negatively correlated with body shame *(r* = -.51, *p* < .01), and body surveillance *(r*= -.47, *p* < .01). Women reporting more frequent recall of experiencing restrictive/critical caregiver eating messages endorsed lower levels of self compassion (*r* = -.18, *p* < .01). Self compassion was negatively associated with body surveillance and objective body consciousness A positive relationship exists between the frequency of recalled restrictive/critical caregiver

			eating messages and body surveillance at low levels of self compassion, slope = .229, t(280) = 2.298, p = .022, and an inverse association at high levels of self compassion, slope = -.283, t(280) = -2.279, p = .023.
		5.	Further, the relationships between frequency of recollecting restrictive/critical caregiver eating messages and body shame was strongest when self compassion was low, slope = .361, t(269) = 5.580, p < .001
Duarte et al. (2015)	**FRS** SCPAS **SCS** WHOQOL-BREF	1.	Self compassion was significantly positively correlated with quality of life. In particular, psychological quality of life was associated with self compassion R^2= 0.45, $p < .001$
		2.	Higher self compassion scores were associated with BMI (R^2 = -.10, $p < .010$).
		3.	Body dissatisfaction had a direct effect on self compassion of -.11 (bBD = -.08; SEb=.03; Z = -3.00; p = .003.
		4.	
Ferreira et al. (2013)	**SCS** OAS **EDI** **EDE 16.0D** DASS	1.	ED patients presented significantly lower scores on self compassion and higher scores on self critical judgment,, external shame, depressive, anxiety and stress symptoms
		2.	For both ED and non clinical patients, self compassion was negatively correlated with body dissatisfaction, R^2= -.42, $p < .05$, R^2 =-.34, $p < .001$ respectively.
		3.	There was a mediating effect of self compassion on the relationship between external shame and drive for thinness.
		4.	In the non clinical sample, external shame predicted the drive for thinness and self compassion. This accounted for 19.8% of the drive for thinness.
		5.	In the ED sample, external shame significantly predicted drive for thinness as well as self compassion. Shame accounted for 21.2% of drive of thinness.
		6.	In the ED sample, body dissatisfaction predicted higher levels of drive for thinness, partially through decreased self compassion. This accounted for 31.2% of variance. The *Sobel* test confirmed partial mediation (z = -2.63, p = .009)
		7.	In the non clinical sample, mediating effect of self compassion on relationship between body image dissatisfaction and drive for thinness, accounted for 38.4% variance. However, *Sobel* test was non-significant (z = -1.66, p = .099), indicating that self compassion did not mediate the association between body dissatisfaction and drive for thinness.

Ferreira et al. (2014)	**EDE 16.0D** SEI IES-R CES **SCS**	1.	Self compassion was the best predictor of eating psychopathology. It emerged as the only positive dimension of self compassion as a significant predictor (*B* = -.84, *p* < .001) with the model explaining 37.6% of eating psychopathology severity variance.
		2.	There was a moderating effect of self compassion on relationship between shame memory variables and eating psychopathology
		3.	There was a significant interaction of self compassion and traumatic features of shame memory on predicting eating psychopathology R^2 = .53 [F(1, 30) = 8.405, *p* = .007)
Homan et al. (2015)	**SCS** Body comparison subscale from **BEECOM** **BAS** CSW	1.	Self compassion was inversely associated with body comparison (*r* = -.42, *p*<.001) and appearance self worth (*r* = -.55 *p* <.001) , and positively associated with body appreciation (*r*= .62, *p* <.001)
		2.	In moderation analysis, where body comparison was the predictor, self compassion showed a significant positive relationship with body appreciation, *B*=.37 (95% CI=.30, .45), *SE*= .04, *t*(252) = 9.47, *p* <.001)
		3.	In moderation analysis, where body comparison was the predictor at low levels of self compassion, body comparison was strongly related to poorer body appreciation *B* = -.22 (95% CI =.29, -.15), *SE*= .03, *t*(252) = -6.47, *p* <.001)
		4.	In moderation analysis, where body comparison was the predictor at high levels of self compassion, body comparison was more weakly associated with body appreciation *B*= -.11 (95% CI =-.18, -.05), *SE*= .03, *t*(252) = -3.39, *p* <.001)
		5.	At low levels of self compassion, appearance self worth was strongly related to lower body appreciation, B = -.29 (95% CI = -0.37, -0.20) SE = .04, t(252) = -6.71, p < .001. This association was weaker at higher levels of self compassion.
Kelly et al. (2013a)	**EDE-Q** ESS **SCS-SF** **FSC**	1.	Lower self compassion was associated with greater fear of self compassion, greater pathology on the EDE-Q, and higher shame.
		2.	There was a three way interaction of self compassion, fear of self compassion and time (R^2= -.07, *p* = < .05).
		3.	Contrary to hypotheses, the estimated rate of change for patients with high self compassion and low fear of self compassion did not differ significantly from that of other patients.

		4.	The eating disorder symptoms of patients with combinations of low self compassion and high fear or self compassion did not change over time (12 weeks). By contrast, all other combinations had significant reductions.
		5.	Patients high in self compassion and low in fear of self compassion, had the most significant rate of change in eating disorder symptoms (B = -.43, (SE = .11), p < .001)
		6.	At baseline, self compassion and fear of self compassion were negatively correlated, but shared less than 40% variance.
		7.	Shame and eating disorder pathology were more severe the higher patients' fear of self compassion and the lower their dispositional self compassion.
Kelly et al. (2013b)**	**EDE-Q** ESS **SCS-SF**	1.	Early self compassion change was moderately correlated with early shame change (r = 0.30, p = < .05), with these two variables sharing less than 10% of their variance.
		2.	Early self compassion change X time emerged as a significant predictor of change in eating disorder symptoms, F(1, 195) = 4.74, p < .05, effect size r = .15.
		3.	Estimates revealed that patients who had relatively larger increases in self compassion early in treatment had significant decreases in eating disorder symptoms over 12 weeks, B = -0.20 (SE = 0.06), p < .001, and to a lesser degree, so too did patients who had relatively smaller increases in self compassion, B = -0.13, (SE = 0.06), p < .05.
		4.	When controlling for EDE-Q change X time, there was a significant effect of early self compassion change X time, F(1, 175) = 6.77, p = .01, effect size r = .19 .
		5.	Only larger *early* improvements in self compassion showed significant decreases in shame, over time B = -0.10 (SE = 0.04), p < .05.
Kelly et al. (2014a)	BMI **SCS** RSE **BI-AAQ** **EDE-Q**	1.	Self-compassion was negatively correlated with global eating pathology, (r = -0.41, p = < .001) and positively correlated with body image flexibility, (r = 0.41, p = < .001).
		2.	Results from hierarchical regression indicated that self compassion and BMI was not significant
		3.	Among individuals who had lower and average levels of self compassion, BMI was related to greater global eating pathology, weight concerns and eating concerns. However, these relationships were not attenuated or absent in women who had high levels of self compassion
Kelly et al. (2014b)	**EDE-Q** **SCS-SF**	1.	Amongst students, low self compassion was the strongest predictor of EQE-Q Global *(B= -*.50, p = < .01*)*, restraint *(B = -42, p = < .01) eating concerns (B* = -.27, p = < .05*)* weight

	FSC		concerns *(B* = -.65, *p* = < .01*)* and shape concerns *(B* = -.65, *p* = < .01*)*
	RSE	*2.*	Amongst patients, fear of self compassion emerged as the strongest predictor of EDE-Q global *(B* = .74, *p* = < .01).
		3.	Self compassion as not a significant predictor of EDE-Q global.
Liss et al. (2015)	**OBCS**	1.	Negative eating attitudes were positively correlated with BMI in both groups of women, but they were only significantly positively correlated with depression for those low in self compassion
	SCS		
	EAT-26		
	PHQ-8	2.	Women with higher levels of self compassion had lower shame *F(1, 201) 80.55, p < .001*, and healthier attitudes towards food $F(1, 201) = 40.31$, $p < .001$.
	BMI		
		3.	Women with higher self compassion also reported lower levels of body surveillance $F(1, 201) = 36.38$, $p < .001$.
Pisitsungkagarn et al. (2014)	**BAS**	1.	Self esteem was predicted by body image satisfaction, and self-compassion. Their interactions were significant, F(3, 298) = 35.48, p < .001)
	RSES		
	SCS	*2.*	Self compassion predicts self esteem, *B* = 0.30 (SE = 0.05) *B = 0.34 p < .001*
		3.	The magnitude of the effect of self compassion on body imagine satisfaction was *B = 0.34 p < .001*
		4.	Body image satisfaction positively and significantly predicted self esteem n participants with low and high self compassion. This prediction was strongest in participants with low self compassion (*B* = 0.39, *p* < .001)
		5.	High self compassion has a moderating effect on self esteem, related to physical appearance.
Prowse et al. (2013)	EDE-Q	1.	Females scored significantly lower than males in acceptance of body image (*t* (179) = 3.70, *p* < 0.01)
	KIMS		
	BI-AAQ	2.	Participants with higher eating disorder symptomology scored lower on self compassion (r = -.40, p < .01)
	DASS-21		
	EIPQ	3.	Body image acceptance was correlated with positively correlated with self compassion (r = 0.48, p < .01).
	SOSI		
	SCS	4.	Self compassion predicts body image acceptance (*B* = 0.25, p < .001).

	Self control Scale PWI		
Schoenefeld et al. (2013)*	**SCS** DTS **BI-AAQ** **IES** RES	1.	Participants scoring higher on self compassion also reported higher levels of intuitive eating (r = .39, p < .01), distress tolerance (r = .53, p < .01) and body image flexibility (r = .49, p < .01)
		2.	There was an indirect effect of self compassion on initiative eating scores, via BI-AAQ, While controlling for distress tolerance scores, this was estimated to be .31 (SE = .04, Z(286) = 7.70, p < .001) (95% CI = .23 to .39)
Taylor et al. (2015)	**SCS-SF** MEQ **EAT-26**	1.	Self compassion was positively correlated with mindful eating (r = .34, p < .01) and negatively correlated with eating disorder symptomatology (r = -.17, p < .05)
		2.	Self compassion positively predicted mindful eating (p < .001)
		3.	Self compassion explained 11% of the adjusted variance in mindful eating R^2adj = .11, F(1,148) = 18.81, p < .001
		4.	Self compassion and mindful eating significantly predicted BMI, F(2, 147) = 3.83, p = .02
Tylka et al. (2015)	PSPS **SCS-SF** **SATAQ-1** **EAT-26**	1.	Self compassion was associated with lower thin-ideal internalization
		2.	When self compassion was low, media thinness-related pressure predicted thin-ideal internalization B= .588, t (434) = 6.40, p < .001
		3.	Self compassion buffers the relationship between media thinness-related pressure and thin-related internalization
		4.	Self compassion was significantly associated with lower disordered eating, r = -.39, p < .001 (
		5.	Self compassion was inversely related to women noticing thinness related pressures from friends, family, partners and the media
Wasylkiw et al. (2012)	RSE **SCS** **BSQ** **BAS**	1.	Body image constructs were significantly and positively correlated with self esteem and self compassion
		2.	Self esteem was a significant negative predictor of BSQ scores, but dropped to a non significant level when self compassion was included.

	BES	3.	When controlling for self esteem, as self compassion increased, body preoccupation decreased.
		4.	Self compassion was a significant positive predictor of body appreciation.
	RSE	1.	When controlling for self esteem, increased self compassion was associated with less guilt following eating foods perceived to be unhealthy.
	SCS		
	BSQ	2.	Body preoccupation significantly and negatively predicted self compassion $F(1, 186) = 34.31$, $p < .01$, adj $R^2 = .15$.
	RRRS		
	CES-D	3.	Self compassion (B = -11.26, SE =1.15, t= -9.77, p < .01) was a significant predictor of depressive symptoms, $F(1,186) = 95.36$, $p < .01$, adj. $R^2 = .34$.
Webb et al. (2013)	**SCS**	1.	Self compassion scores were negatively associated with binge eating severity ($r = .25$, $p < .01$).
	ETS		
	USAQ	2.	The linear relationship between self-compassion and BMI approached statistical significance ($r = -.12$, $p = 0.08$)
	BES		
		3.	The indirect effect of self compassion on BES scores via emotional tolerance while controlling for unconditional self-acceptance was estimated to be -.05 (SE = .02, $Z(207) = -2.2$, $p < .05$)

Abbreviations:BMI (Body Mass Index)

Measures: EDE-Q (The Eating Disorder Examination Questionnaire, Fairburn & Beglin, 1994; Fairburn, Cooper & O'Connor, 2008), KIMS (Kentucky Inventory of Mindfulness Skills, Baer, Smith & Allen, 2004), BI-AAQ (Body Image Acceptance and Action Questionnaire, Sandoz & Wilson, 2006), DASS-21 (Depression, Anxiety and Stress Scale, Lovibond & Lovibond, 1995), EIPQ (Ego Identity Processes Questionnaire, Balistreri, Busch-Rossnagal & Geisinger, 1995), SOSI (Sense of Self Inventory (Basten, 2007), SCS Self compassion Scale (Neff, 2003), Self Control Scale (Tangeny, Baumeister & Boone, 2004), PWI (4th Ed) Personal Wellbeing Index (International Wellbeing Group, 2006), BAS (Body Appreciation Scale, Avalos, Tylka & Wood-Barcalow, 2005), RSES (Rosenberg's Self Esteem Scale, Rosenberg, 1965), DTS (Distress Tolerance Scale, Simons & Gaher, 2005), CES-D (Center for Epidemiological Studies for Depression, Radloff, 1977), FCS (Fears of Compassion Scale, Gilbert et al., 2011), CEQ (Credibility/Expectancy Questionnaire, Devilly & Borkovec, 2000), HRS (Homework Rating Scale, Kazantis, Deane & Ronan, 2004), EDE 16.0D (Fairburn, Cooper, O'Connor, 2008), BEECOM (Body, Eating, and Exercise Comparison Orientation Scale, Fitzsimmons-Cradt, Bardone-Cone, & Harney, 2012), CSW (Contingencies of Self-Worth Scale, Crocker, Luhtanen, Cooper, & Bouvrette, 2003), FRS (Figure Rating Scale, Thompson & Altabe, 1991), SCPAS (Social Comparison through Physical Appearance Scale, Ferriera, Pinto-Gouveia, & Duarte, 2013), WHOQOL-BREF (World Health Organisation Brief Quality of Life Assessment Scale, The WHOQOL Group, 1998), SCS-SF (Self Compassion Scale Short Form, Raes, Pommier, Neff, & Van Gucht, 2011), MEQ (Mindful Eating Questionnaire, Framson, Kristal, Schenk, Littman, Zeliadt, & Benitez, 2009), EAT-26 (Eating Attitudes Test, Garner, Olmsted, Bohr, & Farfinkel, 1982), PSPS (Perceived Socioculturel Pressures Scale, Stice, Ziemba, Margolis, & Flick, 1996), SATAQ-1 (Internalisation subscale of the Sociocultural Attitudes Towards Appearance Questionnnaire, Heinberg, Thompson, & Stormer, 1995), ETS (Emotional Tolerance Scale, Kenardy, Arnow, &

Agras, 1996), USAQ (Unconditional Self-Acceptance Questionnaire, Chamberlain & Haaga, 2001), IES (Intuitive Eating Scale, Tylka, 2006), CEMS (Caregiver Eating Messages Scale, Kroon Van Diest & Tylka, 2010), OBCS (Objectified Body Consciousness Scale, McKinley & Hyde, 1996), OAS (Other as Shamer Scale, Goss, Gilbert & Allan, 1994), SEI (Shame Experiences Interview, Matos, & Pinto-Gouveia, 2014), IES-R (Impact of Event Scale- Revised, Weiss, & Marmar, 1997), CES (Centrality of Event Scale, Berntsen & Rubin, 2006), ESS (Experience of Shame Scale, Andrews, Qian, & Valentine, 2002), ACMTQ (Autonomous and Controlled Motivation Questionnaire, Zuroff, Koestner, Moskoitz, McBride, Marshall, & Bagby, 2007), SPS (Social Provisions Scale, Cutrona & Russel, 1987), BSQ (Body Shape Questionnaire, Cooper, Taylor, Cooper & Fairburn, 1987; Evans & Dolan, 1993), BES (Body Esteem Scale, Franzoi & Shields, 1984), RRRS (Revised Rigid Restraint Scale, Adams & Leary, 2007), BES (Binge Eating Scale, Gormally, Black, Daston, & Rardin, 1982).

Table 3

Application of the Quality Assessment Tool for Quantitative Studies

Name of study	Selection bias	Study design	Confounders	Blinding	Data collection methods	Withdrawals and Drop-outs	Global quality rating
Albertson et al. (2015) USA	Moderate	Strong	Moderate	Weak	Strong	Moderate	Moderate
Carter et al. (2015) Canada	Strong	Moderate	Moderate	Moderate	Strong	Strong	Strong
Daye et al. (2014) USA	Moderate	Weak	Moderate	Moderate	Moderate	Weak	Moderate
Duarte et al. (2015) Portugal	Strong	Weak	Weak	Moderate	Moderate	Strong	Moderate
Ferreira et al. (2013) Portugal	Strong	Moderate	Strong	Moderate	Moderate	Weak	Moderate
Ferreira et al. (2014) Portugal	Strong	Moderate	Moderate	Moderate	Strong	Strong	Moderate
Homan et al. (2015) USA	Moderate	Moderate	Moderate	Moderate	Moderate	Weak	Moderate
Kelly et al. (2013a) Canada	Strong	Moderate	Weak	Moderate	Moderate	Moderate	Moderate
Kelly et al. (2013b) Canada	Strong	Moderate	Moderate	Moderate	Strong	Moderate	Moderate

Kelly et al. (2014a) Canada	Moderate	Moderate	Weak	Moderate	Moderate	Moderate	Moderate
Kelly et al. (2014b) Canada	Strong	Moderate	Weak	Moderate	Moderate	Weak	Weak
Kelly et al. (2015) Canada	Strong	Strong	Moderate	Moderate	Strong	Strong	Strong
Liss et al. (2015) USA	Moderate	Weak	Strong	Moderate	Moderate	Moderate	Moderate
Pisitsungkagarn et al. (2013) Thailand	Moderate	Moderate	Moderate	Moderate	Moderate	Weak	Moderate
Prowse et al. (2013) Australia	Moderate	Moderate	Weak	Moderate	Moderate	Weak	Weak
Schoenefeld et al. (2013) USA	Moderate	Moderate	Weak	Moderate	Strong	Weak	Moderate
Taylor et al. (2015) USA	Moderate	Moderate	Moderate	Moderate	Moderate	Weak	Moderate
Tylka et al. (2015) USA	Moderate	Moderate	Strong	Moderate	Moderate	Strong	Moderate
Wasylkiw et al. (2012) Canada	Moderate	Moderate	Weak	Moderate	Moderate	Weak	Weak
Webb et al. (2013) USA	Moderate	Weak	Weak	Moderate	Moderate	Moderate	Weak

Author Guidelines- European Eating Disorders Review

Manuscript Submission

European Eating Disorders Review has now adopted ScholarOne Manuscripts, for online manuscript submission and peer review. The new system brings with it a whole host of benefits including:

- Quick and easy submission
- Administration centralised and reduced
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Manuscript style. All submissions, including book reviews, should be double-spaced and clearly legible.

The first page should contain the **title** of the paper, full names of all authors, the address where the work was carried out, and the full postal address including telephone, fax number and email to whom correspondence and proofs should be sent. The name(s) of any **sponsor(s)** of the research contained in the paper, along with **grant number(s)** should also be included.

The second sheet should contain an **abstract** of up to 150 words. An abstract is a concise summary of the whole paper, not just the conclusions, and is understandable without reference to the rest of the paper. It should contain no citation to other published work. Include up to five **keywords** that describe your paper for indexing purposes.

- **Research articles** reporting new research of relevance as set out in the aims and scope should not normally exceed 6000 words with no more than five tables or illustrations. They should conform to the conventional layout: title page, summary, introduction, materials and methods, results, discussion, acknowledgements and references. Each of these elements should start on a new page. Authors may not find it necessary to use all of these subdivisions, and they are listed here only as a guide.
- **Review articles** should offer a synthesis of current knowledge in a field where rapid or significant progress has been made. The text should ideally not exceed 7000 words, 50 references and 5 figures or tables.
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  Brief reports bring with them a whole host of benefits including: quick and easy submission, administration centralised and reduced and significant decrease in peer review times, first publication priority (this type of manuscript will be published in the next available issue of the journal).
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Reference style . The APA system of citing sources indicates the author's last name and the date, in parentheses, within the text of the paper.

A. A typical citation of an entire work consists of the author's name and the year of publication .

Example: Charlotte and Emily Bronte were polar opposites, not only in their personalities but in their sources of inspiration for writing (Taylor, 1990). Use the last name only in both first and subsequent citations, except when there is more than one author with the same last name. In that case, use the last name and the first initial.

B. If the author is named in the text, only the year is cited .

Example: According to Irene Taylor (1990), the personalities of Charlotte. . .

C. If both the name of the author and the date are used in the text, parenthetical reference is not necessary .

Example: In a 1989 article, Gould explains Darwin's most successful. . .

D. Specific citations of pages or chapters follow the year .

Example: Emily Bronte "expressed increasing hostility for the world of human relationships, whether sexual or social" (Taylor, 1988, p. 11).

E. When the reference is to a work by two authors, cite both names each time the reference appears .

Example: Sexual-selection theory often has been used to explore patters of various insect matings (Alcock & Thornhill, 1983) . . . Alcock and Thornhill (1983) also demonstrate. . .

F. When the reference is to a work by three to five authors, cite all the authors the first time the reference appears. In a subsequent reference, use the first author's last name followed by *et al* . (meaning "and others") .

Example: Patterns of byzantine intrigue have long plagued the internal politics of community college administration in Texas (Douglas *et al* ., 1997) When the reference is to a work by six or more authors, use only the first author's name followed by *et al* . in the first and all subsequent references. The only exceptions to this rule are when some confusion might result because of similar names or the same author being cited. In that case, cite enough authors so that the distinction is clear.

G. When the reference is to a work by a corporate author, use the name of the organization as the author .

Example: Retired officers retain access to all of the university's educational and recreational facilities (Columbia University, 1987, p. 54).

H. Personal letters, telephone calls, and other material that cannot be retrieved are not listed in References but are cited in the text .

Example: Jesse Moore (telephone conversation, April 17, 1989) confirmed that the ideas. . .

I. Parenthetical references may mention more than one work, particularly when ideas have been summarized after drawing from several sources. Multiple citations should be arranged as follows .

Examples:

- List two or more works by the same author in order of the date of publication: (Gould, 1987, 1989)
- Differentiate works by the same author and with the same publication date by adding an identifying letter to each date: (Bloom, 1987a, 1987b)
- List works by different authors in alphabetical order by last name, and use semicolons to separate the references: (Gould, 1989; Smith, 1983; Tutwiler, 1989).

All references must be complete and accurate. Where possible the DOI for the reference should be included at the end of the reference. Online citations should include date of access. If necessary, cite unpublished or personal work in the text but do not include it in the reference list. References should be listed in the following style:

Journal Article

Gardikiotis, A., Martin, R., & Hewstone, M. (2004). The representation of majorities and minorities in the British press: A content analytic approach. *European Journal of Social Psychology*, *34* , 637-646. DOI: 10.1002/ejsp.221

Book

Paloutzian, R. F. (1996). *Invitation to the psychology of religion* (2nd ed.). Boston: Allyn and Bacon.

Book with More than One Author

Natarajan, R., & Chaturvedi, R. (1983). *Geology of the Indian Ocean* . Hartford, CT: University of Hartford Press.
Hesen, J., Carpenter, K., Moriber, H., & Milsop, A. (1983). *Computers in the business world* . Hartford, CT: Capital Press. and so on.
The abbreviation *et al.* is not used in the reference list, regardless of the number of authors, although it can be used in the text citation of material with three to five authors (after the inital citation, when all are listed) and in all parenthetical citations of material with six or more authors.

Web Document on University Program or Department Web Site

Degelman, D., & Harris, M. L. (2000). *APA style essentials* . Retrieved May 18, 2000, from Vanguard University, Department of Psychology Website: http://www.vanguard.edu/faculty/ddegelman/index.cfm?doc_id=796

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Hien, D., & Honeyman, T. (2000). A closer look at the drug abuse-maternal aggression link. *Journal of Interpersonal Violence, 15* , 503-522. Retrieved May 20, 2000, from ProQuest database.

Abstract from Secondary Database

Garrity, K., & Degelman, D. (1990). Effect of server introduction on restaurant tipping. *Journal of Applied Social Psychology, 20* , 168-172. Abstract retrieved July 23, 2001, from PsycINFO database.

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Shea, J. D. (1992). Religion and sexual adjustment. In J. F. Schumaker (Ed.), *Religion and mental health* (pp. 70-84). New York: Oxford University Press.

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Section Two: Research paper

What is the relationship between self harm and self compassion, in the context of voice hearing?

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Abstract

Self compassion has been implicated as a protective factor in an array of mental health difficulties and appears to have a large effect size in its relationship with psychopathology (MacBeth & Gumley, 2012). However few studies have examined this factor in relation to voice hearing experiences, and more specifically self injury behaviours. it was hypothesised that greater self compassion would moderate the relationship between voice hearing and frequency of self injury. Participants were 80 individuals with experiences of voice hearing. Correlations were found between beliefs about voices and ratings of compassion. Results also indicate that ratings of positive self compassion significantly moderate the association between omnipotence and self injury. Furthermore, positive self compassion had a moderating effect on the relationship between interpersonal trauma and self injury. Despite some methodological limitations, the current study lends support for use of compassion focused therapy protocols in voice hearers, and more specifically for those who present with self injury behaviours. Future research should examine more closely the function of self injury in voice hearers, which may provide insights into the specific role of positive self compassion in ameliorating self harming behaviours.

Key words: self compassion, voices, self injury, trauma

Introduction

The experience of auditory verbal hallucinations (AVHs, or 'hearing voices') is reported to occur in approximately 70% of people who have received diagnoses of psychosis, but have also been found to be relatively common among the general population (Waters et al., 2012). While there is evidence to suggest that some people experience positive voices (Jenner et al., 2008), individuals report that voice hearing is frequently experienced as severely distressing and is most likely to have started in negative or explicitly traumatic circumstances (Woods et al., 2015). Similarly, Longden, Madill and Waterman (2012) note that "voice hearing has been portrayed as a source of comfort, instruction, and guidance or as a critical, commanding presence that threatens, terrorizes, and attacks" (p. 28). It is estimated that up to 10% of people will experience hearing a voice during the course of their lives, and that many do not use mental health services and have never thought of themselves as 'mentally ill' (Romme, Escher, & Dillon, 2009; Beavan, Read, & Cartwright, 2011). The term *voice hearing* will be used in throughout this paper to refer to auditory hallucinations (the favoured terminology in professional literature) as this is considered more neutral and less subjective (James, 2001; Romme & Escher, 1993, 2000).

Voice hearing and self-harm

The experience of voice hearing and self-harm are linked, with approximately one in five people with 'psychosis' engaging in self-harming behaviours (Challis, Nielssen, Harris & Large, 2013) and more than half of those making multiple attempts (Harkavy-Friedman, Nelson & Venarde, 2001). The most frequently occurring command hallucinations are to self-harm (Bucci et al., 2013). A recent systematic review suggests that earlier deliberate self-harm and low mood were the strongest predictors of self-harm in first episode

'psychosis' (Challis, Nielssen, Harris & Large, 2013). Mork et al. (2013) report that for individuals with a diagnosis of a psychotic disorder (for example schizophrenia), self-harm is particularly pronounced. A recent meta-analysis revealed a threefold risk of self harm when psychotic symptoms are present (Honings, Drukker, Groen, & van Os, 2016). However, the underlying mechanism behind this association remains unclear. The authors postulate that psychotic experiences and self injurious behaviour share risk factors, including emotion-oriented coping style and exposure to traumatic experiences and adverse life events, increasing the risk of psychopathology in general.

The content of command hallucinations predicts self-harm (Rogers, Watt, Gray, MacCulloch & Gournay, 2002), particularly in the absence of paranoid delusions. Command hallucinations are widely regarded as distressing and indicative of high risk of harm to self and others (Woods et al., 2015). Malevolent beliefs about voices are associated with self harm (Simms, McCormack, Anderson, & Mulholland, 2007). However, how voice hearing might specifically precipitate self harm remains relatively unexplored.

The vast majority of people who self harm have a history of child and/or adult sexual abuse as well as abandonment and neglect (Everett & Gallop 2000; Vivekananda 2000). McAllister (2003) proposes that in adulthood, self harm may become one way of dealing with memories of such abuse, through repetition, communication or symbolism of the trauma. Further, she suggests that self harm can offer an individual with trauma experiences a sense of control through re-enactment. While the literature indicates a link between self harm and voice hearing, the specific mechanisms underpinning this remains unclear. Self harm does not always occur as a result of a direct 'command' voice, it can occur in response to the experience of hearing voices as a method of coping with resultant distress.

Command hallucinations

Command hallucinations are amongst the most distressing symptom of auditory hallucinations. Command hallucinations are defined as auditory hallucinations pertaining to the ordering of specific acts, often considered violent or destructive (Hellerstein, Frosch, Koenigsberg (1987). They are often perceived as uncontrollable which might, in part, account for this distressing nature (Braham, Trower, & Birchwood, 2004; Bucci et al., 2013). Studies suggest that voice 'omnipotence' is significantly associated with compliance and harmful commands (Bucci et al., 2013) and that beliefs about social rank have important mediating effects upon content-specific demands (Fox, Gray & Lewis, 2004). More specifically, they found that individuals who complied with commands to self harm reported significantly higher levels of inferiority than both self harm non-compliers and commands to harm others. Chadwick, Lees, and Birchwood (2000) define malevolence as the intent of the voice to harm and carry out its threatening intent, while omnipotence relates to a perceived lack of control of the voice, the power they possess and perceived consequences of disobedience.

Compliance with command hallucinations is increased when the individual perceives the voice to have good personal intentions (Joireman, Anderson & Stratchman, 2003). Further, compliance has been found to be linked to beliefs about the power of the commander (Joireman, Anderson & Stratchman, 2003) and perceived consequences of non-compliance (Barrowcliff & Haddock, 2010). Familiarity of the voice (Junginger, 1995), and the relationship between the voice hearer and their voice are important in understanding rate of compliance (Braham, Trower, & Birchwood, 2004).

Command hallucinations and intoxication from alcohol and/or drug use have also been found to be associated with self harm, although the most prevalent reason for self harming is distress in relation to symptoms of voice hearing (Harvey et al., 2008). In schizophrenia spectrum disorders, younger age (Mork et al. 2013), previous history of self

harm (Patel & Upthegrove, 2009) and depression (Mork et al. 2012; Simms et al. 2007) have been implicated. Birchwood, Meaden, Trower, and Gilbert (2000) suggest that an imbalance of power between an individual and their voice(s) may have origins in their perceived social rank and sense of group belonging. They report that there are parallels between power differentials between the voice and voice hearer, and the individual and others in their social world. Moreover, they suggest that the distress experienced by an individual as a result of their voice hearing is closely linked to their perceived social rank. Fox, Gray and Lewis (2004) argue that a person may be more vulnerable to act upon commands to self-harm when there is "perceived low social rank, alongside perceived powerful (malevolent) voice" (p. 527). This in turn may lead to the formation of secondary depression and to subsequent feelings of helplessness and hopelessness. Consequently, the beliefs an individual holds about their voices, their perceived power and social rank in relation to the voice appear important factors in the distress experienced by a voice hearer and their compliance with commands.

Trauma and voice hearing

Meta-analysis has confirmed the association between childhood trauma and psychosis in adulthood (Varese et al., 2012). Moreover, there is growing evidence of a dose-response relationship (Russo et al., 2014) between childhood trauma and voice hearing. Sitko, Bentall, Shevlin, O'Sullivan and Sellwood (2014) found that the link between childhood sexual abuse and auditory hallucinations was mediated by anxious attachment style in a general population sample.

Self-compassion

There is growing evidence that self-compassion is a significant positive predictor of psychological well-being (Neff, Rude, & Kirkpatrick, 2007) and is considered to be a salient source of positive self-regard (Neff, 2013) and a significant predictor of self-worth stability

(Neff & Vonk 2009). Neff (2003) defines the concept of self-compassion as the interplay between three components: Self-kindness versus self-judgment, feelings of common humanity versus isolation, and mindfulness versus over-identification.

A paper reviewing studies that all used the Neff (2003) self-compassion measure suggests that 'compassion is an important explanatory variable in understanding mental health and resilience' (p. 545) (MacBeth & Gumley, 2012). They report a large effect size for self compassion and psychopathology, specifically in relation to depression, anxiety and stress. Self-compassion appears to increase resilience to the experience of mental distress and facilitates an adaptive coping response to adversity (Gilbert & Procter, 2006). Childhood trauma, in particular emotional abuse, has been found to be associated with significantly lower self-compassion (Tanaka, Wekerle, Schmuck, Paglia-Boak, & The MAP Research Team, 2011) and supports research suggesting an aversive parenting-low self-compassion linkage. More specifically, Braehler, Harper and Gilbert (2013) propose that traumatic experiences in childhood may increase sensitivity to internal threats (bullying, low self-worth, shame) that is maintained and increases distress for voice hearers. Moreover, Gilbert (2010) suggests that for individuals who experience trauma, fear of self compassion is common and is influenced by a fear that this will lead to reliving of painful childhood experiences, wherein they did not feel the compassion they so desperately needed. Braehler et al. (2013) found that Compassion Focused Therapy (CFT) for individuals with psychosis was associated with more increasingly compassionate narrative when compared to treatment as usual. This was further examined by Gumley and Macbeth (2014) who reported that greater narrative compassion was significantly associated with lower negative symptoms of psychosis. CFT aims to promote the development of compassion and aid emotional recovery from psychosis, and is particularly concerned with shame, self criticism and threats that may be experienced in relation to psychosis (Braehler, Harper, & Gilbert, 2013).

Studies propose that self-compassion can result in the reduction of negative self-related outcomes and improve psychiatric symptoms (Gilbert & Procter, 2006; Leary, Tate, Adams, Batts, & Hancock, 2007). Similarly, Longden and Procter (2012) suggest that self compassion acts as a buffer factor against not only the development but also the maintenance of several mental disorders, including depression and anxiety. The specific relationship between childhood trauma, voice hearing and self-compassion has yet to be empirically tested. There is potential clinical value in highlighting links between early trauma, voice hearing and self-compassion. Specifically, this study may lead to a greater understanding of the impact of self-compassion in relation to voice hearing which, in turn, may inform psychological interventions.

The primary aim of the present study was to examine the association between self compassion and self harm in people affected by auditory hallucinations. More specifically, the study aimed to examine the relationship between both positive and negative subscales of self compassion in self harm. Further, the study aimed to determine whether self-compassion moderates the link between interpersonal trauma and self-harm in voice hearers. Finally, since previous research has identified an association between trauma experiences and voice hearing, this study sought to determine whether beliefs about voices impacts upon the occurrence of self harm, in the context of self compassion. It is hypothesised that positive self compassion will act as a buffer against frequency of self injury, in voice hearers and that will also occur in those with trauma experiences.

Method

Participants

The present study intended to explore the relationship between self harm and self compassion, in the context of voice hearing experiences. The study was not limited to people with specified psychiatric diagnoses (APA, 1994, 2010).

Those included in the study identified as being voice hearers and were recruited via relevant interest groups and charities. Participants with and without experiences of self harming behaviours were recruited.

Advertisements were placed on a range of mental health charity websites, including The Hearing Voices Network, Lancashire Mind and Student Minds. An advertisement was also placed on social media including Facebook and Twitter. The study was shared via Twitter and Facebook posts from self-harm and mental health charities, including, Self-Injury Support, Mind, Intervoice, Emergence, Soteria, MhIST and MoodSwings. In addition, a national charity and provider of adult health and social care services (Making Space) shared details of the study across their residences and via self support groups for voice hearers. Finally, posters and information sheets were displayed in the waiting rooms of Hearing Voices Groups across the country and adverts were submitted to charitable newsletters, including Self-Injury Support. All online and hardcopy adverts and information sheets contained a link to the survey, along with the contact details of the researcher if participants sought further information. Participants were directed to the online survey where they were asked to review the Participant Information Sheet detailing further information about the study and provided sample questions (particularly in relation to early trauma experiences and self-harm) to enable participants to make an informed decision to consent to participants. Participants were unable to access the study without providing consent.

After completing the survey, participants had the opportunity to read a debriefing sheet. This page explained the research aims in lay terminology. Participants were also

signposted to services from which they could access support should they experience any distress as a result of completing the online survey.

Measures

Demographic questionnaire

Participants sex, age, ethnicity and religious beliefs were requested.

Hearing voices

The Hamilton Program for Schizophrenia Voices Questionnaire (HPSVQ: Van Lieshout & Goldberg, 2007) is a 13-item self-report questionnaire that provides a unitary index of severity comprising nine items (frequency, negative content, loudness, duration, interference with life, distress, impact on self-appraisal, clarity and compliance with commands). Items are rated on a five-point Likert scale of impairment or severity. The 4 remaining items examine the time of day and situations in which voices occur, the location and clarity of the voice, its impact on self-esteem, compliance with commanding voices and whether the week that is rated is typical. Scores range from 0 to 45. Scores of 0 to 7 indicate absent/minimal auditory verbal hallucination severity, 8 to 13 mild severity, 14 to 25 moderate severity and score of 26 and above indicate severe levels of auditory hallucinatory experiences. In the present study, the mean score was 18.71 (SD = 9.50). The Cronbach's α score for the present study was .92.

The revised Beliefs About Voices Questionnaire (BAVQ-R: Chadwick, Lees & Birchwood, 2000) is a 35 item self-report measure of an individual's beliefs, emotions and behaviour regarding auditory hallucinations. The measure includes three sub-scales relating to beliefs: malevolence (six items: e.g. 'My voice is punishing me for something I have done'); benevolence (six items: e.g. 'My voice wants to protect me'); and omnipotence (six items). Two further sub-scales, 'resistance' and 'engagement', measure emotional and behavioural relationships to auditory hallucinations. 'Resistance' has five items on emotion

(e.g. ‘My voice frightens me’) and four on behaviour (e.g. ‘When I hear my voice usually I tell it to leave me alone’). ‘Engagement’ has four items on emotion (e.g. ‘My voice reassures me’) and four on behaviour (e.g. ‘When I hear my voice usually I listen to it because I want to’). All responses are rated on a 4-point scale: disagree (0); unsure (1); agree slightly (2); agree strongly (3). The measure thus assesses degree of endorsement of items. Individuals hearing more than one auditory hallucination complete the questionnaire for their ‘dominant voice’. In the present study, the reliability was good, with a Cronbach’s α score of .83.

Trauma

The Brief Betrayal Trauma Survey (BBTS: Goldberg & Freyd, 2006) consists of 12 items that can be separated into those traumas involving a high degree of betrayal, for example sexual assault by close family member, and those involving low betrayal, for example a natural disaster. The measure examines traumatic events before and after the age of 18. The total maximum score of these items was 72, indicating the highest possible score of trauma. The minimum score was 12 indicating that no trauma occurred. In addition, 10 of the items specifically refer to interpersonal trauma (of which 30 was the maximum score). In the present study, interpersonal trauma was used as measure of trauma experiences. The mean score was 17.29 (SD = 5.14). Internal consistency in the present study was good, α = .87. The measure has been widely used in large survey designs with clinical and non-clinical participants (e.g. Goldsmith, Freyd & DePrince, 2012; Stein et al., 2013).

Self harm

The Inventory of Statements about Self Injury (ISAS; Klonsky, & Glenn, 2009) is a 46-item-self report measure that explores self-harm behaviours and the function of self harm. Within self harm behaviours individuals are asked to estimate the frequency of a range of different self harm behaviours. It also explores the experience of non-suicidal self-harm and the function of these behaviours, using a three point Likert scale to indicate degree of

relevance (“Not relevant”, “Somewhat relevant”, and “Very relevant”). Only participants who indicated that they self harm completed this measure. Internal consistency in present study was good (α = .84). In the present study, the mean score for frequency of self injury was 2215.36.

Self compassion

The Self-Compassion Scale (SCS; Neff, 2003) is a 26-item-self report measure that uses a 5-point (1-5) Likert scale to measure the frequency of a behaviour (“Almost Never” to “Almost Always”). The measure allows for subscale calculations relating to “Self-Kindness”, “Self-Judgment”, “Common Humanity”, “Isolation”, “Mindfulness” and “Over-identified”. It is reported to have good construct validity and good test–retest reliability when participants’ responses to the Self-Compassion Scale were compared across two time variables. Test–retest reliability for the overall score is .93 (Neff, 2003). Internal consistency in present study was good (α =.73). The mean score for positive self compassion was 32.04 (SD = 11.67), and 49.55 (SD = 11.02) for negative self compassion. The scores subscales were as follows: self kindness (10.77, SD = 5.26), common humanity (10.25, SD = 4.01), mindfulness (11.03, SD =3.97), self-judgment (19.97, SD = 4.60), isolation (14.89, SD =3.76), over identification (14.92, SD = 3.92).

Ethical considerations

Since participants were asked questions related to trauma and self harm, it was made explicit at the beginning of the survey that if distress occurs, the participant may end the survey immediately if they wished to. Furthermore, contact details for various organisations, providing immediate support was also made available at the beginning and at the end of the survey. Ethical approval was granted from Lancaster University’s Faculty of Health and Medicine Research Ethics Committee (FHMREC).

Missing data

All data ranges were checked for each variable entered to ensure that all data were entered within the prescribed ranges. The Little's MCAR test (Little, 1988) suggested that the occurrence of missing data was at random, $\chi^2 = 2176$ df = 2621; $p < 1.0$, which indicated that the data were missing at random. In order to utilise all available data, multiple imputation was chosen to estimate the missing data. Expectation maximisation was utilised as a method to analyse and impute missing data values (Dempster, Laird, & Rubin, 1977; Ruud, 1991). Where participants had missed more than three items on a single measure, these data were excluded from the analyses.

Statistical analysis

Visual inspection of histograms for each measure, along with statistical tests of normality, revealed that all measures were normally distributed apart from the measure of self injury (ISAS) which was highly positively skewed as not all participants self-harmed. This variable was transformed using +1Log (Manikandan, 2010). Table 2 outlines descriptive statistics for each measure used in the analysis.

Bivariate associations between the different measures were tested using correlational analysis. In order to explore the interrelationships between variables and categories of the beliefs about voices questionnaire (BAV-Q) among self harm experiences in all participants, a Pearson correlation analysis (two tailed) was performed. The significance level was set at .05. Further, independent sample t-tests were performed in order to evaluate differences between voice hearers who did and did not self harm, as well as severity of voice hearing and the occurrence of trauma experiences. Interactions were observed between dependent variables and outcome measures. Moderation models were estimated to; 1) examine the indirect effect of voices on self harm via positive self compassion and 2) to examine the indirect effect of trauma on self harm, via positive self compassion. PROCESS for SPSS (Hayes, 2013) was used for these calculations. The statistical significance of the indirect

effects were assessed using bootstrapped bias-corrected percentile based confidence intervals (CIs) of 5000 bootstrap draws (Effron & Tibshirani, 1993). All data analyses were conducted using IBM Statistical Package for Social Sciences v21 (IBM Corp, 2012).

A meta-analysis by Muris and Petrocchi (2016) proposes that it is not appropriate to compute a total score of the SCS, and individual scales should be used to identify the protective components of self compassion. Accordingly, subscales were utilised in the analysis.

Results

Descriptive statistics

A total of 109 participants entered an online survey. However, 29 participants did not progress after completing the consent process, resulting in a sample of 80 participants. 64 of the participants were female (80%). Table 1 provides an overview of the demographic information. 80 participants took the survey. 80 (100%) of participants completed the HPSVQ measure and n = 74 (92.50%) BAV-Q for voices. Participants who indicated they had experiences of self injury (n = 36) completed the ISAS measure, n = 79 (98.75%) completed the BBTS measure. 70 participants (87.50%) completed the SCS measure of self compassion. Overall, n = 46 (57.5%) of participants completed all the measures fully.

The majority of participants had experienced at least one interpersonal trauma (n = 71, 89.1%). Most participants experienced a moderate severity of voices (n = 41; 51.3%), while 21 experienced severe ‘symptoms’, although no cut offs were used during analysis.

For participants who self harmed (n = 36; 45% of total participants), cutting was reported as the most frequently occurring form of self injury (n = 24, 64.9%), with n= 25 (86.3%) of participants reporting that self harming behaviours began before the age of 16. When examining the function of self harm, most participants reported this as a punishment (n = 31) or release of emotional pressure (n = 30). Self harm was also reported to reduce

anxiety or an overwhelming emotional burden by 31 participants and served as a response to one's own unhappiness or self disgust. A large number of participants reported that self harm had a calming influence upon them (n = 21, 58.3%) and that self harm was a response to suicidal thoughts, without attempting suicide (n = 27, 75%). None of the participants reported this as being a bonding experience with others or an act of revenge.

[INSERT TABLE 1]

Correlations

Table 2 provides the correlation coefficients between the variables included in the analyses. There was no significant relationship between voice hearing severity and trauma experiences. A positive relationship was found between self injury and malevolent and omnipotent voices. Positive correlations were found between benevolent voices and positive subscales of self compassion, malevolent voices and negative subscales of self compassion and omnipotence and negative subscales of self compassion. Significant negative correlations were also found between malevolence and positive aspects of self compassion and omnipotence and positive aspects of self compassion. A significant negative relationship was found between positive self-compassion and frequency of self injury.

A positive correlation was found between severity of voices (HPSVQ) and negative subscales of self compassion. Further, distress of voices was negatively correlated with positive self compassion, $r(68) = -.289$, $p < .02$. Feelings of worthlessness as a result of voice hearing was negatively correlated with positive self compassion $r(68) = -.285$ $p < .02$. Frequency of self injury was also positively correlated with malevolent and omnipotent voices.

Interpersonal trauma was positively associated with frequency of self harm $r(64) = .240$, $p < .05$. No associations were found between interpersonal trauma and self compassion.

[INSERT TABLE 1]

T-tests

An independent sample t-test indicated that severity of voice hearing (HSPVQ) was greater for individuals who experienced at least one interpersonal trauma (M = 17.99, SD = 9.17), than for those who did not (M = 32.25, SD = 3.77. This difference, -14.26, BCa 95% CI [-18.39, -10.09] was significant, t(77) = -3.080, p =.003. There was a difference in the positive self compassion scores for individuals with experience of self harm (M = 26.94, SD = 9.96) and no experience of self harm (M=36.48, SD= 11.33). This difference, 9.55, BCa 95% CI [4.53-14.56] was significant, $t(71) = 3.80$, p =.000.

Moderation

The primary aim was to determine whether self compassion reduces the impact of childhood trauma on frequency of self injury. When examining the moderating effect of positive self compassion on the relationship between interpersonal trauma and self injury, significant relationships were found. When positive self compassion ratings are low, there is a significant positive relationship between interpersonal trauma and self injury, $b = 0.27$, 95% CI [0.0228, 0.5137], $t = 2.18$, $p = .033$. At the mean value of positive self compassion, there is a significant positive relationship between interpersonal trauma and self injury, $b = 0.24$, 95% CI [0.0820, 0.3990], $t = 3.03$, $p = .0035$. When positive self compassion ratings were high, this relationship was non significant, $p = 0.08$.

A further aim was to examine whether self compassion reduces the impact of beliefs about voices on self injury. Positive self compassion did not moderate the relationship between malevolence and self injury. Nor did it moderate the relationship between severity

of voice hearing experiences and self injury. However, it did have a moderating effect on the relationship between omnipotence and self injury. When positive self compassion ratings are low, there is a non significant positive relationship between omnipotence and self injury, b = 0.21, 95% CI [-0.011, 0.4388], t = 1.90, p = .062. At the mean value of positive self compassion, there is a significant positive relationship between omnipotence and self injury, b = 0.26, 95% CI [0.0718, 0.4491], t = 2.76, p = .008. When positive self compassion ratings are high, there is a significant positive relationship between omnipotence and self injury, b = 0.31, 95% CI [0.0163, 0.5975], t = 2.11, p = .0388.

Discussion

The present study examined the link between voice hearing, self harm and self compassion. It found that the frequency of self injury was positively correlated with the experience of malevolent and omnipotent voices. Furthermore, when comparing individuals who did and did not self harm, for those with self harm experiences, malevolence and omnipotence ratings were higher. This lends support for research that suggests that the content of command hallucinations predicts self-harm (Rogers, Watt, Gray, MacCulloch, & Gournay, 2002) and that malevolent beliefs are associated with self-harm (Simms, McCormack, Anderson and Mulholland, 2007). In the present study, participants with experiences of self harm believed their voices to be significantly more malevolent and powerful. However, how these beliefs precipitate acts of self harm remains unclear. Previous research suggests that perceived power of voices influences experiences of self harm and compliance with commands (McNeil, Eisner & Binder, 2000), and in particular to self injury (Fox, Gray & Lewis, 2004). Thus, these findings are consistent with ‘social rank theory’ which postulates that perceived social rank status between voice hearer and the voice would mirror perceived social rank in social relationships (Birchwood, Meaden, Trower,

Gilbert, & Plaistow, 2000). However, it is important to note that the present study did not allow for analysis of the function of self injury, in the context of command 'hallucinations'. While the majority of participants with self harm experiences indicated that their self injury served as a punishment, one cannot conclude that this relates to voice hearing.

Self compassion and voice hearing

Participants who experienced their voices as benevolent had higher ratings on positive subscales of self compassion. Further, increased positive experiences of voices was correlated with increased self kindness, mindfulness and common humanity. Jenner, Rutten, Boonstra, and Sytema (2008) found that for individuals who experienced positive voices, these offered protection, reassurance and company. Results from the present study show that the more severe an individual's voices were, the more they endorsed negative subscales of self compassion, including statements of self judgment, over-identification and isolation. Moreover, malevolence and omnipotence were negatively correlated with positive subscales of self compassion, perhaps due to participants experiencing more negative voices than positive voices. Gilbert (2005) reports that wellbeing is enhanced through self compassion as it enables individuals to feel cared for, connected and emotionally calm. One possible explanation for increased ratings of self judgment and isolation in more severe voices is the experience of voice hearing as being frightening and threatening (Longden, Madill, &Waterman, 2012). Moreover, even positive or neutral voices have been associated with negative emotions, including fear and anxiety (Woods, Jones, Alderson-Day, Callard, & Fernyhough, 2015).

Participants reported less distress and feelings of worthlessness as a result of voice hearing as positive self compassion increased. This echoes studies that suggest that self compassion is associated with greater mental wellbeing, resilience and social connectedness (Barnard & Curry, 2011; Philips & Ferguson, 2013; Neff & McGehee, 2010). Further, it

supports studies examining the relationship between self compassion and measures of voice hearing, including positive symptoms, excitement and emotional discomfort (Eicher, Davis, & Lysaker, 2013) and suggests that greater self compassion may lead to less distress as a result of voice hearing. Similarly, the present study offers support for the link between self-compassion and improvements in psychiatric symptoms (Gilbert & Procter, 2006; Leary, Tate, Adams, Batts, & Hancock, 2007). Braehler et al. (2012) found that when individuals accessed CFT, they showed more compassion in way they talked about psychosis and recovery and demonstrated less negative beliefs about psychosis. While the present study is unable to determine the direction of causality in the link between the impact of voice hearing on distress and self compassion ratings, this may have important implications for the ways in which voice hearers feel about themselves, their voices and living well with voices.

Self compassion and self injury

This is the first study to examine the link between self injury and self compassion in the context of voice hearing, and one of the few to examine self injury and self compassion. This study found that the more self compassionate individuals are, the less they engage in self injurious behaviour. Moreover, for individuals that did engage in self harm, this was less frequent when self compassion was greater. Positive self compassion scores were significantly higher in individuals with no experience of self harm. Interestingly, this study found that positive aspects of self compassion moderated the relationship between omnipotent beliefs about voices and self injury, when positive self compassion were at mean and high ratings. This provides support for the previous research that found that compassionate mind training (CMT) had a positive effect on the hostility of participants voices by making them less persecutory and more reassuring (Mayhew & Gilbert, 2008). Interestingly, they report that CMT aided participants in feeling safe, without the need for submissive, appeasement of their voices. While in the present study, one cannot conclude

that role of self compassion in self injury and voice hearing, one hypothesis is that positive self compassion may serve to buffer the impact of threatening voices that are perceived as powerful. The perceived consequences for lack of compliance with omnipotent voices may be lessened by beliefs of self kindness and acceptance of suffering.

Neff (2003a) proposed that self compassion involves being kind and understanding to oneself in instances of suffering or perceived inadequacy. Those who are more self compassionate are less likely to suppress unwanted thoughts and negative emotions (Leary, Tate, Adams, Allen, & Hancock, 2007). In addition, study findings provided strong support for the contention that self compassion does more than ameliorate psychopathology—it also predicts positive psychological strengths (Neff, Rude & Kirkpatrick, 2007). Thus, one hypothesis is that for participants in this study with greater positive self compassion, they exhibited greater acceptance of their suffering and kindness, which manifested in alternative, healthy coping behaviours (Arimitsu & Hoffman, 2015). Similarly Allen and Leary (2010) suggest that as self compassion increases, it is likely that one will employ non-avoidant coping (such as positive cognitive reframing or problem solving). Sutherland, Dawczyk, De Leon, Cripps, and Lewis (2014) report that for individuals with experience of self injury, "*components of self compassion may operate, often in tandem, to encourage acceptance of one's non suicidal self injury experiences, ameliorate related distress, and foster non suicidal self injury recovery*" (p. 424). Consequently, is it that greater self compassion leads to alternative coping behaviours (besides self harm) in voice hearers?

Trauma and self compassion

The present study did not find any association between interpersonal trauma and aspects of self compassion. One possible explanation for this may lie within the limitations of the measure used to explore trauma, in that it does not examine multiple facets of trauma, for example emotional trauma. Previous research has indicated an association between

childhood emotional abuse and lower self-compassion (Tanaka, Wekerle, Schmuck, & Paglia-Boak, 2011). On the other hand, this negative result may be an artefact of the relatively high levels of trauma seen in the sample. If interpersonal traumas were more evenly distributed, such a relationship may well have been detected.

However, a positive relationship was found between interpersonal trauma and self injury, supporting previous research showing individuals subjected to childhood sexual abuse are more likely to engage in self injury and try to kill themselves, and have higher global symptom severity (Goff, et al., 1991; Mullen, Martin, Anderson, Romans, & Herbison, 1993; Read, 1998, 2001). Importantly, the present study found that positive self compassion acts to moderate the interaction between interpersonal trauma and self injury when ratings of positive self compassion are low and at the mean. Self compassion acts to weaken the impact of negative experiences (Zessin, Dickhauser, Garbade, 2015; Adams & Leary, 2007) and appears to act as a buffer against the negative effects of trauma exposure, such as psychopathology and reduced quality of life (Barnard & Curry, 2011; Neff & McGehee, 2010). Seligowski, Miron, and Orcutt (2015) examined the relationship between self compassion, PTSD symptoms and overall psychological health in a sample of trauma-exposed young adults. They report no direct association between PTSD symptomatology and self compassion, although they indicate that individuals exposed to traumatic events may benefit from interventions that incorporate self-compassion. Thus, while the present study did not find a link between trauma and self compassion, the literature suggests that increasing self compassion may be important in increasing subjective wellbeing and improving life satisfaction.

Clinical implications

Results of the current study may provide support for the use of self compassion training to reduce the distress experienced in voice hearing. Thus, these findings provide

further evidence for the relevance of compassion for individuals who identify as voice hearers. Opportunities to develop self compassion should be promoted to foster feelings of warmth and love towards oneself. As previously mentioned, research has demonstrated that higher levels of self-compassion are related to greater health and well-being (Barnard & Curry, 2011; Neff et al., 2007, 2009).

Increasing positive self compassion appears relevant for individuals with voice hearing experiences and may increase subjective wellbeing and symptom reduction (Seligowski, Miron & Orcutt, 2015). This appears most relevant in the context of self injury and the experience of omnipotent voices. One hypothesis is that by increasing positive self compassion, one's voices become less powerful, resulting in less self injury (either as a means of managing distress or in relation to commands to self harm). Birchwood et al. (2000) propose that the imbalance of power between an individual and their voice(s) may be linked to the appraisal given to their social rank and sense of group belonging. A recent meta-analysis suggests that while it remained unclear as to the underlying mechanisms of the strong association between 'psychotic experiences' and self injury, trauma experiences and adverse life events are also associated with an increased risk in these areas. As such, this "*behaviour reflects the greater likelihood of self-injurious behaviour in more severe states of psychopathology*" (p. 248) (Honings, Drukker, Groen, & van Os, 2016). Further research exploring the function of self injury, in voice hearers will provide greater insights into the role of positive self compassion in moderating the association between omnipotence beliefs and self injury.

Self compassion has been described as a potential buffer against vulnerability and distress because it helps people feel cared for, emotionally calm, and connected to others (Gilbert & Irons, 2005; Neff et al., 2007; Terry, Leary, & Mehta, 2012). This appears relevant when considering self injury experiences. This study lends support to the work of

Sutherland, Dawczyk, De Leon, Cripps, and Lewis (2014) who found that for those with self harm experiences, self compassion contributed towards a greater empathic outlook on distress and enhanced coping responses. The link between reduced self harm and increased positive aspects of self compassion highlight the potential therapeutic benefit of compassion-based intervention in addressing psychological distress (Kelly, Zuroff, Foa, & Gilbert, 2010). Shahar, Carlin, Engle, Hegde, Szepsenwol, & Arkowitz, (2012) propose that self compassion acts to reassure during times of distress, and may be linked to ameliorate self critical experiences that may be relevant to self injury. Gilbert and Procter (2006) suggest that self compassion promotes reassurance and may be a useful antidote to self criticism. Consequently, exhibiting understanding and kindness is important in self harm experiences, but also in voice hearing and may have value in an individual's recovery.

A meta-analysis by MacBeth and Gumley (2012) proposed that the inclusion of positive and negative subscales of compassion would be beneficial in research as it was not possible to identify if high positive self compassion contributed towards lower psychopathology, or if this was influenced by lower ratings of negative self compassion. This study suggests that both aspects are important in understanding voice hearing experiences since negative self compassion is positively associated with malevolence, omnipotence beliefs and severity of voice hearing experiences. Conversely, positive self compassion was negatively associated with malevolence and omnipotence. This has important implications for working therapeutically with individuals with voice hearing (and self injury) since these components can operate in tandem (Sutherland et al. 2014). Enabling individuals to see themselves as more than their 'illness' is an essential aspect of recovery (British Psychological Society, 2014) and links to promoting self kindness and less self judgment. Moreover, this provides support for the movement towards understanding 'psychotic' experiences as a manifestation of general psychological distress and prioritising

the context of a person's life experiences in making sense of their distress (British Psychological Society, 2014; Saha, et al., 2011; Capra, Kavanagh, Hides, & Scott, 2015).

The results of this study support the limited existing research that positive self compassion may serve as a potential protective factor following exposure to trauma. More specifically, positive self compassion moderates the effect of trauma on self injury. Seligowski, Miron and Orcutt (2015) suggest that positive self compassion may increase non judgmental acceptance and kindness towards oneself in relation to their traumatic experiences and show willingness to experience distressing thoughts and emotions, promoting greater psychological health. Similarly, Germer and Neff (2015) suggest that self compassion mediates the relationship between early trauma experiences and later emotional dysregulation and that those with higher self compassion cope better with upsetting events (Vettese, Dyer, Li, & Wekerle, 2011).

Practitioners employing current therapeutic protocols designed to increase self compassion (Gilbert, 2009, 2010; Neff & Germer, 2013) are encouraged to consider self injury experiences in individuals accessing this therapy to facilitate acceptance and kindness in experiencing distress in the context of both voice hearing and trauma experiences. As previously, higher levels of self compassion are related to greater health and well-being (Barnard & Curry, 2011; Neff et al. 2007, 2009), the results of the current study may provide support for the use of self compassion training to increase overall life satisfaction and well-being in voice hearers with trauma and/or self injury experiences.

Limitations

One limitation of this study was the small sample size of convenience. While online recruitment is potentially broad reaching, it also has the potential to exclude participants who do not have online access or use social media.

This study was correlational in nature. Consequently, one cannot determine the directions of causality between self compassion and beliefs about voices and self injury. It is not possible to say if self compassion *causes* less severe voice hearing experiences and self injury, or if it is *caused by* these factors. As a result, further research is required to examine the relationship between self compassion, self injury and voice hearing. More specifically, long-term cohort based follow-up studies that examine the role of self compassion in voice hearers would be beneficial, as well as the impact of improving self-compassion in randomised controlled trials. Such research would provide greater insights into any improved outcomes as a result of CFT and the possible benefits that may be related to positive change in levels of self-compassion.

A potential limitation is the use of self-report measures, including the SCS as this requires a degree of awareness needs into own emotional experiences to realise extent to which are self compassionate (Neff, 2003), and thus may limit the accuracy of scale.

A third issue is the fact that the sample was comprised largely of women (80%), thus limiting the generalisation to the general population. However, while some studies suggest that men generally report higher self compassion score than women (Raes, 2010), a recent meta-analysis suggests that gender differences should not be overemphasised (Yarnell, Stafford, Neff, Reilly, Knox, Mullarkey, 2015).

Fourth, this study did not include a measure of depression or anxiety. Consequently, it is not possible to rule out the contribution of other factors to the associations found between self compassion, self injury and voice hearing experiences. Studies suggest that voice hearers may adopt an emotion oriented coping style (Lin et al., 2011), and that voice hearing and self injury are associated with a variety of psychopathology, meaning that any associations are likely to be confounded or mediated by other factors (Calkins et al., 2014, Honings et al., 2016). Therefore, results of this study should be interpreted tentatively.

In addition, consideration should be given to the use of the self injury measure and whether this was the best way of evaluating severity of self-harm as it merely included a total frequency across an individual's life span. Alternative ways of examining self harm behaviours may have been useful to assess frequency over a given time period.

Conclusion

This study found significant associations between positive self compassion, beliefs about voices and self injury. It also found that positive self compassion moderates the relationship between omnipotence of voices and self injury. In addition, positive self compassion also appears to provide a buffering effect in the association between trauma and self injury. However, tentative interpretations should be made, based on the sample size and demographic characteristics. Despite this, the current study lends support for use of compassion focused therapy protocols in voice hearers. Future research should examine more closely the function of self injury in voice hearers, which may provide insights into the specific role of positive self compassion in ameliorating self harming behaviours.

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Table 1

Summary of demographic information

		n	%
Sex	Male	16	20
	Female	64	80
Age	18-34	40	50
	35-59	36	45
	60-85	4	5
Ethnicity	White British	61	76
	Mixed/Multiple Ethnic groups	5	6
	Asian/Asian British	2	3
	Black/African/Caribbean	1	1
	Black British	1	1
	Other	11	14
Religion	No religion	44	55
	Christian	22	28
	Hindu	1	1
	Jewish	3	4
	Muslim	1	1
	Any other religion	9	11

Table 2

Descriptive statistics for measures of voice hearing, interpersonal trauma, self harm and self compassion

	N	Mean	Median	Minimum	Maximum	Standard Deviation	Skewness	Kurtosis
Severity of voices (HSPVQ)	80	18.76	19.00	7	36	9.45	-.473	.224
Malevolent voices (BAV-Q)	74	7.68	7.00	0	18	5.48	.101	-1.117
Benevolent voices (BAV-Q)	74	5.18	3.50	0	18	5.39	.716	-.936
Omnipotence (BAV-Q)	74	9.59	10.00	0	18	4.74	-.036	-.796
Interpersonal Trauma (BBTS)	79	17.29	16.00	10	30	5.14	.681	.080
Frequency of Self Harm (ISAS)	36	2215.36	-	23	11150	3311.58	3.07	9.50
Positive Self compassion (SCS)	73	32.04	30	13	65	11.67	.588	-.138
Negative Self compassion (SCS)	70	49.56	51.50	22	65	11.02	-.768	-.403

Table 3. *Correlation matrix between self compassion, voice hearing, trauma and self harm*

	1.	2.	3.	4.	5.	6.	7.	8.
1. Malevolent voices (BAV-Q)	-							
2. Benevolent voices (BAV-Q)	-.436**	-						
3. Omnipotent voices (BAV-Q)	.657**	-.019	-					
4. Severity of voices (HPSVQ)	.670*	-.100	.709**	-				
5. Interpersonal Trauma (BBTS)	.022	.170	.194	.123	-			
6. Positive self-compassion (SCS)	-.458**	.395**	-.297**	-.098	-.055	-		
7. Negative self-compassion (SCS)	.386**	-.176	.376**	.208*	.213	-.463**		
8. Frequency of self harm (ISAS)	.239*	.007	.397**	.124	.254*	-.330**	.338**	-

BAV-Q, Beliefs About Voices Questionnaire; HSPVQ, Hamilton Program for Schizophrenia Voices Questionnaire; BBTS, Brief Betrayal Trauma Survey, SCS, Self Compassion Scale; ISAS, Inventory of Statements about Self Injury.

*$p < 0.05$, **$p < 0.01$

Appendices

HPSVQ **Name:**_____
Date:_____

Office Use Only	**Total Score:**

Please circle the **ONE** box that best describes your experience of voices **DURING THE PAST WEEK**, including today.

1. How ***frequently*** did you hear a voice or voices?

No voices	Less than once a day	Once or twice a day	Several times a day	All of the time/Constantly

2. How ***bad*** are the things the voices say to you?

No voices saying bad things	Not that bad	Fairly bad	Very bad	Horrible

3. How ***loud*** are the voices?

Voices not present	Very quiet (like whispering)	Average (same as my own voice)	Fairly loud	Very loud (yelling or shouting)

4. How ***long*** do the voices usually last?

Voices not present	A few seconds to 1 minute	A few minutes	More than 10 minutes but less than an hour	Longer than 1 hour/they just seem to persist

5. How much do the voices ***interfere*** with your daily activities?

No interference	A little bit	Moderately	Quite a bit	Extremely interfering

6. How ***distressing*** are the voices that you hear?

No voices are distressing me	A little bit	Moderately	Quite a bit	Extremely distressing

7. How ***bad*** (worthless/useless) do the voices make you ***feel about yourself****?*

No voices make me feel bad	A little bit	Fairly bad	Very bad	Extremely bad (as bad as I can feel)

8. How ***clearly*** do you hear the voices?

Voices not present	Very mumbled	Fairly mumbled	Fairly clear	Very clear voices

9. How often do you **DO** what the voices say?

No voices telling me what to do	Rarely	Sometimes	Often	Always

---

10. In what ***part of the day*** do you hear the voices most often?[a]

Right when I wake up	Morning	Afternoon	Evening	Just before bed	The voices are equally as likely at all times of the day

11. What kind of ***social situations*** are you in most often when your voices start?

When I am alone	When I am with a few people (like in 'group')	When I am around a lot of people (like in a mall or on a busy street)	No situation in particular/they occur equally in all social situations

12. **Where** do the voices come from?[a]

From Inside my head	From Outside my head	From both Inside and Outside

13. Would you say the last week is like a ***typical*** week of your hearing voices?[a]

Yes	No (Please explain below)

[a] These items are qualitative in nature and are not included in the calculation of the total score.

For examiner only

Scoring Key

The HPS-VQ is a 13-item measure in which each of the first nine items are assigned scores on a five-point Likert scale from zero (least 'severe' or impairing) to four, (most 'severe'; i.e. causes the largest amount of disruption and/or disturbance to one's life). The total score of these nine items is intended to indicate the severity of auditory verbal hallucinations. The four remaining scale items (eg time of day) are not included in the calculation of a total score but are intended to assess qualitative aspects.

Interpretation Guidelines.

Based on the mean, standard deviation and score distributions we propose a set of interpretation guidelines for the HPSVQ below, as a means of increasing its clinical utility, while recognizing that these are only hypotheses and require further research. In generating these guidelines, consideration was given to both the subjective experience (for example, 'mild' range scores require individuals to rate most items at least 'a little bit') and the obtained psychometrics (scores in the 'severe' range are at least one standard deviation above the mean for the validation sample). Our test interpretation scheme proposes a total HPSVQ score of 0 to 7 is indicative of absent to minimal auditory verbal hallucination severity; 8 to 13 mild severity; 14 to 25 moderate severity; 26 and above is indicative of severe levels.

Reference:

Van Lieshout RJ & Goldberg JO (2007) Quantifying self-report of auditory verbal hallucinations in persons with psychosis. Canadian Journal of Behavioural Science, 39, 73 – 77.

BAVQ - R

CHADWICK, PAUL, LEES, SUSAN, BIRCHWOOD, MAX

The revised Beliefs About Voices Questionnaire (BAVQ-R)

(from The British Journal of Psychiatry 2000 177: 229-232)

There are many people who hear voices. It would help us to find out how you are feeling about your voices by completing this questionnaire. Please read each statement and tick the box which best describes the way you have been feeling in the *past week*.

If you hear more than one voice, please complete the form for the voice which is dominant. Thank you for your help.

Name: .....

Age: .....

		Disagree	Unsure	Slightly Agree	Strongly Agree
1	My voice is punishing me for something I have done				
2	My voice wants to help me				
3	My voice is very powerful				
4	My voice is persecuting me for no good reason				
5	My voice wants to protect me				
6	My voice seems to know everything about me				
7	My voice is evil				
8	My voice is helping to keep me sane				
9	My voice makes me do things I really don't want to do				
10	My voice wants to harm me				
11	My voice is helping me to develop my special powers or abilities				
12	I cannot control my voices				
13	My voice wants me to do bad things				
14	My voice is helping me to achieve my goal in life				

15	My voice will harm or kill me if I disobey or resist it				
		Disagree	Unsure	Slightly Agree	Strongly Agree
16	My voice is trying to corrupt or destroy me				
17	I am grateful for my voice				
18	My voice rules my life				
19	My voice reassures me				
20	My voice frightens me				
21	My voice makes me happy				
22	My voice makes me feel down				
23	My voice makes me feel angry				
24	My voice makes me feel calm				
25	My voice makes me feel anxious				
26	My voice makes me feel confident				

When I hear my voice, usually ...

		Disagree	Unsure	Slightly Agree	Strongly Agree
27	I tell it to leave me alone				
28	I try and take my mind off it				
29	I try and stop it				
30	I do things to prevent it talking				
31	I am reluctant to obey it				
32	I listen to it because I want to				
33	I willingly follow what my voice tells me to do				
34	I have done things to start to get in contact with my voice				
35	I seek the advice of my voice				

Brief Betrayal Trauma Survey (BBTS) from Goldberg & Freyd (2006)

For each item below subjects report on exposure "before age 18" (the lower item number, i.e. 1-12) and "age 18 or older" (the higher item number, i.e. 13-24). Responses choices are: never, 1 or 2 times, more than that

1/13. Been in a major earthquake, fire, flood, hurricane, or tornado that resulted in significant loss of personal property, serious injury to yourself or a significant other, the death of a significant other, or the fear of your own death.

2/14. Been in a major automobile, boat, motorcycle, plane, train, or industrial accident that resulted in similar consequences.

3/15. Witnessed someone with whom you were very close (such as a parent, brother or sister, caretaker, or intimate partner) committing suicide, being killed, or being injured by another person so severely as to result in marks, bruises, burns, blood, or broken bones. This might include a close friend in combat.

4/16. Witnessed someone with whom you were not so close undergoing a similar kind of traumatic event.

5/17. Witnessed someone with whom you were very close deliberately attack another family member so severely as to result in marks, bruises, blood, broken bones, or broken teeth.

6/18. You were deliberately attacked that severely by someone with whom you were very close.

7/19. You were deliberately attacked that severely by someone with whom you were not close.

8/20. You were made to have some form of sexual contact, such as touching or penetration, by someone with whom you were very close (such as a parent or lover).

9/21. You were made to have such sexual contact by someone with whom you were not close

10/22. You were emotionally or psychologically mistreated over a significant period of time by someone with whom you were very close (such as a parent or lover).

11/23. Experienced the death of one of your own children.

12/24. Experienced a seriously traumatic event not already covered in any of these questions.

INVENTORY OF STATEMENTS ABOUT SELF-INJURY (ISAS) – SECTION I. BEHAVIORS

This questionnaire asks about a variety of self-harm behaviors. Please only endorse a behavior if you have done it intentionally (i.e., on purpose) and without suicidal intent (i.e., not for suicidal reasons).

Please estimate the number of times in your life you have intentionally (i.e., on purpose) performed each type of non-suicidal self-harm (e.g., 0, 10, 100, 500):

Cutting	_____	Severe Scratching	_____
Biting	_____	Banging or Hitting Self	_____
Burning	_____	Interfering w/ Wound Healing (e.g., picking scabs)	_____
Carving	_____	Rubbing Skin Against Rough Surface	_____
Pinching	_____	Sticking Self w/ Needles	_____
Pulling Hair	_____	Swallowing Dangerous Substances	_____

Other_____, _____

****
********** ***Important*: If you have performed one or more of the behaviors listed above, please complete the final part of this questionnaire. If you have not performed any of the behaviors listed above, you are done with this particular questionnaire and should continue to the next.**

****

2. If you feel that you have a *main* form of self-harm, please circle the behavior(s) on the first page above that you consider to be your main form of self-harm.

3. At what age did you:

First harm yourself? _____ Most recently harm yourself? _____
(approximate date – month/date/year)

4. Do you experience physical pain during self-harm?

Please circle a choice: YES SOMETIMES NO

5. When you self-harm, are you alone?

Please circle a choice: YES SOMETIMES NO

6. Typically, how much time elapses from the time you have the urge to self-harm until you act on the urge?

Please circle a choice:

< 1 hour 1 - 3 hours 3 - 6 hours

6 - 12 hours 12 - 24 hours > 1 day

7. Do/did you want to stop self-harming?

Please circle a choice: YES NO

INVENTORY OF STATEMENTS ABOUT SELF-INJURY (ISAS) – SECTION II. FUNCTIONS

Name:_____

Date:_____

Instructions

This inventory was written to help us better understand the experience of non-suicidal self-harm. Below is a list of statements that may or may not be relevant to your experience of self-harm. Please identify the statements that are most relevant for you:

a. Circle **0** if the statement **not relevant** for you at all
b. Circle **1** if the statement is **somewhat relevant** for you
c. Circle **2** if the statement is **very relevant** for you

"When I self-harm, I am …	**Response**		
1. … calming myself down	0	1	2
2. … creating a boundary between myself and others	0	1	2
3. … punishing myself	0	1	2
4. … giving myself a way to care for myself (by attending to the wound)	0	1	2
5. … causing pain so I will stop feeling numb	0	1	2
6. … avoiding the impulse to attempt suicide	0	1	2
7. … doing something to generate excitement or exhilaration	0	1	2
8. … bonding with peers	0	1	2
9. … letting others know the extent of my emotional pain	0	1	2
10. … seeing if I can stand the pain	0	1	2
11. … creating a physical sign that I feel awful	0	1	2
12. … getting back at someone	0	1	2
13. … ensuring that I am self-sufficient	0	1	2
14. … releasing emotional pressure that has built up inside of me	0	1	2
15. … demonstrating that I am separate from other people	0	1	2
16. … expressing anger towards myself for being worthless or stupid	0	1	2

Response Key: 0 – not relevant, **1 –** somewhat relevant, **2 –** very relevant

"When I self-harm, I am …

17. … creating a physical injury that is easier to care for than my emotional distress	0	1	2
18. … trying to feel something (as opposed to nothing) even if it is physical pain	0	1	2
19. … responding to suicidal thoughts without actually attempting suicide	0	1	2
20. … entertaining myself or others by doing something extreme	0	1	2
21. … fitting in with others	0	1	2
22. … seeking care or help from others	0	1	2
23. ... demonstrating I am tough or strong	0	1	2
24. … proving to myself that my emotional pain is real	0	1	2
25. … getting revenge against others	0	1	2
26. … demonstrating that I do not need to rely on others for help	0	1	2
27. … reducing anxiety, frustration, anger, or other overwhelming emotions	0	1	2
28. … establishing a barrier between myself and others	0	1	2
29. … reacting to feeling unhappy with myself or disgusted with myself	0	1	2
30. … allowing myself to focus on treating the injury, which can be gratifying or satisfying	0	1	2
31. … making sure I am still alive when I don't feel real	0	1	2
32. … putting a stop to suicidal thoughts	0	1	2
33. … pushing my limits in a manner akin to skydiving or other extreme activities	0	1	2
34. … creating a sign of friendship or kinship with friends or loved ones	0	1	2
35. … keeping a loved one from leaving or abandoning me	0	1	2
36. … proving I can take the physical pain	0	1	2
37. … signifying the emotional distress I'm experiencing	0	1	2
38. … trying to hurt someone close to me	0	1	2
39. … establishing that I am autonomous/independent	0	1	2

Response Key: 0 – not relevant, **1 –** somewhat relevant, **2 –** very relevant

(Optional) In the space below, please list any statements that you feel would be more accurate for you than the ones listed above:

(Optional) In the space below, please list any statements you feel should be added to the above list, even if they do not necessarily apply to you:

ITEMS COMPRISING EACH OF 13 FUNCTIONS SCALES

Affect Regulation – 1, 14, 27

Interpersonal Boundaries – 2, 15, 28

Self-Punishment – 3, 16, 29

Self-Care – 4, 17, 30

Anti-Dissociation/Feeling-Generation – 5, 18, 31

Anti-Suicide – 6, 19, 32

Sensation-Seeking – 7, 20, 33

Peer-Bonding – 8, 21, 34

Interpersonal Influence – 9, 22, 35

Toughness – 10, 23, 36

Marking Distress – 11, 24, 37

Revenge – 12, 25, 38

Autonomy – 13, 26, 39

Scores for each of the 13 functions range from 0 to 6.

Studies Validating and Using the ISAS

Psychometric properties of ISAS Section I (Behaviors) are reported in:

Klonsky, E.D. & Olino, T.M. (2008). Identifying clinically distinct subgroups of self- injurers among young adults: A latent class analysis. *Journal of Consulting and Clinical Psychology, 76,* 22-27.

Psychometric properties of ISAS Section II (Functions) are reported in:

Klonsky, E.D. & Glenn, C.G. (2009) Assessing the functions of non-suicidal self-injury: Psychometric properties of the Inventory of Statements About Self-injury (ISAS). *Journal of Psychopathology and Behavioral Assessment, 31,* 215-219.

Additional psychometric studies of the ISAS:

Kortge, R., Meade, T., & Tennant, A. (2013). Interpersonal and intrapersonal functions of deliberate self-harm (DSH): A psychometric examination of the Inventory of Statements About Self-injury (ISAS) scale. *Behaviour Change, 30,* 24-35.

Glenn, C.G. & Klonsky, E.D. (2011). One-year test-retest reliability of the Inventory of Statements About Self-injuiry (ISAS). *Assessment, 18,* 375-378.

Bildik, T., Somer, O. Kabukcu Basay, B., Basay, O., & Ozbaran, B. (2013). The validity and reliability of the Turkish version of the Inventory of Statements About Self-injury. Turkish Journal of Psychiatry.

Other studies using part or all of the ISAS (list not comprehensive):

Hamza, C.A. & Willoughby, T. (2013). Nonsuicidal self-injury and suicidal behavior: A latent class analysis among young adults. *PLOS One, 8(3),* e59955.

Zaki, L.F., Coifman, K.G., Rafaeli, E., Berenson, K.R., & Downey, G. (2013). Emotion differentiation as a protective factor against nonsuicidal self-injury in Bordelrine Personality Disorder. *Behavior Therapy, 44,* 529-540.

Glenn, C.R. & Klonsky, E.D. (2013). Non-suicidal self-injury disorder: An empirical investigation in adolescent psychiatric inpatients. *Journal of Clinical Child & Adolescent Psychology, 42,* 496-507.

Victor, S.E., Glenn, C.R., & Klonsky, E.D. (2012). Is non-suicidal self-injury an "addiction"? A comparison of craving in substance use and non-suicidal self-injury. *Psychiatry Research, 197,* 73-77.

Weinberg, A. & Klonsky, E.D. (2012). The effects of self-injury on acute negative arousal: A laboratory simulation. *Motivation and Emotion, 36,* 242-254.

Glenn, C.R., Blumenthal, T.D., Klonsky, E.D., & Hajcak, G. (2011). Emotional reactivity in nonsuicidal self-injury: Divergence between self-report and startle measures. *International Journal of Psychophysiology, 80,* 166-170.

Glenn, C.R. & Klonsky, E.D. (2011). Prospective prediction of non-suicidal self-injury: A one-year longitudinal study. *Behavior Therapy, 42*, 751-762..

Klonsky, E.D. (2011). Non-suicidal self-injury in United States adults: Prevalence, sociodemographics, topography, and functions. *Psychological Medicine, 41,* 1981-1986.

Lindholm, T. (2011). Functions of non-suicidal self-injury among young women in residential care: A pilot study with the Swedish version of the Inventory of Statements About Self-injury (ISAS). *Cognitive Behaviour Therapy, 40,* 183-189.

Glenn, C.R. & Klonsky, E.D. (2010). A multimethod analysis of impulsivity in non- suicidal self-injury. *Personality Disorders: Theory, Research, and Treatment, 1*, 67-75.

Glenn, C.R. & Klonsky, E.D. (2010). The role of seeing blood in non-suicidal self-injury. *Journal of Clinical Psychology, 66,* 1-8.

Glenn, C.R. & Klonsky, E.D. (2009). Social context during non-suicidal self-injury indicates suicide risk. *Personality and Individual Differences, 46,* 25-29.

Self Compassion Scale

To all interested, please feel free to use the Self-Compassion Scale (SCS) for research or any other use. Masters and dissertation students also have my permission to use and publish the Self-Compassion Scale in their theses. The SCS is appropriate for ages 14 and up (as long as individuals have at lease an 8th grade reading level). If you aren't that interested in using the subscales, you might also want to consider using the Short SCS (12 items), which has a near perfect correlation with the long scale.

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Reference:
Neff, K. D. (2003). Development and validation of a scale to measure self-compassion. *Self and Identity, 2, 223-250.*

Coding Key:
Self-Kindness Items: 5, 12, 19, 23, 26
Self-Judgment Items: 1, 8, 11, 16, 21
Common Humanity Items: 3, 7, 10, 15
Isolation Items: 4, 13, 18, 25
Mindfulness Items: 9, 14, 17, 22
Over-identified Items: 2, 6, 20, 24

Subscale scores are computed by calculating the mean of subscale item responses. To compute a total self-compassion score, reverse score the negative subscale items - self-judgment, isolation, and over-identification (i.e., 1 = 5, 2 = 4, 3 = 3. 4 = 2, 5 = 1) - then compute a total mean.

(This method of calculating the total score is slightly different than that used in the article referenced above, in which each subscale was added together. However, I find it is easier to interpret the scores if the total mean is used.)

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each item, indicate how often you behave in the stated manner, using the following scale:

Almost never				**Almost always**
1	**2**	**3**	**4**	**5**

1. I'm disapproving and judgmental about my own flaws and inadequacies.
2. When I'm feeling down I tend to obsess and fixate on everything that's wrong.
3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
5. I try to be loving towards myself when I'm feeling emotional pain.
6. When I fail at something important to me I become consumed by feelings of inadequacy.
7. When I'm down and out, I remind myself that there are lots of other people in the world feeling like I am.
8. When times are really difficult, I tend to be tough on myself.
9. When something upsets me I try to keep my emotions in balance.
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
11. I'm intolerant and impatient towards those aspects of my personality I don't like.
12. When I'm going through a very hard time, I give myself the caring and tenderness I need.
13. When I'm feeling down, I tend to feel like most other people are probably happier than I am.
14. When something painful happens I try to take a balanced view of the situation.
15. I try to see my failings as part of the human condition.
16. When I see aspects of myself that I don't like, I get down on myself.
17. When I fail at something important to me I try to keep things in perspective.
18. When I'm really struggling, I tend to feel like other people must be having an easier time of it.
19. I'm kind to myself when I'm experiencing suffering.
20. When something upsets me I get carried away with my feelings.
21. I can be a bit cold-hearted towards myself when I'm experiencing suffering.
22. When I'm feeling down I try to approach my feelings with curiosity and openness.
23. I'm tolerant of my own flaws and inadequacies.
24. When something painful happens I tend to blow the incident out of proportion.
25. When I fail at something that's important to me, I tend to feel alone in my failure.
26. I try to be understanding and patient towards those aspects of my personality I don't like.

Appendix 1

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-

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Section Three: Critical Appraisal

Reflections on the limitations and challenges to being self-compassionate

Word Count (excluding references): 3946

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Prepared in accordance with notes for contributors for Psychosis: Psychological, Social and Integrative Approaches

Introduction

Findings from the literature review and research paper, suggest that self compassion may play an important role in mitigating the effects of (i) eating behaviours consistent with an eating disorder diagnosis, and (ii) self injury in voice hearers. Within eating disorders, high self compassion was associated with higher ratings of body satisfaction, body appreciation and lower ratings of shame. In addition, the literature review indicated that in clinical samples, it is fear of self compassion that predicted eating disorder symptomology. Results of the empirical paper indicate that self compassion moderates the association between omnipotent beliefs about voices and self injury. It also moderates the relationship between trauma experiences and self injury. Taken together, these results lend support for the assertion that further attention is required regarding the role of self compassion in individuals who present with problematic eating behaviours and with individuals who have voice hearing experiences.

Within this paper I will consider the three areas relating to my research. First I will discuss how, in my view, self compassion can be socially determined. I will then reflect on my experiences of undertaking this research and finally, I will explore personal challenges in the application of psychiatric terminology in the ethics and write up processes.

Benefits of self compassion

Research findings consistently demonstrate that self compassion is associated with less anxiety, depression and stress (Barnard & Curry, 2011) and facilitates psychological strengths, including happiness, optimism and emotional intelligence (Heffernan, Griffin, McNulty, & Fitzpatrick, 2010; Hollis-Walker & Colosimo, 2011; Neff, Rude, & Kirkpatrick, 2007). Researchers have shown that self compassion offers a buffering effect against stress,

anxiety and depression (Macbeth & Gumley, 2012). Self compassion has also been linked to increased motivation (Gilbert, McEwan, Matos & Rivis, 2011) and is associated with reduced ratings for fear of failure and increased likelihood that individuals will try again when they do fail (Neff, Hseih, & Dejitterat, 2005).

Context

Neff (2016) proposes that the impact of negative emotional experiences is lessened when individuals are able to resist judging and berating oneself and experience a degree of self kindness. Furthermore, she suggests that self compassion involves understanding and acceptance of one's shortcomings. Across the literature, researchers appear to conceptualise the development of self compassion as an individually determined process. However, it is also important to consider the impact of social and political influences in the development and construction of self compassion and how dominant social discourses may perpetuate punitive emotional reactions to oneself, reducing one's ability to be self compassionate. For example, recent literature suggests that austerity measures in the United Kingdom have increased experiences of shame and humiliation, due to a rhetoric which blames poor people for their own need (Psychologists Against Austerity, 2015). Psychologists Against Austerity (2015) propose that these are common emotions shared by those who have encountered changes to disability benefits. Tracy, Robins, and Tangney (2007) propose that these processes can result in feelings of worthlessness due to the experience of being made to feel as though a moral or social standard has been violated. Research suggests that there is a link between the groups researched in my papers and their greater likelihood of being on welfare and/or disability benefits (The UK's Faculty of Public Health, 2016) and that there is a strong link between mental distress and social disadvantage (Boyle, 2013). In the development of self compassion, consideration of social inequality, and its impact on physical and mental

health, is also warranted (Cromby et al., 2013; Psychologists Against Austerity, 2016). In a society in which the dominant narrative towards individuals who use welfare benefits consists of being a 'scrounger' (Pring, 2015), I question how readily one is able to be self compassionate. In addition, punitive responses from governmental parties that require individuals to 'prove' their levels of disability may compound feelings of shame and self criticism.

Within Section One and Section Two, the concept of self compassion was discussed in relation to motivation, self criticism and shame. Blatt (1995) argues that the lack of self criticism is crucial in the development of self compassion. Gilbert, Baldwin, Irons, Baccus, and Palmer (2006) have shown that within Compassionate-Focused Therapy (CFT), self criticism is associated with distress in participants and has been positively linked to a range of psychological difficulties (Gilbert, McEwan, Gibbons, Chotai, Duarte, & Matos, 2012). Moreover, Gilbert, Baldwin, Irons, Baccus, and Palmer (2006) propose that self criticism is experienced as powerful, is not easily dismissed and that it can "generate potent and vivid images" that make it difficult for one to connect with the compassionate aspect of self (p. 197).

David Smail (2005) referred to 'distal' causes of mental distress (e.g. economic climate, dominant political ideologies and the media) and these appear crucial when considering self compassion. Pickett and Wilkinson (2010) argue that distress is influenced by societal level of trust and community, and that this is worsened by social inequality. Since core aspects of self compassion include self kindness and common humanity, to what extent is one able to develop and maintain these concepts in a society in which social inequality is perpetuated by political ideologies? Pickett and Wilkinson (2014) argue that a sense of community is hindered by inequality as individuals are judged as being worth less or more than others. Therefore, when there is an economic disparity between individuals within a

given community, one might argue that self compassion is hampered by judgments (internal and external) and a lack of shared experiences (common humanity).

It is argued that environmental factors have a causal influence on mental distress (Cromby et al., 2013). Similarly, Harper (2016) suggests that this can be exacerbated by societies "where the ability to consume is seen as a key aspect of identity and where a failure to meet perceived social norms can lead to exclusion" (p. 442). I am led to wonder what impact operating with an individualistic society has upon self criticism, and in turn, self compassion. If one deviates from the social norm (for example by experiencing eating related difficulties or voices as researched in the previous papers) to what extent is self judgment and over identification increased, minimising positive aspects of self compassion?

Gender

Gender is another factor that is important to consider when reflecting on the concept of self compassion. There are known gender differences in the application of self compassion, as women may be socialised to be more self sacrificing, prioritising the needs of others over their own, impacting their ability to be self compassionate (Baker-Miller, 1986; Raffaelli & Ontai, 2004). With the tendency of women to be other-oriented (Gilligan & Attanucci, 1988), one must also consider societal influences that promote self sacrifice traits in females and the potential for criticism when one deviates from a stereotyped norm. Neff (2012) points out that self criticism is common in our (Western) society, but even more so amongst women. While research promotes the benefits of self compassion on psychological wellbeing, to what extent are women truly able to practice this in their current socio-political setting? If, as in many societies, women are trained or encouraged to be caregivers (Dorian & Killebrew, 2014), are women potentially viewed as deviating from this role when they engage in self compassionate behaviours and activities and to what extent are they able to

show self kindness, whilst managing internal and external experiences of shame and self criticism?

Research has found differences in self compassion ratings of men and women, with women tending to score lower (Neff, Hseih, & Dejitthirat, 2005; Neff & McGehee, 2010; Yarnell & Neff, 2012; Lockard, Hayes, Neff, & Locke, 2014). These researchers postulate that this may be due to the different messages which young women receive from society about their appearance, body image and expectations as females. Lockard, Hayes, Neff and Locke (2014) suggest that these implicit and explicit messages may contribute to a self critical stance, impacting upon self compassion. Further, DeVore (2013) suggests that as women are more self critical, they also demonstrate a tendency to judge themselves more negatively.

While gender is an important aspect to consider when reflecting on self compassion, one must also consider how this interacts with other contextual factors (culture, religion etc.). Gilbert, Gilbert and Sanghera (2004) examined experiences of shame (izzat) in South Asian women's lives and draw upon the influence of the wider community. Specifically, they reference participant's experiences of considering the view of their relatives and the impact of their decisions on other's perceptions of family, rather than acting on one's own wishes/desires. Consequently, one's sense of sense worth (which is, in part influenced by the views of others) appeared related to how a woman conducts herself, which is likely to have implications on self compassion (Kassam, 1997).

Cultural context

A possible limitation with the concept of self compassion relates to its applicability across cultures. Does self compassion apply to other cultures as it derives from a Western perspective? The limited studies to date indicate some cross cultural variance. For example,

self compassion was highest in Thailand where individuals are thought to value compassion as part of Buddhism practice and parenting practices (Neff, Pisitsungkagarn, & Hsieh, 2008). Moreover, Birkett (2014) found that Chinese students experienced both positive and negative aspects of self compassion to a significantly greater degree than students from the United States. While research exploring self compassion across cultures is in its infancy, studies suggest that there may be differences in the composition of self compassion subscales.

Researchers suggest that in Western societies, such as America, there are strong socially dominant messages that emphasize positive compassion but also a competitive ethos (Leary & Hoyle, 2009). Further research is warranted to examine the extent to which individuals conceptualise and understand self compassion across cultures and the extent to which an individualistic culture hinders or facilitates self compassion. Mantzios, Rentzelas, and Egan (2016) propose that due to the increasing wealth of research on self compassion, further examination of this concept in individualistic and collectivistic cultures is required. Further, they suggest that consideration should be given to the introduction of self compassion interventions and how this may be understood in a person's cultural context. Mesquita (2001) suggests that there are differences in how collectivist and individualistic cultures reflect on behaviours and emotions, with individualistic societies linking feelings of pride and shame to reflections on the self. Thus, it is not clear if interventions that promote self compassion are effective with people from cultures that endorse an individualistic or collectivist orientation.

Western societies promote competition for survival and systems are set up to encourage comparison between peers. While Neff suggests that short falls in one's experiences can be accepted and honoured as part of the human condition, I propose that compassion at a societal level is required first, before 'true' self compassion can be achieved.

Religion/spiritual beliefs

Self compassion is an important construct in Buddhist teachings and philosophy (Neff, 2003) that has been introduced into Western psychology. Whilst in Buddhist communities, self-compassion is crucial and no word exists to distinguish self from other compassion (Brodar, Crosskey, Thompson, 2015), the applicability of this concept across different religious and spiritual domains is a relatively new area of exploration in the literature. Consequently, it raises further issues to consider in how challenging self-compassion may be for individuals to realise.

Little research exists that explores the role of self compassion in individual's religious and spiritual beliefs. Akin and Akin (2015) examined the role of self-compassion in one's spiritual experiences and report that a core component of self compassion (common humanity) predicted spiritual experiences in a positive manner. That is a sense of connectedness served to enhance an individual's spiritual experiences. Conversely, they identified that these experiences were weakened by self-criticism and rumination. One might hypothesis about the role of the wider context in these experiences of self judgment and over-identification, that impact negatively on one's overall self compassion and spiritual experiences.

Within the Christian faith, the theme of self-denial and perfectionism is heavily emphasized (Brodar, Crosskey, Thompson, 2015). This theme promotes the avoidance of self indulgence and any action that could be perceived as self-centred. The authors argue that Christianity contains messages of striving for moral perfection, leading one to question the impact of self-criticism and shame experiences, known to impede self compassion. Their study found that perceived forgiveness by God was significantly lower in individuals low in self-compassion and authors suggest that participants may feel unworthy of forgiveness or support. Homan (2014) reported similar findings that those who had encountered experiences in which God (across a range of religion faiths) was perceived as dismissing or

disapproving were more likely treat themselves with disdain. This leads me to reflect on how challenging it might be to consider one's actions or behaviour as part of the 'human condition' and accept one's shortcomings and show self-kindness as part of self compassion.

Other considerations

A criticism of self compassion research is it's limitation in conducting research with clinical samples since much of the research focuses on non clinical samples. In addition, it is argued that much of the research includes correlational analysis, limiting the extent to which conclusions can be drawn about the relationship between self compassion and psychological constructs (Pauley & McPherson, 2010). Consequently, they propose that there is a lack of robust research that examines the experience of psychological distress and self compassion. Moreover, they argue that it may be difficult for individuals to truly adopt or strive for common humanity, as individuals' experiences of psychological distress are deeply personal.

A core aspect of self compassion is mindfulness and being present in the moment, and accepting this without judgment. Boellinghaus, Jones, and Hutton (2013) argue that this acceptance of moment-by-moment experiences may be countercultural in Western, consumerist societies that do not facilitate this. Mantzios, Rentzelas, and Egan (2016) report that aspects of self compassion (for example self kindness) present differently across different cultures and have different implications for self care. They propose that some self kindness behaviours depict acts that relate to self care of the body and the mind in a comforting and soothing manner, while others can be viewed as damaging and uncaring to one's mental and physical wellbeing. Consequently, they suggest that "in considering theories of compassion, self-compassion and self-kindness, there is a need to emphasize care and self-care, as it appears that these components are key in alleviating the suffering for both the body and mind" (Mantzios, Rentzelas, & Egan, 2016; Kabat-Zinn, 2003) (p. 6).

As argued above, there are limitations in the construct of self compassion as an individualised concept. As a researcher, while I can observe positive impacts of self compassion on mental wellbeing, I struggle to accept this as a concept that is devoid from contextual influences (including gender, societal and cultural).

Reflections on self-care and the therapeutic context

Baer (2010) argues that self compassion can be viewed as a mechanism of action in different forms of therapy. A common theme across the literature suggests that psychotherapeutic outcomes are influenced by empathy and therapeutic alliance (Roth & Fonagy, 2005; Norcross & Wampold, 2011). Accordingly, it is essential for professionals to monitor their own wellbeing and seek support for stress (American Psychological Association, 2002; British Psychological Society, 2009). The concept of 'self care' is highlighted as being valuable in reducing one's own psychological distress, whilst also ensuring that high quality care is provided to others (Boellinghaus, Jones, & Hutton, 2013). Similarly, Gilbert (2005) argues that an essential component of effective therapy is compassion for both self and the client. Neff (2009) goes on to argue that self-compassion is crucial for self-care and has important implications for managing one's own psychological wellbeing.

Within the process of the research, I have reflected on my own ability to engage in self care and to be self compassionate. From observations of my own behaviours, I have noticed during times of high stress, engaging in these practices proves difficult. Conversely, this is likely when self care and self compassion are most warranted and perhaps most useful. Recently the British Psychological Society (BPS) (2016) and New Savoy published results from a staff wellbeing survey for 2015, indicating that almost half of psychological professionals surveyed reported depression and feelings of failure. Efforts to improve

psychological wellbeing in the workplace and resilience have become a priority due to concerns regarding burnout, low morale and the impact of stress in professionals responsible for improving mental health of the public (BPS, 2016). This has enabled me to reflect on the barriers to self compassion and the wider context for health care professionals. It is important to consider the implications for professionals who struggle to adopt self care practices and be self compassionate, when the burden of being more compassionate is placed upon those who are in healthcare (Hymes, 2013). I question the extent to which the ability to be self compassionate can be separated from external influences. For example, I have noticed that when I compare myself to others and make judgments about my own ability to cope with stress and demands, it makes it less likely that I will engage in self care. During the research process, I noticed that when I perceived peers to further ahead in their write up, this led to internal criticism of self and increased striving. This resulted in reduced time spent caring for my emotional and physical needs, despite recognising that this may have been useful. During this time, self care was not viewed as a priority, and my ability to be self compassion was significantly reduced.

Boellinghaus, Jones, and Hutton (2013) report similar findings that engaging in loving kindness mediation, for some participants, was difficult due to feelings of discomfort and selfishness. In this regard, participants discussed seeking "permission" to be self compassionate. Similarly, Pauley and McPherson (2010) reported that participants experienced difficulty in being self compassionate. They suggest that participants' longstanding negative attitudes about their mental distress appeared to influence their ability to be kinder to themselves and change ways of relating to themselves. Taken together, to what extent might external cues (from wider society) compound these views and feelings of inadequacy, hindering one's ability to engage in self compassionate practice? Furthermore, if developing self care and compassion is viewed as risky or unsafe for professionals (meaning

they do not engage in this practice), what impact might this have, not only on the delivery of quality care to clients, but also on the facilitation of self compassion in clients as an intervention?

Language

One of the challenges I have faced in undertaking this research is in the use of language across my literature review and empirical paper. The use of psychiatric diagnoses and medicalised language (e.g. 'eating disorder', 'pathology') has been a source of conflict. Such terminology, it is argued, relates to the 'medical model' and understandings of mental distress. The medical model suggests that certain behaviours, psychological experiences and bodily problems can be applied in the same way to understanding an individual's behaviour, thoughts and feelings (Boyle, 2013). During my research, I have been mindful of the language used but have also been influenced by the expectation for my papers to be published in reputable journals that utilise medicalised terminology. When I included a footnote in my empirical paper to state my rationale for use of the term, 'voice hearer', feedback from supervisors suggested that I exclude this and perhaps use terminology such as 'hallucinations' as this is consistently used in therapeutic models such as Cognitive Behavioural Therapy. A desire to not perpetuate medicalised understandings of psychological experiences, whilst also writing in an academic way for publication, have proved challenging. Boyle argues that medical language diminishes individual experience of distress and that the "research agenda...privileges genetic, biological and pharmaceutical research" (p. 3). In reflecting on the process to gain ethical approval, I can recall frequent discussions with the chair of the research committee, following their feedback for me to include specific psychiatric diagnoses related to voice hearing experiences. Within my empirical paper, I sought to include anyone who identified as a voice hearer, regardless of diagnoses. This was influenced by my view

that experiences of mental distress can be viewed on a continuum and that we all display a spectrum of traits and personality characteristics. After much discussion, I was able to gain approval without the need to include individuals with a 'mental disorder' diagnosis. However, this process is worthy of consideration in the wider context of mental health research and the use of medicalised language that may act to perpetuate invalidation of alternative accounts of understanding mental distress. Individuals may have been excluded from my research if they did not identify with a psychiatric label, or indeed did not meet the diagnostic criteria despite having unusual experiences (Beavan, Read & Cartwright, 2011). Boyle (2007) suggests that research efforts to understand the 'ill' or 'deficient' individual and links to the brain or psyche are widespread. She argues that such research is widely reported in textbooks and the media. Consequently, it is important to consider if less research is funded when medicalication is not used?

Moreover, consideration for the consequences of using medicalised language in journal publications that are accessible to the general population should be given. To what extent does this increase stigma and the perception that mental distress is only understood as a genetic or medical phenomena? Boyle (2013) suggests that perhaps the continued use of medicalised language occurs, even by those who want to challenge medical assumptions due to limitations in an alternative language. With the increasing movement to employ alternative terminology (e.g. voice hearer), this may improve in future research. Consequently, I hope that my use of medical language throughout my papers reflects attempts to think about a problem, rather than describe them and is consistent with my position that 'mental disorders' are undistinguishable from 'normal' behaviour, as all experiences can be viewed on a continuum.

Reflections and conclusion

Throughout this journey I have become more aware of my limitations in my ability to be self compassionate. Coming from a position of relative privilege, this has led me to consider the further challenges those whom I work with psychologically may encounter. Consideration of context is the cornerstone for any psychologist, and has allowed me to reflect on ways in which my own behaviour has been influenced by social context.

I propose that in the same way that experiences of mental distress can be socially defined, so too can self compassion. Lindisfarne (1998) suggests that attention be given to definitions of social constructions and individuals in positions of power who define them. As a result, it is important for clinicians and researchers to give space for context, and consider the language used, and its implications for challenging the 'medical model'. As Read (2005) states, "The simple truths are that human misery is largely inflicted by other people and that the solutions are best based on human – rather than chemical or electrical – interventions" (p.597). As a result, I propose that while self compassion can be developed and is beneficial at an individual level, it is also essential to consider ways in which interventions can be introduced from a societal level.

This reflective paper attempted to highlight challenges one might encounter to being self compassionate and how consideration of self compassion as an individual concept may be unhelpful. While the literature highlights a broad range of benefits to being self compassionate, it is important for professionals to reflect on wider factors that limit its application for individuals with whom they are working. In addition, consideration should be given to the challenges professionals might experience in being self compassionate, as they too, are influenced by context. Further research examining the factors outlined above may highlight possible areas for intervention.

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Section Four: Ethics

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Faculty of Health and Medicine Research Ethics Committee (FHMREC)

Lancaster University

Application for Ethical Approval for Research

Instructions

1. Apply to the committee by submitting
   - ✓ **The University's Stage 1 Self-Assessment Form (standard form or student form) *and* the Project Information & Ethics questionnaire. These are available on the Research Support Office website:** LU Ethics
   - ✓ **The completed FHMREC application form**
   - ✓ **Your full research proposal (background, literature review, methodology/methods, ethical considerations)**
   - ✓ **All accompanying research materials** such as, but not limited to,
     1) Advertising materials (posters, e-mails)
     2) Letters of invitation to participate
     3) Participant information sheets
     4) Consent forms
     5) Questionnaires, surveys, demographic sheets
     6) Interview schedules, interview question guides, focus group scripts
     7) Debriefing sheets, resource lists
2. **Submit all the materials electronically** as a **SINGLE** email attachment in PDF format. Instructions for creating such a document are available on the FHMREC website (http://www.lancs.ac.uk/shm/research/ethics/).
3. **Submit one collated and signed paper copy** of the full application materials. If the applicant is a student, the paper copy of the application form must be signed by the Academic Supervisor.
4. Committee meeting dates and application submission dates are listed on the research ethics committee website http://www.lancs.ac.uk/shm/research/ethics. Applications must be submitted by the deadline stated on the website, to:

   Diane Hopkins
   Faculty of Health & Medicine
   B03, Furness College
   Lancaster University, LA1 4YG
   d.hopkins@lancaster.ac.uk
5. Attend the committee meeting on the day that the application is considered.

1. Title of Project: Understanding voice hearers' ideas about themselves and their voices
2. If this is a student project, please indicate what type of project by ticking the relevant box: □ PG Diploma □Masters dissertation □MRes □MSc ▫ DClinPsy SRP □ PhD Thesis □PhD Pall. Care/Pub. Hlth/Org. Hlth & Well Being □MD ✓DClinPsy Thesis □ Special Study Module (3rd year medical student)

3. Type of study ✓ Involves direct involvement by human subjects □ Involves existing documents/data only. Contact the Chair of FHMREC before continuing.

Applicant information
4. Name of applicant/researcher: Kelly Price
5. Appointment/position held by applicant and Division within FHM Trainee on the Doctorate in Clinical Psychology Programme.
6. Contact information for applicant: E-mail: _____k.price1@lancaster.ac.uk Telephone:___07882130512 Address:____ Clinical Psychology, Faculty of Health and Medicine, Furness College, Lancaster University , LA1 4YF
7. Project supervisor(s), if different from applicant: Name(s): Ian Fletcher, Prof Bill Sellwood and Dr Helena Rose E-mail(s): i.j.fletcher@lancaster.ac.uk, b.sellwood@lancaster.ac.uk , helena.rose@5bp.nhs.uk
8. Appointment held by supervisor(s) and institution(s) where based (if applicable): Ian Fletcher: Senior Lecturer at Lancaster University Prof Bill Sellwood: Professor of Clinical Psychology at Lancaster University Dr Helena Rose: Field Supervisor and Clinical Psychologist in Wigan & Leigh Early Intervention in Psychosis Team
9. Names and appointments of all members of the research team (including degree where applicable) Kelly Price BSc(Hons) Ian Fletcher PhD Prof Bill Sellwood, PhD Dr Helena Rose, DClinPsy

The Project

NOTE: In addition to completing this form you must submit a detailed research protocol and all supporting materials.

10. Summary of research protocol in lay terms (maximum length 150 words).

Early experiences of trauma are associated with voice hearing in adulthood. Studies also show that there is a link between the experience of trauma and the content of voices and that self compassion is lower in individuals who experience adverse childhood experiences. Research also indicates a link between voice hearing content and self harm and suggests that command hallucinations may increase self harm experiences. The aim of the present study is to use quantitative methods to explore the link between the content of voice hearing and self harm. We are interested to know if the content of voices impacts upon the experience of self harm. Further, we want to determine if self compassion moderates self harm in people who hear voices.

11. Anticipated project dates

Start date: _July 2015 – June 2016

12. Please describe the sample of participants to be studied (including number, age, gender):

Participants will be asked if they identify as being a voice hearer. As such, the sample will drawn from the general population and it will not be known if participants are known to services or not. Participants who identify as being voice hearers will be invited to undertake the study. Participants who do and do not engage in self harming behaviours will be invited to participate in the study. Participants will be asked to complete an online survey.

Participants over the age of 18 will be eligible to participate. For this study, the aim is to recruit a minimum of 100 participants. There is no maximum limit on the participants for recruitment as it is hoped that the study can recruit as many participants as possible within the time frame (by the end of December 2015).

Beaven, Read & Cart (2011) estimate that “roughly 5%–15%’, or ‘about one in ten’, of the adult population hears voices” (p.289). Therefore, the aim of recruiting 100 participants is considered feasible, alongside the recruitment strategy employed. More specifically, as the study is open to anyone who identifies as a voice hearer, and is not limited to a clinical sample of individuals accessing services, this increases the likelihood of achieving the minimum number required. In addition, as the study will be advertised through social media, it is hoped that this will increase the feasibility of this being achieved.

13. How will participants be recruited and from where? Be as specific as possible.

Recruitment will occur through the use of an online advertisement inviting individuals to participate. With their agreement, these will be placed within a range of mental health charity websites, for example, Mind, Intervoice, Hearing Voices Network, Paranoia Network, Rethink, Time To Change and Creative Support. In addition, the study will be advertised through self harm charities, such as, Self Injury Support (formerly BCSW), National Self Harm Network and Asylum magazine. An advert of the study will also be placed on social media sites including Facebook and Twitter. Finally, posters and information sheets will be pinned to notice boards in charitable organisation waiting rooms and adverts will be submitted to charitable newsletters. All online and hardcopy adverts and information sheets contain a link to the survey, along with the contact details of the researcher if participants wish for further information before they take part. The social media post and poster will ask potential participants if they experience hearing voices, feeling paranoid or unusual beliefs. This phrasing has been used as the lead investigator felt that this language moved away from a diagnostic and medicalised model, and rather incorporated experiences described by service users that is endorsed by the British Psychological Society as helpful alternative descriptions (BPS, Guidelines on Language in Relation to Functional Psychiatric Diagnosis 2014).

Those who wish to take part will click on a link directing them to the online survey where they will complete the online Participant Information Sheet and consent form before proceeding to the measures. Participants will be asked to complete a consent form upon accessing the link. They will also be provided with sample questions from the psychometrics (particularly in relation to early trauma experiences and self harm) to enable participants to make an informed decision to consent to participate. Participants will be asked to tick to box to indicate that they are over the age of 18. Following their consent, participants will be asked to complete a set of psychometric measures online.

14. What procedure is proposed for obtaining consent?

Upon accessing the link to the online questionnaire, participants will be presented with the participant information sheet outlining the study and the purpose of the research. This will be described in lay terms and outline the right of participant to withdraw and to stop the survey at any time point. Within the participant information sheet, they will also have access to sample questions contained within the survey.

The participant information sheet will also ensure that participants are aware that there is a possibility they may feel distress as a result of answering the survey questions. The contact details relevant organisations will be outlined within the document to ensure that participants are aware of the support service available should this occur. While participants will be asked about difficult experiences, they will not be asked to provide detailed information about these experiences.

Participants will be made aware of that their participation will be anonymous within the participant information sheet. Finally, the researcher's contact details including

work email address and research phone number will be provided if the participant feels unsure about any part of the study and wishes to ask further questions before they continue. Before participants can continue to the survey, they will be asked to tick a box to electronically give their consent to participate, and to confirm that they are above 18 years of age. Participants will be prompted to read each item of the consent form and will tick each item before being able to proceed to the survey. Participants will not be able to proceed to the survey without ticking each item.

15. What discomfort (including psychological), inconvenience or danger could be caused by participation in the project? Please indicate plans to address these potential risks.

Since participants will be asked sensitive questions related to trauma and may be asked questions about self-harm (if they indicate that they do self harm), it is acknowledged that some may experience distress as a result of their participation. It will, therefore, be made explicit within the participant information sheet at the beginning of the online survey that if distress occurs, the participant may end the survey immediately if they wish to. Furthermore, contact details for various organisations who can offer immediate support should participants experience distress will also be available at the beginning and at the end of the survey. These will include details for Victim Support and the Samaritans as well as signposting participants to seek support/guidance from their GP. In addition, participants will also be signposted to Mind and Rethink.

In addition, in order for participants to provide informed consent to participate in the study, they will be provided with sample questions from the psychometric tests.

Participants will be made aware that they can contact the researcher prior to completing the online study to discuss any questions they may have about the research.

It is important to note that while it is possible that participants may experience distress as a result of specific questions relating to self harm and trauma, research indicates that participants report a mostly beneficial impact of engaging in closed questionnaire studies online (Jorm, Kelly, & Morgan, 2007). More specifically, studies have found no increase in suicidal thoughts or behaviour following participation in online surveys relating to experiences of suicidal ideation (Cukrowicz, Smith & Poindexter, 2010; Gould et al., 2005).

The online study will not ask questions that pertain to risk towards others.
Participants will have no face-to-face support from the primary investigator following their participation in the study. In addition, as participants will be anonymous, it will not be possible to determine their identity should a risk be identified towards themselves. However, the questions they will be asked relate to self harm, and not suicide specifically. Participants will be signposted to appropriate support services and will be debriefed following their participation in the study.

Participants will be able to withdraw from the study at any time. Whilst completing the survey, should they wish to withdraw, they will be able to exit the online study without giving a reason. It will not be possible to withdraw once participants have completed the survey as their data will be anonymised.

16. What potential risks may exist for the researcher(s)? Please indicate plans to address such risk?

As this research will not involve direct contact with research participants, the risk to the researcher is considered minimal.

In the event that the researcher is contacted by participants who are experiencing distress, the researcher will signpost the participant to the appropriate sources of support. In addition, they will reflect on these during supervision with the research supervisor, and take appropriate action as required.

17. Whilst we do not generally expect direct benefits to participants as a result of this research, please state here any that result from completion of the study.

While there will be no expected direct benefits to participants, it is possible that involvement in a research project about their experiences may help participants feel listened to as they are given an opportunity to share their experiences by contributing to the research in this field.

Participants will be asked if they wish to receive a summary of the findings of the research upon its completion and will be asked to provide their email address if they wish. This may help participants better appreciate the value of their participation and how it may help clinicians and researchers working with people who hear voices. The email address data provided by participants will be kept separate from the unidentifiable research data.

18. Details of any incentives/payments (including out-of-pocket expenses) made to participants:

There will be no direct incentives made to participates who engage in this study.

19. Briefly describe your data collection and analysis methods, and the rationale for their use

<u>Data Collection</u>

The data will be gathered through Lancaster University's online survey software, Qualtrics. Within this, participants will complete a battery of psychometric measures online. These measures have been selected to assess the variables pertinent to the research question. This method of data collection was chosen as it has the potential to reach wider sample of participants compared with face to face interviews.
Consideration will be given to the order or the measures used within the survey to ensure that participants are not exposed to the most difficult material at the end of the survey, as this will be foremost in their minds.

Based on the number of questions within the online survey and the estimated time taken to read through the participant information sheet and consent form, it is estimated that the survey will take 20 minutes to complete.

Measures

Participants will complete the following measures.

Trauma:
The Brief Betrayal Trauma Survey (BBTS: Goldberg & Freyd, 2006)
Consists of 12 items addressing a range of traumas. The traumas can be separated into those involving a high degree of betrayal, for example sexual assault by close family member, and those involving low betrayal, for example a natural disaster. The measure asks the same questions for before and after the age of 18.

Hearing voices
The Hamilton Program for Schizophrenia Voices Questionnaire (HPSVQ: Van Lieshout & Goldberg, 2007).
The HPSVQ is a 13-item self-report questionnaire that can be completed in approximately four minutes. It provides a unitary index of severity comprising nine items (frequency, negative content, loudness, duration, interference with life, distress, impact on self-appraisal, clarity and compliance with commands), each rated on a five-point Likert scale of impairment or severity. The 7 remaining items examine the time of day and situations in which voices occur, the location and clarity of the voice, its impact on self-esteem, compliance with commanding voices and whether the week that is rated is typical. Internal consistency was found to be adequate. Correlation with the PSYRATS-AH (i.e. currently the gold standard clinical interview measure for the multidimensional assessment of voices; Haddock et al., 1999) indicated adequate convergent validity (r = 0.76; Van Lieshout & Goldberg, 2007).

The revised Beliefs About Voices Questionnaire (BAVQ-R: Chadwick, Lees & Birchwood, 2000) *35 item self-report measure of patients' beliefs, emotions and behaviour about auditory hallucinations. The BAVQ-R is a 35-item measure of people's beliefs about auditory hallucinations, and their emotional and behavioural reactions to them. There are three sub-scales relating to beliefs: malevolence (six items: e.g. 'My voice is punishing me for something I have done'); benevolence (six items: e.g. 'My voice wants to protect me'); and omnipotence (six items). The five new items assessing omnipotence were obtained over a period of 3 years. The wording of each item reflects statements which are commonly made during psychological assessment or therapy. Two further sub-scales, 'resistance' and 'engagement', measure emotional and behavioural relationships to auditory hallucinations. 'Resistance' has five items on emotion (e.g. 'My voice frightens me') and four on behaviour (e.g. 'When I hear my voice usually I tell it to leave me alone'). 'Engagement' has four items on emotion (e.g. 'My voice reassures me') and four on behaviour (e.g. 'When I hear my voice usually I listen to it because I want to'). All responses are rated on a 4-point scale: disagree (0); unsure (1); agree slightly (2); agree strongly (3). The measure thus assesses degree of endorsement of items. As with the original BAVQ, individuals hearing more than one auditory hallucination complete the questionnaire for their 'dominant voice'.*

Self harm:
Inventory of Statements about Self Injury (ISAS; Klonsky, & Glenn, 2009)
46-item-self report measure that explores self-harm behaviours and the function of self harm. Within self harm behaviours individuals are asked to estimate the frequency of a range of different self harm behaviours. It also explores the

experience of non-suicidal self-harm and the function of these behaviours, using a 3-point Likert scale to indicate degree of relevance ("Not relevant", "Somewhat relevant", and "Very relevant").

**only participants who indicate that they self harm will be asked to complete this measure

Self compassion:
Self-Compassion Scale (SCS; Neff, 2003)
26-item-self report measure that uses a 5-point (1-5) Likert scale to measure the frequency of a behaviour ("Almost Never" to "Almost Always"). The measure allows for subscale calculations relating to "Self-Kindness", "Self-Judgment", "Common Humanity", "Isolation", "Mindfulness" and "Over-identified". This measure is reported to have good construct validity and good test-retest reliability has been obtained when participants' responses to the Self-Compassion Scale were compared across two time variables. Test-retest correlation was .93 for the overall score(Neff, 2003).

Analysis

Parametric or non-parametric statistics will be chosen depending on the distribution of the data. Descriptive statistics will be used to outline the variables of interest in the datasets as appropriate.

Correlational and multiple regression analysis will be used to examine the strength of the associations between the key variables considered (trauma, hearing voices, self harm and self compassion).

The primary hypotheses will be examined using a series of regression analyses, carried out with the SPSS analytic procedures. A demographic questionnaire will be included in the survey.

Our primary hypotheses will be examined using a series of moderation analyses, carried out with the SPSS analytic procedures. The variables will be investigated with correlations, t-tests, and chi-square tests as appropriate to identify significant relationships between the predictors and dependent variable, and between the predictor variables themselves. Regression analyses will be employed to identify the significant predictors of self-harm.

We aim to explore the following:

1) Self compassion (SCS) as a moderator between distress in voice hearing (HPSVQ, BAVQ-R) and self harm (ISAS)
2) The relationship between trauma (BBTS), voice hearing (HPSVQ, BAVQ-R) and self harm (ISAS)
3) The link between voice hearing(HPSVQ, BAVQ-R) and self harm (ISAS)

A demographic questionnaire will be included in the survey.

20. Describe the involvement of users/service users in the design and conduct of your research. If you have not involved users/service users in developing your research protocol, please indicate this and provide a brief rationale/explanation.

In the development of this research project, the researcher liaised with a service user with experience of hearing voices and self harm. In addition, the researcher has requested input from experts by experience from a local NHS trust in relation to the accessibility to recruitment materials and to ensure that it is conducted as sensitively as possible. This liaison will be supervised by the field supervisor (Dr Helena Rose) who provides clinical input into this service.

21. What plan is in place for the storage of data (electronic, digital, paper, etc.)? Please ensure that your plans comply with the Data Protection Act 1998.

The anonymous data collected via Qualtrix will be downloaded and stored in the researcher's secure, online storage system on the University server. Following completion of the study, the data will be encrypted and securely transferred to the DClinPsy admin team. These data will be stored securely within the Division of Health Research in line with Lancaster University and the Data Protection Act (1998). Data will be stored in a password protected file at the university for ten years.

Participants who wish to receive a summary of the findings of the research will provide an email address. These personal/identifying details will be encrypted and securely transferred to the DClinPsy admin team. These data will be stored securely within the Division of Health Research in line with Lancaster University and the Data Protection Act (1998) up to the time that the research has been submitted as part of thesis. Following this, the data will be deleted.

22. Will audio or video recording take place? ☑ no □ audio □video

23. What are the plans for dissemination of findings from the research?

The final report will be written as part of a thesis and submitted to the university for examination. The report will also be submitted for publication in an academic journal and may be presented to university and research conferences. Those participants who requested a summary of the findings of the research will be sent a summary document via email. In addition, a summary document of the findings will also be shared with the charity organisations involved in advertising the research study.

24. What particular ethical problems, not previously noted on this application, do you think there are in the proposed study? Are there any matters about which you wish to seek advice from the FHMREC?

An issue not yet addressed is with regard to the personal email addresses that participants will provide if they wish to have a summary of the findings sent to them, following completion of the study. Importantly, while the personal email will make them identifiable, this will not be linked to the data from the online study, meaning that their responses and email address will not be linked.

If participants do not wish to receive this feedback, they will remain anonymous.

Signatures: Applicant: …*Kelly Price*.....

Date:

……..

Project Supervisor* (if applicable):

……..

Date:

……..

*I have reviewed this application, and discussed it with the applicant. I confirm that the project methodology is appropriate. I am happy for this application to proceed to ethical review.

Research protocol

Understanding voice hearers' ideas about themselves and their voices

Introduction

The experience of auditory verbal hallucinations (AVHs, or hearing voices) is reported to occur in approximately 70% of people who have received diagnoses of psychosis, but have also been found to be relatively common among the general population (Waters et al., 2012). Command hallucinations are defined as auditory hallucinations pertaining to the ordering of specific acts, often considered violent or destructive (Hellerstein, Frosch, Koenigsberg (1987). While there is evidence to suggest that some people experience positive voices (Jenner et al., 2008), individuals report that voice hearing is frequently experienced as severely distressing and is most likely to have started in negative or explicitly traumatic circumstances (Woods et al., 2015).

The experience of voice hearing and self harm are linked, with approximately one in five people with psychosis engaging in self-harming behaviours (Challis, Nielssen, Harris & Large, 2013) and more than half of those making multiple attempts (Harkavy-Friedman, Nelson & Venarde, 2001). Mork et al. (2013) report that for individuals with a diagnosis of a psychotic disorder (for example schizophrenia), self harm is pronounced. A recent systematic review suggests that earlier deliberate self harm and low mood were the strongest predictors of self harm in first episode psychosis (Challis, Nielssen, Harris & Large, 2013).

The content of command hallucinations predicts self-harm (Rogers, Watt, Gray, MacCulloch & Gournay, 2002). Specifically, they suggest that the content of command hallucinations to self harm are significant predictors of self harm, particularly in the absence of paranoid delusions. Command hallucinations are widely regarded as distressing and indicative of high risk of harm to self and others (Woods et al., 2015). Malevolent beliefs are associated with self-harm (Simms, McCormack, Anderson and Mulholland, 2007). However, how verbal hallucinations specifically precipitate self harming behaviours remains relatively unexplored and, there is a lack of literature in this area.

Some studies have explored the relationship between self harm and psychosis. Command hallucinations and intoxication from alcohol and/or drug use have been found to be associated with

self harm, although the most prevalent reason for self harming is distress in relation to symptoms of psychosis (Harvey et al, 2008). While the literature indicates a link between self harm and psychosis, the specific mechanisms underpinning this remain unclear. Research suggests that self harm does not always occur as a result of a direct 'command' voice, it can occur in response to the experience of hearing voices as a method of coping with distress.

Studies have explored characteristics of individuals associated with self-harm in the context of schizophrenia spectrum disorders. Younger age (Mork et al. 2013), previous history of self-harm (Patel & Upthegrove, 2009) and depression (Mork et al. 2012; Simms et al. 2007) have been implicated.

Research suggests a link between experiences of trauma in childhood and the occurrence of psychosis and self-harm and depression. Specifically, there are consistent findings of a relationship between history of childhood sexual abuse and hallucinatory experiences in adulthood (Hammersley et al., 2003; Read et al., 2003). There is evidence of strong links between traumatic experiences in childhood and adolescence, with growing evidence of a dose-response relationship (Russo et al., 2014). Sitko, Bentall, Shevlin, O'Sullivan & Sellwood (2014) propose that dissociation and depression appear specific mechanisms that mediate between childhood trauma and hallucinations.

There is growing evidence that self compassion is a significant positive predictor of psychological well-being (Neff, Rude, & Kirkpatrick, 2007). Self-compassion is considered to be a salient source of positive self-regard (Neff, 2013) and is reported to be a significant predictor of self-worth stability (Neff & Vonk 2009). Neff (2003) defines the concept of self compassion as the interplay between three components: Self-kindness versus self-judgment, feelings of common humanity versus isolation, and mindfulness versus over-identification.

A paper reviewing studies that all used the Neff (2003) self-compassion measure suggests that 'compassion is an important explanatory variable in understanding mental health and resilience' (p. 545) (MacBeth & Gumley, 2012). They report a large effect size for compassion and psychopathology, specifically in relation to depression, anxiety and stress. Self compassion appears to increase resilience to the experience of mental distress and facilitates an adaptive coping response to adversity (Gilbert & Procter, 2006). Childhood trauma, in particular emotional abuse, has been

found to be associated with significantly lower self-compassion in an adolescent population (Tanaka, Wekerle, Schmuck, Paglia-Boak, & The MAP Research Team, 2011) and supports research suggesting an aversive parenting-low self-compassion linkage. Studies propose that self compassion can result in the lessening of negative self-related outcomes and improve psychiatric symptoms (Gilbert & Procter, 2006; Leary, Tate, Adams, Batts, & Hancock, 2007). The specific relationship between childhood trauma, hearing voices and self compassion has not yet been empirically tested. There is potential clinical value in highlighting links between early trauma, voice hearing and self compassion. Specifically, this study may lead to a greater understanding of the impact of self compassion in relation to voice hearing which, in turn, may inform psychological interventions with individuals.

Planned Investigation

Research objectives

The primary aim of the present study is to determine if self compassion moderates the occurrence of self harm in voice hearers, in the context of childhood trauma.

Secondary aims of the study are to explore the relationships between self-harm and beliefs about voices?

Research methods

This sample for this study will be taken from a population of individuals who are voice hearers. Participants who do and do not engage in self harming behaviours will be recruited. A self-report design will be used to test the above objectives in which participants from one population group will be sampled: a sample of participants experiencing psychosis. All participants will be over the age 18.

Participants will be asked to complete an online survey. . The University's online survey software Qualtrics will be used to create the online survey. Based on length of time taken to complete the measures on hard copy, it is estimated that it will take participants between 20 and 40 minutes to complete the survey.

Recruitment will occur through the use of an online advert inviting individuals to participant in the study (Appendix A). These adverts will be placed within a range of mental health charity

websites, including Mind, Intervoice, Hearing Voices Network, Paranoia Network, Rethink, Time To Change and Creative Support. In addition, the study will be advertised through self harm charities, including, Self Injury Support (formerly BCSW), National Self Harm Network and Asylum magazine. An advert of the study will also be placed on social media sites including Facebook and Twitter (Appendix B). Finally, posters and information sheets will be pinned to notice boards in charitable organisation waiting rooms and adverts will be submitted to charitable newsletters. All online and hardcopy adverts and information sheets contain a link to the survey, along with the contact details of the researcher if participants wish for further information before they take part. Those who wish to take part will click on a link directing them to the online survey where they will complete the online Participant Information Sheet (Appendix C) and consent form (Appendix D) before proceeding to the measures. Participants will be asked to complete a consent form upon accessing the link. They will also be provided with sample questions from the psychometrics (particularly in relation to early trauma experiences and self harm) to enable participants to make an informed decision to consent to participants. Following their consent, participants will be asked to complete a set of psychometric measures online.

At the end of the survey participants will have the opportunity to read a debriefing page (Appendix E). This page will explain the research, in particular explaining that the research is interested in exploring how views of oneself might play a part in voice hearing problems. Participants will also be guided to services accessing support should they experience any distress as a result of completing the online survey.

Participants will have the option to request a summary of the findings when the research is complete, in which case they would tick the box ‘summary of findings’.

Proposed measures

As outlined above, participants for this study will be exposed to the following measures whilst completing the online survey.

- Trauma:
  - The Brief Betrayal Trauma Survey (BBTS: Goldberg & Freyd, 2006)

Consists of 12 items addressing a range of traumas. The traumas can be separated in to those involving a high degree of betrayal, for example sexual assault by close family member, and those involving low betrayal, for example a natural disaster. The measure asks the same questions for before and after the age of 18.

- Hearing voices
  - The Hamilton Program for Schizophrenia Voices Questionnaire (HPSVQ: Van Lieshout & Goldberg, 2007).

    The HPSVQ is a 13-item self-report questionnaire that can be completed in approximately four minutes. It provides a unitary index of severity comprising nine items (frequency, negative content, loudness, duration, interference with life, distress, impact on self-appraisal, clarity and compliance with commands), each rated on a five-point Likert scale of impairment or severity. The 7 remaining items examine the time of day and situations in which voices occur, the location and clarity of the voice, its impact on self-esteem, compliance with commanding voices and whether the week that is rated is typical. Internal consistency was found to be adequate. Correlation with the PSYRATS-AH (i.e. currently the gold standard clinical interview measure for the multidimensional assessment of voices; Haddock et al., 1999) indicated adequate convergent validity (r = 0.76; Van Lieshout & Goldberg, 2007).

  - The revised Beliefs About Voices Questionnaire (BAVQ-R: Chadwick, Lees & Birchwood, 2000)

    35 item self-report measure of patients' beliefs, emotions and behaviour about auditory hallucinations. The BAVQ-R is a 35-item measure of people's beliefs about auditory hallucinations, and their emotional and behavioural reactions to them. There are three sub-scales relating to beliefs: malevolence (six items: e.g. 'My voice is punishing me for something I have done'); benevolence (six items: e.g. 'My voice wants to protect me'); and omnipotence (six items). The five new items assessing omnipotence were obtained over a period of 3 years. The wording of each item reflects statements which are commonly made during psychological assessment or therapy. Two further sub-scales, 'resistance' and 'engagement', measure emotional and behavioural relationships to auditory

hallucinations. 'Resistance' has five items on emotion (e.g. 'My voice frightens me') and four on behaviour (e.g. 'When I hear my voice usually I tell it to leave me alone'). 'Engagement' has four items on emotion (e.g. 'My voice reassures me') and four on behaviour (e.g. 'When I hear my voice usually I listen to it because I want to'). All responses are rated on a 4-point scale: disagree (0); unsure (1); agree slightly (2); agree strongly (3). The measure thus assesses degree of endorsement of items. As with the original BAVQ, individuals hearing more than one auditory hallucination complete the questionnaire for their 'dominant voice'.

- Self harm:
  - Inventory of Statements about Self Injury (ISAS; Klonsky, & Glenn, 2009)

46-item-self report measure that explores self-harm behaviours and the function of self harm. Within self harm behaviours individuals are asked to estimate the frequency of a range of different self harm behaviours. It also explores the experience of non-suicidal
self-harm and the function of these behaviours, using a 3point Likert scale to indicate degree of relevance ("Not relevant", "Somewhat relevant", and "Very relevant").

It is important to note that only participants who indicate that they self harm will be exposed to this measure.

- Self compassion:
  - Self-Compassion Scale (SCS; Neff, 2003)

26-item-self report measure that uses a 5-point (1-5) Likert scale to measure the frequency of a behaviour ("Almost Never" to "Almost Always"). The measure allows for subscale calculations relating to "Self-Kindness", "Self-Judgment", "Common Humanity", "Isolation", "Mindfulness" and "Over-identified". This measure is reported to have good construct validity and good test–retest reliability when participants' responses to the Self-Compassion Scale were compared across two time variables. Test–retest for the overall score is .93 (Neff, 2003).

Statistical analysis

The data collected as part of this study will be analysed by the primary investigator. Parametric or non-parametric statistics will be chosen depending on the distribution of the data. Descriptive statistics will be used to outline the variables of interest in the dataset as appropriate. Correlational and multiple regression analysis will be used to examine the strength of the associations between the key variables considered (trauma, self-harm, self-compassion and hearing voices).

It is predicted that self compassion will have a moderating effect on self harming behaviours in voice hearers. It is hypothesised that the greater the distress experienced by voice hearers in relation to voice hearing content, the lower self compassion they will experience. It is also predicted that voice hearers who experienced greater adverse experiences in childhood, will exhibit greater distress with regards to content of voices and self harm behaviours.

The primary hypotheses will be examined using a series of regression analyses. A demographic questionnaire will be included in the survey.

Proposed sample size

For this study, the aim is to recruit a minimum of 100 participants from within one population (voice hearers). There is no maximum limit on the participants for recruitment as it is hoped that the study can recruit as many participants as possible within the time frame (by the end of December 2015).

Beaven, Read & Cart (2011) estimate that "roughly 5%–15%', or 'about one in ten', of the adult population hears voices" (p.289). Therefore, the aim of recruiting 100 participants is considered feasible, alongside the recruitment strategy employed. More specifically, as the study is open to anyone who identifies as a voice hearer, and is not limited to a clinical sample of individuals accessing services, this increases the likelihood of achieving the minimum number required. In addition, as the study will be advertised through social media, it is hoped that this will increase the feasibility of this being achieved.

Ethical considerations

The study will be submitted for review to Lancaster University's Faculty of Health and Medicine Research Ethics Committee (FHMREC). Within the information page and online consent form, participants will be made aware that they can terminate their participation during the completion of the online study. After completion of the survey, t iwll not be possible to withdraw as their data will be anonymised. Since participants will be asked sensitive questions related to trauma and self harm, it is acknowledged that some participants may experience distress as result of their participation. It will, therefore, be made explicit within the patient information sheet at the beginning of the online survey that if distress occurs the participant may end the survey immediately if they wish to. Furthermore, contact details for various organisations who can offer immediate support should participants experience distress will also be available at the beginning and at the end of the survey. These will include details for Victim Support and the Samaritans. In addition, in order for participants to provide informed consent to participant in the study, they will be provided with sample questions from the psychometric tests.

It is important to note that while it is possible that participants may experience distress as a result of specific questions relating to self harm and trauma, research indicates that participants report a mostly beneficial impact of engaging in closed questionnaire studies online (Jorm, Kelly, & Morgan, 2007). More specifically, studies have found no increase in suicidal thoughts or behaviour following participation in online surveys relating to experiences of suicidal ideation (Cukrowicz, Smith & Poindexter, 2010; Gould et al., 2005).

Timescale

- June-July 2015

All research documents will be completed including Participant Information Sheet, consent form, posters and leaflets. Following completion, an application will be submitted for review to Lancaster University's Faculty of Health and Medicine Research Ethics Committee (FHMREC).

- July-August 2015

Upon receiving approval from FHMREC, the recruitment process will begin

- July – November 2015

  Recruitment and data collection.

- November – December 2014

  Statistical analysis of the data

- December – May 2016

  Write up, draft reading and final submission

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Appendix A: Poster adversting study

Doctorate in Clinical Psychology | Lancaster University

Understanding voice hearers' ideas about themselves and their voices

Research Participants Required

Do you have any experiences of 'psychosis'?

(Have you experienced hearing voices, feeling paranoid, or held beliefs you or others deem unusual)

If you would like to be involved in the study by completing an online survey, please go to the following link:

[INSERT LINK TO ONLINE STUDY]

Alternatively, please contact me:

Kelly Price
k.price1@lancaster.ac.uk
[INSENT CONTACT NUMBER]

Appendix B

Social Media post for participants

Research Participants Required!

Do you experience psychosis?

Do you hear voices that others cannot?

Do you have beliefs you or others deem unusual?

If you answered yes to any of these questions I would like to invite you to take part in my research. I am interested to find out more about the link between voice hearing, possible self harm and how voice hearers view themselves.

Please click the link below to find out more information.

INSERT LINK TO PIS

Appendix C Participant information sheet

Doctorate in Clinical Psychology | Lancaster University

Understanding voice hearers' ideas about themselves and their voices

Participant Information Sheet

Before you consent to participating in the study we ask that you read the participant information then click onto the link below if you agree to take part. If you have any questions or queries about taking part in the study, please email the principal investigator, Kelly Price (k.price1@lancaster.ac.uk).

Introduction

My name is Kelly Price and I am conducting this research as part of a doctoral programme in clinical psychology. I would like to invite you to take part in my research. Before you decide, you need to understand why this research is being done and what it would involve for you. Please take time to read the following information carefully. If you have questions about the study or about what it involves for you, please contact me. You do not have to make the decision at this time, so if you have any doubts or feel unsure please take some time to think it over.

What is the purpose of the study?

I am carrying out this research because I would like to find out more about experiences of psychosis. In particular, I would like to find out how adverse life experiences may have an impact on experiences that are related to psychosis. Also, I am interested to know if your experience of voice hearing and possible self harm are linked or not. In particular I would like to know whether the way voice hearers view themselves may be protective.

If you have, at some point in your life experienced psychosis, I would like to invite you to take part in my research by completing an online survey. You do not have to have experience of self harm to be involved in the study.

The aim of the study is to better understand the some of the experiences of voice hearers. I hope that this will contribute to wider knowledge for professionals and influence some of our clinical practice when working with clients.

Do I have to take part?
You do not have to take part. If you decide you would like to, and you continue to the survey, you can also stop at any point throughout the survey if you change your mind. You are free to refuse to take part, without giving a reason. It will not be possible to withdraw once you have completed the survey as your data will be anonymised.

What will I be asked to do if I take part?
If you agree to take part, you will be directed to an online survey. This survey will ask you questions related to early experiences of trauma, questions about unusual experiences, about your experiences of self harm (if you have any) and about the feelings you have towards yourself. Some of the questions in this survey may be very sensitive for you. These include items on childhood bullying, sexual abuse, stressful events, and symptom experiences. Examples of the items are as follows:

1. "You were deliberately attacked severely by someone with whom you were very close"
2. "You were made to have some form of sexual contact, such as touching or penetration, by someone with whom you were very close (such as a parent or lover)"
3. "Do you ever feel as if you are being persecuted in some way?"
4. "Do you ever feel as if there is no future for you?"

If you have self harmed, I am interested in your reasons for this. You will be asked to rate statements about your self-harm and how relevant these are to you on a scale. For example, you will be asked if you have ever self harmed to...

...Calm yourself down
... letting others know the extent of my emotional pain
...trying to feel something (as opposed to nothing) even if it is physical pain I will not be asking you to provide descriptions of your self-harm.

What are the possible disadvantages and risks of taking part?
I do not anticipate that your participation will cause you distress. However, if you do experience distress you may discontinue the survey at any time. At the bottom of this page, and on completion of the survey, there is a list of contact details of various support services that you may contact if you experience distress as a result of participating.

What are the possible benefits of taking part?
Although I cannot promise that the study will help you, participation in this study may provide you with an opportunity to reflect on your feelings and experiences. Research findings obtained during the study will also help us to better understand the experiences of people who hear voices, and may potentially be used to improve psychological treatments.

If you would like me to email you a summary of the findings when the study is complete, please fill in your email address in the box provided at the end of the survey, and tick the box 'summary of findings'. Email addresses will always be stored separately from the survey answers so that anonymity will be maintained.

What will happen if I don't want to carry on with the study?
If you don't want to carry on with the study, you can exit at any time by closing down the browser. If possible, i will use the data you have submitted up until you ended the study.

Will my taking part in the study be kept confidential?

Yes, I will follow ethical and legal practice and all information about you will be handled in strict confidence.

The data collected during the study will be stored in a secure place and only the project researchers will have access to it. Data files stored on the computer will be password protected. No names or addresses will be included and it will not be possible for me to know which responses were made by you as it will be anonymised. All participants will be identified only by numbers in any computerised data files used in the analyses of the results.

What will happen to the results of the research study?
The results of the research will be included in a report that will be submitted for examination by Lancaster University. The results may also be published within an academic journal, and may be presented at conferences. There will be no personal information about any of the people who participate within any of these reports or presentations.

Who is involved in this research?

Research Role	**Name**	**Address**	**Contact**
Chief Investigator	**Kelly Price**	Clinical Psychology Doctorate Programme Faculty of Health & Medicine Furness College Lancaster University LA1 4YF	k.price1@lancaster.ac.uk 01524 592970
Field Supervisor	**Dr Helena Rose**	Clinical Psychologist 5 Boroughs Partnership NHS Trust	
Academic Supervisors	**Ian Fletcher & Bill Sellwood**	Clinical Psychology Doctorate Programme Faculty of Health & Medicine Furness College Lancaster University LA1 4YF	i.j.fletcher@lancaster.ac.uk b.sellwood@lancaster.ac.uk 01524 592970

If you have any experience during your participation that you are unhappy with and wish to make a complaint, please contact:

Dr Jane Simpson Director of Research
Doctorate in Clinical Psychology
Division of Health Research Furness Building Lancaster University Bailrigg
Lancaster LA1 4YG United Kingdom
E-mail: j.simpson2@lancaster.ac.uk
Tel: 01524 592858

OR

Professor Roger Pickup Associate Dean for Research
Faculty of Health and Medicine
Division of Biomedical and Life Sciences Lancaster University
Lancaster LA1 4YD

Email: r.pickup@lancaster.ac.uk Tel: 01524 593718

Where can I obtain further information if I need it?
Should you have any questions regarding this study, please contact Kelly Price at k.price1@lancaster.ac.uk or telephone 07xxxxxxxx.

The following is a list of services you may contact for support, advice, or in emergency:

The Samaritans

The Samaritans are open 24 hours a day 365 days a year. You can contact them to talk through anything that is troubling you. For more information visit their website, or contact them on:

Website: www.samaritans.org Telephone: 08457 90 90 90 Email: jo@samaritans.org

Victim Support

If you've been a victim of any crime or have been affected by a crime committed against someone you know, they can help you find the strength to deal with what you've been through. The services are free and available to everyone, whether or not the crime has been reported and regardless of when it happened.

See more at: www.victimsupport.org.uk Or Call: 0845 30 30 900
Weekdays 9am to 8pm, weekends 9am to 7pm, bank holidays 9am to 5pm

Your GP

Should you experience distress as a result of completing this survey, we recommend that you contact your local GP surgery to speak to seek the appropriate support.

Your local Mental Health Assessment Team and/or care coordinator

Should you experience distress and you are already have contact with local mental health services, we advise that you seek support from them or your identified care coordinator.

Mind

Mind is a charity organisation, providing advice and support to anyone experiencing a mental health difficulty.
Should you experience distress and wish to access support services, you can contact Mind on their phone lines which are open 9am to 6pm, Monday to Friday (except for bank holidays) on **0300 123 3393**

Or email : info@mind.org.uk

Or text: 86463

You can access more information at : http://www.mind.org.uk/information-support/helplines/
http://www.mind.org.uk/about-us/contact-us/

Thank you for reading this information sheet

*****INSERT LINK TO SURVEY HERE*****

Appendix D Consent

Doctorate in Clinical Psychology | Lancaster University

Study Title:

Understanding voice hearers' ideas about themselves and their voices

We are asking if you would like to take part in a survey to find out more how adverse life experiences may have an impact on experiences that are related to psychosis and whether the way voice hearers view themselves may be protective.

Before you consent to participating in the study we ask that you read the participant information sheet and tick the box at the side of each statement below if you agree.

If you have any questions or queries before signing the consent form please contact the principal investigator, Kelly Price (k.price1@lancaster.ac.uk or. XXXXXXXXXX)

	Tick to agree
1. I confirm that I have read the information sheet and fully understand what is expected of me within this survey.	☐
2. I confirm that I have had the opportunity to ask any questions and to have them answered.	☐
3. I understand that my answers will be electronically stored and then analysed along with the responses from the other respondents in this survey.	☐
4. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected.	☐
5. I understand that once my responses have recorded it will not be possible for them to be withdrawn.	☐
6. I understand that the information from my responses will be pooled with other participants' responses, anonymised and may be published.	☐
7. I consent to information and quotations from my survey being used in reports, conferences and training events.	☐
8. I understand that any information I give will remain strictly anonymous, unless I wish to provide an email address to obtain a summary of the results. I understand that it will not be possible to link the responses I provide on the survey and any email address I give.	
9. I consent to Lancaster University keeping electronic responses for 10 years after the study has finished.	
10. I consent to take part in the above study. YES/NO	☐

Appendix E Debrief sheet

Doctorate in Clinical Psychology | Lancaster University

DEBRIEFING SHEET

Understanding voice hearers' ideas about themselves and their voices

Thank you for your participation. The following page aims to give you a summary of the main aims of our investigation.

Hearing voices is **not** in itself a sign of mental health difficulties. Research has shown that hearing voices is quite common among people with no history of mental health difficulties. Hearing voices can be distressing for some people, but for others they can be a positive experience. I have been attempting to identify different experiences that may cause voice hearing. For some people, voices may be related to stressful experiences, particularly in their early lives.

People engage in self harm for a number of reasons. I am interested in finding out if there is a link between hearing voices and self harm. Also, I am interested in the ways that people think about themselves and if the content of voice hearing is linked to this. We are attempting to find out what role self compassion plays for people who hear voices and self harm. Self compassion relates to the way we view ourselves and can protect against difficult experiences we might encounter.

I will analyse the measures carried out as part of this study, and I hope that the findings of this study will help us to develop better ways to support individuals with distressing voices and who self harm.

If you would like further information concerning any of these topics, or would like to be kept informed about the progress and results of the study, please contact or Kelly Price at k.price1@lancaster.ac.uk or phone XXXXXXX. We understand that some of the topics covered in this investigation and the materials used in this study might have caused you some discomfort. If you still feel upset as a result of the procedures involved in this study, please contact any of the support services we have provided contact details for at the bottom of this page.

The following is a list of services you may contact for support, advice, or in emergency:

The Samaritans

The Samaritans are open 24 hours a day 365 days a year. You can contact them to talk through anything that is troubling you. For more information visit their website, or contact them on:

Website: www.samaritans.org
Telephone: 08457 90 90 90 Email: jo@samaritans.org

Victim Support

If you've been a victim of any crime or have been affected by a crime committed against someone you know, they can help you find the strength to deal with what you've been through. The services are free and available to everyone, whether or not the crime has been reported and regardless of when it happened.

See more at: www.victimsupport.org.uk Or Call: 0845 30 30 900
Weekdays 9am to 8pm, weekends 9am to 7pm, bank holidays 9am to 5pm

Your GP

Should you experience distress as a result of completing this survey, we recommend that you contact your local GP surgery to speak to seek the appropriate support.

Your local Mental Health Assessment Team and/or care coordinator

Should you experience distress and you are already have contact with local mental health services, we advise that you seek support from them or your identified care coordinator.

Mind

Mind is a charity organisation, providing advice and support to anyone_experiencing a mental health difficulty.

Should you experience distress and wish to access support services, you can contact Mind via:

Phone: **0300 123 3393 (**9am to 6pm, Monday to Friday, except for bank holidays)

Or email: info@mind.org.uk
Or text: 86463

You can access more information at : http://www.mind.org.uk/information-support/helplines/ http://www.mind.org.uk/about-us/contact-us/

Rethink

This is a charity organisation, offering practical advice on issues related to mental health, including support on living with mental health difficulties, medication, care and treatment.

Call: 0300 5000 927**.** (10.00-14.00 Monday to Friday)
Twitter: @ Rethink_ England
Facebook: Rethink Mental Illness

Appendix F

Research and Enterprise Services Division | Lancaster University

Applicant: Kelly Price
Supervisor: Dr Ian Fletcher and Prof Bill Sellwood
Department: DHR
UREC Ref: RS2015/17

03 September 2015

Dear Kelly,

Re: Understanding voice hearers' ideas about themselves and their voices

Thank you for submitting your research ethics application for the above project for review by the Faculty of Health and Medicine Research Ethics Committee (FHMREC). The application was recommended for approval by FHMREC, and on behalf of the Chair of the University Research Ethics Committee (UREC), I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact the Research Ethics Officer, Debbie Knight (01542 592605 ethics@lancaster.ac.uk) if you have any queries or require further information.

Yours sincerely,

S. C. Taylor

Sarah Taylor
Secretary, University Research Ethics Committee

Cc Fiona Aiken, University Secretary, Professor Roger Pickup (Chair, FHMREC); Prof Stephen Decent (Chair, UREC).

Lancaster University
Research and Enterprise Services Division
Lancaster University
Bowland Main
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F: +44 (0)1524 593 220
www.lancaster.ac.uk

Faculty of Health and Medicine Research Ethics Committee (FHMREC)
Lancaster University

Application for Amendment to Previously Approved Research

Instructions: Please re-submit your original research ethics approval documents with any amendments highlighted in yellow, attaching this form as a cover sheet.
Completed documentation should be submitted as a single PDF by email and in ***signed*** hard copy to:

Dr Diane Hopkins
Faculty of Health & Medicine
B03, Furness College
Lancaster University
LA1 4YT
d.hopkins@lancaster.ac.uk

1. Name of applicant: Kelly Price
2. E-mail address and phone number of applicant: k.price1@lancaster.ac.uk 07882130512
3. Title of project: Understanding voice hearers' ideas about themselves and their voices
4. Project reference number: RS2015/17
5. Date of original project approval as indicated on the official approval letter (month/year) September 2015

Amendment request
6. Please outline the requested amendment(s): I would like to extend the period of time that I will recruit participants. In my original application, I estimated that i would end recruitment in December 2016.
7. Please explain your reason(s) for requesting the above amendment(s): I have not, as yet, met the minimum number of participants for my study. In addition, I have approval from charitable organisations to advertise my study on their websites (including studentminds and the Hearing Voices Network). However, these are not yet online. A number of Hearing Voices groups have also indicated that they will advertise the study in their group/waiting rooms in early 2016.

Signatures

Applicant: _____ Date:_____

Project Supervisor: _____. Date: _____

Appendix H

Applicant: Kelly Price
Supervisor: Ian Fletcher/Bill Sellwood
Department: Health Research
FHMREC Reference: FHMREC15039

17 December 2015

Dear Kelly

Re: Understanding voice hearers' ideas about themselves and their voices

Thank you for submitting your research ethics amendment application for the above project for review by the Faculty of Health and Medicine Research Ethics Committee (FHMREC). The application was recommended for approval by FHMREC, and on behalf of the Chair of the University Research Ethics Committee (UREC), I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact the Diane Hopkins (01542 592838 fhmresearchsupport@lancaster.ac.uk) if you have any queries or require further information.

Yours sincerely,

Dr Diane Hopkins
Research Development Officer

CC Ethics@Lancaster; Professor Roger Pickup (Chair, FHMREC)