AN EXPLORATION OF THE IMPACT OF SHAME, NARCISSISM AND SOCIAL RANK ON THE DISTRESS AND WELLBEING OF MID-ADOLESCENTS: DOES SELF-COMPASSION HAVE A ROLE?

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ABSTRACT

Background: Adolescence is a pivotal developmental period in the lifecycle. Aspects of shame, narcissism and social rank have all been associated with distress and wellbeing in adolescence, however no studies to date have investigated the impact of those constructs together in terms of their predictive value. Extant research has identified self-compassion as protective and associated with increased wellbeing.

Aims: This study aimed to explore the relationships between external, internal and shame proneness; grandiose and vulnerable narcissism; social comparison and submissive behaviour, and self-compassion; and to explore the impact of those variables and the relationships between them upon psychological distress and wellbeing.

Method: From the pragmatist approach this study adopted a cross-sectional, quantitative approach. Mid-adolescents aged 16-17 (N=142) were recruited and invited to complete a battery of self-report questionnaires via school or online survey. Correlation and regression analyses were performed to explore relationships and predictive associations between the variables and moderation analysis was performed to test the effects of self-compassion on the regression models.

Results: This population was found to be low in wellbeing and moderate in distress. Multiple regression analyses found distress was predicted by internal shame, shame proneness, submissive behaviour and vulnerable narcissism; wellbeing was predicted by shame proneness; submissive behaviour and vulnerable narcissism (negatively) and social comparison and grandiose narcissism (positively). Self-compassion did not correlate with or predict distress, however its predictive power on wellbeing was marked. Moderation analyses showed self-compassion does not moderate distress or wellbeing.

Conclusion: These novel findings suggest two predictive models for shame, narcissism and social rank in distress and wellbeing for an adolescent population, and show the impact of self-compassion. A more self-compassionate attitude was related to increased wellbeing, hence those high in distress could benefit from compassion-based interventions and educational initiatives. Further investigations are warranted.

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1. INTRODUCTION

1.1. Overview

This chapter first discusses definitions of the constructs of interest in this study; their theoretical foundations and importance in adolescence. Psychological distress and wellbeing, shame, narcissism, social rank and self-compassion have been the focus of detailed theory and research individually hence the second section focuses on relationships between the constructs. The two literature reviews are embedded here and initially explore shame, narcissism and social rank and their relationships to psychological distress and wellbeing, followed by self-compassion and its impact on adolescent psychological distress and wellbeing. These provide a rationale for the aims and research questions of the current study.

Psychological distress and psychological wellbeing will be referred to as 'distress' and 'wellbeing' from here on.

1.2. Adolescence

'Adolescence' from the Latin 'adolescere' means 'coming or growing to maturity'. It signals a significant, formative and transitional developmental period between childhood and adulthood comprising extensive biological growth and transitions in social roles (Blakemore & Mills, 2014; Curtis, 2015; Sawyer, Azzopardi, Wickremarathne & Patton, 2018; Steinberg, 2014), characterized by changes in neurology (Andersen & Teicher, 2008; Blakemore & Mills, 2014), increased and shifting social interactions (Spear, 2000) and changes in stress responses (Lyss, Andersen, LeBlanc & Teicher, 1999). However, there is a lack of consensus over an operational definition (APA, 2002; Curtis, 2015; Sawyer et al., 2018).

The concept of adolescence evolved during the late 19th century as a response to social phenomena, namely structural familial changes as part of the new industrial age (Bennett & Robards, 2013; Demos & Demos, 1969,). However it

is observed biologically in other species and may not be a human social construction as many argue (Crone & Dahl, 2012; Newcomb, 1996).

G. Stanley Hall's publication of *Adolescence* in 1904 is commonly viewed as the inception of 'adolescence' as a distinct area of research (Arnett, 2006), with clear Darwinian influence on his evolutionary and genetic model (Demos & Demos, 1969). He originated the term 'sturm und drang', describing adolescence as a time of "great turbulence and tumult" and a period of universal emotional and behavioural disturbance (Arnett, 1999; 2006). This view has been rigorously challenged (Bandura, 1972; Rutter, Tizard, Yule, Graham & Whitmore, 1976; Schneider & Stevenson, 1999). Ostgard-Ybrandt and Armelius (2004) argued that most adolescents have a positive experience of teenager years. However, whilst issues experienced during this time may not be pathological or require professional assistance, many confront psychological and behavioural problems (Bongers, Koot, van de Ende & Verhulst, 2003). Adolescence may not be a universally experienced period of great distress (Arnett, 1999) yet young people in Western cultures today face significant challenges as they transition to adulthood, negotiating changing familial relationships, mood instability, increased rates of risk taking behaviour and academic pressures (Allen & Allen, 2009; Larson & Sheeber, 2009; Swahn & Bossarte, 2007).

1.2.1. Biological Changes and Cognitive Development

Adolescence signals the most dramatic period of physical changes experienced outside the womb (Bennett & Robards, 2013), although there exists temporal variance with regards to onset and completion. Young people accommodate rapidly changing bodies leading to body image anxiety, comparison with others and emerging sexuality (Bennett & Robards, 2013). There is an increased sensitivity to pathological or psychiatric issues possibly due to interactions between novel environmental pressures and preprogrammed neural debt (Andersen & Tiecher, 2008). Stress can be experienced as qualitatively different than in other life stages and may last longer (McCormick, Mathews, Thomas & Waters, 2010).

The adolescent brain changes not only with regards to social cognition (ability to mentalise; greater intensity and awareness of social emotions such as guilt, embarrassment, shame and pride) and the social environment (Blakemore & Mills, 2014; Crone & Dahl, 2012) but also in the areas responsible for impulse control, emotional regulation and strategic planning (Bennett & Robards, 2013). Piaget (1950) identified emerging and increasing abilities in abstract thinking, namely self-reflection and preoccupation with how others perceive them.

1.2.2. Psychosocial Aspects

The central task in adolescence is to individuate from parental and familial influences to form a sense of identity (Bennett & Robards, 2013; Lapsley, 1993). This identity formation and development is critical for the 'self' (Erikson, 1968; Marcia, 1987) and can lead to the question 'who am I?' (Tanti, Stukas, Halloran & Foddy, 2011). Peer relationships supplant family influences and others' evaluation of self becomes paramount (Larson & Richards, 1991) hence peer rejection can indicate unworthiness (O'Brien & Bierman, 1988) which in turn, has a direct impact upon identity. This is further complicated by adolescence being a period of heightened sensitivity to environmental sociocultural signals (Blakemore & Mills, 2014), indicating the pivotal role social content and acceptance play via influence on a number of adolescent-typical behaviours (Blakemore & Mills, 2014). Hence, the increasing importance of technology and the impact of media (social and otherwise) can be added pressures for todays' adolescents (Strasburger, Wilson & Jordan, 2009).

1.2.3. Window of Adolescence

There is no agreement over the boundary ages that adolescence covers. The World Health Organisation (WHO, 2017) state adolescence as being 10-19 years, yet it is commonly seen as commencing with puberty, a biological process differing in timing across genders and generations (Crone & Dahl, 2012).

A current argument defines the ages as 10-24 years as this is more inclusive and arguably vital for 'developmentally appropriate' social policies, laws and services (Bennett & Robards, 2013; Sawyer et al., 2018). This is due to the belief that

adolescence now occupies a larger lifespan percentage, taking account of technological and societal changes occurring in the West (Bennett & Robards, 2013; Crone & Dahl, 2012). However, chronological age is only one way of defining adolescence (APA, 2002).

1.2.4. Mid-adolescence

Modern theorists have split adolescence into specific subgroups - early (12-14 years), mid (15-17 years) and late (18-21 years) (Harter, 1999; Kroger, 2000) as differing processes occur within each banding. Mid-adolescence is when the 'self' comes to the fore, constructed via social and cognitive processes. Harter (2012) identified this age group as having unstable and intense self-awareness, arguing it presents major developmental challenges wherein the adolescent is managing both separation (individuation from parents) and connection (maintaining appropriate familial relationships) whilst inventing new identities and creating their own narratives. Elkind (1967) proposed this age group as 'egocentric' due to self-focus and 'all-or-nothing thinking' situated around personal fables of omnipotence, perceptions of uniqueness and feelings of invulnerability (also referred to in the literature as 'narcissism', Aalsma, Lapsley & Flannery, 2006).

1.2.5. Developmental Theories of Adolescence

A detailed description of the myriad theories of adolescence is beyond the remit of this review however a brief explanation of the main theories is offered. Figure 1 shows the main proponents (Curtis, 2015).

Hall (1904) propounded a biosocial approach, expanding upon Darwinian (1859/1979) phylogenetic evolution. His theory of recapitulation suggests that development is a predetermined genetic process brought about by physiological factors (Curtis, 2015; Muuss, 1988). Darwin also influenced Freudian theories (1962), highlighting drives and instincts; unconscious and conscious processes; psychosexual stages of development and mechanisms of defence. Erikson (1968) developed a stage theory of identity development concerned with social rather than intra-psychic aspects.

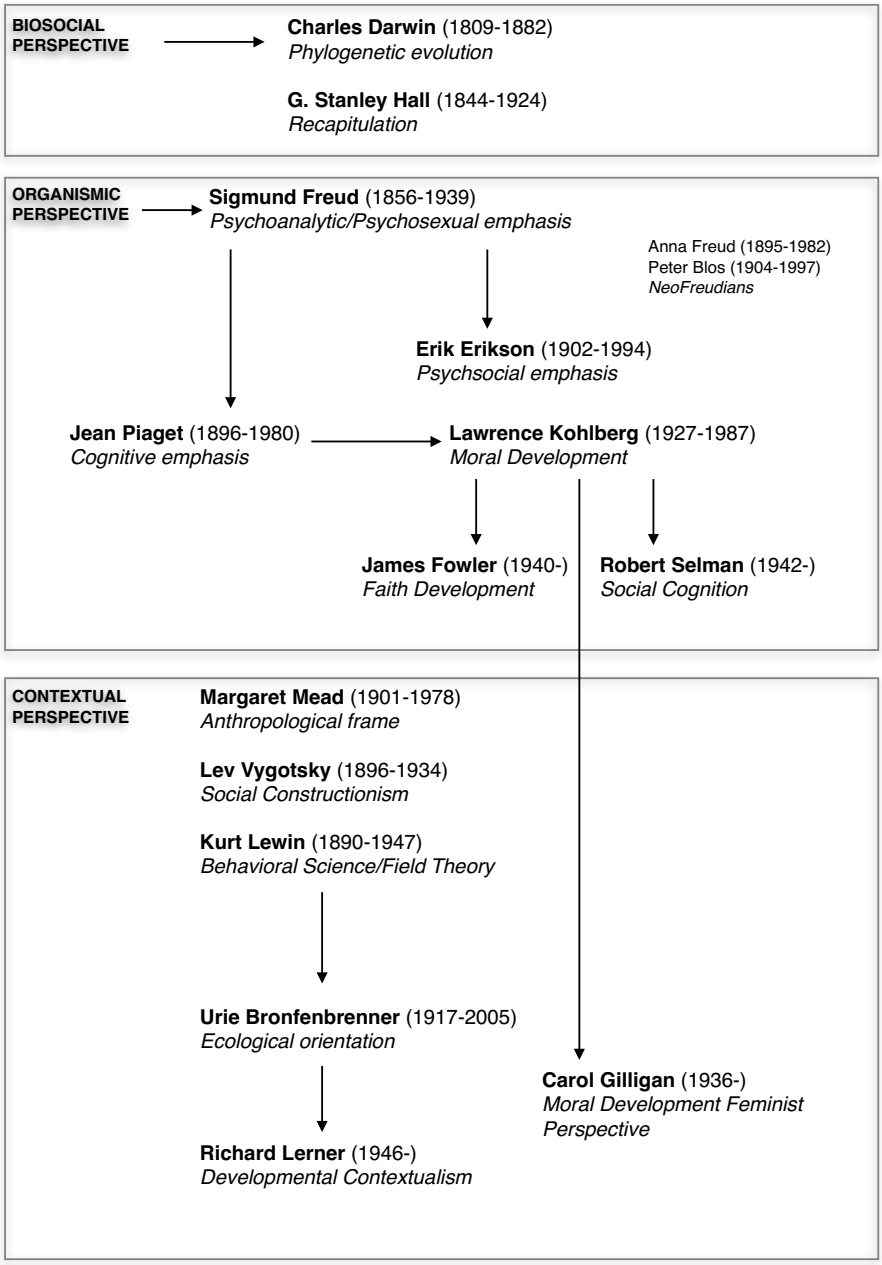

Figure 1 Classic Theoretical Perspectives of Adolescent Development, Curtis 2015

His eight stages are based on conflict of two opposing forces (in adolescence – identity vs identity confusion) focusing on the development and growth of cognition (Piaget & Inhelder, 2000). If the conflict is resolved satisfactorily then the positive aspect becomes assimilated and healthy development is augmented. However, if the conflict is unresolved then it may augur psychopathology (Muuss, 1988). Following on from Piaget, Kohlberg's (1980) theory of moral development expands the structural cognitive approach.

As a response to biological determinism, various theorists proposed ideas based on social and cultural contexts including Margaret Mead, Urie Bronfenbrenner and Richard Lerner (Muuss, 1988). These contextual theories have a significant role in defining adolescence (Curtis, 2015). Mead (1950) researched Samoan adolescents to see if adolescent distress ('storm and stress') was biologically or culturally determined. Although Mead's (1950) work has been criticised (see Freeman, 1983) it signified a shift in perspectives when physiological changes were seen as only one explanation for adolescent difficulties. Cultural; social pressures and expectations; educational and family factors may all contribute to adolescent distress. Lewin's (1939) Field Theory set the foundation for Bronfenbrenner's (1979) Ecological Theory of human development, highlighting the interaction between the person and their environment and the significance of context (Curtis, 2015). Lewin also influenced Vygotsky's (1978) social development theories which state that social learning precedes cognitive development and language enhances learning, preceding knowledge (Curtis, 2015; Powell & Kalina, 2009).

1.2.5.1. Critique of theories Developmental theories have been widely critiqued (Curtis, 2015; Hendry & Kloep, 2012), not least because they are ethnocentric and being generalized to Western cultures, ignore other cultures. Many theorists developed their ideas via White, middle class American males in the early to middle twentieth century (Gilligan, 1982; Hendry & Kloep, 2012) and many of the empirical studies have been carried out with White, middle class undergraduate populations (Lerner & Galambos, 1998; Ohye & Daniel, 1999) hence they may lack generalizability, are reductionist and gender biased (Jaffee & Hyde, 2000). Notably, research on adolescence in minority groups or differing cultures is lacking, hence caution is required when reporting findings (APA, 2002).

It is clear that no one theory can account for the developing adolescent throughout different cultural, economic and historical contexts (Berzonsky, 2000) and adolescence is a process that has biological drivers but is not absolute.

1.2.6. Mental Ill-health in Adolescence

The global prevalence of mental ill-health in young people is estimated at 10-20% (Patel, Flisher & McGorry, 2007) and predicts poor achievement educationally; substance misuse; poor physical health and conduct problems in later life (Patel et al., 2007). These figures present a serious burden to the global economy due to an estimated 15-30% of disability-adjusted life years lost to mental health issues when young (Kieling, Baker-Henningham, Belfer, Conti, Ertem, Omigbodun et al., 2011). Depression, anxiety and stress are reported as the most common mental health issues experienced by adolescents (Cummings, Caporino, & Kendall, 2014) hence these three indicators of distress have been chosen for this study. Prevalence rates of depression rise to between 9-25% (Boyle, Offord, Hoffman, Catlin, Byles, Cadman et al., 1987; Kessler, Avenevoli & Merikangas, 2001) with a gender bias towards females (60% to 40% female to male ratio), (Tilghman-Osborne, Cole, Felton, & Ciesla, 2008).

1.3 Definitions, Theories and Links to Adolescence

This section will explain definitions of the constructs of distress and wellbeing, followed by shame, narcissism, social rank and self-compassion with explanations of their relevance in adolescence.

1.3.1. Psychological Distress and Psychological Wellbeing

The Two Continua Model (Keyes, 2005) argues distress and wellbeing are related but distinct dimensional constructs. Wellbeing is not solely the absence of distress or mental ill-health but the presence of mental health (Keyes, 2005; WHO, 2014). These ideas have been replicated and research has supported the model (Compton, Smith, Cornish & Qualls, 1996; Greenspoon & Saklofske, 2001; Suldo & Shaffer, 2008; Westerhof & Keyes, 2010).

1.3.1.1. Psychological distress definition There is no clear, articulated, consensus-agreed definition of distress. It is, effectively, a blanket term describing various distressing symptomology ranging from depression and

anxiety through to functional disabilities and behavioural issues (Drapeau, Marchand, & Beaulieu-Prevost, 2012). Mirowsky and Ross (2002) define it as an emotional state characterized by symptoms of depression and anxiety; Wheaton (2007) suggests it is an emotional disturbance that has a negative impact on social functioning, hence studies have examined risk factors and protective components; distress is also used as diagnostic criteria for psychiatric disorders (Phillips, 2009; Watson, 2009). There are differences in how distress is viewed. Some argue it is transient in nature (Horwitz, 2007) and some suggest it is a moderately stable phenomenon (Wheaton, 2007).

1.3.1.2. Psychological wellbeing definition Wellbeing is a nebulous concept, hard to define and difficult to measure (Thomas, 2009). There is a surfeit of empirical research on psychopathology (Seligman & Csikszentmihalyi, 2000); however, the study of wellbeing is beginning to expand (Dodge, Daly, Huyton & Sanders, 2012). Many researchers believe it to be a multi-dimensional construct (Diener, 2009; Stiglitz, Sen & Fitoussi, 2009). The World Health Organisation (WHO, 2014) define a state of wellbeing as one "in which every individual realizes his/her potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his/her community".

There are two traditions of wellbeing research – the hedonic and eudaimonic perspectives (Ryan & Deci, 2001; Waterman, 1993). Hedonic is defined as emotional wellbeing (Keyes, 2007) and involves positive feelings/affect, absence of negative affects (Diener 1984; Diener, Suh, Lucas & Smith, 1999; Lyubomirsky & Lepper, 1999), hence satisfaction and pleasure in life lead to happiness (Delle Fave, Massimino & Bassi 2011). The eudaimonic perspective considers the importance and meaning of personal endeavours (Ryan & Deci, 2001; Ryff, 1989) and relates to the realization of potential and positive psychological functioning (Delle Fave, Massimi & Bassi, 2011; Ryff, 1989; Waterman, 1993). Westerhof & Keyes (2008; 2010) propose both hedonic and eudaimonic wellbeing operating in tandem define positive mental health (Huta & Ryan, 2010).

The UK Government has implemented measures of wellbeing for the UK. The Office for National Statistics (ONS) produced a paper on domains and measures of national wellbeing (Beaumont, 2011) stating 'wellbeing is an area which the national debate showed was important to people'. GDP (gross domestic product) is no longer the mark of a thriving nation, GNH (gross national happiness) may be a better mechanism of measurement (Leonhard, 2016).

1.3.1.3. Importance in adolescence As stated in 1.2.6.,10-20% of adolescents globally are experiencing symptoms of distress. Data for adolescent mental health in the UK is scant and outdated (Mental Health Foundation, 2015) with the most recent surveys carried out by the ONS in 1999 and 2004. Those surveys found 10% of children and young people (aged 5-16 years) had a clinically diagnosable mental problem, with prevalence of emotional problems (depression or anxiety) at 4%. These figures may not be indicative of current levels and may be higher due to the level of cuts made to health and social services and increasing pressure on education.

1.3.2. Shame

1.3.2.1. Shame definition and theories The source of the word 'shame' is from the French Teutonic root 'skam' meaning 'to cover oneself' (Harper, 2011). 'Shame' has been comprehensively researched and theorised across many disciplines and was seen as the "bedrock of psychopathology" (Miller, 1996, p151). However, there are divergent views about its constituent elements. Empirical testing requires particular methodologies that may not yet exist (Gilbert, 1998). This view is further elucidated by Blum (2008) who argues issues with reliability and validity within current methodologies are related to variation over definitions, approaches and methods of measurement.

The variety of shame theories span psychoanalytic approaches (e.g. Jacoby, 1994; Lansky 1992), affect-cognitive theories (e.g. Lewis, 1992, 1995b), cognitive behavioural theories (e.g. Beck, Emery & Greenberg, 1985), sociological and anthropological approaches (e.g. Goffman, 1968: Scheff, 1988). Some developmental psychologists believe it can occur during the first few months of life (Nathanson, 1992; Schore, 1994) yet others propose shame as a

social or self-evaluative emotion beginning at 2-3 years of age (Lewis, 1993, 1995a; Stipek, 1995). This is due to the cognitive ability for self-awareness coming 'on-line' around 18 months (Fischer, 1980).

Shame is a complex phenomenon and can be examined as a mechanism or via its component parts (Tangney, 1996); as an emotion (primary, secondary or composite); a cognition/belief about the self; behaviourally; as an evolved mechanism or through interpersonal relationships (Gilbert, 1998). It can also describe internal experiences, inter-relational occurrences and cultural practices (Gilbert, 1998). Blum (2008) argues shame involves affect, emotion and feeling. Whilst some view it as an emotion (Tangney, 1990, 1996) it remains controversial as to what kind of emotion shame might be (Gilbert, 1998). Emotions influence information processing, self-evaluation and self-regulatory behaviour (Ferguson, Stegge, Miller, & Olsen, 1999). Keltner and Buswell (1996) argue shame is a discrete, universal and 'self-conscious' emotion (see Ekman,1993; Tangney & Fischer, 1995; Tracy, Robins & Tangney, 2007), however, others disagree: Martens (2005) posits shame is a primitive, physiological response to rejection.

Self-conscious emotions are cognitively complex (Lagattuta & Thompson, 2007) and prompted by self-reflection and self-evaluation (Kim, Thibodeau & Jorgensen, 2011; Lewis, 1995b; Tangney & Fischer, 1995; Tangney, Stuewig & Mashek, 2007) originating from self-judgement (Blum, 2008). They are central motivators and regulators of thoughts, feelings and behaviours (Campos, 1995; Fischer & Tangney, 1995), requiring the ability to determine self from other (Lewis & Brooks-Gunn, 1979). Shame has a direct relationship to negative self-evaluation (Levin, 1971; Lutwak, Panish & Ferrari, 2003) not only for, and of, the individual i.e. the core self is believed to be defective, (Heaven, Ciarrochi, & Leeson, 2009) but also negative perception of the self in the minds of others (Mollon, 1984). Hence social survival may be related to the function of shame (Kim, Thibodeau & Jorgensen, 2011) and can be useful for maintaining and negotiating social relationships (Fessler, 2004; Gilbert, 1998). Levin (1971) states 'feelings of shame can cause one to want to hide and avoid interpersonal contact as a protection against rejection and conceal the affective experience from one's own awareness, shame generates concealment out of fear of

rendering the self unacceptable (Morrison 1983).

To encompass its multifactorial nature Gilbert (1998, 2002) forged the biopsychosocial model of shame, taking into account evolutionary and social motivational systems. Humans are motivated to seek attachments to others individually (Bowlby, 1969; Cassidy & Shaver, 1999) and in groups (Baumeister & Leary, 1995) and have concern about social standing within groups (Gilbert, 1992, 2002). This model informs the view taken on shame in this study.

1.3.2.2. The biopsychosocial model of shame Gilbert (2007a) argues the impact and quality of social relationships on the shaping of our minds and brains is powerfully influential, from birth (Gerhardt, 2004) and throughout life (Cacioppo, Berston, Sheridan & McClintock, 2000). Positive regard by one's social group is crucial to forming relationships that foster a sense of safety and connectedness (Duarte & Pinot-Gouveia, 2016) hence humans have developed capacities for self-conscious awareness (Tracy & Robins, 2004). This ability enables us to make predictions of 'how we exist for others' (Gilbert, 2007a). Hence the threat system can be triggered by experiences that are 'negative' (e.g. criticism, rejection, abuse, persecution) thereby endangering social position (Etcoff, 2003; Gilbert & Irons, 2009), consequently shame is the emotional response to exposure of failures or defects (Lewis, 1995b; Tangney & Dearing, 2002). Gilbert (2007a) states 'shame may be the price we pay for becoming such self-aware social beings' and is an evolutionary response thereby warning of our inability to engender positive representations of ourselves in others' minds. In order to protect ourselves from continuing or future rejection, exclusion or persecution we initiate responses and behaviours that are self-blaming and submissive (Gilbert, 1997, 2002, 2003, 2007a; Gilbert & Irons, 2009; Matos, Pinto-Gouveia & Costa, 2011). Gilbert suggests there are two main aspects of shame: external shame, and internal shame.

External shame (Gilbert, 1998; Gilbert, 2000a; Gilbert, 2007a) is how one believes themselves to exist in the minds of others: where the attentional and monitoring internal systems are focused externally on what others may think of the self. The need to create positive views of self in the minds of others is important in maintaining social bonds (Gilbert & Proctor, 2006) hence shame can

result from social comparison. Therefore external shame is linked to 'negative affect in the mind of others' towards us and can be associated with being rejected, criticized etc. requiring the recruitment of defensive responses to navigate this, through submission, avoidance, aggression etc.

Internal shame (Gilbert, 1998; Gilbert, 2007a) is negative attention focused on the self (as in 'I am flawed'). There are links to complex memory systems (past experiences of being shamed, Kaufman, 1989), negative self-evaluations and judgements (Gilbert, 2007b; Tracy & Robins, 2004) when self-criticism and self-persecution are internal processes that can involve feelings of anger and/or disgust towards the self (Gilbert & Irons, 2005; Whelton & Greenberg, 2005). When the attention on the self is directed inwards and the global self becomes an object of negative evaluation the individual feels small and exposed, producing a desire to hide and avoid others (Simonds, John, Fife-Schaw, Willis, Taylor, Hand et al., 2016; Andrews, Qian, & Valentine, 2002; Blum 2008; Ferguson, et al., 1999).

Shame proneness is the term used to describe predispositional differences in cognitive, affective and behavioural responses that occur in response to negative internal cognitions against the self (Lewis, 1971) and beliefs of the self as 'bad' (Tangney & Dearing, 2002). However it is less clearly defined than internal shame (Leeming & Boyle, 2004). Shame proneness has been found to be maladaptive (Tangney & Dearing, 2002; Woien, Ernst, Patock-Peckham, & Nagoshi, 2003) and can indicate vulnerability towards affective disorders (Blum, 2008). There are subtle differences between shame proneness and internal shame that have not always been acknowledged in research (Leeming & Boyle, 2004).

1.3.2.3. Shame in adolescence Adolescents experience a growing capacity for self-awareness and reflection. The biological, physical, cognitive and emotional changes, along with the growing social and emotional influence of peer groups, provide fertile ground for the development of shame, as adolescents aspire to group acceptance and belonging (Anastasopoulos, 1997) - this suggests a link between shame and social rank (see 1.3.4.). With this increased ability to self- and other-reflect, adolescents are more prone (than children) to ruminative

processes when an inward focus on the 'bad self' in shame becomes all-consuming. This can predict depression symptomology (Nolen-Hoeksema, 2000).

Rumination can be a product of the adolescent's increased ability to self-reflect and socially compare themselves. Joireman (2004) showed a moderate association between rumination and shame whilst Orth, Berking & Burkhardt (2006) evidenced rumination as a mediator between shame and depressive symptoms.

1.3.3. Narcissism

1.3.3.1. Definition and theories The word narcissism originates in Greek mythology and was first considered as a psychological construct by the psychoanalytic school with Freud's (1914) essay *On Narcissism* delineating it as a feature of 'normal psychodynamic development' (Lapsley & Stey, 2012). Much research exists in the psychoanalytic tradition however narcissism has had more recent consideration by social and personality psychologists studying its links with self-esteem and self-regulation (Brown, Budzek & Tamborski, 2009).

There is a lack of clear and accepted conceptualization of narcissism (Miller & Campbell, 2008) and much inconsistency and ambiguity in assessment (Cain, Pincus & Ansell, 2008; Miller & Campbell, 2008; Pincus, Ansell, Pimentel, Cain, Wright & Levy, 2009), however, Pincus & Roche (2011, p. 31) define it as 'one's capacity to maintain a relatively positive self-image through a variety of self-regulation, affect-regulation, and interpersonal processes, and it underlies individuals' needs for validation and admiration, as well as the motivation to overtly and covertly seek out self-enhancement experiences from the social environment' (see Pincus et al., 2009).

Miller and Campbell (2008) state the social personality perspective of narcissism is dimensional and not necessarily pathological. Social psychologists are interested in assessing 'normal' narcissism as an aspect of personality (Pincus et al., 2009). Non-pathological narcissism has been associated with positive psychological wellbeing and high self-esteem (Sedikides, Rudich, Gregg,

Kumashiro & Rusbult, 2004) via increasing personal agency (Oldham & Morris, 1995). Whilst pathological narcissism has been researched in depth, there is less empirical work examining the construct in adolescence (Barry & Ansel, 2011); certainly, the concept of 'normative' or 'adaptive' narcissism in adolescence requires more research (Lapsley & Stey, 2012).

1.3.3.2.Conceptualisation of narcissism Miller, Hoffman, Gaughan, Gentile, Maples & Campbell, (2011) state there is 'substantial heterogeneity' in the construct of narcissism. The psychoanalytic view is that it is a defence formed to protect the self from anxiety, frustration, separation, and disappointment (Blos, 1962; Lapsley & Stey, 2012; Rothstein, 1986), as well as a defensive form of self-esteem regulation (Raskin, Novacek & Hogan, 1991).

Many theorists view narcissism as having a vulnerability to shame (Broucek, 1991; Morrison, 1989). Shame is seen as the root of narcissistic self-regulation (Tracy, Cheng, Robins & Trzesniewski, 2009) and hence narcissism is a defence against shame (Lewis, 1980; O'Leary & Wright, 1986). Those vulnerable to narcissism may demonstrate anger, aggression, helplessness, emptiness, low self-esteem, avoidance of interpersonal relationships and suicide (Dickinson & Pincus, 2003; Ronningstam, 2005). However, Kohut (self psychology, 1971) posits a positive function, distinguishing narcissism as the 'cutting edge of the growing creative self' (Lapsley & Stey, 2012).

Narcissism is a paradoxical construct (Jordan, Spencer, Zanna, Hoshino-Browne & Correl, 2003) both within its affective and behavioural expression and the concurrent possibility for negative and positive social outcomes (Barry & Ansel, 2011), and subclinically is viewed similarly to other personality traits as being on a continuum (Besser & Priel, 2010; Miller & Campbell, 2008).

There are connections to social rank (see 1.3.4.) as outward grandiosity may conceal underlying feelings of inferiority which suggest narcissism is comparative. Insecurity about social competence is associated with increases in narcissism which in turn is related to the effort to construct, maintain, defend and enhance the desired self (Ronningstam, 2009).

Researchers have concluded that there are two sub-types of narcissism[1] – grandiose and vulnerable (Dickinson & Pincus, 2003; Gabbard, 1989; Gersten, 1991; Kohut, 1971; Miller et al., 2011; Wink, 1991).

1.3.3.3. Grandiose narcissism Pathological grandiose narcissism is characterized by behaviours that are arrogant; entitled; exploitative; envious; self-absorbed; reactive to criticism, to diminish the emotional responses to shame and disappointment in the self (Besser & Priel, 2010; Watson, Hickman & Morris, 1996; Watson, Morris & Miller, 1997). It is viewed as maladaptive when used to exert power over, or position oneself as 'better than' others (Barry, Frick & Kilian, 2003). Grandiose narcissism has an adaptive function when expressed as self-confidence, high self-esteem and the ability to take responsibility in decision-making (Barry & Ansel, 2011).

1.3.3.4. Vulnerable narcissism Some theorists believe pathological vulnerable and grandiose narcissism share similarities of association with grandiose fantasies about self, feelings of entitlement, and 'acceptable' exploitation of others for self-gain (Dickinson & Pincus, 2003). This 'covert grandiosity' in vulnerable narcissism however, may be related to measures of overt sensitivity (Besser & Priel, 2010).

Vulnerable narcissism is expressed through shyness and constraint, with seemingly empathic features, and inability to modify declining self-esteem (whereas those expressing grandiose narcissistic tendencies use more self-enhancement strategies). Bosson, Lakey, Campbell, Ziegler-Hill, Jordan and Kernis (2008) argue vulnerable narcissism can be related to intense feelings, shame proneness and high reactivity to distressing events. Others are depended upon for feedback to manage unstable self-esteem, hence having a fragile sense of self can create hypervigiliance to perceived social rejection (Besser & Priel, 2010) which then creates greater anxiety in relationships (Mikulincer, Kedem & Paz, 1990). This also shows a link to social rank (see 1.3.4.).

[1] There are varying terms that describe the two classifications however this study will use the terms 'grandiose' and 'vulnerable'.

1.3.3.5. Normative narcissism It is important to distinguish between pathological presentations and normative tendencies when discussing, assessing and testing the construct of narcissism (Bleiberg, 1994; Harter, 2012). Lapsley and Stey (2012) have stated six tenets to describe normative narcissism, namely 1) grandiosity without the exploitation of others; 2) illusions without a sense of entitlement; 3) expressions of invulnerability without shame; 4) a sense of omnipotence that doesn't risk isolation from others; 5) the desire for realistic admiration vs the unrealistic demands for attention and preening self-preoccupation and 6) positive affect and warm relationships with others vs derision, lack of empathy and envy. They argue there are clear boundaries between normal and dysfunctional narcissism (Cicchetti, 2016).

Benefits have been identified in normative narcissism (Sedikides et al., 2004) and evidence suggests a link between narcissism and wellbeing (Hill & Roberts, 2012) as well as greater life satisfaction. This finding was greater for adolescents than for adults (Hill & Roberts, 2012). Normative narcissism may also contribute to self-esteem and wellbeing via increasing personal agency (Oldham & Morris, 1995). It could be argued that adolescence is a time when a form of normative narcissism comes to the fore, functioning as a protective and beneficial factor and reducing with age.

1.3.3.6. Issues with the concept of narcissism Narcissism has been identified as 'one of the most important contributions of psychoanalysis' but the most confusing (Pulver, 1970). It has been described as a motivational state, a normal phase of development, an amalgamation of personality traits and a personality disorder (Krizan & Herlache, 2018). These disparate explanations give rise to the confusion around the concept and account for the lack of consensus. A recent paper posits the Narcissism Spectrum Model (NSM, Krizan & Herlache, 2018) – a synthesis of personality, social psychological and clinical evidence. This approach attempts to address the issues surrounding the construct and offers an account of narcissistic traits as combinations of approach-oriented (the grandiose traits) and avoidance-oriented (the vulnerable traits) 'qualities of entitlement and self-importance' (Krizan & Herlache, 2018). They position entitled self-importance at the centre of the construct which accounts for both grandiose and vulnerable aspects across the human spectrum.

The core for both aspects of narcissism is a 'sense of oneself and one's needs being special and more important than others' (Krizan & Herlache, 2018), occurring in both clinical and non-clinical populations. In adolescence this may be experienced as a dichotomy – the growing awareness of self positioned against the need to belong and be accepted by their peers. The NSM amalgamates the differing views surrounding the construct of narcissism and positions it on a spectrum of narcissistic traits, as opposed to narcissistic personality disorder being a separate entity to normative narcissism (Krizan & Herlache, 2018).

1.3.3.7. Narcissism in adolescence The process of individuation during mid-adolescence, and the progression towards autonomy that runs concurrently with a need for physical and emotional parental/familial connection (Harter, 2012; Waddell, 2006) may be experienced as a separation. The result of this might be anxiety and be compensated for by a narcissistic inflation of the self (Hill & Lapsley, 2011; Rothstein, 1986). Consequently, narcissism plays a role in assisting the adolescent to meet these developmental and social demands. Perceiving the self as omnipotent and unique may smooth the transition and process of individuation (Blos, 1962; Hill & Lapsley, 2011; Hill & Roberts, 2011).

Adolescent egocentrism as explained by Elkind's (1967) constructs of the personal fable and the imaginary audience is seen as part of normal adolescent narcissism (Hill & Lapsley, 2011). The 'personal fable' is a belief in personal uniqueness and the sense that 'nobody understands me', (consisting of subconstructs of subjective omnipotence, personal uniqueness and invulnerability). The 'imaginary audience' describes a feeling of being the focus of attention in everyone's minds. These both contribute to feelings of isolation, increased self-criticism and emotional over-identification (Neff, 2003a) and are argued to coexist alongside the separation-individuation process (Hill & Lapsley, 2011). However, the personal fable and related constructs have been heavily criticized (Lapsley, 1993; Lapsley & Murphy, 1985; Lapsley & Rice, 1988) including the notion that there are differential implications for outcomes of the subconstructs. Aalsma et al., (2006) established that ideas of personal uniqueness were associated with depressive symptoms and suicidal ideation for adolescents whereas feelings of omnipotence were beneficial. They showed the

personal fable constructs are differentially experienced with both successful management of self at one level and dysfunction at another (see Goossens, Beyers, Emmen & van Aken, 2002; Schonert-Reichl, 1994).

1.3.4. Social Rank Theory (SRT)

1.3.4.1. Definition and theories SRT (Gilbert, 1989, 1992) is an evolutionary theory with its focus in relational social power (Puissant, Gauthier & Van Oirbeek, 2011). All social species have specific behavioural displays and signals to denote and manage conflict and threat (Gilbert & Miles, 2000). SRT operates via cognitive mechanisms (social comparison), behavioural mechanisms (submissive behaviour) and emotional processes (shame) (Puissant, Gauthier & Van Oirbeek, 2011).

Festinger (1954) developed the comprehensive theory of social comparison marking it as a crucial variable in social relationships (Gilbert, Price & Allan, 1995) for individuals (Wood, 1989) and groups (Pratto, Sidanius, Stallworth & Malle, 1994). Explanations about why people socially compare themselves are myriad (Suls & Wills, 1991) however, it is a process of internal comparative self-evaluation designed to delineate the self and diminish uncertainty (hence increase feelings of safety) in social relationships. The link between the costs of social conflicts and the effects of social rank on mood states was first investigated by Price (1972).

Social threat in humans is related to loss of approval/acceptance. We have evolved as social beings with a need for kinship and belonging (Bailey, 1988; Bailey, Wood & Nava, 1992) and with an associated desire to avoid feelings of inferiority and shame (Gilbert, 1997). Social evolution has led us to believe certain traits and abilities are more attractive to others (Barkow, 1989; Gilbert, 1989, 1997; Kemper, 1990) which in turn will provide social acceptance and safety. Therefore behaviours that are both ‘acquisitive and defensive’ (Gilbert, 2000a) are focused on the wish to obtain, or the fear of losing, our presumed ‘attractiveness’ in others’ minds (Gilbert, 1992, 1997, 2000a, 2000b), which then result in either assertive or acquiescent behaviours (Gilbert & Allan, 1994).

Two strategies have been identified to gain rank in social groups, namely aggression and attraction. Whilst aggression is common in animals, humans tend to favour attraction (Barkow, 1989; Gilbert, 1989). Being perceived as socially acceptable and of value to others is more advantageous than threatening others (Gilbert, 2000a).

1.3.4.2. Social comparison Wood (1996, p521) defines social comparison as 'the process of thinking about information about one or more other people in relation to the self'. It can provide the foundation for aggressive social competition and the regulator of attraction and is an important mediator of our social and emotional experiences and self-esteem (Suls & Wills, 1991; Wood, 1989). Those who judge themselves to be superior (or equal) to others can feel less socially inhibited (Price, 1988).

Negative social comparisons may signal the potential loss of affiliation to the group and this is associated with anxiety as marginalisation, group expulsion and/or the loss of support becomes conceivable (Gilbert, Price & Allan, 1995). If we are seen by others as inferior, the consequences of this may mean we are excluded from potentially benevolent relationships (Gilbert, McEwan, Bellew, Mills & Gale 2009). Hence our social status will be constantly under self-surveillance in comparison to others (Barkow, 1989).

1.3.4.3. Submissive behaviour Submissive displays are responses with physical expression including gaze avoidance, crouching, submissive body postures, lowered voice tone (Gilbert & Allan, 1994) and are mostly associated with perceptions of low or inferior social status in conflictual situations. They are an evolved, protective, defence strategy (MacLean, 1990) used towards superior-ranking others as a way of avoiding or ceasing attack (Gilbert, 1992; 1993; Gilbert & Allan, 1994; Keltner & Harker, 1998).

The fear of losing social status (not being seen to be 'attractive' and therefore inferior) can actuate submissive behaviours. Submissive behaviour is linked with shame as shame is associated with a loss in status (Gilbert, Pehl & Allan, 1994; Kaufman, 1989) and can induce avoidance behaviours (Lewis, 1987). The view of self as inferior, unwanted and outcast from the group is termed involuntary

subordinate self-perception (Gilbert, 1992, 2000b). The unwanted/involuntary nature of the inferior status is critical. From this lowly position there is a greater propensity to behave submissively (Gilbert, 2000b). Submissive behaviours are paradoxical because they can protect the self by de-escalating conflict situations and promote rejection of self as submissive behaviours can be viewed by others as unappealing (Morf, Torchetti & Schurch, 2011).

Price (1969) stated that defensive behaviours are the 'crux' of SRT – the loser of the fight needs to signal retreat to the victor. This primitive ability functions in challenge situations and as a confidence regulator, consequently favourable and self-enhancing social comparisons can also boost self-belief (Gilbert, Price & Allan, 1995).

1.3.4.4. Social rank in adolescence Peer affiliation becomes of prime importance during this critical period as individuation occurs, allegiances are transferred from family/parental systems to peer groups and a changing identity is moulded (Eccles, Wigfield & Schiefele, 1998). These crucial shifts in interpersonal relationships precipitate changes in perceptions of rank and social status hence the actual and imagined evaluation of others becomes increasingly significant (Simonds et al., 2016). This signals an increase in vulnerability to psychological distress (Oldehinkel, Rosmalen, Veenstra, Dijkstra & Ormel, 2007).

Social comparison is a predominant process in adolescence as 'horizontal' relationships increase (Singelis, Triandis, Dharm & Gelfand, 1995) resulting in an escalation in direct social comparison between self and others and increased sensitivity to perceptual rank in relation to peers (Puissant, Gauthier & Van Oirbeek, 2011). Seltzer (1989) sees this as related to the adolescent process of self-formation rather than self-re-evaluation in later adulthood.

1.3.5. Self-Compassion

Self-compassion, a recent concept in Western psychology, developed out of Eastern traditions (Neff, 2003a). Self-compassion research was originally conducted by Neff (2003) and empirical research is expanding (MacBeth & Gumley, 2012).

1.3.5.1. Definitions Various definitions abound and the one employed for this study is 'sensitivity to the suffering of the self and others; with a deep commitment to try and alleviate and prevent it' (Dalai Lama, 2001; Gilbert, 2010, p3). This definition states compassion is 'of the self' and others, and self-compassion is concerned with awareness of, and sensitivity towards, one's own suffering, without disconnection or avoidance. Neff (2003a) argues it also involves attenuation of our own suffering and treating or healing self with kindness (Neff, 2003a).

Neff (2003a) states the 'common human experience' is the juxtaposition of active non-judgement of self or one's perceived 'failures', and our understanding we are contextually part of a 'shared fallibility'. Neff's (2003a) work on self-compassion developed from criticisms of the construct of self-esteem being central to psychological health (Baumeister, Smart & Boden, 1996; Crocker & Park, 2004; Hewitt, 1998; Neff, 2003a; Seligman, 1995). Self-esteem involves evaluations of self-worth obtained via comparisons and judgements (Harter, 1999; Neff, 2003a), including views of others' evaluations (Aspinwall & Taylor, 1993; Suls & Wills, 1991). Self-esteem is hard to elevate and 'resistant to change' (Swann, 1996). Hence the concept of self-compassion is one of several alternatives used to measure wellbeing (Bennett-Goleman, 2001; Kornfield, 1993; Rosenberg, 1999; Salzburg, 1997). Compassion functions to curb over-identification with thoughts and emotional reactions (which block the paths to alternative emotional responses or thoughts - Bennett-Goleman, 2001) thus creating 'mental space' (Neff 2003a) for kindness to be introduced.

1.3.5.2. Theories There are three different approaches to compassion incorporating differing ideas. Goetz, Keltner and Simon-Thomas (2010) see compassion as located in compassion-based affective conditions such as sympathy, empathy and pity. They suggest compassion is an evolutionary product, a beneficial and desirable trait that developed as a caregiving strategy, helpful in terms of 'cooperative relations between non-kin'.

However, Gilbert (2009, 2014) suggests compassion is motivational not emotional. He incorporates the evolutionary concept with the Buddhist tradition,

but presents it as a secular theory. Gilbert (2014) states compassion is linked to two different mindsets. The first explains the drives, abilities and the willingness to perceive, participate with and accept suffering rather than evade or disconnect from suffering in self and others. The second is action-based and involves the mastery and sagacity of how to surmount suffering (Germer & Siegle, 2012). His theory includes competencies such as care for wellbeing, sympathy, distress tolerance and non-judgement.

Neff (2003a) also explains compassion as part of a system of motivational constructs, and utilizes Buddhist tenets to explain the construct in a secular way. These are: loving-kindness, sympathetic joy and equanimity (Buddhaghosa, 1975; Hofman, Grossman & Hinton, 2011). Neff (2003a) states there are three inter-related binary components (i.e. the concept along with its negation), namely i) self-kindness rather than self-criticism; ii) common humanity – acknowledgement that our experiences are a part of the human condition (i.e. we all experience suffering sometimes) as opposed to seeing them as isolating, iii) mindfulness as opposed to overidentification with or avoidance of feelings (Barnard & Curry 2011; Neff, 2003a). Neff (2003a) argues the concepts are distinct from each other yet interact and intersect on different levels that both enhance and generate each other, for instance, mindfulness is required to create the distance from thoughts/feelings that can then allow feelings of self-kindness to emerge, and can also help reduce self-criticism and increase self-understanding (Joplin, 2000).

1.3.5.3. Compassion in adolescence Adolescence is the period in the lifespan when self-compassion is likely to be lowest (Neff, 2003a). The increased introspection, self-awareness and ability to determine differing social perspectives (Keating, 1990) can lead adolescents to perpetually self-evaluate in comparison to others as they seek to establish new identities and positions in the social hierarchy (Brown & Lohr, 1987; Harter, 1999). These comparisons and evaluations are often self-critical (Harter, 1993; Simmons, Rosenberg & Rosenberg, 1973; Steinberg, 1999). Adolescent self-absorption or egocentrism (Elkind, 1967) may be instrumental in increasing self-criticism, feelings of isolation and emotional over-identification (Neff, 2003a), which is an explanation for why self-compassion may be absent or reduced in adolescence.

1.4. Relationships Between Constructs and Their Impact in Adolescence

The preceding section discusses the constructs of interest in this study (namely, shame, narcissism, social rank and compassion) along with explanations of psychological distress and wellbeing and their relationships to adolescence. The section that follows reviews the existing literature firstly for shame, narcissism and social rank, and secondly for self-compassion. Whilst it is expected that shame, narcissism and social rank may be more linked to distress this study seeks to understand the connections between the constructs and their relationships to distress as well as wellbeing. The sections are separated in this way as self-compassion is viewed as a construct that may have an over-riding positive effect on the inter-related triad of shame, narcissism and social rank.

1.4.1. Relationships Between Shame, Narcissism, Social Rank, Distress and Wellbeing and Their Impact in Adolescence

There is much research examining the above constructs, their relationships with each other and their role/impact in adolescence, however, there is no research to date that links all the concepts together.

The following review will discuss identified studies examining shame in adolescence; shame and narcissism in adolescence, and shame and social rank in adolescence, and their subsequent effects and relations to distress and wellbeing (Appendix A).

1.4.1.1 Shame and distress in adolescence Studies have shown relationships between shame and anxiety; low self-esteem; eating disorders; anger at self; narcissism and depression (Andrews, Brewin, Rose, & Kirk, 2000; Beck, 1967; Ferguson et al., 1999; Tangney, Wagner, Fletcher, & Gramzow, 1992). Childhood and adolescent shame experiences are key elements in the development of sense of self and associated 'life-story' (Duarte & Pinto-Gouveia, 2016). As such, shame experiences influence the day-to-day ongoing inferences people make and their expectations, impacting on social interactions (Berntsen & Rubin 2006; Pinto-Gouveia & Matos 2011), (links to SRT). Early shame experiences can have deleterious effects and research shows a correlation

between early shame memories and depression (Cunha, Matos, Faria & Zagalo, 2012; Matos & Pinto-Gouveia, 2010; Matos, Pinto-Gouveia & Duarte, 2012; Matos, Pinto-Gouveia & Gilbert, 2013). Other studies show a positive relationship between shame and depressive symptomology (Åslund, Nilsson, Starrin, & Sjoberg, 2007; Stuewig & McCloskey, 2005; Tilghman-Osborne et al., 2008).

Shame-related threats to the social self which increase during adolescence trigger HPA (hypothalamic-pituitary-adrenal) axis activation and inflammatory immune processes (Dickerson, Kemeny, Aziz, Kim & Fahey, 2004), these biological alterations are also present in depression (Holsboer, 2000; Schiepers, Wichers & Maes, 2005).

Longitudinal studies on adolescents have shown direct, strong relationships between shame or shame proneness and various types of distress. Tilghman-Osborne et al., (2008) found shame and characterological self-blame (CSB) were strongly related to depressive cognitions and symptomology with shame having a greater association than CSB. They also found longitudinally that depressive symptoms predicted subsequent levels of shame and CSB, although they suggested shame and CSB as consequence rather than cause of depression. Shame and CSB are argued to be maladaptive as shame increases vulnerability towards depressive symptomology, feelings of anger and other forms of psychopathology; and CSB promotes rumination. This can predict depression symptomology (Nolen-Hoeksema, 2000).

Tangney and Dearing (2002) conducted a longitudinal study with adolescents and found greater shame proneness predicted higher drug and alcohol use; more suicide attempts; more unsafe sexual practices and fewer college applications. Stuewig and McCloskey's (2005) longitudinal study identified a link between child maltreatment and adolescent shame proneness, with an association between shame proneness and symptoms of depression. A similar finding was reported by De Rubeis and Hollenstein (2009) with shame proneness a significant predictor of depressive symptoms (accounting for 30% of the variance) with avoidant coping as a significant partial mediator. Their analyses showed shame proneness and depressive symptoms were moderately

stable over time. They suggest the coping mechanisms are an important predictor in depression and used the TOSCA-A (Tangney, Wagner, Galvas & Gramzow, 1991) hence there was no differentiation between the various aspects of shame.

External and internal shame are inter-related, however, external shame is more linked to depressive symptoms (Leary, 2004, 2007) due to the relationship between the possible loss of social status and subsequent rejection. Research suggests a stronger relationship between external shame and depressive symptomology than internal shame, however this is based on a small number of studies (11) that used the Other as Shamer Scale (OAS, Allan, Gilbert & Goss, 1994; Goss, Gilbert & Allan, 1994*).* Other properties of this scale may account for the strong associations (Kim, Thibodeau & Jorgensen, 2011). Cunha et al., (2012) identified external and internal shame as significant mediators of the effect of shame memories on depression and anxiety, however external shame showed a more powerful effect than internal shame. This supports the view that adolescence is a time when the internal focus is externally driven (i.e. 'how am I viewed by others?') as the task of constructing the self is related to interactions with others. It also validates the biopsychosocial model of shame in adolescence.

1.4.1.2. Narcissism and its relationship to shame and distress in adolescence

Bleiberg (1994, p. 31) states, "…the passage through adolescence bears the hallmarks of narcissistic vulnerability: a proneness to embarrassment and shame, acute self-consciousness and shyness, and painful questions about self-esteem and self-worth." Shame is a common 'unintented consequence' to the adolescent's increasing self-awareness and self-consciousness (Ryan & Kuczkowski, 1994).

Kohut (1971) viewed shame as developmentally important to the expression of narcissism, as a response to the 'narcissistic wound', however, Lewis (1980) argued it was a causal factor rather than a response. Hence narcissism is a response mechanism through which to manage shame (Morrison, 1989). Broucek (1982) consolidated both perspectives contending shame is both

response and stimulus and attested to shame being the ‘keystone affect’ in narcissism (Wright, O’Leary & Balkin, 1989).

Much empirical work on narcissism in adolescence examines the links between self-esteem and aggression, especially in adolescent males (see Thomaes, Bushman, Stegge, & Olthof, 2008). The majority of research studies and theoretical papers on narcissism are from the psychoanalytic tradition; however, there are increasing explorations from social psychology. There are fewer research papers looking explicitly at narcissism from a developmental perspective (Hill & Lapsley, 2011), this may be due to the task of conceptualizing narcissism into the normative non pathological developmental processes involved in adolescence. Normative narcissism may be the form experienced developmentally in adolescence. However, it is still unclear how this type of narcissism is differentially determined (Hill & Lapsley, 2011).

Recent research pinpoints narcissism as more prevalent in current younger generations than past and narcissistic tendencies towards self-perception are increasing in current Western societies (Barry & Ansel, 2011; Twenge & Campbell, 2003; Twenge, Konrath, Foster, Campbell & Bushman, 2008). This may be related to the explosion of social networking sites (Buffardi & Campbell, 2008). However, Trzesniewski, Donnellan, & Robbins, (2008a, 2008b) refute Twenge et al’s. (2008) study outlining several methodological and conceptual issues (eg limitations of using convenience samples).

The personal fable and related constructs as discussed in 1.2.4. have been heavily criticized (Lapsley, 1993; Lapsley & Murphy, 1985; Lapsley & Rice, 1988) including the notion that there are differential implications for, and outcomes of, the subconstructs. Aalsma et al.,(2006) established that ideas of personal uniqueness were associated with depressive symptoms and suicidal ideation for adolescents whereas feelings of omnipotence were beneficial. They showed the personal fable constructs are differentially experienced within adolescent narcissism with both successful management of self at one level and dysfunction at another (see Goossens et al., 2002; Schonert-Reichl, 1994).

There is evidence to show some forms of narcissism are not stable constructs and decline from adolescence into adulthood (Carlson & Gjerde, 2009). Carlson and Gjerde's (2009) study showed a significant increase of narcissism from aged 14-18 followed by a non-significant decrease from 18-23. This suggests raised and/or increasing levels of narcissism during the adolescence phase of development indicate a normative function. Adolescents are more likely to score higher on narcissism measures than older participants (Foster, Campbell & Twenge, 2003).

1.4.1.3. Social rank and its relationship to shame and distress in adolescence

Research is scant in this area and the few papers identified examined the effect of attachment on social rank and distress in adolescence. One paper was identified that examined relationships between self-criticism, submissive behaviour and depression and will be included in this review. No papers were identified that studied wellbeing and positive social comparison in adolescence. Hence literature presented here is drawn from undergraduate and adult studies.

Being viewed or perceived as socially unattractive can lead to shame and resentment, social anxiety, anger and depression, and can be triggered by the sense of being put down or being negatively judged by perceived powerful others. These judgements can trigger shame and resentment (Broucek, 1991; Gilbert, 1992) and a feeling of social insecurity which is also linked to psychopathology (Gilbert, McEwan, Mitra et al, 2009; MacDonald & Leary, 2005). Conversely, positive social comparison and feeling socially secure is advantageous to wellbeing, physical and mental health (Baumeister & Leary, 1995; Cozolino, 2007), and it is important to note peers can be a major source of support and form the basis of a new sense of belonging (Buhrmester, 1996).

Shame has been identified as an important component of social rank and can come from external sources (in aggressive behaviours used to reduce another's unattractiveness) as well as internal processes believing one is flawed and worthless and the perception that others believe this too (Gilbert, 2000b). Existing literature outlines the connection between shame and social rank, highlighting the issues with loss of social status or low status in the social

hierarchy which are strong indicators of depressive symptomology (Gilbert & McGuire, 1998; Fournier, 2009; Sloman, 2008; Sloman, Gilbert & Hasey, 2003).

Social status takes centre stage during this period both cognitively and physiologically - socioaffective sensitivity has been witnessed in neural circuitry (Somerville, 2013). Whilst positive social comparison can have a protective function, negative social comparison is a principal component in depression (Swallow & Kuiper, 1988), and has been linked to psychopathology (Furnham & Brewin, 1988; Gilbert & Trower, 1990); stress (Buunk & Hoorens, 1992) and shame attacks due to the loss of social status and viewing self as inferior, feeling damaged and lacking in self-worth (Gilbert, 1990; Kaufman, 1989). Allan and Gilbert (1995) found poor social comparison was associated with higher levels of interpersonal sensitivity, depression and hostility. Admittedly these studies were on adult populations however it is possible the impact is similar for adolescents.

Submissive behaviours are associated with interpersonal issues and depression proneness (Gilbert, Allan & Goss 1996); social anxiety; substance misuse; eating disorders and psychosis (Johnson, Leedom & Muthadie, 2012; Sturman, 2011). Giacolini et al. (2013) found submissive behaviour was linked to vulnerability and mental health issues in both clinical and non-clinical Italian student groups (see Irons & Gilbert, 2005). Their study supported the theory that involuntary subordination and subsequent feelings of inferiority and marginalization are linked to depression and anxiety (Gilbert, 1992; Gilbert et al, 2009).

The focus on social power within relationships is paramount for adolescents who are generally hyper-sensitive to issues of comparison, submission and feelings of inferiority in relation to their peers (Pinna Puissant, Gauthier & Van Oirbeek, 2011). Peer rejection can become common in adolescence (Wang, Iannotti & Nansel, 2009) and perceived loss of status will likely induce feelings of shame (Gilbert, Pehl & Allan, 1994; Kaufman, 1989) as well as depressive symptoms (Pinna Puissant, Gauthier & Van Oirbeek, 2011) as a response to the loss of rank and belief in oneself as inferior. This corresponds with the ‘sociometer theory’ (Leary, 2005) which suggests that psychological distress can be caused by a lack of acceptance. Hence negative and humiliating interpersonal experiences (e.g. bullying) can lead to external and internal threats of loss of

acceptance and belonging (Leary, 2005; Sloman, 2008). This can lead to involuntary subordination; mental health issues (Rigby, Slee & Martin, 2007) and depression (Aslund, Nilsson, Starrin & Sjoberg, 2007).

Gilbert (2000b) argued the viability of the connection between shame (internal, external and shame proneness) and social rank suggesting that experiences of shame relate to mechanisms of underlying submissiveness. He posited that perceptions of inferiority have direct influence on emotion, precipitating involuntary submissive behaviours. Loss of approval from others can trigger these submissive behavioural strategies along with social anxiety, shame and depression. Gilbert (2000b) found shame, social anxiety and depression correlate highly with submissive behaviours and feeling inferior. However, this does not show causation and the temporal relationships between these variables is unclear. Similarly, Ongen (2006) argued adolescents have a greater susceptibility to external standards and are at risk of depressive symptomology when they compare themselves critically to others. Whilst his paper highlighted cultural differences around self-criticism (the Turkish students were affected negatively by comparative self-criticism as opposed to internalized self-criticism, in contrast to Western students, see Thompson & Zuroff, 2004) he found submissive behaviour predicts depression, suggesting this may be more universal than culturally specific.

Irons and Gilbert (2005) contended social rank plays an important role in predicting adolescent depression and anxiety symptomology even when controlling for the significant impact of attachment style. They posited differential relations between the social rank factors and distress in adolescence, namely that social comparison was linked to depression and submissive behaviour to anxiety.

Despite clear evidence suggesting negative social comparison and submissive behaviours are linked to shame and distress, there is evidence that positive social comparison is linked to enhanced wellbeing (Diener & Fujita, 1997). Classical social comparison theory suggests those who make positive social comparison to others (i.e. believe themselves to be better than others) have higher wellbeing (Diener & Fujita, 1997; Wills, 1981; Wood, Taylor & Lichtman,

1985). However recent literature has found individual differences in social comparison styles (Buunk & Gibbons, 2000) that argue frequent social comparison is related to negative affect (Lyubomirsky & Ross, 1997; Lyubomirsky, Tucker, & Kasri, 2001). Whilst research suggests these ideas have validity for adults the lack of empirical research with adolescents means caution should be applied as there may be developmental issues for adolescents resulting in differing findings.

1.4.2. Summary

The existing evidence suggests clear relationships between shame and social rank, shame and narcissism and their differing impacts on distress and wellbeing in adolescents. There are no studies examining both social rank and narcissism in adolescents, however the comparative nature of adolescent egocentrism suggests a link between the two constructs and hence highlights a gap in the literature. There is a need for further exploration of all these constructs, their modes of operation and interaction particularly during mid-adolescence, a pivotal time of self-awareness.

As previously argued, adolescence is a critical period when young people are more vulnerable to shame, social comparison and normative narcissism which could lead to distress. Evidence suggests rising rates of distress in adolescents and increases in narcissism. However this is contentious as narcissism as a construct is complex and confusing − differences between normative and pathological narcissism are not clearly delineated (Hill & Lapsley, 2011); narcissistic experiences of mid-adolescence may need re-labelling, and evidence suggests narcissism rises during mid-adolescence and falls post 18 years suggesting normative narcissism is part of 'normal' adolescence (Carlson & Gjerde, 2009).

Adolescence can be paradoxical - risks for psychopathology rise (mortality increases 200% during this time, Dahl, 2001); however, adolescents are physically stronger with better cognitive skills than children. Two constructs under review are also paradoxical. Social rank and narcissism both have aspects that can enhance wellbeing (positive social comparison and some

aspects of grandiose narcissism) or trigger/increase distress (submissive behaviour and some aspects of vulnerable narcissism). Evidence suggests they are both complex and complicated constructs and their measurement is therefore an important issue.

This review identifies narcissism as a defence against shame, which in turn can be triggered by negative social comparison resulting in submissive behaviours. There are no empirical papers examining this process, hence identifying a gap in knowledge.

Many empirical studies used measures conflating shame and guilt (e.g. TOSCA, TOSCA-A, Tangney et al.,1991) suggesting a need for greater delineation of shame to determine the likely effects of all aspects. Several studies show external shame, more than internal shame, as predictive of depressive symptomology.

Reviewing these studies identified gaps in current knowledge. Exploration examining which combination of specific aspects of shame, social rank and narcissism predict distress and wellbeing in adolescents is currently required.

1.4.3. Relationships Between Self-Compassion, Wellbeing and Distress and Their Impact in Adolescence

The same approach as above was employed to determine relevant articles for the second narrative review, (Appendix B for further information). This review will discuss extant literature on self-compassion, adolescence, and wellbeing and distress. The following is a narrative account of the identified literature. Research in this area is rapidly expanding both in adult and adolescent populations.

All identified papers used the SCS or SCS-SF (Self-compassion scale, Self-compassion scale short form, Neff, 2003b; Raes, Pommier, Neff & Van Gucht, 2011). Many of these used a composite score containing reverse-scored negative items. However recent evidence demonstrates these negative items are not reflective of self-compassion (Brenner, Heath, Vogel & Crede, 2017;

Lopez et al., 2015; Muris, 2016). Brenner et al., (2017) identify the negative items as 'self-coldness' and state they are related to negative psychological outcomes (i.e. depression, anxiety and stress) by triggering the threat system, whereas the positive aspects (self-compassion) relate to positive psychological outcomes such as wellbeing (via triggering of the safety system). Muris (2016) argues for removal of negative items and for self-compassion to be assessed specifically using the positive aspects of the scale. Hence there is a contentious issue with measurement in the identified literature.

1.4.3.1 Compassion and psychological distress in adolescence Studies investigating relationships between self-compassion and distress in adolescents have been minimal but are growing exponentially (Muris, Meesters, Pierik & de Kock, 2016; Xavier, Pinto-Gouveia & Cunha, 2016). The current research findings mirror those of adult samples (Macbeth & Gumley, 2012; Marsh, Chan & Macbeth, 2017).

Neff and McGehee's (2010) study with adolescents found low levels of self-compassion were significantly related to higher levels of anxiety and depression symptoms. They found support for an association between self-compassion and egocentrism, as those who exhibited personal fable behaviours also had lower reported levels of self-compassion, suggesting those who identify experiences as 'unique' have lower wellbeing. One feature of self-compassion is recognition that suffering is a part of life. Without the understanding that failures and distress are part of the human condition it is harder to feel compassion for the imperfection and inevitable losses. The sense of isolation this can engender may also compound self-blame and self-criticism, further decreasing self-compassion.

Marsh, Chan and Macbeth (2017) carried out a meta-analysis examining self-compassion and distress in adolescents. They identified 19 suitable papers (N=7049) and found an inverse relationship between self-compassion and anxiety, depression and stress (r=-.55; 95% CI -.61 to -.47), replicating results found in adult samples. These results suggest a lack of self-compassion is an important component in maintaining and/or causing psychological distress in adolescents.

Several papers found older adolescent females have the lowest levels of self-compassion compared to younger females and males (Bluth & Blanton, 2015; Bluth, Campo, Futch & Gaylord, 2017; Castilho, Carvalho, Marques & Pinito-Gouveia, 2017; Sun, Chan & Chan, 2016) with age moderating the association between anxiety and depressive symptoms and self-compassion (Bluth et al, 2017; Muris et al, 2016). This coincides with a reported increase in depression in older adolescent females (Nolen-Hoeksema & Hilt, 2009). The gender difference may be explained by Elkind's (1967) personal fable and imaginary audience theories, as metacognitive abilities increase during adolescence. Female adolescents are more prone to rumination which increases with the self-absorption engendered by feeling unique and believing one is the focus of others' attention (Bluth et al., 2017). It may be that older female adolescents might be fearful of, and more resistant to, self-compassion believing they do not deserve kindness (Bluth et al., 2017), whereas self-compassion may operate via a different pathway for male adolescents (Bluth et al., 2017). Fears of self-compassion and receiving compassion from others has been found to strongly correlate with self-criticism, anxiety, depression and stress and to negatively associate with self-compassion and self-reassurance (Gilbert, McEwan, Catarino, Baião & Palmeira 2014). However, it may be related to measurement as these studies used the total score and not the positive items of the scale. Use of the negative items in the instrument may obscure the nature of self-compassion in gender.

Interventions aimed at increasing self-compassion in adolescents are viable (Bluth & Eisenlohr-Moul, 2017; Bluth, Gaylord, Campo, Mullarky & Hobbs, 2016a; Galla, 2016) in terms of reducing rumination (Galla, 2016), reducing depressive symptomology and increasing life satisfaction (Bluth et al., 2016a; Galla, 2016). This demonstrates self-compassion is modifiable and can be strengthened with practice (Gilbert & Proctor, 2006). Muris and Meesters (2014) emphasized the advantages of self-compassion interventions which can buffer the effects and development of negative self-conscious emotions in young people (see Bluth et al., 2016b) with life-long implications (Pine, Cohen & Brook,1999).

1.4.3.2. Compassion and psychological wellbeing in adolescence Empirical research has shown a strong consistent relationship between self-compassion and wellbeing (Barnard & Curry, 2011) and may operate via a different pathway to negative psychological outcomes (Bluth & Eisenlohr-Moul, 2017). Studies show those who rate as more compassionate are liable to have greater life satisfaction; be more socially connected; experience lower levels of depression, anxiety, shame and burnout (Barnard & Curry, 2011; Mills, Gilbert, Bellew, McEwan & Gale, 2007; Neff, Rude & Kirkpatrick, 2007; Williams, Stark & Foster, 2008; Yamaguchi, Kim & Akutsu 2014; Zessin, Dickhauser & Garbade, 2015), and report lower levels of procrastination, rumination and perfectionist tendencies (Leary, Tate, Adams, Allen & Hancock, 2007; Sirois, 2014).

Leary et al., (2007) researched the emotional and cognitive processes involved in managing self-relevant distressing events in undergraduates. High self-compassion scores equated with lower emotional perturbance and higher acceptance suggesting self-compassion enhances resilience during periods of stress (Neff, 2003a; Gilbert, 2005).

Several studies identify self-compassion as a protective factor (Bluth et al., 2016b; Klingle & Van Vliet, 2017; Marshall, Parker, Ciarrochi, Sahdra, Jackson, & Heaven, 2015) with positive associations between self-compassion and wellbeing in adolescents (Bluth et al., 2016a), distress tolerance (Bluth et al., 2017) and perceived life satisfaction (Bluth et al., 2016a). Bluth et al., (2016b) also identified physiological advantages with high self-compassion associated with lower blood pressure and cortisol output.

Klingle and Van Vliet (2017) conducted the one qualitative study examining self-compassion from an adolescent perspective. They found themes consistent with existing research and theory, namely self-acceptance and positive interpersonal relations (e.g. Gilbert, 2009); positive attitude and emotional regulation (e.g. Ferguson, Kowalski, Mack & Sabiston, 2014). The principal finding within the group of six adolescents was a striving for self-improvement in conjunction with acceptance of self ‘as is’. Self-compassion offers a ‘sense of safeness’ (Gilbert, 2009) in which the adolescent is more able to consider internal adjustments without triggering defensive responses or feelings of unworthiness (Neff, 2011).

Due to the sample size and recruitment methodology future qualitative studies should examine those low in self-compassion in order to determine what the challenges may be to developing self-compassion and how barriers might be managed.

However, caution is advisable when considering directions of association or causality between self-compassion and wellbeing factors. The temporal order of change has yet to be defined. It may be that negative emotional states reduce the capacity to feel self-compassion, or that both self-compassion and distress influence each other bidirectionally, although current evidence indicates self-compassion has a protective function (Marshall et al., 2014) and may be antecedent to distress (Bluth et al., 2017).

1.4.4. Summary

Existing research on self-compassion in adolescence shows self-compassion is protective, buffering emotional distress and increasing feelings of wellbeing. Self-compassion has been identified as a more helpful construct in psychological health than self-esteem, as self-esteem is comparative (Aspinwall & Taylor, 1993; Harter, 1999; Neff, 2003a; Suls & Wills, 1991) and social rank is linked with distress (Gilbert & McGuire, 1998; Fournier, 2009; Sloman, 2008) suggesting self-compassion is a more prudent measure of wellbeing in adolescents than self-esteem.

Evidence suggests self-compassion is lowest in adolescence (Neff, 2003a) and whilst self-compassion has clear benefits it may be compassionate feelings could trigger fear reactions and avoidance (Gilbert, 2010; Gilbert, McEwan, Matos & Rivis, 2011). This suggests the importance of addressing the blocks to compassion prior to compassionate therapeutic interventions.

As discussed in 1.4.1.3. the SCS (Neff, 2003b) was used as the measure of self-compassion in all studies. Recent papers (e.g. Muris, 2016) have suggested using only the positive aspects as opposed to an aggregated score. Hence this study has opted to disregard all questions in the SCS-SF (Raes et al.,2011) requiring reverse scoring. The negative aspects of the SCS (Neff, 2003b),

namely self-judgement, isolation and over-identification (which are linked to psychopathology), draw on detrimental mechanisms that are in opposition to the protective nature of self-compassion (Muris, 2016).

Evidence suggests self-compassion is a construct that can be learned and strengthened via practice (Bluth et al., 2016a; Bluth et al., 2015; Galla, 2016; Gilbert & Proctor, 2006). This is encouraging and indicates methods that teach self-compassion may be beneficial to adolescents.

1.5. Study Rationale

The literature reviews highlighted several gaps within the extant literature. The constructs of shame, narcissism and social rank have been shown to be important during adolescence with complex relationships to distress and wellbeing. There are inter-relations between the variables that have yet to be analysed together. This study also aimed to identify which aspects might predict distress and which might predict wellbeing, and examine possible moderator effects of self-compassion.

There are clear, identified connections between shame and distress, submissive behaviour and distress, and vulnerable narcissism and distress. Grandiose narcissism, positive social comparison and self-compassion have been shown to equate with wellbeing hence teasing out the specific configuration of aspects that relate to distress and to wellbeing in adolescence will further the existing knowledge base.

1.6. Clinical Implications

This novel exploratory study aims to elucidate the associations between aspects of shame, narcissism, social rank in a mid-adolescent population; the impact of such on their distress and wellbeing and if self-compassion moderates those relationships. Due to rising adolescent psychopathology further evidence of existing mechanisms between constructs pertinent to adolescence is required. Additional understanding of how self-compassion may mitigate distress and/or increase wellbeing in this population is also of value.

1.7. Research Questions

The rationale and aims of this study inform the following research questions:

Research question 1

Are there significant associations between aspects of shame, narcissism and social rank?

Research question 2

Which aspects of shame/narcissism/social rank are most significantly associated with distress?

Research question 3

Which specific aspects of shame/narcissism/social rank are the best predictors of distress?

Research question 4

Which aspects of shame/narcissism/social rank are significantly associated with wellbeing?

Research question 5

Which specific aspects of shame/narcissism/social rank are the best predictors of wellbeing?

Research question 6

(a) Are there significant associations between self-compassion and aspects of shame, narcissism, social rank, distress and wellbeing?

(b) What percentage of the variance for distress is predicted by self-compassion?

(c) What percentage of the variance for wellbeing is predicted by self-compassion?

(d) Does self-compassion have a moderating role in

i. Distress

ii. Wellbeing

2. METHOD

2.1. Overview

This chapter presents the epistemological framework underpinning the research and details of ethical considerations. Information regarding the design and a detailed description of the research methodology (including materials and procedures used) are presented, ending with consideration of the analytic strategy employed.

2.2. Epistemological Position

This research takes a pragmatic epistemological position, a philosophical perspective that has at its foundation the practical consequences of theories, concepts and knowledge (see Peirce, 1905). It is not to discover 'universal truths' but to investigate questions and provide acceptable predictions of observable phenomena in a given domain (Cacioppo, Semin & Berntson, 2004; Thagard, 2002). Whilst there is considerable contention and debate around a definition of the philosophy (Chamberlain, 2015), Rescher (2005, p83) summarises that what 'is true of beliefs, right of actions, and worthwhile in appraisal is what works out most effectively in practice'. A contemporary pragmatist, Rorty, (1982) asserts that 'no description or interpretation of the world is closer to reality than any other, but that some are more useful in particular contexts and for particular purposes'. Pragmatism is pluralist as it accepts various differing interests and forms of knowledge; critical as it invites questioning; non-relativist in that knowledge can be judged by its capacity to advance productive action, and action-oriented in that 'everyday' issues are of primary importance (Cornish & Gillespie, 2009). The pragmatic view is that theory represents useful frameworks for describing or predicting observed data as opposed to 'actual structures in the world' (Cacioppo et al., 2004, p217). It is not denial of existing reality, however, it is a statement of the boundaries of our ability to discern and argue (Pharies, 1985). Hence how 'useful' is a piece of knowledge? Ideas need to make a concrete difference for action (Peirce, 1878).

Through its pragmatist position, this research intends to increase understanding of the experience of distress and wellbeing in mid-adolescence, and explain a phenomenon in this age group through the lens of shame, narcissism and social rank. From that it aims to identify which factors are likely to benefit from more focus in order to develop practical strategies and approaches to promote wellbeing and alleviate distress in this population, and to understand the role of self-compassion in those processes. Creating and evaluating interventions that are useful is a priority in pragmatist health research (Cornish & Gillespie, 2009) and current data suggests adolescents may be experiencing unprecedented stress (WHO, 2017), hence attending to this is important. Whether this is an 'ultimate truth' is immaterial - by explicating the issues adolescents experience in this era it is hoped valid areas for study will emerge (Glaser & Strauss, 1967). For those adolescents who report high scores on the shame, narcissism and social rank measures; high on distress and low on wellbeing measures, can a construct like self-compassion help raise their wellbeing and reduce their distress? It may be distress and wellbeing have an external reality beyond the variables chosen for this investigation, and it may be that these constructs 'exist' in this generation of adolescents within a specific historical and cultural context. However, the perspectives taken in this study are not statements of truth, more mechanisms of explanation.

2.3. Ethical Approval and Considerations

2.3.1. Ethical Approval

Ethical approval for the study was obtained from the University of East London Ethics Committee (see Appendices C & D) . All changes required by the board were addressed before recruitment commenced. Due to challenges with recruitment the study took place in two phases: Phase I (within a secondary school environment) and Phase II (via online recruitment). Approval was granted for both school and online data collection and approval was sought and obtained from two school headteachers. The study was compatible with the British Psychological Society's Code of Human Research Ethics (2010) taking into account the nature of the research - working with a vulnerable population (16-17

year olds). The study did not recruit participants from clinical services, therefore no additional ethical approval was required. Parental consent was not obtained due to the age of participants (those aged 16+ do not require parental consent).

2.3.2. Informed Consent – Phase I and II

Participants were provided with an information sheet (Appendices E, F, G, H) outlining key information regarding the study, including confidentiality and anonymity; participants' right to withdraw and how the data would be used and stored. Researcher and Director of Studies (DoS) contact details were provided, along with contact information for a University official for reporting concerns. Participants were encouraged to contact the researcher if they had any questions post participation. Phase I participants (school collection) were given a consent form to sign. Phase II (online) were required to tick a box marked 'I agree' to proceed'. Participants were informed of their rights to withdraw their data until analysis took place and were given a date by which to contact the researcher. It was not possible to match data to participant information as these were kept in separate electronic files.

2.3.3. Confidentiality, Anonymity and Data Protection

2.3.3.1. Phase I Participants were ascribed a unique identifying number from the headteacher which was used on their questionnaire data. The headteacher had access to the students' names and corresponding identifying numbers whereas the researcher could only see identifying numbers. In line with data protection participants were unable to share contact details with the researcher, however all participants were entered into the prize draw. In order to pass the vouchers to the prize draw winners the researcher passed the ID number of the winners to the headteacher who then passed the shopping voucher on.

Participants were informed their questionnaire responses would remain anonymous and no data would be shared with the school. The questionnaire responses were kept in a locked cabinet in a locked office only accessible by the researcher. This data will be destroyed after five years in accordance with the Caldicott Principle (Department of Health, 2003) and Data Protection Act (HM

Government, 1998).

2.3.3.2. Phase II Participants were informed that their data (collection and digital storage) would be anonymous. A unique identifying number was ascribed to each participant and used in the database where responses were recorded, however it was not possible to connect any questionnaire data to an individual participant. Those who wished to be entered into the prize draw were asked to email the researcher their contact details which were kept in a separate file and deleted after the draw had taken place and the winners informed. All electronic files were password protected and accessed via a password-protected computer. The anonymous data from the questionnaires will be kept for five years in a password-protected file and then deleted in accordance with the Caldicott Principle (Department of Health, 2003) and Data Protection Act (HM Government, 1998).

2.3.4. Potential Distress

The battery of questionnaires included questions regarding shame and social comparison hence it was possible that some participants may experience difficult thoughts and feelings. The information sheet outlined potential risks. Participants were informed that if any distressing feelings were triggered they could either contact the researcher (full contact details were provided) or several online agencies (with 24-hour helplines). Participants were also informed that they could withdraw anytime up until analysis of responses.

2.3.5. Debriefing

2.3.5.1. Phase I Upon completion of the questionnaires participants were presented with a debrief sheet and encouraged to speak with the headteacher or researcher if they had any questions regarding the research study or wished to discuss how participation made them feel. The debrief sheet thanked them for their participation and gave reseacher contact details and a list of supporting agencies (see Appendix I).

2.3.5.2. Phase II The online battery of questionnaires concluded with the debrief

sheet thanking the participants together with researcher contact details and information for several supporting agencies (see Appendix J).

2.4. Design

This study took a cross-sectional, within-subjects correlational quantitative approach, employing a variety of self-report questionnaires completed at a single time point, with the aim of examining predictive relationships between the chosen variables. The dependent (outcome) variables were levels of distress and wellbeing and the predictor variables were levels of shame (internal, external, shame proneness); levels of narcissism (grandiose and vulnerable); social comparison and submissive behaviour; and self-compassion.

2.5. Participants

2.5.1. Inclusion Criteria

Inclusion criteria were broad in order to recruit a wide demographic. Participants were required to be 16 or 17 years old and proficient in the English language (translated versions of the questionnaires were not available). This was not explicitly stated on the recruitment process for the school sample as it was assumed that students of this age being taught in the UK at this level of education would be proficient in English. It was implied for the online version of the study as it was written in English and this was the language used throughout the questionnaires.

2.5.2. Exclusion Criteria

Participants for the online study were excluded if they were not 16-17 years old. It was assumed that students who could neither read nor comprehend English would not attempt the questionnaires, hence low proficiency in English was not set as an exclusion criterion. By law, young people are required to be in education until the age of 18 within the UK and therefore it was assumed that all participants in Phase II were attending either college or secondary school (Department for Education, 2016).

2.5.3. Sample

Convenience sampling was employed for Phase I. Participants were recruited by an online request via Facebook for schools to agree to participate in data collection. Two secondary schools agreed (a private girls school and a mixed secondary state school, both in the south of the UK). It was only possible to obtain data from the private girls school. The sample recruited from this school did not meet required power to perform the relevant analyses; was exclusively female and possibly lacking in diversity, hence a second phase of recruitment was undertaken.

Phase II employed a convenience and snowball sampling method. An advertisement was placed on social media (Facebook) with a request for those willing to assist to share it. This post was shared by a number of 'friends' to their 'friends'. It was assumed participants would be from the UK as online advertising was placed through the researchers network of UK contacts. However there was no stipulation for participants to be from the UK and the researcher had no control over locality of 'friends of friends'.

86 participants were recruited in Phase I and 56 participants in Phase II resulting in a total of 142.

2.6. Materials

2.6.1. Shame

2.6.1.1. External shame The Other As Shamer Scale (OAS; Allan, Gilbert, & Goss, 1994; Goss, Gilbert, & Allan; 1994) consists of 18 items measuring external shame (global judgements of how people think others view them). For example, respondents indicate the frequency on a five-point scale (0–Never to 4–Almost always) of their perceptions of negative social evaluations such as, 'I feel other people see me as not quite good enough' and 'I think that other people look down on me'. No referential time period is given. Higher scores on this scale suggest increased external shame and the total score was used in this study (as

with previous research, e.g. Pinto-Gouveia & Matos, 2011). This scale has a high internal consistency with Cronbach's α of .92 (Goss et al., 1994); α=.91 (Pinto-Gouveia & Matos, 2011) and α=.93 (Matos and Pinto-Gouveia, 2014). This scale was chosen because it is the only valid instrument designed to specifically measure external shame.

2.6.1.2. Internal shame The Experience of Shame Scale (ESS, Andrews, Qian & Valentine, 2002) was derived from Andrews and Hunter's (1997) interview measure of shame, consisting of 25-items measuring three domains of shame:- character (personal habits, manner with others, what sort of person you are and personal ability); behaviour (shame about doing something wrong, saying something stupid and failure in competitive situations) and body (feeling ashamed of one's body or parts of it). Participants are asked to indicate the frequency of experiencing, thinking and avoiding any of the three areas of shame over the past year. Higher scores indicate higher shame and the total score was used in this study. Items are rated on a 4-point Likert scale (1-not at all, 4-very much). Andrews et al. (2002) found high internal consistency Cronbach's α=.92 with good test-retest reliability over 11 weeks (*r*=.83). The ESS was developed as a measure of global shame and includes some items that are more related to external shame (i.e. concerns about what others think about the self), highlighting issues with its construct validity. However the alternative option The Internalized Shame Scale (ISS, Cook, 1994) was not viable due to prohibitive cost.

2.6.1.3. Shame-proneness The Adolescent Shame-Proneness Scale (ASPS, Simonds et al., 2016) examines the experience of shame in adolescents (aged 11-18). It was developed to assess global negative self-evaluation and encompasses internal and external shame. It is a 19-item measure assessing three components of shame-proneness:- negative self-evaluation (i.e. 'I am no good'; 'other people must think I am stupid'); externalization (e.g. 'I wanted to scream and shout'; 'I wanted to hurt someone') and emotional discomfort (e.g. 'I felt sad'; 'I had a horrible feeling inside'). Participants are asked to consider situations in which they have experienced shame and then respond to statements expressing different feelings, thoughts and behaviours related to shame. Items are rated using a 4-point Likert scale (0-not at all, 3-a lot). The

scale has not had its temporal stability assessed. The ASPS correlates well with scores on existing measures of shame-proneness. Simonds et al., (2016) suggest using the subscales as opposed to a total score.

This measure was chosen as it was developed to examine shame phenomenology in a non-clinical, adolescent sample.

2.6.2. Narcissism

2.6.2.1. Grandiose and vulnerable narcissism The Brief Pathological Narcissism Inventory (B-PNI, Schoenleber, Roche, Wetzel, Pincus & Roberts, 2015) is a 28-item multidimensional self-report measure focusing on 'pathological narcissism'. It consists of seven subscales that function as characteristics for two higher order factors:- grandiose and vulnerable aspects of pathological narcissism. It utilises a 6-point Likert scale (ranging from 0=not at all like me, to 5=very much like me) to rate each item. No referential time period was stated. Grandiose narcissism is served by three of the subscales namely exploitativeness (e.g. 'I can usually talk my way out of anything'), Self-sacrificing self enhancement (e.g.'I feel important when others rely on me') and grandiose fantasy (e.g. 'I often fantasize about accomplishing things that are probably beyond my means'), and vulnerable narcissism by the remaining four subscales, namely contingent self-esteem (e.g. 'When people don't notice me, I start to feel bad about myself'), hiding the self (e.g. 'I often hide my needs for fear that others will see me as needy and dependent'), devaluing (e.g. 'Sometimes I avoid people because I'm afraid they won't do what I want them to') and entitlement rage (e.g. 'I get annoyed by people who are not interested in what I say or do'). The B-PNI was adapted from the Pathological Narcissism Inventory (Pincus et al., 2009) which showed good internal consistency ranging from Cronbach's α=.71 to .93 for the 7 sub-scales within the two higher order factors of grandiose and vulnerable narcissism.

2.6.3. Social Rank

2.6.3.1. Social comparison The Adolescent Social Comparison Scale - Revised (ASCS-R) was developed for use with young people from the adult Social

Comparison Scale (SCS, Allan & Gilbert, 1995) and adapted for use in a clinical project (Lang, 1994). It takes into account factors that adolescents often find important, such as peer pressure. Through a set of bipolar constructs, participants are asked to make ten global comparisons about themselves in relation to their peers, rated on a 10-point Likert scale (e.g. 'Compared to your friends, how confident do you feel'). Certain questions are phrased such that higher scores suggests inferior participant social comparison, hence these items are reversed scored. Thus the final score is a representation of a more adaptive social comparison (i.e. participants feel more superior, attractive and accepted in comparison to others). This questionnaire was selected as it has been shown to give a reliable measurement of a relevant aspect of social rank theory, namely how positively/negatively people compare themselves to others (Irons, 2001; Lang, 1994). Lang (1994) found good internal consistency (in a group of 12-19 year old students) with a Cronbach's α=.78.

2.6.3.2. Submissive behaviour The Adolescent Submissive Behaviour Scale (ASBS) was adapted for use with young people from the Submissive Behaviour Scale (Gilbert & Allan, 1994, Allan & Gilbert, 1997) and as the ASBS-R was adapted for use in a clinical project (Lang, 1994) aimed at assessing adolescents' self-reported submissive behaviour in social situations. The 12-items are scored using a 5-point Likert scale (1=never, 5=always) with a total score range of 0-60. A higher score indicates greater submissive behaviour and the total score was used in this study. Respondents are requested to rate how they would behave in a situation with their peer group in which they respond submissively (e.g. 'I do things because others are doing them, rather than because I want to'). The scale was selected as it is possible to ascertain a measurement of a person's submissive behaviour in social/conflict situations or alternatively gives an indirect measure of dominant behaviour.

2.6.4. Self-Compassion

The Self-Compassion Scale short form (SCS-SF, Raes et al., 2011) is the shortened version of the Self-Compassion Scale. It is a self-report 12-item questionnaire which evaluates respondents' perceived behaviours towards themselves in distressing situations. It assesses three factors of positive self-

compassion : self-kindness (e.g. ‘I try to be loving towards myself when I’m feeling emotional pain’); common humanity (e.g. ‘I try to see my failings as part of the human condition’), and mindfulness (e.g. ‘When something upsets me I try to keep my emotions in balance’), and three factors concerning a lack of self-compassion : self-judgement (e.g. ‘I’m disapproving and judgemental about my own flaws and inadequacies’); isolation (e.g. ‘When I fail at something that’s important to me, I tend to feel alone in my failure’) and over-identification (e.g. ‘When something upsets me I get carried away with my feelings’). Respondents are requested to indicate how often they engage with these constructs on a 5-point Likert scale (1=almost never to 5=almost always). No referential time frame was indicated.

More recent studies (Lopez et al., 2015; Brenner et al., 2017) have argued that the SCS/SCS-SF have two separate general factors – self-compassion and self-coldness/self-criticism and does not justify using a composite score. Hence this study will split the SCS-SF into the two compassion factors (‘positive’ and ‘negative’) and use solely the ‘positive’ items. Higher scores on the ‘positive’ subscale indicate higher levels of self-compassion. The SCS has good internal consistency and reliability for all the subscales from Cronbach’s α=.75 to .81 for the factors and Cronbach’s α=.92 for the total SCS. The SCS has demonstrated construct validity using measures of social connectedness, perfectionism, emotional intelligence, anxiety, depression, and life satisfaction (Neff, 2003b).

2.6.5. Distress

The Depression, Anxiety and Stress Scale (DASS-21, Lovibond & Lovibond, 1995). The DASS-21 is a shortened version of the DASS in which three subscales - consisting of the dimensions of depression, anxiety and stress - are reduced from 14 to 7 items equalling 21 items in total. It is a self-report measure in which the items describe distressing emotional symptoms (depression: e.g.’I couldn’t seem to experience any positive feeling at all’, anxiety: e.g.‘I was aware of dryness of my mouth’ and stress: e.g.‘I found myself getting agitated’). Respondents are requested to rate each item using a 4-point Likert scale (from 0-did not apply to 3-most of the time) with higher scores indicating greater levels of distress. Participants are asked to rate their answers based on the past week.

Lovibond and Lovibond (1995) reported good internal consistency for each construct (depression sub scale Cronbach's α=.91, anxiety sub-scale Cronbach's α=.84 and stress sub-scale Cronbach's α=.90), and Henry and Crawford (2005) have demonstrated high internal consistency for the total score - Cronbach's α=.93. The DASS-21 has also demonstrated good concurrent validity (Antony, Bieling, Cox, Enns & Swinson, 1998) and shows high convergent validity with other measures of anxiety and depression (Henry & Crawford, 2005).

The manual (Lovibond and Lovibond, 1995) recommends the DASS-21 raw scores to be doubled in order to be comparable to the DASS scores, however this was deemed unnecessary as this study was not determining level of severity for treatment in a clinical setting, hence the maximum score is 63. The DASS-21 was selected over the DASS to reduce participant burden and it has been shown to have a cleaner factor structure compared to the longer version (Antony et al., 1998).

2.6.6. Wellbeing

The Warwick-Edinburgh Mental Health WellBeing Scale (WEMWBS, Tennant et al., 2007) is a 14-item scale with five response categories measuring the construct of psychological wellbeing and cover both hedonic (e.g. 'I've been feeling good about myself') and eudaemonic (e.g. 'I've been interested in new things') perspectives of wellbeing. Items are scored on a 5-point Likert scale (1-none of the time, to 5-all of the time) and are worded positively (such as 'I've been feeling optimistic about the future') and summed to provide a single score ranging from 14-70, with higher scores indicating greater wellbeing. The scale has good content validity and high internal consistency (Cronbach's α=.89, .91 and .90, in Stewart-Brown & Janmohamed, 2008; Taggart, Friede, Weich, Clarke, Johnson & Stewart-Brown, 2013; Tennant et al., 2007).

2.6.7. Demographics

Participants completed a demographic questionnaire requesting age in years and months; gender and ethnicity.

2.7. Procedure

2.7.1. Informal Pilot Study

An informal pilot study was executed with a small number (5) of local adolescents known to the researcher, in order to assess acceptability of the questionnaires and determine accurate timings on completion of the measures. The participants agreed to take part in the pilot and completed the questionnaires in a room supervised by the researcher. All data were destroyed after completion and participants were thanked for their time and provided with a meal.

2.7.2. Phase I – School Data Collection

2.7.2.1. Informed consent and information collection The headteacher of the school agreed for her students in Year 11 to participate in the study. At an agreed time/location the students were presented with the information sheet and consent forms (Appendices E & K). These and the battery of measures were in paper form. Due to the possibility that some students may have experienced pressure to participate it was emphasized that consenting to take part was entirely voluntary. All students were directed to the information sheet outlining their choice. The students who consented (86 out of 88) progressed to a demographic questionnaire (Appendix L) and the main questionnaire battery which took 20- 30 minutes to complete. Participants could withdraw their consent at any point during completion of measures. Following completion the participants were presented with a debrief sheet offering support if they experienced any distress completing the questionnaires. The researcher was physically present and available to answer any questions. Participants were offered the opportunity to be entered into a draw to win one of three £40 shopping vouchers. All participants were given an identification number and the headteacher had the list of names corresponding to the numbers, guaranteeing anonymity as the researcher could not connect data to names. Students were prohibited from giving contact details to the researcher due to data protection. The winners were later picked by a random number generator and the numbers

given to the headteacher who identified the winning students. Raw data were entered into a password-protected spreadsheet only accessible by the researcher. The data was then transferred to data analysis software (SPSS, v25: IBM, 2017) for analysis.

2.7.3. Phase II – Online Data Collection

2.7.3.1. Informed consent Participants accessed the study online via Facebook or email links. Qualtrics was used as the online survey platform. Participants were presented with the information and consent sheets (see Appendix G, H, M). Participants could not access the questionnaire battery unless indicating their consent. They could not continue to each section without completing all items to ensure that data sets were complete for each participant. Any uncompleted questionnaires had their data removed from the dataset prior to analysis (see 3.3.). Participants were asked if they wanted to be included in a prize draw winning one of three £40 shopping vouchers.

2.7.3.2. Information collection After indicating consent to participate participants were presented the demographic form (see Appendix N) to complete followed by the questionnaire battery. The battery appeared in the same order as they had for the participants in Phase I of the study to maintain consistency. Completion then took 20- 30 minutes. The online survey concluded with the debrief sheet (see Appendix J) where participants were thanked for their time and provided with information should they require psychological support, as well as the contact details of the researcher should they have any questions. Consent was further evidenced by participants submitting their data post the debrief sheet. Raw data was automatically transferred to data analysis software (SPSS, v25: IBM, 2017) for analysis.

2.7.4. Prize Draw

The participants who wished to be included in the prize draw were assigned a number and a random number generator function was used to determine the winners of the three £40 shopping vouchers. The vouchers were offered as a way of thanking participants, in recognition of their time. The winners were

contacted via their email and sent to their addresses. The contact details for participants was then destroyed.

2.8. Data Analysis

Data were analysed using the Statistical Package for the Social Sciences (SPSS) Version 25 (IBM, 2017). Macros were added for moderation analyses (Hayes, 2012, 2018, PROCESS v3.0, IBM). Descriptive statistics were calculated for the demographic information collected and the clinical variables used. Initially, correlational analyses were conducted to examine relationships between all scales (aspects of shame, narcissism, social rank; distress; wellbeing; self-compassion). To detect a moderate correlation at a power of .80, G* Power (Erdfelder, Faul, & Buchner, 1996), determined a sample size of 92 was necessary. The correlational analyses were examined to determine specific relationships between all aspects of shame, narcissism and social rank. From there a range of correlational analyses were conducted using the subscales of the variables (namely subscales of internal shame, shame proneness and narcissism) to examine relationships between the variables at a more detailed level. G* Power (Erdfelder et al., 1996) revealed a necessary sample size of 68 at a power of .80.

A multiple regression analysis was conducted to test the predictive power of variables on distress (using scale totals and subscale data). Harris (1985) recommends a minimum of ten participants per predictor variable, hence a sample size of 140 was required (14 x 10=140) and G* Power test for a medium effect (.25) with power of .80 and 14 predictors states a sample size of 86 was required. A backwards stepwise multiple regression was conducted to determine which specific variables significantly predicted distress. This was chosen as an acceptable analysis to use for exploratory model building (Wright, 1997) as well as countering Type II errors. The same tests were carried out (multiple regression and backwards stepwise multiple regression) to determine which variables significantly predicted wellbeing.

The correlational analyses were examined to determine the significant relationships between self-compassion and all other variables, followed by

inclusion of self-compassion to the multiple regression data to establish the predictive role of self-compassion on distress and wellbeing. Moderation analyses were undertaken to explore the relationships between self-compassion and distress and self-compassion and wellbeing (Hayes, 2012).

3. RESULTS

3.1. Overview

This chapter details the sample characteristics and data screening procedures employed (e.g. sample characteristics; missing data; outliers; data distribution and assumptions of normality), followed by the outcome of analyses for each research question. Appendix O outlines the scales and constructs referenced in this section.

3.2. Sample Characteristics

Table I details participants' ethnic characteristics for the 142 respondents who completed the measures, from Phases I and II. Out of the full complement of students (n=88) who were available to participate in Phase I, two declined to take part leaving a sample size of 86. Phase II obtained 106 online respondents in total, with 56 (52.8%) completing all the measures. Twenty nine participants (27.3%) closed the survey at the information page and the remaining 21 respondents (19.8%) completed between one and seven questionnaires, hence demographic information was available for the 21 non-completers. Completers (n=56) were compared to non-completers (n=21) in order to reduce the possibility of biased inferences. Hence:

- 51.8% completers identified as White British compared to 38.1% non-completers;19.6% completers identified as White Irish compared to 33.3% non-completers, equaling 71.4% completers identifing as White and 71.4% non-completers identifying as White.
- 76.8% completers identified as female as opposed to 71.4% non-completers; and 23.2% completers identified as male compared to 28.6% non-completers.
- The mean age for both completers and non-completers was 16.8.

These comparisons suggest those who did not complete the survey (for whom demographic information was available) were similar to those who did.

The mean age of participants in Phase I was 16.95 (SD=0.30) and 16.81 (SD-0.43) in Phase II. Phase I consisted exclusively of female participants (N=86), however Phase II was 76.8% female, 23.2% male (female N=43, male N=13).

Table I
Participant characteristics based on ethnicity
N=142

	PHASE 1		PHASE 2		TOTALS	
	N	%	N	%	N	%
Ethnic Background						
White						
White British	54	38.03	29	20.42	83	58.45
White Irish	2	1.41	11	7.75	13	9.16
White German	2	1.41			2	1.41
Mixed/Multiple Ethnic Group						
Mixed European			1	0.70	1	0.70
White & Black Caribbean	1	0.70	2	1.41	3	2.11
White & Black African	1	0.70			1	0.70
White & Asian	2	1.41	4	2.82	6	4.23
Asian or Asian British						
Indian	5	3.53			5	3.53
Pakistani	3	2.12			3	2.12
Bangladeshi	1	0.70			1	0.70
Chinese			3	2.12	3	2.12
Asian other			1	0.70	1	0.70
Black or Black British	1	0.70			1	0.70
Caribbean	1	0.70	4	2.82	5	3.52
African						
South American			1	0.70	1	0.70
TOTAL	73	51.41	56	39.44		90.85
Missing	13	9.15	0	0.00		100.00
TOTAL	**86**		**56**			
TOTAL N					**142**	

3.3. Missing Data

Missing data are distinguished as missing completely at random (MCAR), missing at random (MAR) and missing not at random (MNAR). MCAR poses less threat to statistical inferences than MAR or MNAR (Dong & Peng, 2013). Missing data can be problematic as it can produce statistical biases and therefore render conclusions non-generalisable (Rubin, 1987, Schafer, 1997), and removing all cases with missing data can lead to loss of information thereby decreasing statistical power (Peng, Harwell, Liou & Ehman, 2006).

At close of recruitment for Phase II there were 106 recorded responses, however, only 56 of these were suitable - 29 did not click past the information page and the remaining 21 completed between 7-87% of the survey. The respondents who did not submit their responses were deemed non-consensual and their data were excluded from the study, hence only those with completed batteries of questionnaires were used. This resulted in data only missing at item-level. Schafer (1999) states a missing data rate of 5% is inconsequential with 10% of missing data likely to bias statistical analysis (Bennett, 2001). The data were examined and overall missing data on the questionnaires was low (1.70%) indicating the risk of bias as minimal. Participant age had the highest amount of missing data at 8.45% all of which occurred in Phase I. As all participants in Phase I were in the same year at school this did not prove problematic. Age was not used as a variable within the analyses and served specifically as a criterion for inclusion.

List deletion of cases with item-level missing data was deemed unsuitable as this would have reduced the available data for analysis (Davey & Savla, 1998). Little's (1998) Chi-squared analysis of missing values was conducted on all measures to determine if missing data were MCAR (Rubin, 1987). The null hypothesis was supported for all measures.

Mean imputation is a method employed in which the missing value is replaced by the mean of the cases that are available. Mean imputation was chosen as an acceptable approach to handle the missing data as when missing data are 20% or less, mean imputation provides satisfactory representations of missing data

(Downey & King 1998).

3.4. Outliers

Univariate outliers (an extreme score in a variable) were assessed prior to multivariate outliers (extreme scores in two or more variables) as multivariate outliers are sensitive to violations of normality (Tabachnick & Fidell, 2013).

3.4.1. Univariate Outliers

Univariate outliers were determined via calculating the standardised Z scores on total scores for all measures where a value greater than 3.29 (two-tailed) was significant (Tabachnick & Fidell, 2013). One participant was identified with a standardised Z score above 3.29 (Appendix P). Box plot analysis showed nine extreme scores from six participants (0.04% of all values). Determining outliers and the treatment of such is a contentious issue (e.g. Aguinis, Gottfredson & Joo, 2013; Leys, Ley, Klein, Bernard, & Licata, 2013) and several procedures were implemented to detect them namely standardising scores; three standard deviations from the mean and absolute deviation from the median, all showing varying options. However, two out of the three options used suggested that only one extreme score was unacceptable. Field (2009) recommends retaining outliers where data reflects genuine scores from the population of interest. In this case the score was retained, as it was deemed an 'interesting' outlier and not an error outlier (Aguinis, Gottfredson & Joo, 2015). Deletion of outliers can lead to artificial range restriction (McNamara, Aime, & Vaaler, 2005) and may preclude future learning (Mohrman & Lawler, 2012). Analysis was run with and without the outlier to ensure transparency as well as examining its influence on the fit of the model (Yuan & Bentler, 1998). Transformation of scores was considered, however the possibility of introducing statistical bias and undervaluing the outlier were considered important issues hence transformation was not pursued (Ghosh & Vogt, 2012).

3.4.2. Multivariate Outliers

Mahalanobis distances were calculated for all measures (OAS, ESS, ASPS, ASCS-R, ASBS-R, B-PNI, SCSSF, WEMWBS, DASS21) and no multivariate outliers were identified at $p<.001$.

3.5. Data Distribution

3.5.1. Reliability of Measures

The reliability of each measure for the current sample was assessed using Cronbach's alpha (α) as a measure of internal consistency. High internal consistency was found for OAS, ESS, ASPS, ASBS, B-PNI, SCSSF-N, WEMWBS and the DASS-21 indicating reliability. The SCSSF-P showed adequate internal consistency, while the ASCS demonstrated low internal consistency at .67 suggesting it is an unreliable measure. It is generally accepted that .70 is a suitable cut-off point for scale reliability (Field, 2009), although Kline (1999) argues that when measuring psychological constructs values below .70 can be expected due to the diversity of constructs measured. Further investigation (based on analysis of separate questionnaire items) showed the removal of Q4 would increase the α to .70, (Appendix Q) which suggested that this question for this sample was problematic. However, the full questionnaire was used as it was beyond the remit of this study to re-test a revised questionnaire.

3.5.2. Parametric Assumptions

Parametric tests require the assumptions of normality to be met. Statistical inferences can become degraded if there are violations of normality. Normality was assessed via statistical and graphical methods (Appendices R & S).

Table II Distribution Data for All Measures

SCALE	M	SD	MIN	MAX	S-K	Rku	Shapiro Wilk
OAS	24.94	11.69	0	68	2.49	1.62	.048*
ESS	57.96	17.22	25	102	1.02	-1.16	.013*
ESS – CH	25.98	9.06	12	49	2.1	-1.86	.001*
ESS – BEH	21.15	6.43	9	37	0.95	-1.9	.019*
ESS – BOD	10.87	3.74	4	16	-0.94	-2.82	.001*
ASPS	27.06	11.34	0	56	-0.79	-2.22	.218
ASPS – EXT	4.78	3.18	0	30	1.16	-2.11	.001*
ASPS – EMD	9.45	3.27	0	12	-3.98	1.75	.001*
ASPS – NSE	12.83	6.9	0	15	1.02	-1.1	.07
ASCS-R	53.85	10.58	21	76	-1.86	1.33	.049*
ASBS-R	32.37	8.78	14	56	-0.046	-0.46	.541
B-PNI - GR	31.85	9.85	7	56	-0.019	-0.83	.879
B-PNI GR EXP	9.58	4.02	1	20	0.96	-1.13	.096
B-PNI GR SSSE	11.06	3.77	3	20	-0.02	-1.6	.06
B-PNI GR GF	11.2	4.86	0	20	-0.55	-1.4	.020*
B-PNI-VU	35.37	14.58	3	76	0.02	-0.73	.662
B-PNI VU CSE	10.35	5.31	0	20	-0.38	-1.82	.011*
B-PNI VU HTS	10.89	4.79	0	20	-0.76	-1.27	.056
B-PNI VU D	6.51	4.25	0	20	2.48	-0.08	.002*
B-PNI VU ER	7.61	4.19	0	20	1.8	-0.28	.010*
SCS-SF P	16.48	4.35	6	27	-0.37	-0.21	.295
WEMWBS	28.84	9.07	7	53	0.59	-0.6	.546
DASS-21	24.72	13.36	0	58	1.75	-0.87	.024*
DASS-21 D	9.38	4.77	0	20	0.46	-1.3	.001*
DASS-21 A	7.16	5.11	0	20	3.12	-0.79	.001*
DASS-21 S	8.17	5.2	0	20	1.66	-1.87	.073

* significant at p<.05

Table II includes the means (M), standard deviations (SD), minimum and maximum scores, skewness (SK), kurtosis (Rku) and Shapiro-Wilks (S-W), values for the all the measures. The Shapiro-Wilks test (S-W) was chosen over the Kolmogorov-Smirnoff test (K-S) as K-S has been reported as having lower power with S-W as the best choice for testing normality (Thode, 2002). If a distribution of a variable is normal it is expected to have a skewness and kurtosis value of zero. A significant result (p<.05) in the S-W indicates that the sample is significantly different from a normal population (Field, 2009). The S-W test was significant for the OAS, ESS, ASPS subscales EXT and EMD, ASCS-R, B-PNI subscales GR GF; VU CSE; VU D and VU ER; and DASS-21 suggesting non-normality for those variables. However, small deviations from the normal distribution in larger samples can result in the S-W being significant (Field,

2009), hence it is recommended that skewness, kurtosis, histograms and Q-Q plots are interpreted alongside S-W results.

Following Bulmer's (1979) criteria the OAS, ESS/ESS CH, all ASPS subscales, ASCS-R, B-PNI VU D and B-PNI VU ER, and DASS-21/DASS-21 A and S, show as highly skewed (> +/-1) ; the ESS-BEH, ESS-BOD, ASPS, B-PNI GR EXP; GR GF; VU HTS and WEMWBS as moderately skewed (between +/- .5 and 1) and the ASBS-R, B-PNI GR, B-PNI SSSE, B-PNI VU, B-PNI VU CSE, SCSSF-P, and DASS-21 D (between +/- 0 to .5) as fairly symmetrical. This is in line with the results from the S-K test. Logarithmic and square root transformations were performed on the skewed and kurtosis variables (OAS, ESS, ASCS-R, SCSSF and DASS-21), but did not improve the data and are not necessarily seen as worthwhile (Glass, Peckham & Sanders, 1972). George and Mallery (2010) and Field (2009) suggest that skewness and kurtosis values +/- 1.96 (or +/- 2.58 for larger samples) are within normality. This suggests that the OAS and subscales ESS CH, ASPS-EMD, B-PNI VU D and DASS-21 A are skewed and all other variables are within adequate boundaries. In a larger sample the size of the skewness is more important than the significance level, and a statistically significant skewness may well not deviate from normality enough to make a meaningful difference in the analysis (Tabachnick & Fidell, 2012).

Normality in real-world populations is disputed and controversial (Micceri, 1989; Rasmussen & Dunlap, 1991), hence parametric tests are suitably powerful if alpha levels are conservative and the sample is large (Ghasemi & Zahediasl, 2012). Ghasemi and Zahediasl (2012) argue normality violations should not cause major issues with samples greater than 30 or 40 hence it is possible to use parametric procedures when the data are not normally distributed (Elliott & Woodward, 2007).

Visual inspection of histograms and Q-Q plots suggest that distributions for this sample were bordering on normality for most variables hence parametric tests were chosen. Bootstrapping procedures were employed to strengthen robustness and mitigate against the effects of any violations of normality (DiCiccio & Efron, 1996; Field, 2009; Salibian-Barrera & Zamar, 2002), inferences can be made about the sampling distribution by calculating standard

errors and confidence intervals. Significance values are based on bootstrapping with a 95% bias-corrected and accelerated (BCa) CI and 1,000 bootstrap samples.

3.6. Research Question 1: Are there significant associations between aspects of shame, narcissism and social rank?

3.6.1. Glossary

i. Aspects of Shame = External shame; internal shame (character, behaviour, body) shame proneness (negative self-evaluation, externalization, emotional discomfort).
ii. Aspects of Narcissism = Grandiose narcissism (exploitativeness, self-sacrificing self-enhancement, grandiose fantasy); vulnerable narcissism (contingent self-esteem, hiding the self, devaluing, entitlement rage).
iii. Aspects of social rank = Social comparison, submissive behaviour.

3.6.2. Bivariate Correlations

Pearson correlation coefficients (*r*) of all variables (scales and subscales), demonstrating the strength, direction and significance of relationships between the variables are listed in Appendix T. Even though conducting multiple tests on the same variable can increase Type I errors a correction for conducting multiple tests was not employed as vulnerability to Type II errors can occur, and correlations coefficients are indeed effect sizes – a significant *p*-value is meaningless if the effect size is small. It is also important to note there were no differences in values when correlations were run as separate bivariate correlations. Confidence intervals were utilized as they are more informative by showing the size of the population effect (Field, 2009).

The strength of the relationships was determined as outlined in Evans (1996) with *r*=+/-.00-.19 as very weak; +/-.20-.39 as weak; +/-.40-.59 as moderate; +/-.60-.79 as strong and +/-.80-1 as very strong.

3.6.2.1. Shame The relationship between all shame measures (OAS, ESS, ASPS) were examined. There was a strong positive correlation between all variables (OAS and ESS *r*=.76, *p*<.001, CI=.69-.81; OAS and ASPS *r*=.74, *p*<.001, CI=.63-.81; ESS and ASPS *r*=.75, *p*<.001, CI=.67-.81).

3.6.2.2. Shame and narcissism There was a moderate to strong positive correlation between all shame measures and vulnerable narcissism (OAS/ESS/ASPS and B-PNI VU *r*=.59 to .62, *p*<.001, CI range from .47-.72) and a weak positive correlation between all shame measures and grandiose narcissism (OAS/ESS/ASPS and B-PNI GR *r*=.23 to .32, *p*<.001, CI range from .09 to .46). This suggests that adolescents with higher shame scores also tended to report higher levels of narcissism (vulnerable more so than grandiose).

3.6.2.3. Shame and social rank There was a strong positive correlation between all shame measures and submissive behaviour (OAS/ESS/ASPS and ASBS *r*=.61 to .64, *p*<.001, CI range from .50-.73) and a moderate negative correlation between all shame measures and social comparison (OAS/ESS/ASPS and ASCS *r* =-49 to -.50, *p*<.001, CI range from -.62 to -.36). Indicating that adolescents who have higher levels of shame are also likely to report higher levels of submissive behavior, and more inferior social comparison.

3.6.2.4. Narcissism and social rank There was a moderate positive correlation between vulnerable narcissism and submissive behaviour (B-PNI VU and ASBS *r*=.46, *p*<.001, CI=.32-.58) and a moderate negative correlation between vulnerable narcissism and social comparison (ASCS *r*= -.37, *p*<.001, CI= -.50 - -.22). This suggests that an increase in vulnerable narcissism is related to an increase in submissive behaviour and more inferior, negative social comparison.

Grandiose narcissism did not significantly correlate with social comparison or submissive behaviour, but there was a moderate positive correlation between grandiose and vulnerable narcissism (B-PNI VU and B-PNI GR *r*=.57, *p*<.001, CI .45-.68), suggesting that those reporting higher levels of grandiose narcissism are likely to also report higher levels of vulnerable narcissism. There was a strong negative correlation between social comparison and submissive behaviour (ASCS and ASBS *r*=-.63 *p*<.001, CI -.72 to -.51). This indicates those

who rank themselves lower than others tend also to display higher levels of submissive behaviour.

3.7. Research Question 2: Which aspects of shame/narcissism/social rank are significantly associated with distress?

3.7.1. Bivariate Correlations

3.7.1a. Main Scales

The relationships between aspects of shame; narcissism, and social rank and distress were examined using Pearson's product-moment correlation coefficient.

There was a strong positive correlation between all aspects of shame and distress as measured by the DASS-21 (OAS, ESS, ASPS and DASS-21 r=.61; r=.66 and r=.64 respectively, p<.001, CI range from .48 to .75). This suggests those adolescents higher in self-reported shame, were also more likely to experience distress.

Following this, a moderate positive correlation between vulnerable narcissism and distress was found (B-PNI VU and DASS-21 r=.56, p<.001, CI=.42 to .67) along with a weak positive correlation between grandiose narcissism and distress (B-PNI GR and DASS-21 r=.32, p<.001, CI=.19 to .45). This indicates that those adolescents who reported higher levels of narcissism were significantly more likely to experience distress.

A moderate positive correlation between submissive behaviour and distress was found (ASBS and DASS-21 r=.54, p<.001, CI .40 to .66) as was a moderate negative correlation between social comparison and distress (ASCS and DASS-21 r= -.43, p<.001, CI -.55 to -.27). This implies that adolescents self-reporting high levels of submissive behaviour and/or inferior social comparison tend to also experience higher distress.

3.7.1b. Subscales

Subscales were inspected in order to identify the impact of specific aspects of the constructs and to refine the results. Closer inspection of the subscale data showed that the subscales of depression, anxiety and stress were closely correlated hence the total score of the DASS-21 was deemed appropriate for all following statistical analyses. The three subscales for internal shame (ESS, - character, body and behaviour) were also closely correlated allowing for the total score of the ESS to be used for subsequent statistical analyses.

The ASPS (shame proneness) has three subscales, all of which correlated differently with different measures, reflecting results found in Simonds et al., (2016). Thus the three subscales were used as separate variables. The emotional discomfort and the negative self-evaluation subscales both had a moderate positive correlation with distress (ASPS EMD and DASS-21 r=.59, p<.001, CI .47-.68, ASPS NSE and DASS-21 r=.57, p<.001, CI .42-.70) whereas the externalization subscale was lower (ASPS EXT and DASS-21 r=.41, p<.001, CI .25-.54). This suggests that those who reported higher levels of emotional discomfort and negative self-evaluation were more likely to experience higher levels of distress. The same was true of externalization however the association was weaker.

All subscales within the B-PNI were investigated. There was a positive moderate correlation between grandiose narcissism self-sacrificing self enhancement and distress (BPNI GR SSSE and DASS-21 r=.35, p<.001, CI .20-.50); a slightly lower positive moderate correlation with grandiose narcissism grandiose fantasy. However, no significant correlation was found with grandiose narcissism exploitativeness and distress. All vulnerable narcissism subscales correlated positively with distress with contingent self-esteem the highest, followed by hiding the self, then devaluing, with entitlement rage lowest (BPNI VU CSE and DASS-21 r=.50, p<.001, CI .37-.62.

3.8. Research Question 3: Which aspects of shame/narcissism/social rank are the best predictors of psychological distress?

3.8.1. Multiple Regressions

Multiple regression analysis was conducted with DASS-21 total score (distress) as the criterion variable and shame measures (OAS, ESS, ASPS NSE, ASPS EXT, ASPS EMD); narcissism measures (B-PNI GR EXP, B-PNI GR SSSE, B-PNI GR GF, B-PNI VU CSE, B-PNI VU HTS, B-PNI VU D, B-PNI VU ER) and social rank measures (ASBS-R, ASCS-R) as the predictor variables.

3.8.1.1. Assumption I – Ratio of cases to predictor variables Harris (1985) suggests a minimum of ten participants per predictor variable (14 x 10=140) N=142 did meet minimum number requirements, and G* Power test for a medium effect (.25) with power of .80 and 14 predictors states a sample size of 86 was required (Appendix U).

3.8.1.2. Assumption II – Independent errors, normality, homoscedasticity and linearity Standardised residuals were inspected via scatterplot, P-P plot and histogram (Appendix V). The majority of residuals sat between -2 and 2 and were evenly distributed indicating linearity and homoscedasticity had been met (Tabachnick & Fidell, 2012). The assumption of independent errors was met as inspection of the Durbin-Watson (1971) statistic was 1.93, close to the ideal score of 2.

3.8.1.3. Assumption III – Multicollinearity Investigation of the correlation matrix suggested multicollinearity (where two or more variables may be highly linearly related) may not be an issue as no *r* values above .80 were reported; however, Tabachnick and Fidell (2012) suggest lower values may be problematic. Tolerance and Variance Inflation Factor (VIF) were inspected with Tolerances ranging from .23 to .61 and VIF ranging from 1.4 to 4.4. Bowerman and O'Connell (1990) argue if the average VIF is greater than 1 then multicollinearity may exist, however, Myers (1990) suggests a value of 10 as cause for concern, and Hair, Anderson, Tatham & Black (1998) state a VIF of less than 10 as inconsequential.

3.8.1.4. Outliers Investigation of the standardized residuals indicated four cases (2.8%) outside the suitable range +/- 2. Mahalanobis distances were checked and no score exceeded the critical value (df=14, value=29.14), also Cook's distance was below one for all cases. This suggested that no cases were exerting a strong influence on the model (Field, 2009) and hence all were included in the analysis.

3.8.1.5. Regression model A multiple regression with all aspects of shame, narcissism and social rank predictors included followed by a backwards stepwise regression was conducted. A backwards stepwise multiple regression was performed to counter any Type II errors, as forward selection can increase suppressor effects. Backwards stepwise multiple regression is also an acceptable analysis to use for exploratory model building (Wright, 1997) and determines which predictors are making the biggest contributions via dropping variables that are not significant. The first model explained 55.8% of the variance of psychological distress $F(14,127)=11.46$, $p<.001$, $r=.75$, however, only the variable internal shame (ESS - $\beta=.24$, $t=2.75$, $p=.007$) was statistically significant once accounting for all other predictors (see Table III).

Table III Backwards step-wise multiple regression for Distress (DASS-21)

Predictors entered	B	β	t	p	SE beta	*R*	R^2	F	Sig
(Constant)	-4.72		-.54	.60	8.78	**.75**	**.56**	**11.46**	**.000***
OAS (Ext Shame)	.16	.14	1.28	.20	.12				
ESS (Int Shame)	.24	.30	2.75	.01*	.09				
ASPS NSE (Shame proneness negative self evaluation)	-.26	-.13	1.93	.27					
ASPS EXT (Shame proneness externalisation)	.50	.12	1.58	.12					
ASPS EMD (Shame proneness emotional discomfort)	.79	.19	1.92	.06					
ASCS (Social Comparison)	-.12	-.09	-1.13	.26					
ASBS (Submissive Behaviour)	.20	.13	1.39	.17					
B-PNI GR EXP (Grandiose narcissism exploitativeness)	.08	.02	.35	.73					
B-PNI GR SSSE (Grandiose narcissism self sacrificing self enhancement)	.31	.09	1.07	.28					
B-PNI GR GF (Grandiose narcissism grandiose fantasy)	-.15	-.05	-.71	.48					
B-PNI VU CSE (Vulnerable narcissism contingent self esteem)	-.02	-.01	-.08	.93					
B-PNI VU HTS (Vulnerable narcissism hiding the self)	-.17	-.06	-.71	.48					
B-PNI VU D (Vulnerable narcissism devaluing)	.46	.15	1.71	.09					
B-PNI ER (Vulnerable narcissism entitlement rage)	.18	.06	.64	.53					
Backwards Stepwise									
(Constant)	-10.85		-3.42	.00*		**.73**	**.54**	**31.41**	**.000***
ESS (Int Shame)	.27	.35	3.98	.00*					
ASPS EXT (Shame proneness externalisation)	.52	.12	1.81	.07					
ASPS EMD (Shame proneness emotional discomfort)	.63	.15	1.78	.08					
ASBS (Submissive Behaviour)	.23	.15	1.94	.05*					
B-PNI VU D (Vulnerable narcissism devaluing)	.58	.18	2.89	.00*					

***significant equal to and below p<.05 Bootstrap results are based on 1000 bootstrap samples N=142**

In the final model, the five predictors with the highest significance were kept (see Appendix W for full analysis table), resulting in a model with the total variance explained at 53.6% $F(5,136)=31.41$, $p<.001$, retaining ESS (β=.35, t=3.98, $p<.001$), ASPS EXT (β=.12, t=1.81, NS), ASPS EMD (β=.15, t=1.78, NS) ASBS-R (β=.15, t=1.93, $p<.05$) and B-PNI VU (β=.19, t=2.89, $p<.01$). This indicates that internal shame, shame proneness (externalization and emotional discomfort) and vulnerable narcissism (devaluing) predict distress. Although the shame proneness variables did not reach significance within the model, the variables were trending in the expected direction. Removal of these variables reduced the

total variance suggesting there may have been exerting marginal influence.

Although there was a 2% difference in predictive value between the model with all predictors and final model with five predictors (in favour of all predictors) the end model indicates that a large percentage of the variance is explained via the final five predictors. Therefore the remaining nine predictors not in the final model explain a small amount of the variance.

3.9. Research Question 4: Which aspects of shame/narcissism/social rank are significantly associated with psychological wellbeing?

3.9.1. Bivariate Correlations

3.9.1a Main scales

The relationships between aspects of shame; narcissism and social rank and wellbeing were examined using Pearson's product-moment correlation coefficient.

A moderate negative correlation was found between all aspects of shame and wellbeing as measured by the WEMWBS (OAS, ESS, ASPS and WEMWBS r=-.44; r=-.44 and r= -.45 respectively, p<.001, CI range from -.58 to -.27). This indicates that those self-reporting increased levels of shame also reported decreased levels of wellbeing.

There was a moderate negative correlation between vulnerable narcissism and wellbeing (B-PNI VU and WEMWBS r=-.38, p<.001, CI=-.51 to -.21) and no correlation between grandiose narcissism and wellbeing. This suggests that adolescents with higher levels of vulnerable narcissism tend to also have lower levels of wellbeing, whereas grandiose narcissism has no relationship with wellbeing.

A moderate negative correlation was identified between submissive behaviour and wellbeing (ASBS and WEMWBS r=-.55, p=.00, CI -.68 to -.40) and a moderate positive correlation between social comparison and wellbeing (ASCS

and WEMWBS *r*=.49, *p*=.00, CI .35 to .61). This implies that those reporting lower levels of submissive behaviour tend to experience higher levels of wellbeing as do those who tend to rate themselves higher than others in social comparison.

3.9.1b. Subscales

There were differences between the subscales on the ASPS (shame proneness) and WEMWBS. The negative self-evaluation and emotional discomfort subscales both moderately negatively correlated with wellbeing, (ASPS NSE and WEMWBS *r*=-.42, *p*<.001, CI -.56- -.27, ASPS EMD and WEMWBS *r*=-.42, *p*<.001, CI -.56- -.27), however externalization had a lower negative correlation with wellbeing (ASPS EXT and WEMWBS *r*=-.26, *p*<.001, CI -.43- .10). This indicates that those who tended towards more positive self-evaluation and lower emotional discomfort tended to experience higher wellbeing. This was similar for externalization however the association was not as strong.

None of the grandiose narcissism subscales significantly correlated with wellbeing. However, within vulnerable narcissism, the contingent self-esteem, hiding the self and devaluing subscales all correlated negatively with wellbeing (BPNI VU CSE and WEMWBS *r*=-.37, *p*<.001, CI -.51- -.21, BPNI VU HTS and WEMWBS *r*=-.41, *p*<.001, CI -.56- -.24, BPNI VU D *r*=-.29, *p*<.001, CI -.45- -.12) although the entitlement rage subscale did not significantly correlate. This suggests that adolescents reporting lower contingent self-esteem, hiding the self and devaluing also reported higher wellbeing. All grandiose subscales and vulnerable narcissism entitlement rage subscale had no relationship with wellbeing.

3.10. Research Question 5: Which aspects of shame/narcissism/social rank are the best predictors of psychological wellbeing?

3.10.1. Multiple Regressions

As with research question 3 a multiple regression analysis was conducted replacing the criterion variable DASS-21 with the WEMWBS total score (wellbeing) and shame measures (OAS, ESS, ASPS NSE, ASPS EXT, ASPS EMD); narcissism measures (B-PNI GR EXP, B-PNI GR SSSE, B-PNI GR GF, B-PNI VU CSE, B-PNI VU HTS, B-PNI VU D, B-PNI VU ER) and social rank measures (ASBS-R, ASCS-R) as the predictor variables. The same assumptions were applied as for research question 3. (Appendix X for full analysis).

3.10.1.1. Assumption I – Ratio of cases to predictor variables Sample numbers were deemed suitable as before, see *3.8.1.1.*

3.10.1.2. Assumption II – Independent errors, *normality, homoscedasticity and linearity* Standardised residuals were inspected via scatterplot, P-P plot and histogram (Appendix Y). The majority of residuals sat between -2 and 2, however, three cases were above +/- 2.5 with one exceeding +/- 3, although cases were evenly distributed. The assumption of independent errors was met as inspection of the Durbin-Watson (1971) statistic was 1.99, close to the ideal score of 2, hence linearity and homoscedasticity had been met (Tabachnick & Fidell, 2012).

3.10.1.3. Assumption III – Multicollinearity Tolerance and Variance Inflation Factor (VIF) were the same as for research question 3 – see *3.8.1.3*.

3.10.1.4. Outliers Investigation of the standardized residuals indicated seven cases (4.9%) outside the suitable range +/- 2; three cases (2.1%) outside +/- 2.5 and one case (0.7%) above the critical value of 3. Mahalanobis distances were checked and no score exceeded the critical value (df=7, value=24.32), also Cook's distance was below one for all cases - .00 to .10 (Cook & Weisberg,

1982). This suggested that no cases were exerting a strong influence on the model (Field, 2009) and hence all were included in the analysis.

3.10.1.5. Regression model

Table IV Backwards stepwise multiple regression for Wellbeing (WEMWBS)

Predictors entered	B	β	t	p	SE beta	*R*	R^2	F	Sig
						.67	**.44**	**7.24**	**.001***
(Constant)	30.63		4.57	.001	6.70				
OAS (Ext Shame)	-.04	-.05	-.40	.69	.09				
ESS (Int Shame)	-.06	-.11	-.86	.39	.07				
ASPS NSE (Shame proneness negative self evaluation)	.36	.27	1.98	.05*	.18				
ASPS EXT (Shame proneness externalisation)	-.41	-.14	-1.70	.09	.24				
ASPS EMD (Shame proneness emotional discomfort)	-.29	-.11	-.93	.35	.31				
ASCS (Social Comparison)	.18	.21	2.34	.02*	.07				
ASBS (Submissive Behaviour)	-.26	-.25	-2.32	.02*	.11				
B-PNI GR EXP (Grandiose narcissism exploitativeness)	.24	.10	1.32	.19	.18				
B-PNI GR SSSE (Grandiose narcissism self sacrificing self enhancement)	.14	.06	.63	.53	.22				
B-PNI GR GF (Grandiose narcissism grandiose fantasy)	.29	.16	1.85	.07	.16				
B-PNI VU CSE (Vulnerable narcissism contingent self esteem)	-.17	-.10	-.86	.39	.19				
B-PNI VU HTS (Vulnerable narcissism hiding the self)	-.32	-.17	-1.77	.08	.18				
B-PNI VU D (Vulnerable narcissism devaluing)	-.47	-.22	-2.29	.02*	.21				
B-PNI ER (Vulnerable narcissism entitlement rage)	.28	.13	1.31	.19	.21				
Backwards Stepwise									
STEP 10						**.63**	**.39**	**18.06**	**.001***
(Constant)	33.76		5.33	.001*					
ASPS EXT (Shame proneness externalisation)	-.40	-.14	-2.06	.04*					
ASCS (Social Comparison)	.17	.20	2.24	.02*					
ASBS (Submissive Behaviour)	-.34	-.33	-3.57	.001*					
B-PNI GR GF (Grandiose narcissism grandiose fantasy)	.28	.15	2.14	.03*					
B-PNI VU HTS (Vulnerable narcissism hiding the self)	-.37	-.21	-2.60	.01*					

Bootstrap results are based on 1000 bootstrap samples *significant equal to and below p<.05
N=142

Table IV shows the initial multiple regression with all aspects of shame,

narcissism and social rank predictors included followed by a backwards stepwise regression, including the standardized regression coefficients (□), t values (t), bootstrapped significance values (p), SEs, *R*, *R*-squared, *F*-value and significance of the model. A backwards stepwise multiple regression was run in order to determine which predictors were making the biggest contributions via dropping statistically insignificant variables. The first model explained 38.3% of the variance $F(14,127)=7.23$, $p<.001$; however, only the variables shame proneness (negative self-evaluation) (β=.27, t=1.98, $p<.05$), social comparison (β=.21, t=-2.34, $p<.05$), submissive behaviour (β=-.25, t=-2.32, $p<.05$), and vulnerable narcissism (devaluing) (β=-.22, t=-2.29, $p<.05$) were statistically significant once the impact of other variables had been controlled for.

In the final model, the eleven predictors with the least significance were removed (namely OAS; ESS; ASPS NSE; ASPS EMD; B-PNI GR EXP; B-PNI GR SSSE; B-PNI VU CSE; B-PNI VU D; B-PNI VU ER) resulting in a model with the total variance explained at 39.9% $F(5,136)=18.06$, $p<.001$, retaining ASPS EXT (shame proneness externalisation - β=-.14, t=-2.06, $p<.05$), ASCS-R (social comparison - β=.20, t=2.24, $p<.05$), ASBS-R (submissive behaviour - β=-.33, t=-3.57, $p<.001$), B-PNI GR GF (grandiose narcissism grandiose fantasy - β=.15, t=2.14, $p<.05$) and B-PNI VU HTS (vulnerable narcissism hiding the self - β=-.21, t=-2.60, $p<.01$). These findings suggest that lower levels of shame proneness (externalization), submissive behaviour and vulnerable narcissism (hiding the self), and higher levels of positive social comparison and grandiose fantasy are predictive of higher levels of wellbeing.

3.11. Research Question 6:

a) **Are there significant associations between self-compassion and aspects of shame, narcissism, social rank, distress and wellbeing?**
b) **What percentage of the variance for distress is predicted by self-compassion?**
c) **What percentage of the variance for wellbeing is predicted by self-compassion?**
d) **Does self-compassion have a moderating role in:**
   i. Distress

ii. Wellbeing

3.11.1.(a) Bivariate Correlations

The relationships between self-compassion (as measured by the SCSSF-P) and all other variables were examined using Pearson product-moment correlation coefficient. There was a weak negative correlation with internal shame (ESS total score, r=-.20, p=.01, CI=-.37 to -.02; ESS CH r=-.19, p=.01, CI=-.36 to -.02; and ESS BOD r=-.22, p=.01, CI=-.38 to -.05) and shame proneness (ASPS total score, r=-.18, p=.01, CI=-.36 to -.01; ASPS NSE r=-.20, p=.01, CI=-.37 to -.01); a weak positive correlation with grandiose narcissism (B-PNI GR total score, r=.22, p=.001, CI=.07 to .36; B-PNI EXP r=.21, p=.01, CI=.06 to .35; B-PNI GR SSSE r=.21, p=.01, CI=.06 to .35) and a moderate positive correlation with wellbeing (WEMWBS r=.35, p=.001, CI=.16 to .53). Correlations with all other variables were not significant. Hence those who reported lower levels of shame and those reporting higher levels of grandiose narcissism were more likely to have higher levels of self-compassion; and those who reported higher levels of wellbeing also had higher levels of self-compassion.

3.11.2. Multiple regressions

3.11.2.1. (b) *Distress* A multiple regression was conducted adding self-compassion (SCSSF-P) into the regression model for distress (DASS-21) alongside the ESS, ASPS EXT, ASPS EMD, ASBS-R and B-PNI VU D. All assumptions were met as before. See Table V.

Table V Multiple Regression adding self-compassion to distress model (DASS-21)

Predictors entered	B	β	t	p	*r*	r^2	*F*	*p*
(Constant)	-12.44		-2.64	.001	**.73**	**.54**	**26.06**	**.000**
ESS (Internal Shame)	.28	.35	3.98	.000				
ASPS EXT (Shame Proneness externalisation)	.53	.12	1.83	.07				
ASPS EMD (Shame Proneness emotional discomfort)	.63	.15	1.76	.08				
ASBS (Submissive Behaviour)	.23	.15	1.90	.06				
B-PNI VU D (Vulnerable narcissism devaluing)	.58	.18	2.88	.005				
SCSSF-P (Self-compassion positive aspects)	.08	.03	.46	.65				

Bootstrap results are based on 1000 bootstrap samples N=142

Results show self-compassion did not improve the model and is not a variable that predicts or is related to distress. This was expected based on findings in the above correlational analyses.

3.11.2.2. (c) *Wellbeing* A multiple regression was conducted adding self-compassion (SCSSF-P) into the regression model for wellbeing (WEMWBS) alongside ASPS EXT, ASCS-R, ASBS-R, B-PNI GR GF, B-PNI VU HTS. All assumptions were met as before. See Table VI.

Table VI Multiple regression adding self-compassion to wellbeing model (WEMWBS)

Predictors entered	B	β	t	p	*r*	r^2	*F*	*p*
					.68	**.47**	**19.07**	**.001**
(Constant)	25.68		4.08	.001				
ASPS EXT (Shame proneness externalisation)	-.32	-.11	-1.71	.09				
ASCS (Social Comparison)	.15	.18	2.11	.05				
ASBS (Submissive Behaviour)	-.34	-.33	-3.83	.001				
B-PNI GR GF (Grandiose narcissism grandiose fantasy)	.21	.11	1.62	.11				
B-PNI VU HTS (Vulnerable narcissism hiding the self)	-.35	-.17	-2.44	.02				
SCSSF-P (Self-compassion positive aspects)	.56	.27	4.15	.001				

Bootstrap results are based on 1000 bootstrap samples N=142

Correlation analysis showed that those who reported higher wellbeing had lower scores on shame proneness (externalization), submissive behaviour and vulnerable narcissism (hiding the self). Submissive behaviour had the highest loading. Grandiose narcissism (grandiose fantasy) did not significantly correlate with wellbeing. This suggests it may be acting as a suppressor variable and exerting its influence by suppressing irrelevant variance in the other predictor variable(s) which ameliorates the relationships between predictor and outcome variables (Lancaster, 1999).

The increase in R^2 from .39 to .47 (from 39% to 47% of the variance explained) showed self-compassion as having a marked influence in the model, indicating improved wellbeing with the addition of self-compassion.

3.11.3. Moderation Analyses

Moderation explains under what conditions the predictor is related to the outcome (Kraemer, Kiernan, Essex & Kupfer, 2008) and aims to determine whether the size of the effect of a causal variable on an outcome variable is dependent upon a moderator variable (Hayes, 2012), hence self-compassion may be interacting with the predictor variables which may change the direction or strength of the relationship with distress and wellbeing. Moderation analysis was run in SPSS using Process (V3.0 Hayes, 2018).

3.11.3.1.(d.i.) Distress The variables with the highest loadings (internal shame, vulnerable narcissism devaluing and submissive behaviour) were examined via moderation analyses. See Table VII.

Table VII Moderation analyses Self-compassion and distress (DASS-21)

Outcome variable - DASS-21 (Distress)

PREDICTORS

	r	*r2*	*Δr2*	*F*	*P*	*B*	*t*	*P*
ESS main model	.66	.43		35.14	.000			
ESS Internal shame						.51	10.06	.000
SCSSF-P Self-compassion						.08	.41	.68
Interaction ESSxSCSSF			.000	.08	.77	-.003	-.29	
BPNI VU D main model	.44	.19		10.84	.000			
BPNI VU D Vul Narcissism Devaluing						1.34	5.55	.000
SCSSF-P Self-compassion						-.20	-.80	.43
Interaction BPNI VU DxSCSSF			.000	.000	.98	.000	.01	
ASBS main model	.55	.30	.000	19.73	.000			
ASBS Submissive Behaviour						.82	7.42	.000
SCSSF-P Self-compassion						-.17	-.74	.46
Interaction ASBSxSCSSF			.000	.01	.91	.00	.11	

Table VI shows that although all overall models were significant, there were no significant interaction effects and indeterminate R^2 change scores. For internal shame overall model, $F(3,138)=35.14$, $r^2=.43$, $p<.001$, for the predictors, ESS $b=.51$, $t(138)=10.06$, $p<.001$; SCSSF $b=.08$, $t(138)=.41$, $p=.68$ NS; interaction $b=-.003$, $t(138)=-.29$, $p=77$ NS.

For vulnerable narcissism devaluing overall model, $F(3,138)=10.84$, $r^2=.19$, $p<.001$, for the predictors, BPNI VU D $b=-1.34$, $t(138)=-5.55$, $p<.001$; SCSSF $b=-.20$, $t(138)=-.80$, $p=.43$ NS; interaction $b=.00$, $t(138)=.01$, $p=.99$ NS.

For submissive behaviour overall model $F(3,138)=19.73$, $r^2=.30$, $p<.001$, for the predictors, ASBS-R $b=-.82$, $t(138)=-7.42$, $p<.001$, SCSSF $b=-.17$, $t(138)=-.74$, $p=.46$, interaction $b=.00$, $t(138)=.11$, $p=.91$ NS.

Self-compassion has no moderator role in the relationships between the predictor variables and distress.

3.11.3.2. (d.ii.) Wellbeing

Table VIII Moderation analysis with Self-compassion and wellbeing (WEMWBS)

Outcome variable - WEMWBS (Wellbeing)								
PREDICTORS								
	r	***r²***	***Δr²***	***F***	***p***	***B***	***t***	***p***
ASCS-R main model	**.58**	**.33**		**22.88**	**.000**			
ASCS-R Social Comparison						.38	6.13	.000
SCSSF-P Self-compassion						.66	4.29	.000
Interaction ASCSxSCSSF			**.002**	.45	.50	-.009	-.67	.50
BPNI VU HTS main model	**.53**	**.28**		**17.84**	**.000**			
BPNI VU HTS Vul Narcissism Hiding the self						-.71	-5.14	.000
SCSSF-P Self-compassion						.72	4.56	.000
Interaction BPNI VU HTSxSCSSF			**.008**	1.56	.213	.03	1.25	.21
ASBS-R main model	**.63**	**.40**		**30.64**	**.000**			
ASBS-R Submissive Behaviour						-.55	-7.80	.000
SCSSF-P Self-compassion						.65	4.48	.000
Interaction ASBSxSCSSF			**.000**	.000	.98	.00	.02	.98

Table VIII shows that although all overall models were significant, there were no significant interaction effects and very low R^2 change scores. For social comparison overall model, $F(3,138)=22.88$, $r^2=.33$, $p<.001$, for the predictors, ASCS-R $b=.38$, $t(138)=6.14$, $p<.001$; SCSSF $b=.66$, $t(138)=4.29$, $p<.001$; interaction $b=-.01$, $t(138)=-.67$, $p=50$ NS.

For vulnerable narcissism hiding the self overall model, $F(3,138)=17.84$, $r^2=.28$, $p<.001$, for the predictors, BPNI VU HTS $b=-.71$, $t(138)=-5.14$, $p<.001$; SCSSF $b=.72$, $t(138)=4.56$, $p<.001$; interaction $b=.03$, $t(138)=.02$, $p=.21$ NS.

For submissive behaviour overall model $F(3,138)=30.64$, $r^2=.40$, $p<.001$, for the predictors, ASBS-R $b=-.55$, $t(138)=-7.80$, $p<.001$, SCSSF $b=.65$, $t(138)=4.49$, $p<.001$, interaction $b=.00$, $t(138)=.02$, $p=.98$ NS.

This shows self-compassion does not act as a moderator between the predictor variables and wellbeing, however it does have a role in predicting wellbeing.

4. DISCUSSION

4.1. Overview

This chapter provides the aims of the research, summary of findings and consideration of the sample characteristics. Research questions results are appraised in relation to extant literature and followed by a discussion of practice implications. The strengths, limitations and directions for future research are then considered, followed by summary and conclusion.

4.2. Study Aims

This research aimed to address gaps in the literature and explore relationships between aspects of shame (internal, external and shame proneness), aspects of social rank (social comparison, submissive behaviour) and aspects of narcissism (grandiose and vulnerable), and which variables predict distress and wellbeing in a mid-adolescent population. A further aim was to identify the role of self-compassion and whether it functioned as predictor and/or moderator of the relationships established.

4.3. Summary of Findings

Significant correlations between aspects of shame, narcissism and social rank were found that warranted deeper investigation into the specific constructs predicting psychological distress and psychological wellbeing in a mid-adolescent population. Analyses revealed internal shame, shame proneness (externalization and emotional discomfort), submissive behaviour and vulnerable narcissism (devaluing) predicted distress. Hence participants with high internal shame, negative externalizing and distressing feelings, who behaved submissively and wanted to avoid feeling disappointment around self and others, were more likely to experience distress. Whereas social comparison, grandiose narcissism (grandiose fantasy) positively predicted wellbeing with shame proneness (externalization), submissive behaviour, and vulnerable narcissism (hiding the self) negatively predicting wellbeing. Therefore those who positively

compared themselves to others; had fantasies about high achievement and recognition; were low in submissive behaviour, had fewer negative externalizing feelings and did not feel shame about having needs, were more likely to have psychological wellbeing. These results are further evidence of distress and wellbeing as orthogonal constructs rather than either end of a spectrum (c.f.Two Continua Model, Keyes, 2005).

Introducing self-compassion into the models for distress and wellbeing offered more evidence for distress and wellbeing as distinct constructs. Self-compassion did not correlate with the measures of distress hence there was no effect within the model. However, self-compassion correlated with wellbeing and enhanced the predictive model suggesting self-compassion is an important factor in wellbeing. These results implied developing self-compassion may improve wellbeing.

4.4. Sample Characteristics

The final sample comprised 142 mid-adolescents, 86 were recruited during Phase I (school recruitment) and 56 recruited at Phase II (online study). Complications obtaining a state-run school to participate necessitated online recruitment.

Demographic information for study completers was compared to non-completers. There was little variation in ethnicity and gender between completers and non-completers. These differences were not tested for significance therefore this finding should be regarded tentatively as there may have been significant differences had the remaining 58% provided demographic data. Reasons for non-completion may be myriad but could be related to stresses of academic work and time pressures.

Information regarding family socio-economic status; family configuration; academic status; or clinical status (whether the participant was or had been in receipt of clinical support) were not taken because adolescents might be less inclined to participate if too much personal information, which they may experience as shaming, was required. This sample was a general population

sample implying the majority would be non-clinical; however, it was likely a minority of cases might have been clinical.

This sample showed a female gender bias (83.8% female vs 16.2% male). Phase I took place in a girl's private school; however, the bias was maintained during Phase II (23.2% male participation). As Phase II was an opportunity sample it highlighted that there may be gender differences in willingness to complete surveys, however this is beyond the remit of this research. Future studies could compare genders to determine possible gender differences in adolescents relating to distress and wellbeing. There was also bias in ethnicity with 69% identifying as White; 9.2% Asian/Asian other; 4.2% Black/Black other and 7.7% mixed. This is similar to the ONS Census (2011)[2] reporting of the ethnic composition in the UK, so it might be argued that this study is representative of the UK population in terms of ethnic organization.

Mean scores for the WEMWBS for the overall sample was 28.8 which is much lower than the mean score population norm of 51.7 (Stewart –Brown & Janmodhamed, 2008) indicating this sample reported low levels of wellbeing. The DASS-21 scores for this sample were deemed moderate for depression and anxiety and mild for stress. Mean scores for all shame measures (including subscales; OAS, ESS, ASPS); grandiose narcissism (including subscales; B-PNI GR), subscales devaluing and entitlement rage in vulnerable narcissism (B-PNI VU D; B-PNI VU ER), and submissive behaviour (ASBS) were similar to those found in the original research papers for the measures (see Allan & Gilbert, 1997; Allan, Gilbert, & Goss, 1994; Andrews, Qian & Valentine, 2002; Goss, Gilbert, & Allan 1994; Lovibond & Lovibond, 1995; Raes et al., 2011; Schoenleber et al., 2015; Simonds et al., 2016; Tennant et al., 2007). However, vulnerable narcissism overall score, contingent self-esteem and hiding the self (B-PNI VU; B-PNI VU CSE; B-PNI VU HTS) means were marginally higher than other studies (see Schoenleber et al., 2015), and the social comparison (ASCS) sample mean was lower than previous studies (see Allan & Gilbert, 1995) suggesting this sample more negatively compared themselves and experienced greater vulnerable narcissism than those in previous studies.

[2] ONS Census 2011 reported Ethnic group percentages as White 87%; Asian/Asian British (including Chinese) 7%; Black/African/Carribean/Black British 3%; Mixed 2%; Gypsy/Travellers/Irish Travellers 1%

4.5. Research Question 1: Are there significant associations between aspects of shame, narcissism and social rank?

This study first aimed to determine which variables were significantly associated in order to better understand the relationships between the different aspects prior to further investigation.

A strong positive relationship was found between all shame variables indicating those with high external shame are likely to have high internal shame and be more shame prone than those with lower levels. Hence those who believe others have negatively evaluated them are also likely to be evaluating themselves in a similar fashion, as well as being more prone to shame-type emotional responses (Goss, Gilbert & Allan, 1994).

With regards to SRT, a strong negative association was found between submissive behaviour and social comparison suggesting as submissive behaviour increases, positive social comparison goes down, so the more submissive one behaves the more negatively they compare themselves to others and vice versa. The temporal precedence is unclear.

Grandiose narcissism and vulnerable narcissism had a moderate, positive relationship suggesting the constructs share core aspects relevant to both subtypes and is in keeping with research (Pincus et al., 2009; Zeigler-Hill, Clark & Pickard, 2008). However, differential associations with other measures denote divergence between the two aspects.

All shame variables positively correlated with narcissism – strongly with vulnerable narcissism and weakly with grandiose. This suggests that the higher the external, internal and shame proneness the higher the vulnerable narcissism, and to some extent the higher the grandiose narcissism. This is in opposition to Wright, O'Leary and Balkin (1989) who found a moderate negative relationship between shame and narcissism. However, both shame and narcissism were not differentiated and treated as global concepts. Gramzow and Tangney (1992) also found a negative correlation between shame proneness and narcissism;

however, they, similarly to Wright, O'Leary and Balkin (1989) did not differentiate the constructs. Asheghabadi, Borjali and Hosseinsabet, (2015) found shame correlated weakly and negatively with overt narcissism and positively with covert narcissism. They termed vulnerable narcissism as covert. This finding indicates narcissism (in terms of being a normal part of adolescent development), whether expressed via grandiose or vulnerable methods, is related to shame as a possible 'defence against' (in terms of grandiose) or 'expression of' (vulnerable).

A strong positive association was found between all aspects of shame and submissive behaviour implying that those who were high in external, internal shame and shame proneness also were high in submissive behaviours. This is in keeping with existing research (Gilbert, 1989; Gilbert & McGuire, 1998; Keltner & Harker, 1998) wherein the strong relationship between shame measures and social rank suggest shame experiences correspond with underlying, submissive mechanisms (Gilbert, 2000a). The moderate negative correlation between all aspects of shame and social comparison suggests the higher the shame the lower the positive social comparison, so those who experience high internal, external and shame proneness are more likely to negatively socially compare themselves to others, again in keeping with existing literature (Gilbert, 2000a).

A moderate, positive relationship was detected between vulnerable narcissism and submissive behaviour and a moderate, negative association was found between vulnerable narcissism and social comparison. This shows a link between narcissism and social rank and highlights those with higher levels of vulnerable narcissism are more likely to behave submissively and more likely to compare themselves to others unfavourably.

However, it is important to note no causal conclusions can be drawn from correlational analyses.

4.6. Research Question 2 - Which aspects of shame/narcissism/social rank are most significantly associated with psychological distress?

4.6.1. Main scales

Once the aspects that were significantly associated with distress were identified via correlational analysis, the associations between the same variables and distress (as measured by the total score of DASS-21) were examined. The strongest associations were between all aspects of shame (internal, external and shame proneness) and distress. Those reporting high levels of shame were significantly more likely to experience psychological distress. These results support existing literature (see Åslund, Nilsson, Starrin, & Sjoberg, 2007; Stuewig & McCloskey, 2005; Tilghman-Osborne et al., 2008).

Vulnerable narcissism and submissive behaviour were found to be moderately positively related with distress suggesting those reporting high levels of vulnerable narcissism and/or submissive behaviour were more likely to experience distress. Dickinson and Pincus (2003) identified those as expressing vulnerable narcissism as presenting with shame and both reporting and experiencing greater distress, which these results support. The results found those with high submissive behaviour also coincide with existing literature (Allan & Gilbert, 1995; Cheung, Gilbert & Irons, 2004; Gilbert, 2000; Gilbert & Allan, 1994; Gilbert, Allan, Brough, Melley, & Miles 2002). Social comparison was found to be negatively moderately associated with distress suggesting that those who negatively compared themselves with others are more likely to be distressed whereas those who compared themselves positively reported lower levels of distress (Gilbert, Price & Allan, 1995).

Finding grandiose narcissism weakly but positively associated with distress was inconsistent with existing research. Miller et al. (2014) found grandiose narcissism was unrelated to distress whilst vulnerable narcissism was positively related. Inconsistencies differentiating between the two subtypes of narcissism and between pathological and normative narcissism may account for the differences. This might also highlight a measurement issue. Miller et al. (2014) posit that the PNI overrepresents fragility and under emphasizes antagonistic

behaviours expected in grandiose narcissism.

Lapsley and Aalsma's (2006) study identified those as displaying overt (grandiose) and covert (vulnerable) aspects of narcissism were generally predisposed to higher levels of emotional dysfunction (higher scores on measures of anxiety, relationship problems, depression, esteem and family problems, and pathology of separation individuation) than those deemed moderately narcissistic. However, studies have identified grandiose narcissism as being negatively related to distress (e.g. Sedikides et al., 2004). This research found those who reported higher levels of grandiose narcissism were more likely to experience distress.

4.6.2. Subscales

The subscales of the ASPS and the B-PNI were inspected to obtain a nuanced understanding of the aspects directly related to distress. Internal shame remained as a total score as explained previously.

Emotional discomfort on the shame proneness scale had the strongest positive relationship with distress. Those who reported higher levels of emotional discomfort were more likely to feel distress, thus the visceral experience and recognition of negative feelings was more powerfully distressing than internal negative thoughts or wishing to express feelings of anger and frustration.

All vulnerable narcissism subscales were positively related to distress with contingent self-esteem having the highest loading followed by hiding the self, then devaluing and finally entitlement rage. This suggests those whose self-worth is dependent upon other's attention are slightly more likely to feel distress than those who feel frustration at others for not responding to them suitably. This indicates internalizing emotional responses may have stronger links to feelings of distress than externalizing emotions. However, this division may be too simplistic – there may be some overlap of those experiencing these feelings.

The grandiose narcissism subscales showed no relationship between exploitativeness and distress, however self-sacrificing self-enhancement and

grandiose fantasy were both positively and moderately associated. Those reporting higher levels of fantasizing about accomplishments and needing to be seen as good due to their sacrifices are more likely to experience higher, yet moderate levels of distress.

4.7. Research Question 3 - Which specific aspects of shame/narcissism/social rank are the best predictors of psychological distress?

The stepwise regression identified internal shame, shame proneness (externalization and emotional discomfort), submissive behaviour and vulnerable narcissism (devaluing) as the main predictors for distress. Internal shame showed the highest loading (β=.35), then vulnerable narcissism (devaluing) (β=.18); shame proneness (emotional discomfort) and submissive behaviour (β=.15) and lastly shame proneness (externalization) (β=.12.). This suggests distress is highest for those who feel 'there is something wrong with me'; who wish to avoid others for fear of them not acknowledging their value; who experience negative internal emotions and behave submissively whilst wanting to express frustration. These constructs may have a circular function by the additive effects they may have on each other.

There are no papers to compare these findings with, however, much research exists that identifies external shame as most predictive of depressive symptomology (Leary, 2004, 2007). This is understood to be due to the perceived rejection that might ensue following a loss of social status. External shame and negative social comparison may be paramount at this time, considering social interactions are vital in the construction of self during adolescence. However, these results contrast this as a stronger relationship between internal shame and distress was found. Measurement issues may account for this together with other explanations. Previous studies examined shame and depression whereas this study examined shame and a global construct of distress. The conflation of depression, anxiety and stress may explain why internal shame has stronger predictive power to explain distress

than external shame. It may also be related to the scale used to determine internal shame - the ESS contains both external and internal shame aspects, potentially making it a less accurate representation of internal shame. However, this sample may be more internally self-focused. Their own self-evaluations may be more distressing than their perceived views from others. Internal shame is linked to self-criticism and self-persecution which can involve feelings like anger and disgust towards the self (Gilbert & Irons, 2005; Whelton & Greenberg, 2005) which seems to link more to distress than external shame. Perhaps the approval needed regarding social status is something this sample may feel hard to achieve, viewing themselves as inferior to others, wanting to avoid drawing attention to themselves (involuntary subordinate self-perception, Gilbert, 1992, 2000b), having little interest in being part of the social hierarchy and tending towards isolation and keeping themselves safe. The emphasis on internal focus may also signify the technological and social media pressures faced by this generation - social media (Facebook; Instagram etc) may increase internal negative evaluation of self (see Vogel, Rose, Roberts & Eckles, 2014).

4.8. Research Question 4 - Which aspects of shame/narcissism/social rank are significantly associated with psychological wellbeing?

4.8.1. Main scales

This research argues distress and wellbeing are related but distinct constructs as posited by the Two Continua Model (Keyes, 2002). The following findings are further evidence. Wellbeing (as measured by the WEMWBS) was found to be moderately negatively associated with distress (as measured by the total score of the DASS-21 - r=-.50) suggesting those with higher wellbeing did have lower distress. Only weak to moderate correlations between other variables and wellbeing were identified.

All shame aspects (internal, external and shame proneness) and vulnerable narcissism were negatively moderately related to wellbeing denoting those who reported lower levels of shame, and lower levels of vulnerable narcissism

reported higher levels of wellbeing. The strongest correlation occurred between submissive behaviour and wellbeing (r=-.55) suggesting those who behaved less submissively had higher wellbeing.

Interestingly, no significant correlations were found between grandiose narcissism (total score and all grandiose narcissism subscales) and wellbeing indicating no relationship between them. Whilst the positive connections between narcissism as a construct and wellbeing are not universal (Rose, 2002; Sedikides et al., 2004), Hill and Roberts's (2012) study identified a link between adolescents, narcissism and life satisfaction, largely replicating Ackerman, Witt, Donnellan, Trzesniewski, Robins and Kashy (2011). They used the Narcissistic Personality Inventory test (NPI, Raskin & Terry, 1988) which does not study the vulnerable aspects of narcissism, hence, Hill and Roberts (2012) found a strong link between grandiose narcissism and life satisfaction which they equated with wellbeing.

The results found in this study suggest an issue with narcissism measurement, and/or they may relate to this particular sample of adolescents experiencing grandiose narcissism in a maladaptive fashion. The correlations with all aspects of shame, vulnerable narcissism and distress suggests grandiose narcissism does not have a protective or positive function. These results support Pincus et al. (2005) who found the PNI correlated positively with shame and distress, however, this result was with an aggregated score of both grandiose and vulnerable narcissism and may not be a viable comparison.

Social comparison was found to be moderately positively related to wellbeing indicating those who reported higher positive social comparison reported better wellbeing, consistent with existing research (Diener & Fujita, 1997; Wills, 1981; Wood, Taylor & Lichtman, 1985). Hence those who compared themselves positively with others experienced better wellbeing than those who compared themselves negatively.

4.8.2. Subscales

Inspection of the subscales of the ASPS showed the three subscales (negative

self-evaluation, *r*=-.42), emotional discomfort, *r*=-.42, and externalization, *r*=-.26), all correlated negatively with wellbeing, with externalization having the lowest loading. Hence those with lower scores in shame proneness were likely to score higher in wellbeing. Externalization is the projection of shame outwards, with felt (rather than expressed) anger or aggression as a response and may be a way to distance self from painful feelings of shame (Simonds et al., 2015). In this sample externalization had generally lower correlations than both negative self-evaluation and emotional discomfort across most other variables (see Appendix T). This suggests externalization has less explanatory value and indicates the expression of shame in this sample is predominantly internalized than externalized.

Three of the vulnerable narcissism scales were moderately negatively associated with wellbeing, namely hiding the self *(r*=-.41), contingent self-esteem (*r*=-.37) and devaluing (*r*=-.29), however entitlement rage had no relationship with wellbeing. This implies those who do not feel the need to hide their true feelings for fear of being seen as weak, who are less concerned about how others perceive them and/or do not avoid others out of fear of their needs not being met are more likely to have higher wellbeing, hence those with higher wellbeing show their feelings, do not concern themselves with how others perceive them and/or get their needs met by being in connection with others.

4.9. Research Question 5 - Which aspects of shame/narcissism/social rank are the best predictors of psychological wellbeing?

This research found the following factors to have the greatest predictive value for psychological wellbeing: the stepwise regression identified shame proneness (externalization), submissive behaviour and vulnerable narcissism (hiding the self) as the main negative predictors, and social comparison and grandiose narcissism (grandiose fantasy) as the main positive predictors. The highest regression coefficient was found with submissive behaviour (β=-.33), followed by vulnerable narcissism hiding the self (β=-21); social comparison (β=.20); grandiose narcissism grandiose fantasy (β=.15) and finally shame proneness externalization (β=-.14). Therefore low submissive behaviour, low vulnerable

narcissism (hiding the self), positive social comparison, grandiose narcissism (grandiose fantasy) and low shame proneness (externalization) are predictive of wellbeing in this sample.

This suggests those who are less inclined to behave submissively and are more able to share their needs with others, who positively compare themselves to others; fantasize about achieving great things and are less disposed to anger and frustration are more likely to have greater wellbeing.

Interestingly, grandiose narcissism (grandiose fantasy) did not significantly correlate with wellbeing. Its effects as a suppressor variable suggest it was suppressing irrelevant variance in the other variable(s), concentrating the relationships between the other predictor and wellbeing variables (Lancaster, 1999). However, from correlation alone it is not possible to infer whether a variable may or may not have an impact on wellbeing as correlation measures associations. In this instance, grandiose narcissism (grandiose fantasy) had an impact on wellbeing via strengthening the variance in the other predictors.

There is a paucity of good quality research and evaluations on promoting adolescent wellbeing in the UK (Coverdale & Long, 2015; Edwards, 2003; Harden, Rees & Shepherd, 2001; Oliver, Harden, Rees, Shepherd, Brunton & Oakley, 2008) and most of the studies that do exist originate from the United States or Australasia with their focus on interventions for those in crisis (Coverdale & Long, 2015). Hence no research was found to support or refute these findings, making this an important area for future studies to examine.

4.10. Research Question 6 –

a) **Are there significant associations between self-compassion and aspects of shame, narcissism, social rank, distress and wellbeing?**
b) **What percentage of the variance for distress is predicted by self-compassion?**
c) **What percentage of the variance for wellbeing is predicted by self-compassion?**

d) Does self-compassion have a moderating role in:

i. Distress

ii. Wellbeing

As stated, the positive aspects of the SCS-SF were used rather than the total score. Several researchers suggest this means relationships with mental health symptoms are present but less robust (Barnard & Curry, 2011; Muris et al., 2016; Petrocchi, Ottaviani & Couyoumdjian, 2014) i.e. the positive aspects are more correlated with constructs such as wellbeing rather than symptoms of distress (depression, anxiety etc) which are more associated with the negative aspects of the measure. The SCS-SF was developed for adults, hence there may be issues with using it in a younger sample. It may be necessary to develop different self-compassion scales at differing points of development in order to determine if a temporal schedule exists, as self-compassion may be a construct with its own developmental trajectory.

4.10.1.(a) Correlations

Self-compassion was significantly but weakly associated with internal shame, shame proneness and grandiose narcissism, and moderately associated with wellbeing. There was no significant relationship between self-compassion and distress. Therefore those who reported lower levels of internal shame (namely total score; character and body subscales) and shame proneness (namely total score and negative self-evaluation); and higher levels of grandiose narcissism (namely total score, exploitativeness and self-sacrificing self-enhancement) reported moderately higher levels of self-compassion. The lack of correlation with many other variables is tentative support for low self-compassion in adolescents (Neff, 2003a). Other studies (e.g. Neff & McGehee, 2010) used the total score hence it is not possible to compare these findings with existing research. Further investigations are needed to determine associations between positive self-compassion and distress/wellbeing.

4.10.2. (b) Multiple Regression Distress

Adding self-compassion to the multiple regression for distress showed self-compassion had no predictive value and did not improve the model. Hence there is no significant relationship between self-compassion and distress.

This suggests there is no association between the level of self-compassion and the experience of distress for adolescents in this sample, i.e. there is no difference whether an adolescent has high or low self-compassion in terms of their reported levels of distress.

As stated in 4.10.1. the existing research on self-compassion used the total score from SCS-SF hence comparison to existing studies is not possible.

4.10.3. (c) Multiple Regression Wellbeing

Self-compassion was entered into the multiple regression model for wellbeing and increased the variance from 39% to 47% indicating a marked influence of self-compassion on wellbeing. A negative relationship with submissive behaviour remained as the highest loading; however, both submissive behaviour and self-compassion were the most significant within the model. Hence self-compassion has a direct impact on the experience of wellbeing in this sample. As indicated, the mean scores for wellbeing were below the mean population score for this sample which may explain the lower positive correlation between self-compassion and wellbeing.

4.10.4. (d.i.) Moderation - distress

Moderation analyses on the three variables with the highest loadings showed self-compassion had no moderating influence on distress. This was expected after the regression results determined there was no influence of self-compassion on the model for distress.

4.10.5. (d.ii) Moderation - wellbeing

No moderating effect was found for self-compassion on wellbeing within the moderation analyses on the three variables with the highest loadings on wellbeing, suggesting the relationships between wellbeing, social comparison, submissive behaviour and vulnerable narcissism may not be determined by the level of self-compassion within the sample. This suggests self-compassion may have a developmental nature and is not fully actuated in this age group (see Elkind, 1967). Self-absorption and egocentrism may hinder the mechanism of self-compassion to occur (Muris et al., 2016).

It appears self-compassion (as measured by the positive subscale in the SCS-SF) has a complex relationship with distress and wellbeing in adolescents requiring further investigation. However, given that higher wellbeing is associated with lower levels of distress, helping adolescents develop high self-compassion and wellbeing may be an important area of future research.

4.11. Strengths and Limitations

4.11.1. Data Collection and Sample

A reasonably sized sample was recruited. Recruitment issues and time constraints precluded obtaining a larger sample. A larger sample might have enabled greater understanding and the possibility of conducting structural equation modelling (SEM) on the data.

It could be argued the phased sampling was both problematic and beneficial. In Phase I the sample was from one year group in one private girl's school, whereas in Phase II the self-selected participants were from various parts of the UK and Ireland (as identified via Quatrics software) increasing the diversity of the sample. This study was inclusive in that criteria for participation was broad (age; English speaking) to obtain as diverse a sample as possible. However there was a lack of detailed demographic information (family structure, socioeconomic

status, academic status etc.) which would be worth consideration for future studies. In retrospect offering binary gender choice (male or female) may have alienated participants who did not identify as such.

Online recruitment allows for a wider geographical range, fewer respondent errors and omissions and is convenient for both participant and researcher (Lefever, Dal & Matthíasdóttir, 2007). Online data collection also helps protect against data loss and transferring data for analysis is simplified (Carbonaro & Bainbridge, 2000; Ilieva, Baron & Healey, 2002). Some researchers suggest using a web-based survey improves response rates (Ilieva et al., 2002). Collecting data in the field (Phase I) can be costly and time consuming. This study had the advantages and disadvantages of both methodologies.

In Phase I the researcher was available to answer questions and/or support participants if needed. This was not possible in Phase II hence information was provided outlining details of support agencies. However, it is also easier in online studies to discontinue participation as there is less social pressure to continue (Sproull & Kiesler, 1991).

Phase I and Phase II took place during different times in the school year hence each cohort may have been experiencing differing levels of academic stress. This may have added to greater variability in the data which would be beneficial.

4.11.2. Self-Report Measures

All data in this study were collected via self-report questionnaires. Although advantageous from the perspective of obtaining direct personal perceptions and for improving recruitment, their validity is questionable (Barker, Pistrang & Elliott, 2002). There are issues of social desirability biases (Grimm, 2010); comprehension of the constructs under investigation; forced responses and central tendency. Quantifying responses in vague terms (e.g. 'mostly', 'somewhat') reduces opportunities for flexible responses (Barker et al., 2002). Closed ended questions are easier to analyse, compare and quantify (Barker et al., 2002) however, less favourable for the respondent.

The measures used were only available for English speaking participants because most of the questionnaires were validated in English. This precluded non-English speaking respondents from participating.

4.11.3. Measuring Distress

Differentiating between distress and wellbeing in this study is a strength as evidence suggests they are related yet separate constructs (Compton et al, 1996; Greenspoon & Saklofske, 2001; Sudo & Shaffer, 2008; Westerhof & Keyes, 2010). However the instruments used to obtain data may have been problematic. The DASS-21 was used as the measure for distress and contains three subscales of depression, anxiety and stress. In this study the total score was used rather than the separate subscores, because correlations between items were similar. However, Shea, Tennant and Pallant (2009) argued the total score in the DASS-21 was not a measure of general psychological distress as they found evidence for a two-structure scale with depression as one subscale and anxiety and stress as the other. Future studies could use separate depression and anxiety scales such as the Adolescent Depression Rating Scale (ADRS; Revah-Levy, Birmaher, Gasquet & Falissard, 2007).

4.11.4. Measuring Wellbeing

Wellbeing as a construct is problematic as no agreed definition exists and measurement is complex. Subjective measures involve emotional evaluations and cognitive judgements (Conceicao & Bandura, 2008). Distinguishing between the myriad ways to define wellbeing, from 'life satisfaction', to 'subjective wellbeing' to 'happiness' results in some measures that are reductionist and there is no single survey that fully captures wellbeing. The eudaimonic concept of wellbeing equates with 'being happy' whereas the hedonic approach relates to 'feeling happy' (Bruni & Porta, 2007, xviii). The WEMWBS attempts to measure both feelings and functioning facets of wellbeing and is temporally rather than globally relevant asking how the respondent has felt in the last two weeks. Although the measure is commonly used it may not accurately represent how

participants are feeling. Balancing subjective view with quality of life indicators (e.g. health, physical activity, social interaction etc) may offer a broader perspective on wellbeing (Veit & Ware, 1983).

4.11.5. Measuring Shame

This study used the ESS (Andrews, Qian, & Valentine, 2002) as the measure of internal shame however it contains aspects of both external and internal shame (Pinto-Gouveia and Matos, 2011) thereby rendering the results specific to internal shame tentative. Further studies could use the Internalized Shame Scale (ISS, Cook, 1994), - this study was unable to use the ISS due to cost.

The OAS (Allan, Gilbert, & Goss, 1994; Goss, Gilbert, & Allan; 1994) was used as the external shame measure and although widely used for assessing external shame in adult samples, it is being used more frequently in research with adolescent samples (Vagos, Ribeiro, Brazao, Rijo, & Gilbert, 2016). As expected the OAS correlated highly with the social rank and distress measures but was not found to be significant in the regression models, possibly due to an issue with the measurement of internal shame (ESS). The total score was chosen in this study (see 2.6.1.1.). However, Balsamo et al. (2015) identified a three subscale structure to the OAS and it may be interesting to use the subscales in future research, however the researcher became aware of the paper too late to use in this study.

The ASPS (Simonds et al, 2015) was included as a specific shame measure in adolescence. It was validated in a non-clinical population and identifies in its subscales differing aspects of shame that help further delineate the complexity of the construct. However, it covers both internal and external shame aspects and this conflation may have impacted on the findings.

4.11.6. Measuring Narcissism

Narcissism, as a construct, lacks clear conceptualization (Miller & Campbell, 2008; Wright, 2015) and assessment is inconsistent and ambiguous (Cain,

Pincus & Ansell, 2008; Miller & Campbell, 2008; Pincus, et al, 2009). Whilst grandiose and vulnerable narcissism are accepted as viable constructs their lower order structures have yet to be suitably delineated (Wright, 2015). However, the findings in this study offer further support for narcissism having two factors.

The B-PNI was chosen for this study, however this instrument was developed to measure the clinical expression of narcissism (Wright, 2015). It has been argued normative narcissism should be differentiated from pathological narcissism (Wright, 2015). Hence it may have been advisable to use the Narcissistic Personality Inventory (NPI; Raskin & Hall 1979) which assesses adaptive narcissism, however, Pincus and Lukowitsky (2010) suggest the PNI (the full version of the B-PNI) 'predominantly assesses nondistressed adaptive expressions of the construct' (p.425). These arguments highlight the discrepant views surrounding the construct and its measurement, hence future research could take into account the recent identification of the NSM (see Krizan & Herlache, 2018).

4.11.7. Measuring Social Rank

There are only two instruments that measure social rank in adolescents – the ASCS (social comparison) and the ASBS (submissive behaviour). As stated in 3.5.1. the ASCS had low internal consistency, and removal of one question improved this. The measure may require further investigation or there may be an issue within this sample with the question that asked how different they felt to their friends. The scales were further assessed via an Italian sample of adolescents and the scale constructs were replicated (Giacolini et al., 2013).

4.11.8. Measuring Self-Compassion

The SCS/SCS-SF (Raes et al., 2011) is the only self-report instrument to measure self-compassion. In a recent review of compassion definitions and measures the SCS was found to be one of the strongest as it captures four of the five elements of their aggregated definition of compassion (Strauss, Taylor, Gu,

Kuyken, Baer, Jones & Cavanagh, 2016):- ‘understanding the universality of suffering’; ‘emotional resonance’; ‘tolerating uncomfortable feelings’ and ‘acting or motivation to act to alleviate suffering’ but not ‘recognizing suffering’. However the mindfulness subscale implies an awareness of internal suffering in order to remain emotionally balanced.

Several researchers contend the questionnaire has a two-factor structure not the six factors stated by Neff (2003), (Brenner, Heath, Vogel & Crede, 2017; Lopez et al, 2015). Thus the ‘positive’ aspects of the SCS-SF were used. Muris (2016) and Lopez et al. (2015) assert half the SCS/SCS-SF measures the negative aspects of self-judgement, isolation and over-identification and are moderately to strongly associated to psychopathology (such as self-criticism, social withdrawal and self-focused rumination). Their inclusion and use may inflate the relationships with mental distress. They suggest using the positive scores to measure a ‘purer’ version of self-compassion. In keeping with Gilbert’s (2005) model of social mentalities the two-factor approach has merit as true self-compassion relates to feelings of safety (the parasympathetic nervous system) and self-criticism triggers the threat system (sympathetic nervous system), hence conflating the two subscales may obscure the ‘cleaner’ effects of the positive aspects of self-compassion. Few studies have used the subscales separately (Neff, 2015) hence this research is offering further insights into how self-compassion may function in a more detailed way.

4.11.9. Generalisability

The correlational nature of this research permits no causality inferences to be made. To counter this, longitudinal studies could be conducted to further illuminate causal relationships between the variables.

The use of a non-clinical population raises the issue of external validity and limits how useful the data is, as the findings may not transfer to a clinical population. However, data that helps establish valid norms can enhance understanding of who needs treatment as well as for appraising aspects of functioning for those at subclinical levels (Achenbach, 2006). Achieving accurate normative data

involves precision in defining clearly the population and phenomena of interest (Connor, 1990), hence study replication and measurement improvement will help clarify what 'norms' are. The norms obtained from this study, however, are not generalizable beyond the sample population (largely White British and female) but can add to current understanding of how adolescents may currently be experiencing their worlds.

4.12. Clinical Implications

Adolescence is a fundamentally significant period from several perspectives. As previously discussed, health and wellbeing are foundational to the critical developmental tasks of adolescence (individuation and the emotional and cognitive abilities required for that process to occur; completing education and transitioning to employment, and the forming of adult relationships). Adolescence is also when lifespan health trajectories are established, they are the next generation to parent, and may determine their offspring's health start in life. (Patton et al., 2016).

A Lancet report on adolescent health concluded 'failure to invest in the health of the largest generation of adolescents in the world's history jeopardises earlier investments in maternal and child health, erodes future quality and length of life, and escalates suffering, inequality, and social instability" (Viner,et al., 2012 p4). This is important from both physical and mental health points of view. Adult studies suggest most psychological disorders begin before 25, usually between 11-18 years (Kessler, Berglund, Demler, Jin, Merikangas, 2005). However, recent evidence suggests problems experienced during adolescence do not all extend into adulthood, especially if the episode is brief (Copeland, Shanahan, Costello, Angold, 2011; Patton, et al., 2014). Early intervention with effective therapeutic strategies could be beneficial, especially for those whose problems do extend into adulthood. Mental health problems rise steeply in mid to late adolescence (13% for males and 10% for females, with figures approaching adult rates of 23% by 18-20 years) (Green, McGinnity, Meltzer, Ford & Goodman, 2005), which in turn can negatively impact on working and earning

capabilities as adults (Goodman, Joyce & Smith, 2011). A Children's Society report in 2008 suggested 70% of children and adolescents who experience mental health problems have not received appropriate timely therapeutic interventions. With cuts made to many NHS services this figure may have remained stable or increased. Today's adolescents are developing in unprecedented times - the digital revolution; growing urbanization; the rise of consumerism; increasing academic pressures; lifelong financial debt; changing familial structures etc, hence an unprecedented response may be required to counter the negative and damaging results of this era.

This exploratory study investigated the relationships of specific constructs prevalent in adolescence and to determine the influence of self-compassion on psychological distress and wellbeing. Self-compassion was found to have a distinct relationship to wellbeing but not to distress. Much research has focused on understanding and reducing distress, however, less distress does not necessarily mean increased wellbeing, therefore it may be prudent to extend focus on improving wellbeing (Marsh et al., 2017).

4.12.1. Therapeutic Interventions

This study adds to the growing research on self-compassion demonstrating a consistent positive relationship to wellbeing, as identified in adolescent as well as adult populations. Nevertheless, introducing self-compassion conceptually and practically to adolescents experiencing sub-clinical levels of distress may be problematic. Fears of, and blocks to, compassion have been empirically researched and may relate to over-development of the threat system and under-development of the soothing system where positive feelings are unfamiliar and threat-inducing (Gilbert & Irons, 2009; Gilbert, McEwan, Matos & Rivis, 2011). Gilbert et al., (2011) discovered a positive association between fears of developing compassion and self-criticism and higher scores on psychological distress. Hence, prior to beginning therapeutic work, (group courses; school or youth club classes etc) the fears/blocks would need attending to.

By identifying links between shame and both narcissism and social rank, this research suggests shame may be a fundamental component underlying other

constructs. The temporal precedence and functioning mechanisms behind the constructs are beyond the remit of this research, however reducing shame could benefit adolescents in distress. Improving and increasing self-compassion has been shown to reduce shame (Barnard & Curry, 2011; Mills, et al., 2007; Neff, Rude & Kirkpatrick, 2007; Williams, Stark & Foster, 2008; Yamaguchi, Kim & Akutsu 2014; Zessin, Dickhauser & Garbade, 2015) thereby the benefits of self-compassion interventions could be two-fold.

Neff and Germer (2013) implemented an 8-week intervention (Mindful Self-Compassion, MSC) combining mindfulness, self-compassion and loving kindness practices, and addressed potential barriers to compassion, MSC was formed as a 'hybrid' applicable to clinical and non-clinical populations (Neff & Germer, 2013). Findings suggested MSC increased happiness, life satisfaction and self-compassion and decreased depression, anxiety and stress. The research was not conducted with adolescents, however the reported benefits of MSC may extend to them.

Whilst introducing self-compassion in direct work with adolescents may offer protective benefits it would be prudent to involve the surrounding system. Establishing compassionate-based behaviours in younger cohorts within family and educational systems are initiatives that are gaining momentum (see 4.12.2). Offering compassion skills training to pregnant and new mothers via antenatal classes and online resources may also offer benefits (see www.netmums.com) as mother's who are able to be more compassionate and self-compassionate may have a positive impact on the development of the child and hence adolescent.

As 96% of 16-24 year olds own smart phones, (Statista, 2018) using technology to promote access to health and social care treatments may be beneficial (Gould, Greenberg, Velting & Shaffer, 2003). Hence self-compassion may be increased (and wellbeing improved) with the use of an app. Co-producing self-compassion apps with young people may help decrease barriers to compassion and engage them in promotion with their peers. A U.S. self-compassion and mindfulness program found those who used an app reported lower stress (Donovan, Rodgers, Cousineau, McGowan, Luk, Yates et al., 2016). Donovan et

al., (2016) also engaged those taking part to make improvements to the app.

4.12.2. Education

There is growing awareness of the need for more integrated care surrounding children and young people. There are recent initiatives to train teachers in mental health – The Difference, a third sector enterprise, offers a two year training programme in supporting pupil mental health to reduce exclusion and improve outcomes for young people. The Government produced a joint education and health committee paper in 2017 noting that education has a frontline role to play in the mental health and wellbeing of students, and noting that the preclusion of provision of mental health services in educative establishments due to financial pressure needs to be redressed. This study has identified a model of distress in adolescents which could aid detection of at-risk adolescents by educators, and help them use self-compassion to ameliorate the effects of distress by improving wellbeing.

The integration of education and mental health services is worthwhile and could be enhanced by incorporating compassion. Compassion in Education (CoEd) is a secular English charity providing services to educationalists helping them bring compassion into education. The Mindfulness in schools project (MiSP) is a charity promoting the teaching of mindfulness so all children can possess skills to help them thrive. Unifying these initiatives and disseminating the benefits of compassion and self-compassion to educationalists and child and youth based mental health services would help counter the effects of distress in adolescence.

4.13. Future Research

The multifaceted nature of this research and the myriad interconnections between the variables mean there are many lines of enquiry worth considering, including replicating the study and attending to its limitations.

Specific areas might include:

i. Comparing genders in order to see if there are differences in the

expression of shame, narcissism, social rank and self-compassion and how those possible gender differences might impact on the experience of distress and/or wellbeing.

ii. Longitudinal research could further delineate the relationships between the variables in this study throughout adolescence at multiple time points. This could highlight developmental and sequential trajectories in the experiences of shame, narcissism, social rank and self-compassion, and could determine when these constructs may develop or increase. Although longitudinal research is expensive and can suffer from attrition, it offers further validation of cross-sectional, correlational research, and may help determine how a normative trajectory might appear thereby aiding non-pathologising of 'normal' adolescent behaviour (Newcomb, 1996).

iii. Qualitative research (of which there is a lack in adolescence, Weitkamp, Klein & Midgley 2016) examining the construction of any of the variables of interest. For example Interpretative Phenomenological Analysis (IPA, Smith, Flowers & Larkin, 2009) might highlight the subjective experience of adolescents in terms of shame and social rank. Qualitative research or small 'N' studies can add to current understanding from an experiential viewpoint highlighting individual variability.

iv. The type of self-compassion most valuable to adolescents. It might be beneficial to examine the contributions of the separate components of self-compassion (self-kindness, common humanity and mindfulness, Muris et al., 2016). For example would mindfulness be more effective in instigating and/or enhancing self-compassion than self-kindness? (Neff, 2003). Further investigation into the mechanisms in self-compassion that can improve wellbeing in adolescents could help determine suitable interventions.

v. Self-compassion groups, apps and interventions in children and young people either community based or within school systems.

vi. Studies comparing non-clinical with clinical populations in adolescence – which will further assist in identification of normative processes and pathological expression.

4.14. Summary of Findings and Conclusion

This novel study investigated the impact of aspects of shame, narcissism and social rank, and their interactions, upon distress and wellbeing in adolescence. Further it examined the moderating function of self-compassion on distress and wellbeing. The analyses revealed two distinct regression models for distress and wellbeing respectively. The analyses demonstrated distress in this sample of adolescents was predicted by higher levels of internal shame, aspects of shame proneness, submissive behaviour and an aspect of vulnerable narcissism whereas wellbeing was predicted by lower levels of submissive behaviour, an aspect of vulnerable narcissism, an aspect of shame proneness and higher levels of both positive social comparison and an aspect of grandiose narcissism. Further, analyses identified self-compassion significantly predicted wellbeing but had no associations or moderating role in distress, it also had no moderating role in wellbeing. This suggests self-compassion may have a positive impact on wellbeing but this is not proven. These results offer further evidence of distress and wellbeing as separate constructs, they also indicate self-compassion could have a protective function for those adolescents at risk of significant distress.

This sample reported very low levels of wellbeing and moderate levels of distress. If these figures are indicative of this age group then the introduction or improvement of self-compassion levels is paramount and could be achieved through considered work at the individual, micro and macro levels of society which will, in turn, improve outcomes for generations to come.

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APPENDIX A Literature Review I

Literature Review I :

The literature review was prepared using Booth, Papaioannou and Sutton's (2012) framework to set the search remit:

1. Who = adolescents [adol*]

2. What = shame, narcissism, social rank, psychological distress and psychological wellbeing

3. How (will the study impact on the 'who') = situate and rationalise the current study which was aimed at exploring shame, narcissism and social rank in adolescence using the Boolean operators 'AND' and 'OR'.

The following search terms were used to locate literature pertaining directly to the experience of shame ('shame', 'external', 'internal', 'shame proneness'), narcissism ('narcissism', 'grandiose' and 'vulnerable') and social rank ('social rank', 'social rank theory', 'social comparison' and 'submissive behaviour') in adolescence (adol*).

Search terms pertaining to psychological distress included; 'distress,' 'mental health' 'psychopathology', 'depression', 'anxiety', and terms pertaining to psychological wellbeing included; 'psychological wellbeing', 'well-being', 'well being' and 'mental health.'

A systematic database search was conducted using PsycINFO, PsycARTICLES, CINAHL Plus and Scopus. All results were scanned for relevance to the topic search terms. The grey literature was explored using Google Scholar and other open source repositories (ResearchGate, Academia, CORE). Relevant articles were identified and their reference lists used to search for additional relevant publications and papers. Studies were narrowed down firstly by checking titles, then by reading abstracts and, if found relevant, further reading of introductions and discussions.

Inclusion criteria:

- Studies that investigated shame in adolescence; shame and narcissism; shame and social rank; adolescence and distress; adolescence and wellbeing, regardless of date, methodology and country of publication
- Both clinical and non-clinical populations of adolescents

Exclusion criteria:

- Studies not in the English language
- Poetry, fiction or other artistic material
- Papers that reflected upon any of the search terms as opposed to being a direct unit of investigation

The search identified 13 articles for adolescence and shame; 5 articles for adolescence, shame and social rank, 14 articles for adolescence, shame and narcissism, including research studies, theoretical papers and book chapters. Adolescence and distress/wellbeing retrieved 892 studies.

APPENDIX B Literature Review II

Literature Review II :

The literature review was prepared using Booth, Papaioannou and Sutton's (2012) framework to set the search remit:

1. Who = adolescents [adol*]

2. What = compassion, self-compassion, psychological distress and psychological wellbeing

3. How (will the study impact on the 'who') = situate and rationalise the current study which was aimed at exploring self-compassion in adolescence using the Boolean operators 'AND' and 'OR'.

The following search terms were used to locate literature pertaining directly to compassion and self-compassion ('compassion', 'self-compassion', 'compassion*) in adolescence. Search terms pertaining to psychological distress included; 'distress,' 'mental health', 'psychopathology', 'depression', 'anxiety', and terms pertaining to psychological wellbeing included; 'psychological wellbeing', 'well-being', 'well being' and 'mental health'.

A systematic database search was conducted using PsycINFO, PsycARTICLES, CINAHL Plus and Scopus. All results were scanned for relevance to the topic search terms. The grey literature was explored using Google Scholar and other open source repositories (ResearchGate, Academia, CORE). Relevant articles were identified and used to search for additional relevant publications and papers. Studies were narrowed down firstly by checking titles, then by reading abstracts and, if found relevant, further reading of introductions and discussions.

Inclusion criteria:

- Studies that investigated compassion and self-compassion in adolescence; compassion and self-compassion and distress; compassion and self-compassion and wellbeing, regardless of date, methodology and country of publication
- Both clinical and non-clinical populations of adolescents

Exclusion criteria:

- Studies not in the English language
- Poetry, fiction or other artistic material
- Papers that reflected upon any of the search terms as opposed to being a direct unit of investigation

The search identified 27 articles for the above search terms.

APPENDIX C ETHICAL APPROVAL

UNIVERSITY OF EAST LONDON
School of Psychology

APPLICATION FOR RESEARCH ETHICS APPROVAL

FOR RESEARCH INVOLVING HUMAN PARTICIPANTS

FOR PROFESSIONAL DOCTORATE RESEARCH IN CLINICAL, COUNSELLING & EDUCATIONAL PSYCHOLOGY

ATTACHMENTS YOU MUST ATTACH TO THIS APPLICATION

i. A copy of the invitation letter that you intend giving to potential participants.

ii. A copy of the consent form that you intend giving to participants.

iii. A copy of the debrief letter you intend to give participants (see 23 below)

OTHER ATTACHMENTS (AS APPROPRIATE)

- A copy of original and/or pre-existing questionnaire(s) and test(s) you intend to use.
- Example of the kinds of interview questions you intend to ask participants.
- Copies of the visual material(s) you intend showing participants.
- A copy of ethical clearance or permission from an external organisation if you need it (e.g. a charity or school or employer etc.). Permissions must be attached to this application but your ethics application can be submitted to the School of Psychology before ethical approval is obtained from another organisation if separate ethical clearance from another organisation is required (see Section 4).
- If need one for your research, you can apply for one through the HUB and the School will pay the cost.
- **FOR PROFESSIONAL DOCTORATE STUDENTS WHOSE RESEARCH INVOLVES VULNERABLE PARTICIPANTS:** DBS clearance is necessary if your research involves young people (anyone under 16 years of age) or vulnerable adults (see 4.2 for a broad definition of this). The DBS check that was done, or verified, when you registered for your programme is sufficient and you will not have to apply for another in order to conduct research with vulnerable populations.

Your details

1. **Title of your programme**:

Professional Doctorate in Clinical Psychology

2. **Title of your proposed research**:

Am I Good Enough? An exploration of Adolescent Shame via Social Rank Theory and Narcissism

About the research

1. The aim(s) of your research:

The aim of this exploratory study is to examine the processes involved in maintaining a sense of self in mid-adolescence (16-17 years old). This will be explored by measuring levels of internal and external shame and examining how Social Rank theory, narcissism (grandiose and vulnerable) and self-compassion may mediate or moderate the experience and expression of shame. It will explore how the concepts of shame, social rank, narcissism and self-compassion affect self-reported levels of depression, anxiety and wellbeing within this population.

2. Likely duration of the data collection from intended starting to finishing date:

Data collection will begin once approval has been obtained from UEL ethics and the identified school (estimated April/May 2016). The aim is to end data collection by July 2016, however, if this is not possible, the second phase of recruitment will start in September 2016. If recruitment difficulties are encountered, recruitment will continue until December 2017.

Methods

- **Design of the research:**

The proposed study will adopt a quantitative correlational design. It will explore the relationship between variables of shame (at two levels – internal & external), Social Rank theory, narcissism (at two levels – vulnerable & grandiose) and self-compassion. It will study the effects of these variables on self-reported levels of depression, anxiety and well-being.

The study will involve the administration of a batch of questionnaires. The questionnaires will take no longer than 30 minutes to complete.

2. The sample/participants:

Data will be analysed using multiple regression with six predictor variables. A G*Power 3.1 (Faul et al., 2009) calculation estimates a sample size of 98. Hence the aim is to recruit a minimum of 100 participants. Participants will be male and female adolescents aged between16-17 years of age. Recruitment will take place via a London secondary school and via an online survey that will be available to any students aged 16-17 across the UK. All students between year group 10 and 11 will be invited to take part in the study. The school will determine the timing of the data collection as it will depend on their timetable and number of consented participants. The study could take place during a PSHE (personal, social, health and economic) class. With the online survey an advert will go out on social media (advert attached as addendum 12) namely Facebook – with the aim for a snowball recruitment. Participants additionally need to be sufficiently fluent in English to be able to understand the written instructions and questionnaires.

3. Measures, materials or equipment:

This study will use the following questionnaires/measures:

- Shame:

    - External shame measured via the Other As Shamer scale OAS (Allen, Gilbert & Goss, 1994): an 18 item, 5 point Likert scale questionnaire which includes questions such as 'I feel other people see me as not good enough'; 'I feel insecure about others opinions of me'; and 'Other people always remember my mistakes'.
    - Internal shame measured via the Internal Shame Scale ISS (Cook 1994, 2001): a 30-item, 4 point Likert scale questionnaire which includes questions such as 'I feel like I am never quite good enough'; 'I scold myself and put myself down'; 'I replay painful events over and over in my mind until I am overwhelmed'.
- Social rank:
    - Measured via the Adolescent Social Comparison Rating Scale revised, ASCS-R (Allan & Gilbert, 1995): a 10 item. 10 point comparison scaled questionnaire which includes questions such as 'Compared to your friends how shy do you feel' with 1 being less shy and 10 being more shy; 'Compared to your friends how different do you feel'; 'Compared to your friends how accepted do you feel?'.
    - And the Adolescent Submissive Behaviour Scale ASBS (Gilbert & Allan, 1994, Allan & Gilbert, 1997): a 12 item, 5 point Likert scale questionnaire which includes such questions as 'I agree that I am wrong, even when I know that I was not wrong'; 'I stop myself from telling others when I am angry with them'; 'I play with others even if I don't want to'.
- Narcissism (both grandiose and vulnerable) via the Brief Pathological Narcissism Inventory, B-PNI (Schoenleber, Roche, Wetzel, Pincus & Roberts, 2015): a 26-item, 5 point Likert scale questionnaire which includes questions such as 'I can usually talk my way out of anything'; 'I try to show what a good person I am through my sacrifices'; 'It's hard to feel good about myself unless I know other people admire me'.
- Compassion via the Self-Compassion Scale, SCS (Neff, 2003): a 12-item, 5 point Likert scale questionnaire which includes questions such as 'When I fail at something important to me I become consumed by feelings of inadequacy'; 'I try to see my failings as part of the human condition'; 'I'm intolerant and impatient towards those aspects of my personality I don't like'.
- Depression, anxiety and stress via the DASS-21 (Lovibond & Lovibond, 1995): a 21-item, 4 point Likert scale measure that includes statements such as 'I found it hard to wind down'; 'I found myself getting agitated'; 'I felt that life was meaningless'.
- Well-being measured via the Warwick-Edinburgh Mental Well-Being Scale, WEMWBS (Tennant, Hiller, Fishwick, Platt, Joseph, Weich, et al. 2007): a 14-item 5 point Likert scale measure that includes statements such as 'I've been feeling optimistic about the future'; 'I've had energy to spare'; 'I've been feeling loved'.

- CLEARANCE WILL BE OBTAINED FROM THE AUTHORS FOR ALL MEASURES BEFORE USING. The ISS will need to be purchased.

Participants will be provided with pencils to complete the batch of questionnaires that will be typed up and 'user-friendly'. The titles of the measures will be removed during data collection due to some of the language/terminology used in the titles of the questionnaires.
In the online survey participants will be using their own computers/laptops/phones/tablets to enter their data.

4. If you are using copyrighted/pre-validated questionnaires, tests or other stimuli that you have not written or made yourself, are these questionnaires and tests suitable for the age group of your participants?

YES

5. Outline the data collection procedure involved in your research:

First Option:

Researcher will approach a local school to discuss involvement and procedures regarding permission with Head Teacher. If the Head does not wish for students to take part in the study, another Secondary School will be approached. The Head will be sent a letter outlining the project and if they are agreeable the researcher will arrange an appointment to meet in order to discuss the finer details (obtaining consent, administration of questionnaires etc.)

Second Option:

One school in Hampshire has been identified as being suitable as it has a large and diverse student population (200 per year). The researcher has approached the Head Teacher who has agreed for his students to take part and is happy for the research to be completed at his school. He is familiar with the set of questionnaires and data collection has been discussed.

All potential participants will be provided with an information sheet, which will be sent out to parents [see draft versions in Appendix]. An information letter will be sent out to all parents (via letter and via email) to those under the age of 16 explaining that the Head Teacher will act as 'in loco parentis' as the British Psychological Society guidelines state in their Code of Conduct : 'If the vulnerable person is unable to give informed consent, consent should be sought from those persons who are legally responsible or appointed to give consent on behalf of persons not competent to give consent on their own behalf, seeking to ensure that respect is paid to any previously expressed preferences of such persons. In research with children under the age of 16, and in specific circumstances as described above in Section 4 on Valid Consent, researchers should ensure that parents or guardians are informed about the nature of the study and given the option to withdraw their child from the study if they so wish. The principle of monitoring the assent of the child will also apply'.
Their guidelines say 'where research involves any persons under 16 years of age, consent should be obtained from parents OR FROM THOSE IN LOCO PARENTIS. Parents will be sent the means (via letter and email) in which to opt their child out of the research in addition to this.

Participants aged 16 will not need parental consent and will be provided with an information sheet and consent form to make their own decision as to whether they wish to take part.

Both parents and adolescents will be provided with an opportunity to ask the researcher questions about the study and the use of data before agreeing to take part.

The measures will be completed after demographic information has been collected in order to maintain anonymity. The demographic information requested will be gender; age; nationality; religion/belief; identified ethnicity; class stream [see Appendix].

The measures will be completed in a classroom under suitably quiet conditions, facilitated by a teacher and the researcher. Measures will be provided as paper copies. Participants will be asked to fill in the questionnaires at a time during their school day, arranged between the school/teacher/researcher. The questionnaires will be placed on numbered tables with the same number on each package of questionnaires. Students will be asked to take the number on the table with them as it is their signifier if they wish to remove themselves from the study at a future date. This is to ensure their anonymity.

Post completion of the demographic sheet and the questionnaires participants will be given the opportunity to win a £40 shopping voucher ('One4all' vouchers which can be spent in many different outlets and online stores). A total of three shopping vouchers will be available to be won (i.e., three winners). Participants will be provided with a piece of paper on which to write their contact number or email address if they wished to be entered into the prize draw, this will be part of the study pack , but will be collected separately to the data (e.g., coloured coded paper, which will be collected separately by the researcher).This information will be collated and kept separately from the data – the hard data will be stored in a locked filing cabinet at UEL. Once the winners have been chosen (this will be done via an app that generates random numbers on

request once a range has been entered) and the winners notified, the hard copy will be destroyed and the computer document will be deleted.

It is estimated that the questionnaires will take a maximum of 30 minutes to complete.

Participants will be provided with a debrief sheet detailing supporting organisations (such as Mind, Samaritans). They will also be reminded that they can contact the researcher or research supervisor if they have any questions following participation.

Post analysis the researcher will return at a convenient time to the school to feedback the findings.

If all above options are exhausted and no more data is forthcoming :

Third Option
The survey will be online using a custom developed web-application (Qualtrics). An advert will go out on social media (namely Facebook) for 16-17 year olds to take part in the research (see Addendum 12 for advert).
The participants will have to fulfil criteria (criteria will be aged 16-17 years; in full time education and fluent in English) before being allowed to continue. The researcher's contact details will be available if any participants have questions before they take part. The participation letter will appear at the beginning of the study along with information and consent forms before participants will be allowed to continue to the questionnaires.
Once consent has been established and recorded, participants will be prompted to provide basic demographic and geographic information. All participants who consent to take part in the study will be asked to complete the questionnaires. It will be made clear that the questionnaires should take approximately 30 minutes and requested that responses are entered in a quiet environment.
In addition, participants will be invited to provide their email addresses if they wish to be entered into a prize draw to win £40 worth of One-4-All shopping vouchers in recognition of their contribution to the study.

Ethical considerations

Please describe how each of the ethical considerations below will be addressed:

1. Fully informing participants about the research (and parents/guardians if necessary):

Participants will receive an information letter outlining the purpose of the research and what their involvement will entail in a style appropriate for young people and an information letter will also be sent to the parents of those under 16.
For the online study - The first page participants will be directed to when following the link to the study website will be an information sheet. The participation letter will appear at the beginning of the study along with information and consent forms before participants will be allowed to continue to the questionnaires.
This will provide details on the aims of the study, what participation will involve, risks, benefits, confidentiality and the right to withdraw. The information sheet has been written in accessible language aimed at a wide-range of reading abilities.
Participants will have as long as they wish before the end of the data collection period to decide whether to participate.

See Appendix 3 for a copy of the information sheet that will be replicated on the home page of the study website.

2. Obtaining fully informed consent from participants (and from parents/guardians if necessary):

The main consent form will go to the Head Teacher who is willing to act as 'in loco parentis' Consent forms will be written in a style suitable for young people as well as for the parents of those pupils who are under 16 who wish to opt their child out of the research. See Appendix for both draft examples for parents and young people.

Online data collection - At the bottom of the information sheet, participants will be provided a link to a consent form which they will need to follow to progress with the study. The consent form will detail what giving consent means that the participant is claiming to understand and what participants are consenting to if they chose to give consent. The form has been written in concise accessible language. At the bottom of the page, participants will be asked to explicitly click on a button to indicate their consent in lieu of a signature. Consent will be recorded in the study database. Participants will not be able to proceed any further or access any other parts of the study website if their consent is not recorded.

Please see Appendix 6 for a copy of the consent form that will be replicated on the study website.

3. Engaging in deception, if relevant:

The proposed study does not involve deception.

4. Right of withdrawal:

Participants will be informed of their right to withdraw from the research study at any time prior to analysis (a date will be specified) without disadvantage to them and without being obliged to give a reason. This will be made clear to participants on the invitation letter provided. For participants under the age of 16 parents may also withdraw their child from the study. On withdrawal their data will be removed from the data set and destroyed.

Online - Participants will additionally be informed of their right to withdraw from the study at any time until prior to analysis of the data in the information sheet. They will also be advised on how to exercise their right to withdraw and will be prompted to make a note of their unique participant ID if they wish to withdraw.

5. Anonymity & confidentiality:

In order to maintain anonymity and confidentiality the school participants will be allocated a number which will correspond to their data, this will be achieved by each set of questionnaires being numbered at the top of each page. Desks and questionnaire sheets will be numbered and students will choose to sit wherever they wish to ensure random allocation. This number will also be on their information sheet, which they will be asked to keep as their identifier if they wish to withdraw from the study.

Demographic information will be recorded (see Appendix for draft form) prior to questionnaires being completed by the students. These sheets will be collected from the tables once all students have left the classroom after completion of the measures. They will be stored separately in a locked cabinet at UEL, but they will be separate from the data hence it will not be possible to connect a participant to their data via their demographic information.

If they wish to take part in the draw to win the shopping vouchers they will provide an email address or mobile phone number on a separate sheet, which will be collected as part of the 'Study Pack' but will be stored separately as a hard copy (in a locked filing cabinet at UEL). This sheet will be destroyed once the draw has taken place and the winners notified. This data will not be connected to their demographic information or data from the study.

Test sheets will be kept in a locked cabinet in accordance with the Data Protection Act 1998.

The data will be stored on a password-protected folder on the researcher's computer and will be kept for as long as is necessary to publish the study in an academic journal. Data will be deleted within 5 years of the end of the study.

Consent forms will be stored separately to data collected. Again, the consent forms will the stored in a locked filing cabinet for 5 years, after which point they will be destroyed.

Online - Participants will be allocated a unique identifying number to collate their results in the study database. No identifying information will be collected when obtaining consent or as part of the research tasks.

Email addresses and phone numbers will be collected from participants who wish to be entered into the prize draw. This data may contain potentially identifying information therefore it will be stored entirely separately from the research data and will not be linked to participant's study ID number. Participants will be given an opportunity to take part in the draw by emailing their contact information to the researcher directly. Once the draw has taken place and the vouchers have been sent to the recipients all contact information will be destroyed.

5.1 Will the data be gathered anonymously?

YES

6. Protection of participants:

There are no potential hazards or risks of injury/accident for students recruited into the study. to take part in this research. The researcher will be alert to any signs of participants becoming distressed and offer details for organisations that could offer support. However, this information will be provided to all participants in the debrief, which will take place once the questionnaires have been completed before the students leave the classroom. They will receive a sheet with the information. This will also be sent out to parents after data collection. See Appendix for draft copy.

7. Protection of the researcher:

There are no health and safety risks to the researcher due to the nature of data collection.

8. Debriefing participants:

Those who participate in school will receive a debriefing session post-completion of measures where the researcher will answer any questions and provide a debrief sheet thanking them for their participation and giving them information about their data and how it will be stored, as well as information on the prize draw.
Online – a debriefing paper will be presented post-questionnaires as well as contact details for the researcher should the respondents have any questions.

9. Will participants be paid?

Participants will not be paid but will all be entered into a draw with three chances to win £40 worth of vouchers.

Other permissions and ethical clearances

1. Is permission required from an external institution/organisation (e.g. a school, charity, local authority)?

YES for school data collection NO for online data collection

It will be necessary to acquire permission from the schools that are approached for their students to partake in the research. The details are not known at this point and will be explored following ethical approval and registration of the study.

28. Is ethical clearance required from any other ethics committee?

NO

PLEASE NOTE: Ethical approval from the School of Psychology can be gained before approval from another research ethics committee is obtained. However, recruitment and data collection are NOT to commence until your research has been approved by the School and other ethics committees as may be necessary.

29. Will your research involve working with children or vulnerable adults?*

YES

If YES have you obtained and attached a DBS certificate? YES

If your research involves young people under 16 years of age and young people of limited competence will parental/guardian consent be obtained.

NO

I have been through an extensive recruitment drive and only obtained one school (out of 15 leads) who is willing to take part. I had access to 400 pupils and all parents were emailed the information as well as a link to an easy use online form in which to agree. I only obtained 14 responses – the reasons for this are unclear and possibly myriad. This is not an adequate number to complete my study. As the data collection needs to be done immediately I have few options. I am aware as an investigator I have a primary responsibility to protect participants from physical and mental harm during the investigation. I believe the risk of harm is no greater than they might experience in ordinary life. The Head Teacher is happy to act as 'in loco parentis' and the BPS Guidelines state this is acceptable. We will also be offering parents the chance to opt out of the study. They will be informed via letter and via email.

OCT 2017 – data collection has proved extremely difficult through the school route hence changing final data collection to be online. Only adolescents aged 16-17 will be required for the online data collection method hence it will not involve working with participants who are under 16.

* <u>You are required to have DBS clearance if your participant group involves (1) children and young people who are 16 years of age or under, and (2)</u> 'vulnerable' people aged 16 and over with psychiatric illnesses, people who receive domestic care, elderly people

(particularly those in nursing homes), people in palliative care, and people living in institutions and sheltered accommodation, for example. Vulnerable people are understood to be persons who are not necessarily able to freely consent to participating in your research, or who may find it difficult to withhold consent. If in doubt about the extent of the vulnerability of your intended participant group, speak to your supervisor. Methods that maximise the understanding and ability of vulnerable people to give consent should be used whenever possible. For more information about ethical research involving children see www.uel.ac.uk/gradschool/ethics/involving-children/

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants

BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Virginia Lam

SUPERVISOR: Trishna Patel

COURSE: Professional Doctorate in Clinical Psychology

STUDENT: Liz Greenaway

TITLE OF PROPOSED STUDY: Am I good enough? An exploration of shame in adolescents

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision

notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES

Minor amendments required *(for reviewer)*:

The design and approach itself is indeed ethically sound overall in terms of following all the necessary protocols. One thing to note (re item 18) is that although no active deception will be used, the exact nature and questions of the study are not all revealed before participation. On this I also note that there are more details about the study (the key theme of 'shame' is disclosed to the parent) in the briefing letter to parents of those who are underage compared to what is in the briefing letter received by participants. Unless this is deliberate to enable parents to make a more informed decision on behalf of their child, the researcher may like to consider if it is better to have the briefing contents consistent between parties (as that may influence decisions, and for this age group it is possible that some parents may confer with their child about the study and the participant will learn more about it indirectly through this process meaning the information received pre-participation would not be the same between different groups of participants). Minor thing: the form is filled with layers of Tracked Changes that should be accepted.

Major amendments required *(for reviewer):*

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

☐ HIGH
☐ MEDIUM
☐ LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer *(Typed name to act as signature)*: Virginia Lam

Date: 22 April 2016

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):* Liz P Greenaway
Student number: U1438323

Date: 25.04.16

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

PLEASE NOTE:

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, prior ethics approval from the School of Psychology (acting on behalf of the UEL Research Ethics Committee), and confirmation from students where minor amendments were required, must be obtained before any research takes place.

*For the researcher and participants involved in the above named study to be covered by UEL's insurance and indemnity policy, travel approval from UEL (not the School of Psychology) must be gained if a researcher intends to travel overseas to collect data, even if this involves the researcher travelling to his/her home country to conduct the research. Application details can be found here: http://www.uel.ac.uk/gradschool/ethics/fieldwork/

APPENDIX D AMENDMENT ETHICAL APPROVAL FORM

UNIVERSITY OF EAST LONDON
School of Psychology

REQUEST FOR AMENDMENT TO AN ETHICS APPLICATION

FOR BSc, MSc/MA & TAUGHT PROFESSIONAL DOCTORATE STUDENTS

Please complete this form if you are requesting approval for proposed amendment(s) to an ethics application that has been approved by the School of Psychology.

Note that approval must be given for significant change to research procedure that impacts on ethical protocol. If you are not sure about whether your proposed amendment warrants approval consult your supervisor or contact Dr Mary Spiller (Chair of the School Research Ethics Committee).

HOW TO COMPLETE & SUBMIT THE REQUEST

1. Complete the request form electronically and accurately.
2. Type your name in the 'student's signature' section (page 2).
3. When submitting this request form, ensure that all necessary documents are attached (see below).
4. Using your UEL email address, email the completed request form along with associated documents to: Dr Mary Spiller at m.j.spiller@uel.ac.uk
5. Your request form will be returned to you via your UEL email address with reviewer's response box completed. This will normally be within five days. Keep a copy of the approval to submit with your project/dissertation/thesis.
6. Recruitment and data collection are **not** to commence until your proposed amendment has been approved.

REQUIRED DOCUMENTS

1. A copy of your previously approved ethics application with proposed amendments(s) added as tracked changes.
2. Copies of updated documents that may relate to your proposed amendment(s). For example an updated recruitment notice, updated participant information letter, updated consent form etc.
3. A copy of the approval of your initial ethics application.

Name of applicant:	Liz Greenaway

Programme of study:	Professional Doctorate in Clinical Psychology
Title of research:	Am I Good Enough? An Exploration of Shame in Mid-Adolescents
Name of supervisor:	Dr Trishna Patel

Briefly outline the nature of your proposed amendment(s) and associated rationale(s) in the boxes below

Proposed amendment	Rationale
For the study to be put online and made available UK wide.	I still have a small sample and had several school situations fall through. If the study was available online I would be able to reach many more 16-17 year olds and obtain the numbers required for data analysis. As all young people are legally required to be in full time education until the age of 17 then the sample should be relevant to/with the data I've already collected from a school

Please tick	YES	NO
Is your supervisor aware of your proposed amendment(s) and agree to them?	✔	

Student's signature (please type your name): Liz P Greenaway

Date: 06.10.17

TO BE COMPLETED BY REVIEWER		
Amendment(s) approved	YES	
Comments Inclusion of proposed online data collection – and proposed procedure - is approved.		

It is noted, however, that statements about the purpose and aim of the study in the various information/invitation letters can differ. It would be advisable to be consistent with this. Specific reference to 'depression and anxiety' in the letter to Head teachers (Appendix 1), rather than the more general reference to well-being, may prove off-putting and this could impede Head teacher's willingness to consider your request.

In the letter to Head teachers and parents (Appendix 4), specific reference is made to 'shame'. Again, this seems somewhat heavy-handed and potentially off-putting.

The softer description of the study that is used elsewhere - 'a research study looking at how teenagers your age think and feel about themselves and how that might impact upon well-being' – seems less confrontational than references to 'depression', 'anxiety' and 'shame'. Consideration of this may aid recruitment efforts.

Reviewer: Mark Finn

Date: 2/11/17

APPENDIX E Full Information sheet Phase I

UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

The Principal Investigator(s)
LIZ GREENAWAY
U1438323@uel.ac.u
[redacted]

Consent to Participate in a Research Study
The purpose of this letter is to provide you with the information that you need to decide whether you want to take part in a research study. The study is being conducted as part of my Professional Doctorate in Clinical Psychology at the University of East London.

Project Title
An Exploration of how mid-adolescents maintain their 'sense of self'.

What is the purpose of the study?
I am interested in exploring how teenagers (aged 14-16) manage their sense of self. I will be looking at what the effects of comparing yourself to others might be and how that might be affected by feelings of compassion towards the self. I am also interested in looking at the impact of stress and wellbeing. There is a set of 8 short questionnaires to be completed within school time. The questionnaires shoud take approximately 30 minutes to complete. There is no risk in taking part in this research, however, if you become distressed I will give you details of organisations that will be able to help you.

Why me?
We are inviting teenagers aged 14-16 from a diverse range of backgrounds and the school setting is the most suitable place for us to collect the data.

Do I have to take part?
No. You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time (prior to data analysis date to be determined, however I will contact the school and relay this information) and may do so without giving a reason.

What will I be asked to do?
You will be asked to complete a set of short questionnaires, to which there are no right or wrong answers. The questionnaires will ask about your thoughts and feelings. The questionnaires should take approximately 30 minutes to complete and will be completed during the school day,but will not interfere with your education.

Are there any disadvantages or risks to taking part?

Completing the questionnaires is unlikely to cause any distress. However, if you do get distressed upon completing the questionnaires then please contact the researcher on the above email/phone number.

Will I get anything for taking part?
Everyone who takes part in the study will be given the option of entering into a draw to win a £40 shopping voucher. Three winners will be selected, each winning a £40 shopping voucher.

Confidentiality of the data
Your data will be kept securely on a password protected computer file. Hard copies of completed questionnaire data will be kept in a locked filing cabinet in accordance with the Data Protections Act 1998. As it is likely that the work will be published, the data will be kept in order for this to be achieved. Demographic information will also be collected and stored separately, so it will not be possible to connect you to your data via your demographic information. You will be given a number that you need to remember or keep hold of, as this will serve as your identifier to the data if you wish to withdraw from the study. Any data entries onto the computer will only be accessible by the researcher and her supervisors through a password protected system.

What will happen to the results of the research study?
The results obtained from this research are for a doctoral thesis that will be submitted to the University of East London, and submitted for publication in a psychological journal. The data will be stored for 5 years, following which time it will be shredded and disposed of.

Complaints
If you have concerns about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (contact [redacted] If you remain unhappy and wish to complain formally, you can do this by contacting Dr Mary Spiller, Chair of the School of Psychology Research Ethics Sub-committee, School of Psychology, University of East London, Water Lane, London E15 4LZ.

Who has reviewed the study?
This study has been reviewed and given favourable opinion by the UEL School of Psychology Research Ethics Committee.

If you are happy to take part then please sign the attached consent form to this sheet. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ. Telephone. Email address]
or
Chair of the School of Psychology Research Ethics Sub-committee: Dr Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ.

Many thanks for taking the time to read this information sheet

APPENDIX F Quick Information Sheet Phase I

Liz Greenaway
U1438323@uel.ac.uk

A doctoral research study examining how mid-adolescents maintain their 'sense of self'

I am carrying out a research study looking at how teenagers your age think and feel about themselves and how that might impact upon well-being. This research study involves answering a number of questions to which there are no right or wrong answers. All the questions have been seen by your Head Teacher, who is happy for you to take part in the study. However, it is completely up to you whether you would like to take part or not.

If you do take part, you will be asked to complete a set of questionnaires, this should take about 30 minutes to complete, and you will asked to complete them during a suitable time at during the school day.

If you start to answer the questions and feel that you do not want to continue, you are free to stop at any time without giving a reason. You will see a number at the top of the questionnaire sheets and information sheet, please make a note of this or keep the information sheet, as it is how we will identify your responses if you wish to withdraw your answers at a later stage. It is not used in any other way and we do not know which set of questionnaires belongs to whom (i.e., your responses are anonymous).

All the answers you give will remain confidential, which means that they will not be passed on to any of your Teachers, to your parents or to anyone else. Your anonymised data will be kept in a locked drawer at UEL and once the data has been entered electronically it will be stored as a password protected file on the researcher's computer. All physical data will be destroyed within 5 years of the end of the study.

If you'd like to be entered into the prize draw (three chances of winning £40 worth of 'One4all' shopping vouchers that cover a wide range of shops and online stores) please retain your identifier number and your teacher will be informed who has won. The vouchers will be distributed when all data collection has finished.

APPENDIX G Full Information sheet Phase II

UNIVERSITY OF EAST LONDON

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

The Principal Investigator(s)
LIZ GREENAWAY
U1438323@uel.ac.uk
Mobile [redacted]

Consent to Participate in a Research Study
The purpose of this letter is to provide you with the information that you need to decide whether you want to take part in a research study. The study is being conducted as part of my Professional Doctorate in Clinical Psychology at the University of East London.

Project Title
An exploration of how mid-adolescents maintain their 'sense of self'.

What is the purpose of the study?
I am interested in exploring how teenagers (aged 16-17) manage their sense of self. I will be looking at what the effects of comparing yourself to others might be and how that might be affected by feelings of compassion towards the self. I am also interested in looking at the impact of stress and wellbeing. There is a set of 9 short questionnaires to be completed within school time. The questionnaires should take approximately 30 minutes to complete. There is no risk in taking part in this research, however, if you become distressed I will give you details of organisations that will be able to help you.

Why me?
We are inviting teenagers aged 16-17 from a diverse range of backgrounds and the school setting is the most suitable place for us to collect the data.

Do I have to take part?
No. You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time (prior to data analysis date to be determined, however I will contact the school and relay this information) and may do so without giving a reason.

What will I be asked to do?
You will be asked to complete a set of short questionnaires, to which there are no right or wrong answers. The questionnaires will ask about your thoughts and feelings. The questionnaires should take approximately 30 minutes to complete and will be completed during the school day,but will not interfere with your education.

Are there any disadvantages or risks to taking part?
Completing the questionnaires is unlikely to cause any distress. However, if you do get distressed upon completing the questionnaires then please contact the researcher on the above email/phone number.

Will I get anything for taking part?
Everyone who takes part in the study will be given the option of entering into a draw to win a £40 shopping voucher. Three winners will be selected, each winning a £40 shopping voucher.

Confidentiality of the data
Your data will be kept securely on a password protected computer file. Hard copies of completed questionnaire data will be kept in a locked filing cabinet in accordance with the Data Protections Act 1998. As it is likely that the work will be published, the data will be kept in order for this to be achieved. Demographic information will also be collected and stored separately, so it will not be possible to connect you to your data via your demographic information. You will be given a number that you need to remember or keep hold of, as this will serve as your identifier to the data if you wish to withdraw from the study. Any data entries onto the computer will only be accessible by the researcher and her supervisors through a password protected system.

What will happen to the results of the research study?
The results obtained from this research are for a doctoral thesis that will be submitted to the University of East London, and submitted for publication in a psychological journal. The data will be stored for 5 years, following which time it will be shredded and disposed of.

Complaints
If you have concerns about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions (contact number: [redacted] If you remain unhappy and wish to complain formally, you can do this by contacting Dr Mary Spiller, Chair of the School of Psychology Research Ethics Sub-committee, School of Psychology, University of East London, Water Lane, London E15 4LZ.

Who has reviewed the study?
This study has been reviewed and given favourable opinion by the UEL School of Psychology Research Ethics Committee.

If you are happy to take part then please sign the attached consent form to this sheet. Please retain this invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor Dr Trishna Patel, School of Psychology, University of East London, Water Lane, London E15 4LZ. Telephone. Email address]
or
Chair of the School of Psychology Research Ethics Sub-committee: Dr Mary Spiller, School of Psychology, University of East London, Water Lane, London E15 4LZ.

Many thanks for taking the time to read this information sheet

Quick Information sheet prior to data collection

Liz Greenaway
U1438323@uel.ac.uk

A doctoral research study examining how mid-adolescents maintain their 'sense of self'

I am carrying out a research study looking at how people aged 16-17 think and feel about themselves and how that might impact upon well-being. This research study involves answering a number of questions to which there are no right or wrong answers. It is completely up to you whether you would like to take part or not.

If you do take part, you will be asked to complete a set of questionnaires, this should take about 30 minutes to complete, it might be a good idea to fill them in when you are able to be in a quiet environment.

If you start to answer the questions and feel that you do not want to continue, you are free to stop at any time without giving a reason. If you feel distress then please contact the Samaritans on 116 123 or MIND www.mind.org and go to "I need urgent help" or call them on 0300 123 3393.

All the answers you give will remain confidential and your anonymised data will be transferred into a computer data programme. There will be no way that your data could be connected with you.

If you'd like to be entered into the prize draw (three chances of winning £40 worth of 'One4all' shopping vouchers that cover a wide range of shops and online stores) please email your contact details to the email given at the end of the questionnaires. Once the draw has taken place and the winners notified your contact details will be destroyed.

APPENDIX I Debrief Sheet Phase I

Thank you for taking part in my research, I really appreciate it. If you'd like the chance to win £40 worth of One4All shopping vouchers (there are three chances!) please add your email/mobile number to the separate coloured sheet on your desk. Once we have done the draw we will only use this to contact you if you have won and in order to arrange how we can get the voucher to you. Once the draw has taken place the contact list will be destroyed. Only I will see this information and it will be stored in a locked environment not accessible to others.

Please feel free to ask me any questions now or alternatively if you think of something later on please feel free to contact me via email [u1438323@uel.ac.uk].

All your answers will remain anonymous, we have no way of knowing which answers respond to which student, but if you can keep hold of the number that is on the top of your questionnaires then we can use that to remove your data if you no longer wish to take part in the study.

If any of the questions have caused you to feel discomfort or distress please let me know or contact the following organisations:

*****MIND* ***Wandsworth & Westminster Mind***
3rd Floor, Radstock House, 5 Eccleston Street, London SW1W 9LX Tel: 020 7259 8100
Email: admin@wwmind.org.ukn

The Well in Streatham The Well Centre, 16 Wellfield Road, Streatham, London, SW16 2BP
Tel: 020 8473 1581
SMS: 07797 805819
Email: info@thewellcentre.org

The Samaritans – Call 116 123, or email jo@samaritans.org or visit the Sutton branch at 2B Kidderminster Road, West Croydon, Surrey, CR9 2BQ T: 020 8681 6666

**This information will change depending on location of school

APPENDIX J Debrief Page Phase II

Thank you for taking part in my research, I really appreciate it. If you'd like the chance to win £40 worth of One4All shopping vouchers (there are three chances!) please email me your contact details (name and address) using the email address:
u1438323@uel.ac.uk
Once we have done the draw we will only use this to contact you if you have won and in order to arrange how we can get the voucher to you. Once the draw has taken place the contact list will be destroyed. Only I will have access to this information and it will be stored in a locked environment not accessible to others.
Please feel free to ask me any questions now or alternatively if you think of something later on please feel free to contact me via email [u1438323@uel.ac.uk].
All your answers will remain anonymous, I have no way of knowing which answers respond to which student, but if you can keep hold of your identifier number then that can be used to remove your data if you no longer wish to take part in the study. The data will be analysed from January 1st 2018, from that date it will not be possible to remove your data.
If any of the questions have caused you to feel discomfort or distress please let me know or contact the following organisations:
Samaritans on 116 123 or
MIND www.mind.org and go to 'I need urgent help' or call them on 0300 123 3393.

APPENDIX K Consent form Phase I

UNIVERSITY OF EAST LONDON

Consent for participation in a research study

AN EXPLORATION OF HOW MID-ADOLESCENTS MAINTAIN THEIR 'SENSE OF SELF'

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw myself from the study at any time prior to analysis without disadvantage to myself and without being obliged to give any reason

Participant's Name (BLOCK CAPITALS)

…….

Participant's Signature

……..

Researcher's Name (BLOCK CAPITALS)
LIZ GREENAWAY
……..

Researcher's Signature

……

Date: ……..…….

APPENDIX L Demographic Form Phase I

Please complete the following questions:

Gender □ Male □ Female

Age in years and months _____

Ethnic Origin

White	□ British □ Irish □ Other White
Mixed	□White & Black Caribbean □White & Black African □White & Asian □Other Mixed
Asian or Asian British	□Indian □Pakistani □Bangladeshi □Other Asian
Black or Black British	□Caribbean □African □Other Black
Other Ethnic Groups	□Chinese □Other Ethnic Group
Please state	……
Do not wish to disclose	……

APPENDIX M Consent page Phase II

UNIVERSITY OF EAST LONDON

Consent for participation in a research study

AN EXPLORATION OF HOW MID-ADOLESCENTS MAINTAIN THEIR 'SENSE OF SELF'

I confirm I have read and understood the information page.
I confirm that if I had questions to ask I was able to ask them and that I received satisfactory answers.
I understand that my involvement in the study is voluntary.
I understand that I can withdraw from the study up to the end of December 2017 without giving a reason.
I understand that if I withdraw during the study all the information I provided will be deleted.
I understand that I will not be able to withdraw my responses for completed questionnaires if I am unable to provide my unique study identifier.
I understand that the data I provide will be anonymous and will be confidential between the researcher and her supervisor.
I understand that all information about the study will be destroyed after 5 years.
I hereby freely and fully consent to participate in the study, which has been fully explained to me.
Please indicate your consent by clicking 'YES' below

APPENDIX N Demographic Form Phase II

Demographics/diversity form
Please complete the following questions:

Gender

- ◯ Male
- ◯ Female
- Do not wish to disclose

Age - in years and months

☐

Ethnic origin - White

- ◯ British, English, Welsh, Scottish, Northern Irish
- ◯ Irish
- ◯ Irish Traveller/Gypsy
- ◯ European - please state ☐
- ◯ Any other White background - please state ☐

Mixed or multiple Ethnic group

- ◯ White and Black Caribbean
- ◯ White and Black African
- ◯ White and Black Asian
- ◯ Any other mixed background - please state ☐

Asian or Asian British

- ◯ Indian
- ◯ Pakistani
- ◯ Bangladeshi
- ◯ Chinese
- ◯ Japanese
- ◯ Any other Asian background - please state ☐

Black or Black British

- ◯ Caribbean
- ◯ African
- ◯ Any other Black background - please state ☐

Latin-American

- ◯ Please state ☐

Please specify if your Ethnic origin is not stated above or indicate you do not wish to disclose your ethnicity

APPENDIX O Scales, Subscales and Constructs Used in the Study

MEASURE	SUBSCALE	SCALE NAME	CONSTRUCT
OAS		Other as Shamer Scale	External shame
ESS		Experience of Shame Scale	Internal shame
	ESS-CH	*Experience of Shame Scale – character*	
	ESS-BOD	*Experience of Shame Scale – body*	
	ESS-BEH	*Experience of Shame Scale – behavioural*	
ASPS		Adolescent Shame Proneness Scale	Shame proneness
	ASPS-NSE	*Adolescent Shame Proneness Scale – negative self evaluation*	
	ASPS-EXT	*Adolescent Shame Proneness Scale – externalisation*	
	ASPS-EMD	*Adolescent Shame Proneness Scale – emotional discomfort*	
ASCS-R		Adolescent Social Comparison Scale Revised	Social comparison
ASBS-R		Adolescent Submissive Behaviour Scale Revised	Social comparison
B-PNI		Brief Pathological Narcissism Inventory	Narcissism
B-PNI GR	B-PNI GR EXP	*Brief Pathological Narcissism Inventory – Grandiose – exploitativeness*	Grandiose Narcissism
	B-PNI GR SSSE	*Brief Pathological Narcissism Inventory – Grandiose – self-sacrificing self enhancement*	
	B-PNI GR GF	*Brief Pathological Narcissism Inventory – Grandiose – grandiose fantasy*	
B-PNI VU	B-PNI VU CSE	*Brief Pathological Narcissism Inventory – Vulnerable – contingent self esteem*	Vulnerable Narcissism
	B-PNI VU HTS	*Brief Pathological Narcissism Inventory – Vulnerable – hiding the self*	
	B-PNI VU D	*Brief Pathological Narcissism Inventory – Vulnerable – devaluing*	
	B-PNI VU ER	*Brief Pathological Narcissism Inventory – Vulnerable – entitlement rage*	
SCSSF		Self-Compassion Scale short form	Self-compassion
	SCSSF-P	*Self-Compassion Scale short form - Positive*	
WEMWBS		Warwick-Edinburgh Mental Health Well-being Scale	Psychological well-being
DASS-21		Depression Anxiety and Stress Scale	Psychological distress
	DASS-21D	*Depression Anxiety and Stress Scale – Depression*	
	DASS-21A	*Depression Anxiety and Stress Scale – Anxiety*	
	DASS-21S	*Depression Anxiety and Stress Scale – Stress*	

APPENDIX P Outlier Scores

SCALE	PARTICIPANT	Z-SCORE	EXTREME SCORE	SD 3 FROM MEAN	MAD
OAS	133	3.68	68.00	60.01	64.56
	11	2.99	60.00		
ASCS-R	136	-3.10	76.00	85.59	32.61
	11	-3.10	76.00		
ASBS-R	21	2.68	56.00	58.71	34.54
B-PNI VU	133	2.78	76.00	79.11	58.56
SCSSF	127	2.99	53.00	52.99	31.13
DASS	133	2.48	58.00	64.80	48.92
	79	2.48	58.00		

APPENDIX Q ASCS ITEM TOTAL SCORES CRONBACH α

Item-Total Statistics

	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
SC04_ASCS_01	47.570	86.787	.459	.449	.613
SC04_ASCS_02	48.711	103.987	.130	.162	.675
SC04_ASCS_03	49.292	94.240	.440	.370	.625
SC04_ASCS_04	48.873	110.045	-.046	.102	.709
SC04_ASCS_05	49.880	95.279	.403	.297	.631
SC04_ASCS_06	48.641	97.519	.292	.095	.649
SC04_ASCS_07	48.070	90.272	.406	.399	.626
SC04_ASCS_08	47.401	88.499	.400	.324	.626
SC04_ASCS_09	48.620	85.263	.531	.427	.598
SC04_ASCS_10	47.673	91.783	.305	.152	.648

APPENDIX R Normality on Main Scales

Tests of Normality

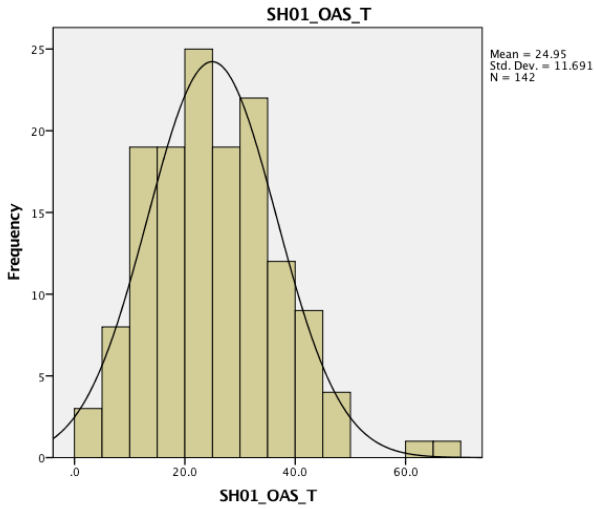
	Kolmogorov-Smirnov[a]			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
OAS	.055	142	.200*	.981	142	.048
ESS	.073	142	.058	.976	142	.013
ASPS	.089	142	.007	.987	142	.218
ASCS	.085	142	.013	.981	142	.049
ASBS	.043	142	.200*	.991	142	.541
BPNI GR	.053	142	.200*	.995	142	.879
BPNI VU	.046	142	.200*	.993	142	.662
SCSSF	.057	142	.200*	.993	142	.699
WEMWBS	.057	142	.200*	.991	142	.546
DASS21	.067	142	.200*	.978	142	.024

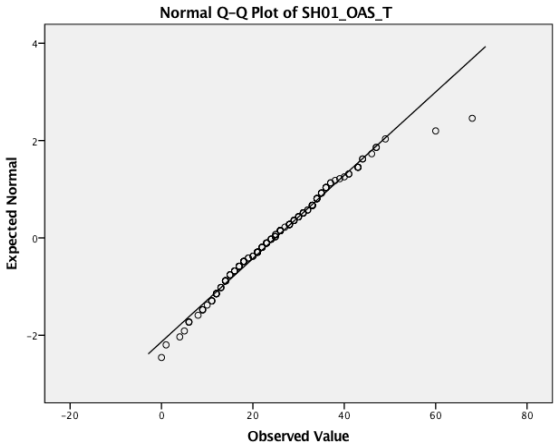
*. This is a lower bound of the true significance.

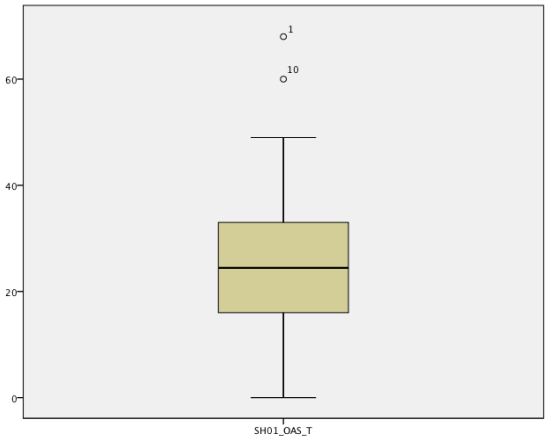
a. Lilliefors Significance Correction

APPENDIX S Normality Plots

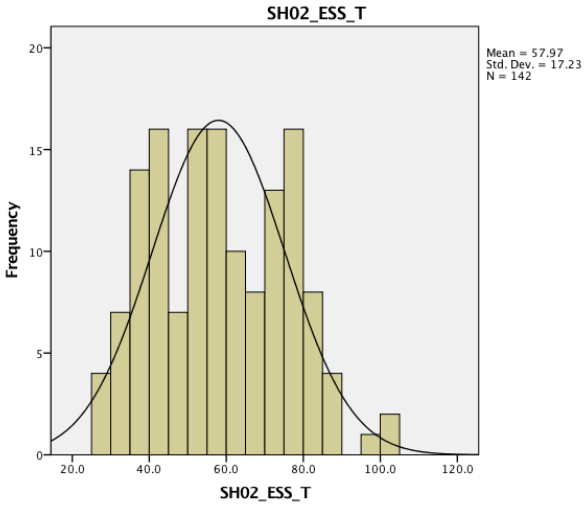
OAS – Other as Shamer Scale

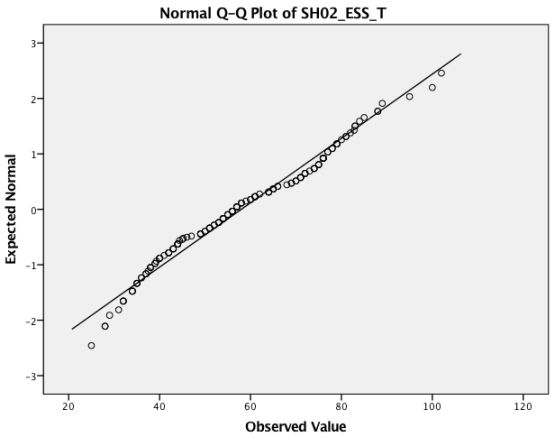


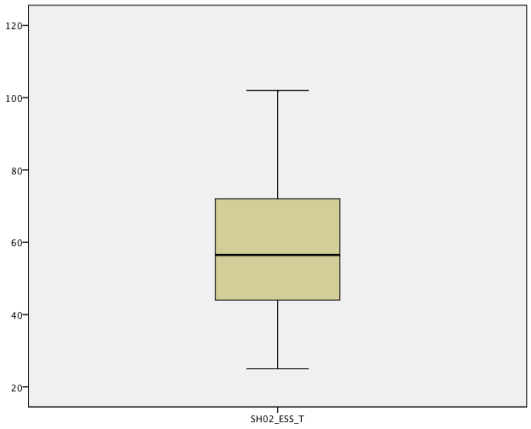




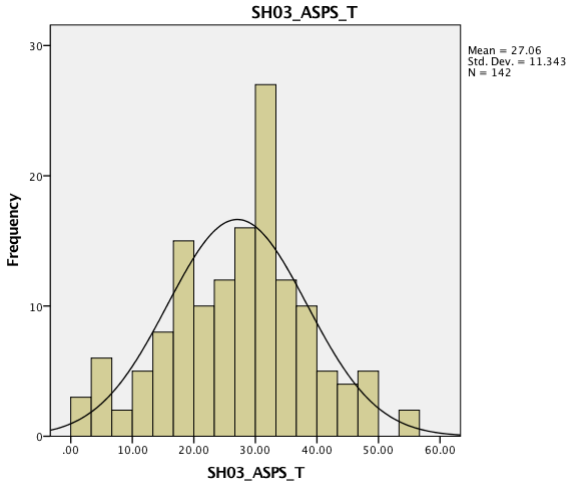
ESS – Experience of Shame Scale

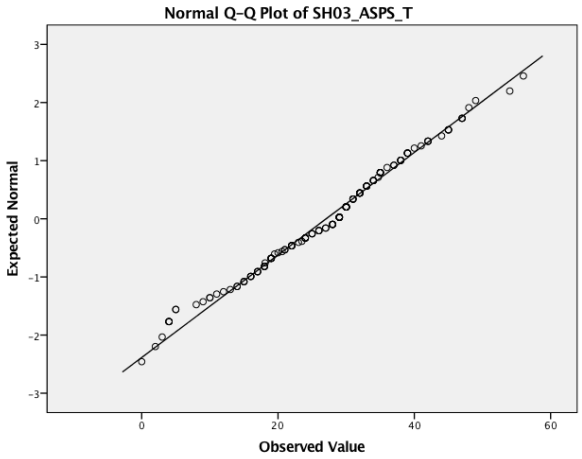


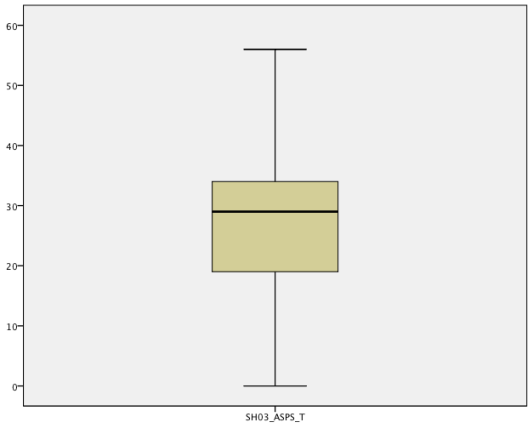




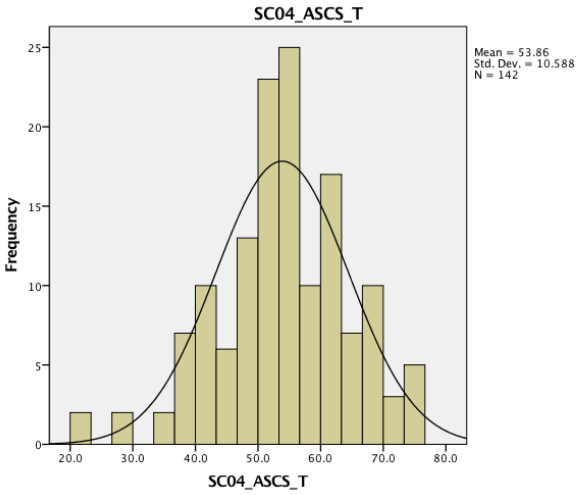
ASPS – Adolescent Shame Proneness Scale

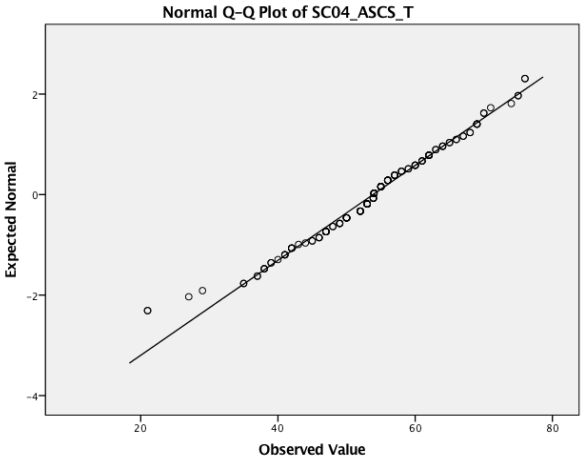


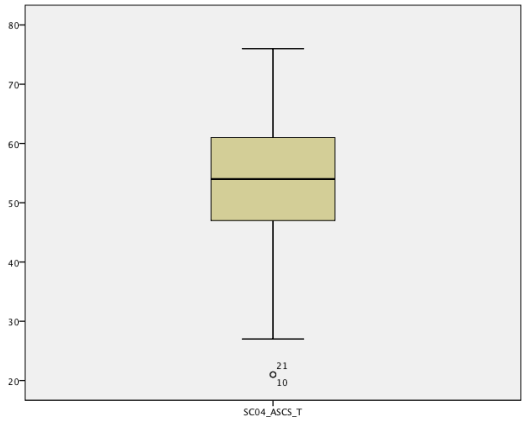




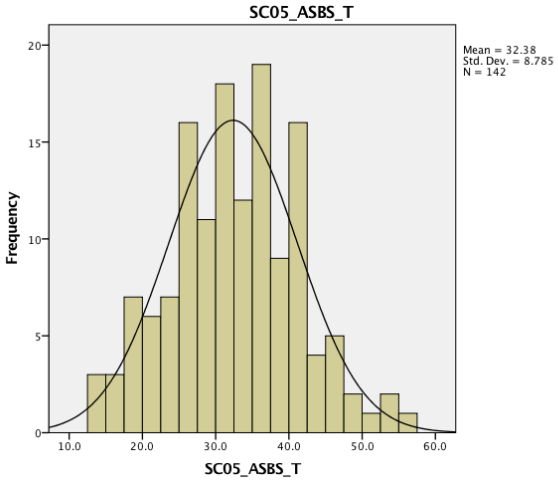
ASCS-R – Adolescent Social Comparison Scale - Revised

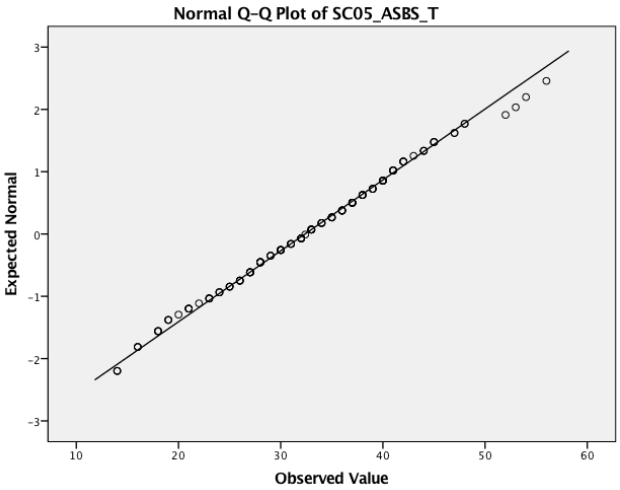


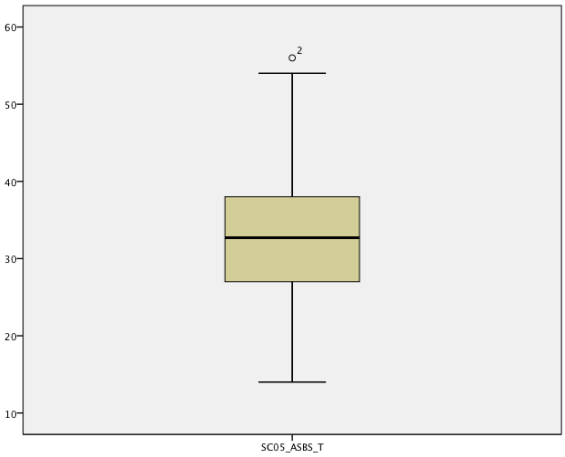




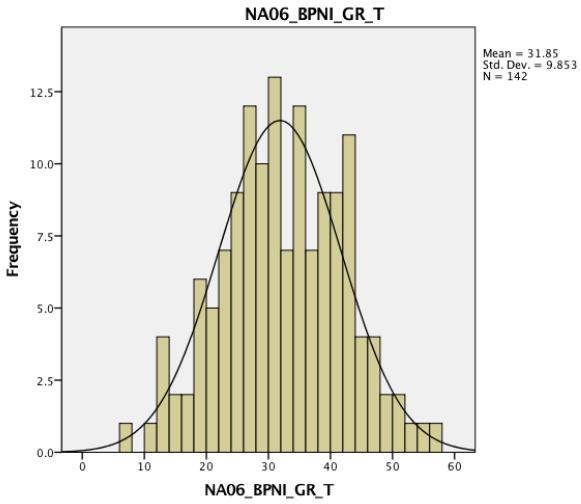
ASBS-R – Adolescent Submissive Behaviour Scale - Revised

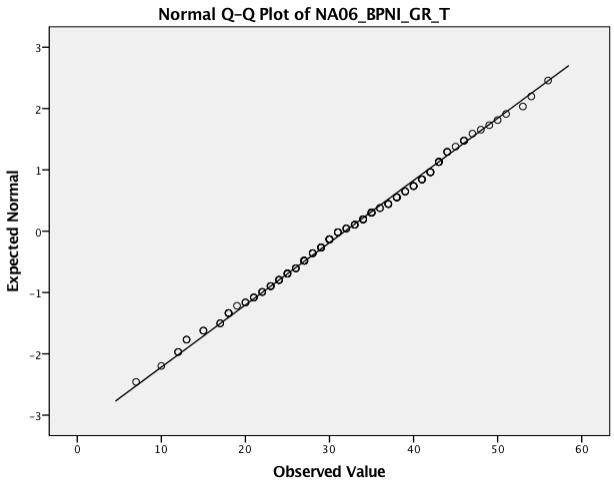


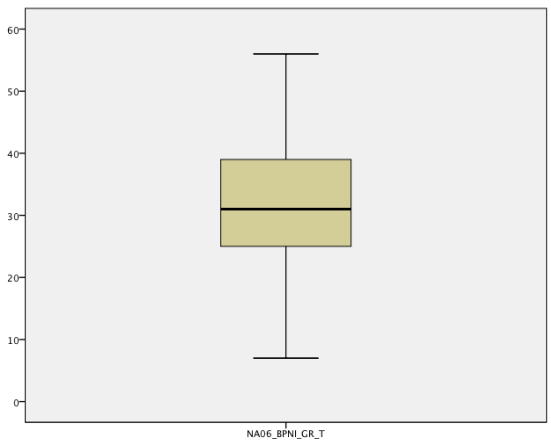




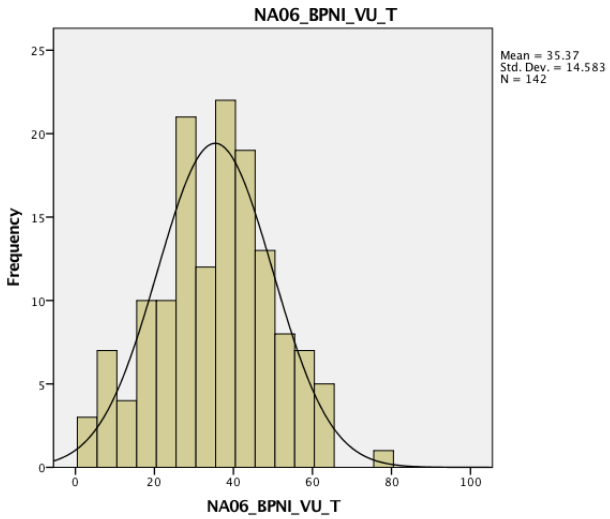
B-PNI GR – Brief Pathological Narcissism Inventory - Grandiose

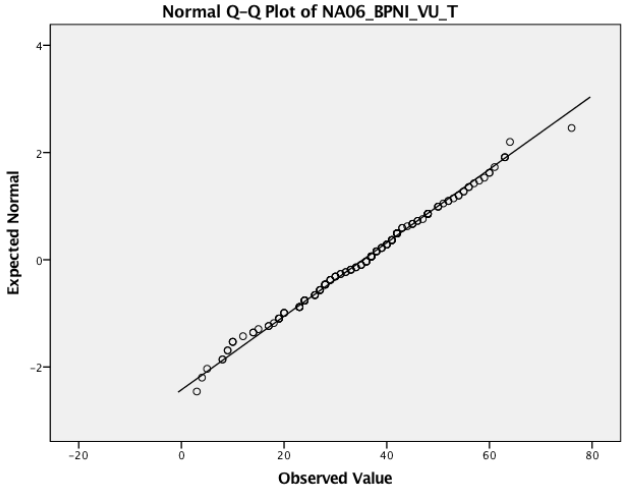


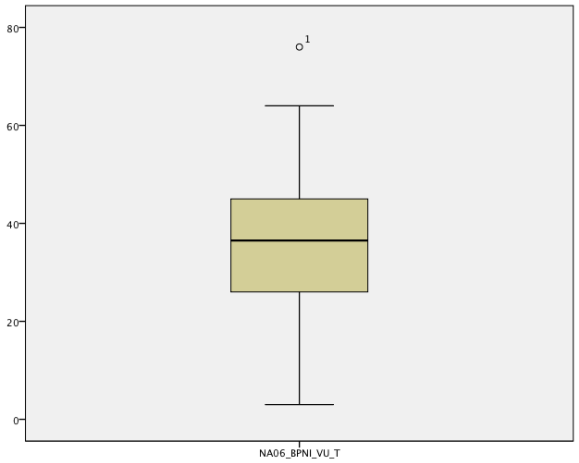




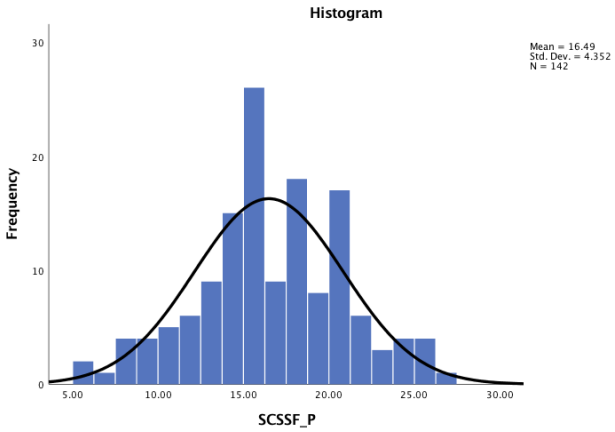
B-PNI VU – Brief Pathological Narcissism Inventory - Vulnerable

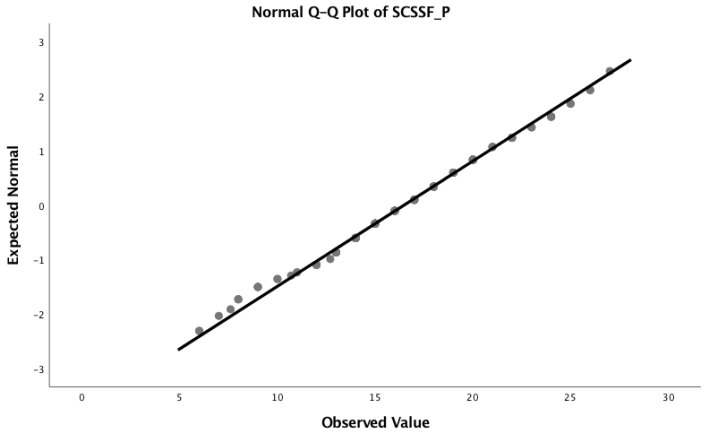


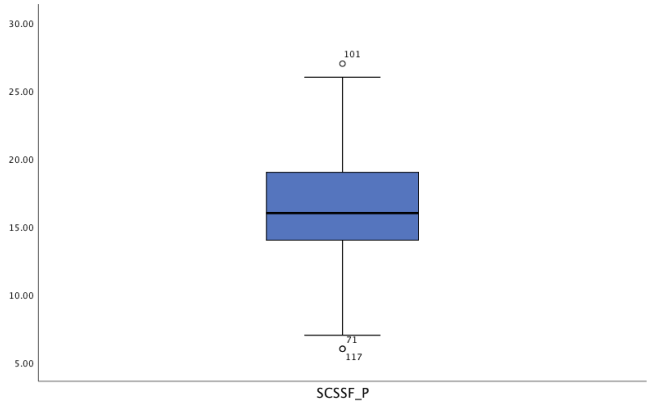




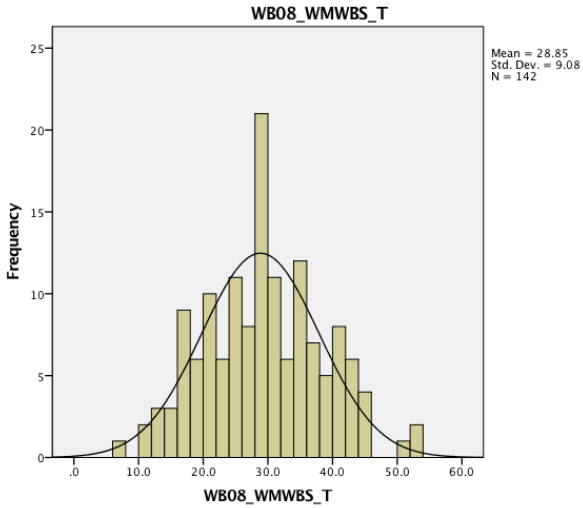
SCSSF-P – Self-Compassion Scale Short Form - Positive

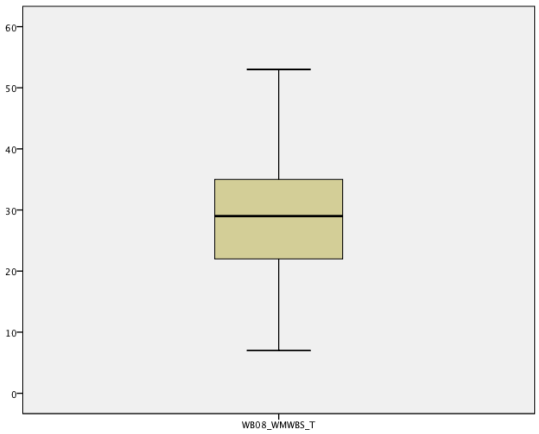


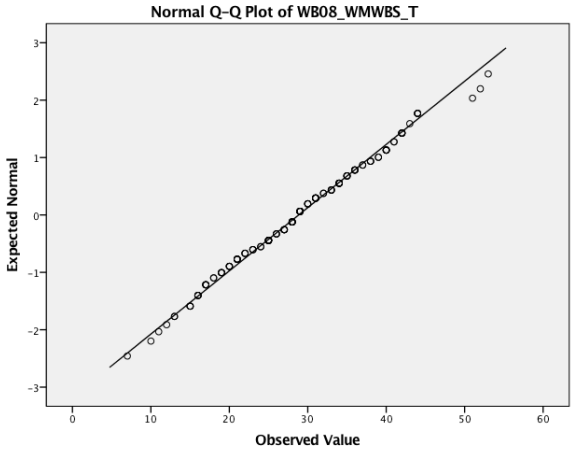




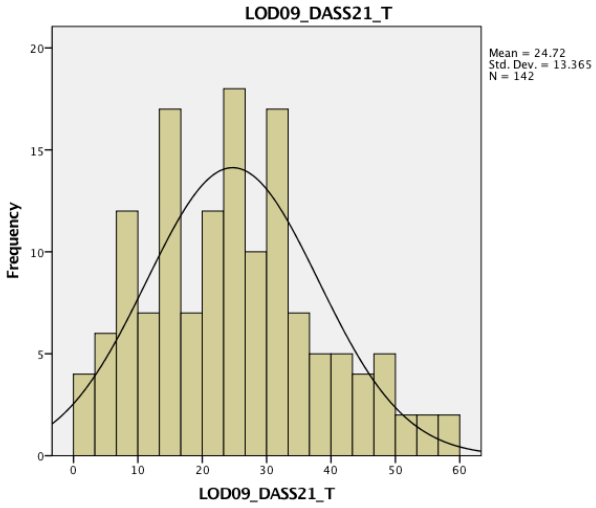
WEMWBS – Warwick-Edinburgh Mental Health Wellbeing Scale

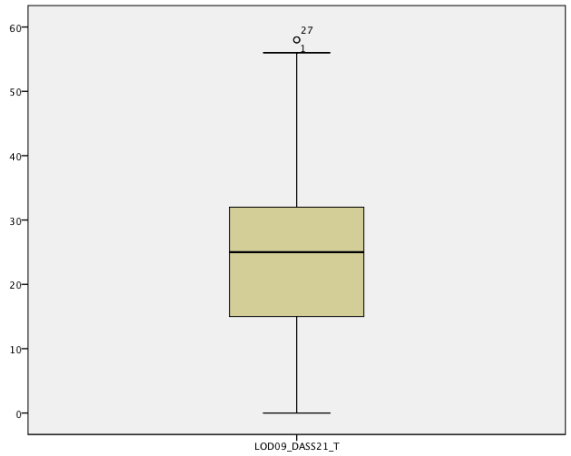


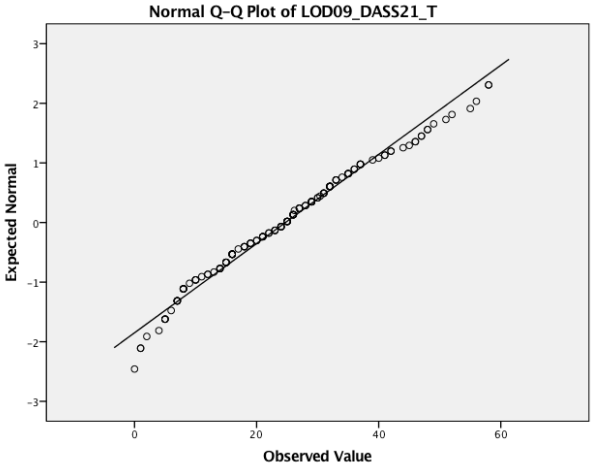




DASS-21 – Depression, Anxiety and Stress Scale







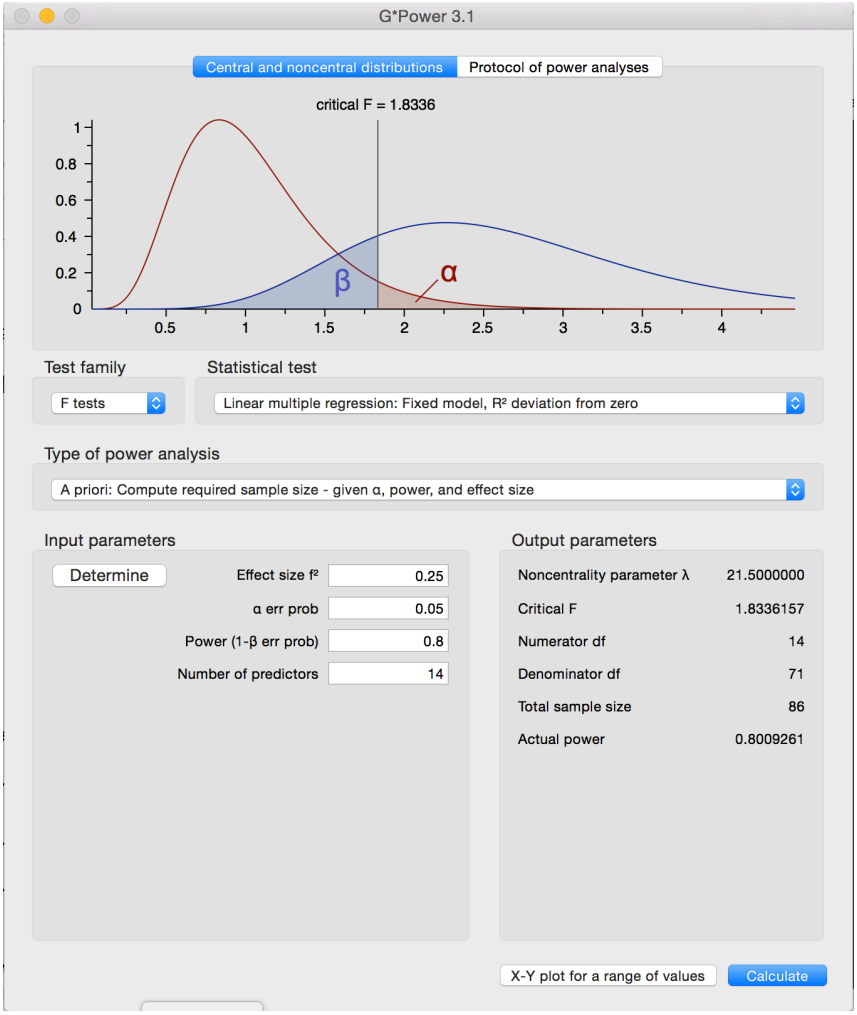
APPENDIX T Full Pearson's Correlation Coefficients, Bootstrapped Signficance Values and Confidence Intervals

	OAS	ESS	ESS CH	ESS BEH	ESS BOD	ASPS	ASPS NSE	ASPS EXT	ASPS EMD	ASCS	ASBS	BPNI GR	BPNI GR EXP	BPNI GR SSSE	BPNI GR GF	BPNI VU	BPNI VU CSE	BPNI VU HTS	BPNI VU D	BPNI VU ER	SCSSF P	DASS-21	DASS-21 D	DASS-21 A	DASS-21 S	WEMWBS
OAS	1	**.757****	**.741****	**.619****	**.626****	**.740****	**.758****	**.410****	**.569****	**-.490****	**.621****	**.290****	.086	**.279****	**.300****	**.624****	**.627****	**.547****	**.430****	**.316****	-.154	**.609****	**.594****	**.503****	**.520****	**-.435****
CI		.689-	.665-	.524-	.533-	.635-	.665-	.253-	.456-	-.607-	.500-	.142-	-.075-	.129-	.145-	.506-	.529-	.422-	.274-	.156-	-.354-	.482-	.486-	.361-	.384-	**-.577-**
		.810	.800	.701	.711	.811	.823	.544	.661	-.362	.722	.425	.254	.414	.466	.722	.724	.655	.559	.468	.045	.718	.684	.633	.635	**-.278**
ESS		1	**.949****	**.908****	**.742****	**.751****	**.753****	**.349****	**.674****	**-.503****	**.639****	**.318****	.116	**.337****	**.287****	**.599****	**.644****	**.553****	**.331****	**.300****	**-.195***	**.657****	**.615****	**.549****	**.582****	**-.439****
CI			.931-	.869-	.646-	.674-	.664-	.176-	.591-	-.609-	.537-	.165-	-.068-	.176-	.117-	.483-	.533-	.431-	.140-	.117-	**-.371-**	.539-	.490-	.423-	.439-	**-.585-**
			.964	.936	.818	.816	.829	.506	.753	-.377	.729	.457	.271	.482	.436	.704	.741	.669	.508	.473	**-.025**	.746	.729	.668	.696	**-.294**
ESS CH			1	**.782****	**.599****	**.758****	**.766****	**.353****	**.668****	**-.479****	**.575****	**.308****	.120	**.317****	**.280****	**.588****	**.614****	**.528****	**.345****	**.315****	**-.190***	**.637****	**.604****	**.518****	**.572****	**-.391****
CI				.714-	.474-	.677-	.687-	.180-	.590-	-.604-	.458-	.136-	-.036-	.169-	.120-	.466-	.512-	.405-	.171-	.140-	**-.363-**	.520-	.478-	.369-	.430-	**-.540-**
				.841	.705	.824	833	.506	.736	-.334	.683	.448	.279	.459	.435	.696	.709	.640	.508	.478	**-.016**	.746	.718	.652	.690	**-.242**
ESS BEH				1	**.561****	**.592****	**.591****	**.221****	**.591****	**-.411****	**.604****	**.284****	.045	**.302****	**.305****	**.496****	**.550****	**.474****	**.247****	**.237****	-.127	**-.555****	**.507****	**.474****	**.493****	**-.348****
CI					.443-	.454-	.477-	.046-	.492-	-.536-	.491-	.126-	**-.103-**	.144-	.149-	.350-	.432-	.329-	.071-	.071-	.292-	.414-	.361-	.309-	.342-	**-.496-**
					.660	.699	.688	.375	.679	-.276	.703	.423	**.214**	.445	.446	.633	.660	.599	.394	.394	.027	.695	.649	.629	.629	**-.193**
ESS BOD					1	**.601****	**.595****	**.371****	**.468****	**-.448****	**.509****	**.229****	**.168***	**.263****	.120	**.480****	**.532****	**.452****	**.262****	**.212***	**-.217****	**.526****	**.496****	**.458****	**.442****	**-.474****
CI						.476-	.483-	.206-	.328-	-.555-	.390-	.063-	-.002-	.098-	-.064-	.351-	.396-	.322-	.109-	.048-	**-.380-**	.400-	.373-	.323-	.285-	**-.596-**
						.706	.703	.510	.594	-.319	.619	.381	.329	.402	.300	.603	.642	.576	.405	.367	**-.048**	.642	.614	.580	.585	**-.340**
ASPS						1	**.933****	**.659****	**.857****	**-.501****	**.614****	**.234****	.039	**-.286****	**.220****	**.588****	**.573****	**.551****	**.400****	**.284****	**-.182***	**.630****	**.599****	**.486****	**.593****	**-.451****
CI							.909-	.557-	.807-	-.618-	.503-	.090-	.121-	.120-	.020-	.475-	.462-	.413-	.215-	.111-	**-.359-**	.509-	.475-	.336-	.454-	**-.589-**
							.954	.747	.896	-.370	.717	.377	.193	462	.411	.690	.682	.667	.557	.449	**.006**	.725	.700	.621	.724	**-.301**
ASPS NSE							1	**.409****	**.728****	**-.570****	**.637****	**.176***	-.039	**.259****	**.188***	**.583****	**.638****	**.549****	**.360****	**.226****	**-.196***	**.567****	**.571****	**.416****	**.520****	**-.424****
CI								.249-	.650-	-.687-	.530-	.000-	-.198-	.102-	.019-	.446-	.518-	.414-	.203-	.049-	**-.372-**	.419-	.443-	.238-	.373-	**-.563-**
								.556	.789	-.433	.730	.347	.136	.413	.349	.700	.744	.659	.517	.398	**-.009**	.691	.668	.577	.660	**-.270**
ASPS EXT								1	**.448****	-.113	**.206****	**.170***	**.187***	.086	.123	**.304****	.145	**.226****	**.337****	**.276****	-.119	**.409****	**.358****	**.358****	**.371****	**-.260****
CI									.309-	-.283-	-.010-	-.007-	-.002-	-.072-	-.038-	.151-	-.019-	,061-	.183-	.111-	-.273-	.247-	.187-	.185-	.212-	**-.428-**
									.565	.067	.389	.335	.364	.238	.287	.458	.298	.379	.477	.420	.048	.543	.505	.506	.518	**-.100**
ASPS EMD									1	**-.423****	**.585****	**.274****	.034	**.361****	**.248****	**.512****	**.497****	**.533****	**.299****	**.240****	-.103	**-.592****	**.522****	**.458****	**.598****	**-.416****
CI										**-.535-**	.475-	.141-	-.118-	.219-	.076-	.369-	.369-	.422-	.141-	.072-	.300-	.470-	.368-	.333-	.488-	**-.563-**
										-.303	.679	.416	.196	.494	.412	.630	.619	.637	.444	.394	.101	.686	.649	.569	.699	**-.267**
ASCS										1	**-.632****	-.041	.096	-.157	-.040	**-.369****	**-.462****	**-.377****	**-.196***	-.070	.107	**-.432****	**-.486****	**-.279****	**-.381****	**.490****
CI											**-.725-**	-.172-	-.061-	.293-	-.190-	**-.501-**	**-.586-**	**-.524-**	**-.351-**	-.248-	-.065-	**-.555-**	**-.606-**	**-.429-**	**-.519-**	.354-
											-.514	.104	.232	-.016	.119	**-.224**	**-.312**	**-.219**	**-.037**	.101	.286	**-.273**	**-.348**	**-.109**	**-.217**	.610
ASBS											1	.099	-.130	**.190***	.161	**.463****	**.538****	**.460****	**.274****	.125	-.071	**.545****	**.510****	**.442****	**.496****	**-.550****
CI												-.059-	-.301-	.011-	.010-	.321-	.409-	.302-	.118-	.042-	-.001-	.396-	.365-	.282-	.353-	**-.678-**
												.255	.043	.358	.301	.585	.647	.593	.425	.287	.092	.662	.618	.572	.618	**-.398**
BPNI GR												1	**.707****	**.786****	**.833****	**.574****	**.405****	**.395****	**.479****	**.545****	**.220****	**.320****	**.292****	**.273****	**.287****	.022
CI													.620-	.709-	.773-	.446-	.217-	.263-	.325-	.375-	.069-	.188-	.129-	.128-	.143-	-.130-
													.786	.850	.877	.684	.564	.521	.617	.686	.365	.447	.437	.423	.436	.167
BPNI GR EXP													1	**.347****	**.336****	**.279****	.097	**.173***	**.300****	**.345****	**.208***	.145	-.103	**.195***	.086	.112
CI														.201-	.175-	.116-	-.087-	.021-	.141-	.189-	.064-	.017-	-.052-	.032-	-.064-	-.073-
														.494	.484	.434	.276	.312	.444	.488	.350	.294	.268	.357	.236	.261
BPNI GR SSSE														1	**.530****	**.563****	**.480****	**.411****	**.376****	**.500****	**.208***	**.350****	**.297****	**.287****	**.349****	-.067
CI															.381-	.425-	.342-	.270-	.218-	.370-	.059-	.203-	.153-	.134-	.193-	-.216-
															.650	.686	.624	.535	.519	.607	.350	.496	.428	.439	.482	.081
BPNI GR GF															1	**.495****	**.368****	**.339****	**.432****	**.432****	.113	**.258****	**.276****	**.170***	**.239****	.004
CI																.334-	.207-	.166-	.294-	.242-	-.066-	.094-	.100-	.028-	.074-	-.161-
																.628	.521	.492	.555	.588	.283	415	.433	.320	.398	.183
BPNI VU																1	**.825****	**.775****	**.789****	**.748****	-.100	**.557****	**.488****	**.467****	**.524****	**-.376****
CI																	.763-	.682-	.716-	.656-	-.329-	.423-	.325-	.320-	.390-	**-.510-**
																	.873	.846	.847	.819	.109	.677	.634	.604	.645	**-.210**
BPNI VU CSE																	1	**.586****	**.447****	**.480****	-.159	**.500****	**.497****	**.379****	**.451****	**-.367****
CI																		.454-	.308-	.334-	-.373-	.372-	.361-	.242-	.313-	**-.516-**
																		.702	.563	.602	-.044	.622	.613	.513	.578	**-.205**
BPNI VU HTS																		1	**.482****	**.323****	-.082	**.444****	**.425****	**.382****	**.371****	**-.413****
CI																			.347-	.164-	-.288-	.294-	.258-	.232-	.207-	**-.563-**
																			.594	.463	.122	.587	.556	.513	.517	**-.240**
BPNI VU D																			1	**.616****	-.070	**.432****	**.430****	**.366****	**.349****	**-.293****
CI																				.498-	-.252	.252-	.264-	.196-	.169-	**-.448-**
																				.712	-.121	.593	.569	.518	.495	**-.122**
BPNI VU ER																				1	.019	**.360****	**.273****	**.339****	**.349****	-.072
CI																					-.171-	.180-	.100-	.169-	.181-	-.254-
																					.182	.531	.436	.495	.493	.104
SCSSF P																					1	-.097	-.082	-.116	-.057	**.350****
CI																						-.277-	.259-	.275-	-.253-	.159-
																						.075	.097	.054	.141	.532
DASS-21																						1	**.852****	**.898****	**.911****	**-.498****
CI																							.793-	.861-	.876-	**-.607-**
																							.900	.930	.938	**-.377**
DASS-21 D																							1	**.604****	**.649****	**-.515****
CI																								.469-	.524-	**-.625-**
																								.730	.754	**-.399**
DASS-21 A																								1	**.788****	**-.401****
CI																									.714-	**-.520-**
																									.854	**-.259**
DASS-21 S																									1	**-.406****
CI																										**-.532-**
																										-.268
WEMWBS																										1
CI																										

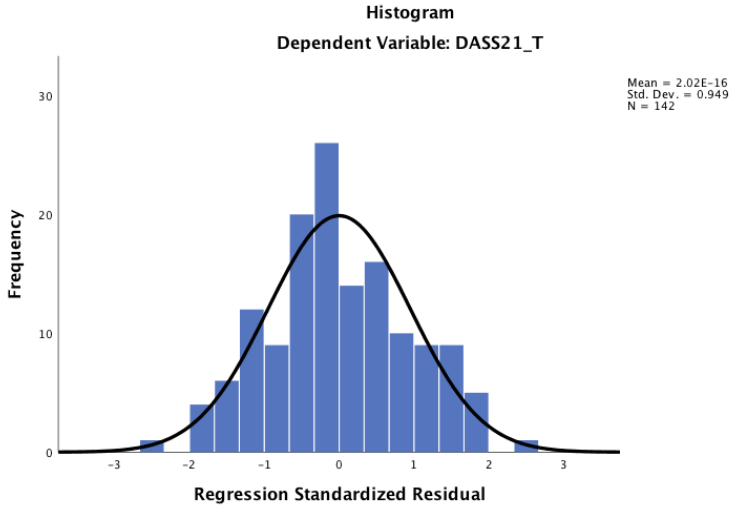
OAS (Other as Shamer Scale) **ESS** (Experience of Shame Scale) **ESS CH** (Experience of Shame Scale character) **ESS BEH** (Experience of Shame Scale behaviour) **ESS BOD** (Experience of Shame Scale body) **ASPS** (Adolescent Shame Proneness Scale) **ASPS NSE** (Adolescent Shame Proneness Scale negative self evaluation) **ASPS EXT** (Adolescent Shame Proneness Scale externalisation) **ASPS EMD** (Adolescent Shame Proneness Scale emotional discomfort) **ASCS** (Adolescent Social Comparison Scale) **ASBS** (Adolescent Submissive Behaviour Scale) **BPNI GR** (Brief Pathological Narcissism Inventory grandiose) **BPNI GR EXP** (Brief Pathological Narcissism Inventory grandiose exploitativeness) **BPNI GR SSSE** (Brief Pathological Narcissism Inventory grandiose self-sacrificing self enhancement) **BPNI GR GF** (Brief Pathological Narcissism Inventory grandiose grandiose fantasy) **BPNI VU** (Brief Pathological Narcissism Inventory vulnerable) **BPNI VU CSE** (Brief Pathological Narcissism Inventory vulnerable contingent self esteem) **BPNI VU HTS** (Brief Pathological Narcissism Inventory vulnerable hiding the self) **BPNI VU D** (Brief Pathological Narcissism Inventory vulnerable devaluing) **BPNI VU ER** (Brief Pathological Narcissism Inventory vulnerable entitlement rage) **SCSSF P** (Self Compassion Scale short form 'positive') **SCSSF N** (Self Compassion Scale short form 'negative') **DASS-21** (Depression, Anxiety and Stress Scale) **DASS-21 D** (Depression,

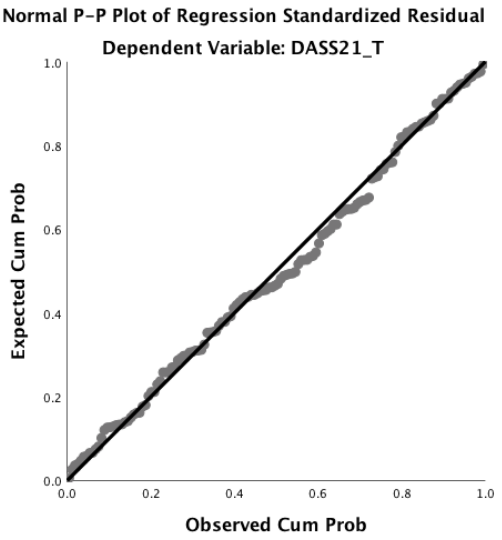
Anxiety and Stress Scale depression) **DASS-21 A** (Depression, Anxiety and Stress Scale anxiety) **DASS-21 S** (Depression, Anxiety and Stress Scale stress) **WEMWBS** (Warwick-Edinburgh Mental Wellbeing Scale).*p<.01, ** p<.001

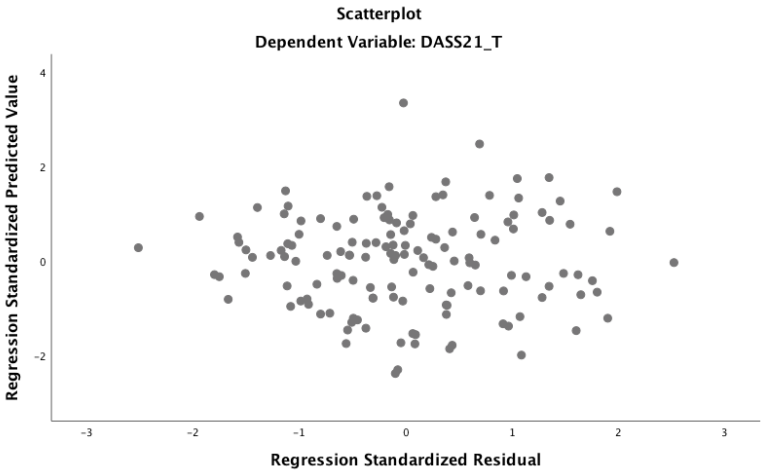
APPENDIX U G*Power – 14 Predictors



APPENDIX V Tests of Normality for Multiple Regression – all variables on Distress (DASS-21)







APPENDIX W Full Stepwise Regression Table – Distress (DASS-21)

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			Correlations			Collinearity Statistics	
		B	Std. Error	Beta	t	Sig.	Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	-4.724	8.788		-.538	.592					
	OAS	.160	.125	.140	1.283	.202	.609	.113	.076	.292	3.429
	ESS	.237	.086	.305	2.752	.007	.657	.237	.162	.283	3.539
	ASPSNSE	-.261	.238	-.135	-1.097	.275	.567	-.097	-.065	.230	4.349
	ASPSEXT	.504	.319	.120	1.578	.117	.409	.139	.093	.602	1.661
	ASPSEMD	.791	.412	.194	1.920	.057	.592	.168	.113	.342	2.924
	ASCS	-.116	.103	-.092	-1.128	.261	-.432	-.100	-.067	.526	1.902
	ASBS	.201	.145	.132	1.392	.166	.545	.123	.082	.385	2.595
	BPNIGREXP	.082	.234	.025	.351	.726	.145	.031	.021	.700	1.429
	BPNIGRSSS	.313	.291	.088	1.074	.285	.350	.095	.063	.515	1.940
	BPNIGRGF	-.148	.208	-.054	-.713	.477	.258	-.063	-.042	.610	1.640
	BPNIVUCSE	-.021	.254	-.009	-.085	.933	.500	-.007	-.005	.342	2.920
	BPNIVUHTS	-.167	.233	-.060	-.715	.476	.444	-.063	-.042	.497	2.010
	BPNIVUD	.464	.271	.147	1.709	.090	.432	.150	.101	.468	2.135
	BPNIVUER	.177	.278	.056	.636	.526	.360	.056	.038	.456	2.195
2	(Constant)	-4.711	8.753		-.538	.591					
	OAS	.159	.124	.139	1.286	.201	.609	.113	.076	.295	3.393
	ESS	.236	.085	.304	2.778	.006	.657	.238	.163	.288	3.468
	ASPSNSE	-.266	.230	-.137	-1.155	.250	.567	-.102	-.068	.244	4.099
	ASPSEXT	.510	.309	.121	1.650	.101	.409	.144	.097	.637	1.570
	ASPSEMD	.794	.409	.194	1.942	.054	.592	.169	.114	.345	2.902
	ASCS	-.115	.102	-.091	-1.130	.261	-.432	-.099	-.066	.528	1.893
	ASBS	.200	.143	.131	1.396	.165	.545	.122	.082	.389	2.570
	BPNIGREXP	.084	.233	.025	.359	.720	.145	.032	.021	.703	1.423
	BPNIGRSSSE	.308	.285	.087	1.080	.282	.350	.095	.063	.532	1.881
	BPNIGRGF	-.149	.207	-.054	-.720	.473	.258	-.064	-.042	.611	1.636
	BPNIVUHTS	-.171	.229	-.061	-.747	.457	.444	-.066	-.044	.515	1.941
	BPNIVUD	.464	.270	.147	1.716	.089	.432	.150	.101	.468	2.135
	BPNIVUER	.170	.264	.053	.644	.521	.360	.057	.038	.503	1.987
3	(Constant)	-4.185	8.600		-.487	.627					
	OAS	.160	.123	.140	1.296	.197	.609	.113	.076	.295	3.393
	ESS	.241	.083	.310	2.884	.005	.657	.246	.169	.296	3.378
	ASPSNSE	-.280	.226	-.145	-1.237	.218	.567	-.108	-.072	.251	3.982
	ASPSEXT	.530	.304	.126	1.744	.083	.409	.152	.102	.657	1.523
	ASPSEMD	.786	.407	.192	1.932	.056	.592	.168	.113	.346	2.893
	ASCS	-.116	.102	-.092	-1.136	.258	-.432	-.100	-.067	.528	1.893
	ASBS	.190	.140	.125	1.357	.177	.545	.119	.079	.405	2.472
	BPNIGRSSSE	.327	.280	.092	1.169	.245	.350	.102	.068	.550	1.818
	BPNIGRGF	-.140	.205	-.051	-.685	.495	.258	-.060	-.040	.620	1.613
	BPNIVUHTS	-.165	.227	-.059	-.725	.470	.444	-.064	-.042	.518	1.931
	BPNIVUD	.474	.268	.151	1.771	.079	.432	.154	.104	.474	2.111
	BPNIVUER	.175	.263	.055	.665	.507	.360	.058	.039	.505	1.982
4	(Constant)	-4.310	8.580		-.502	.616					
	OAS	.163	.123	.142	1.324	.188	.609	.115	.077	.295	3.388
	ESS	.247	.083	.319	2.993	.003	.657	.254	.175	.300	3.328
	ASPSNSE	-.290	.225	-.150	-1.285	.201	.567	-.112	-.075	.252	3.966
	ASPSEXT	.552	.301	.131	1.832	.069	.409	.159	.107	.665	1.504
	ASPSEMD	.778	.406	.191	1.918	.057	.592	.166	.112	.346	2.891
	ASCS	-.113	.101	-.089	-1.112	.268	-.432	-.097	-.065	.529	1.890
	ASBS	.182	.139	.120	1.309	.193	.545	.114	.076	.407	2.455
	BPNIGRSSSE	.385	.265	.109	1.453	.149	.350	.126	.085	.609	1.641
	BPNIGRGF	-.131	.204	-.048	-.645	.520	.258	-.056	-.038	.623	1.606
	BPNIVUHTS	-.174	.226	-.062	-.768	.444	.444	-.067	-.045	.520	1.924
	BPNI_VU_D	.557	.237	.177	2.348	.020	.432	.202	.137	.602	1.660
5	(Constant)	-3.967	8.544		-.464	.643					

	OAS	.153	.122	.134	1.259	.210	.609	.109	.073	.299	3.340
	ESS	.244	.082	.314	2.962	.004	.657	.251	.173	.302	3.312
	ASPSNSE	-.274	.223	-.141	-1.225	.223	.567	-.106	-.071	.255	3.920
	ASPSEXT	.561	.300	.133	1.869	.064	.409	.161	.109	.666	1.501
	ASPSEMD	.770	.405	.188	1.902	.059	.592	.164	.111	.346	2.888
	ASCS	-.121	.100	-.096	-1.211	.228	-.432	-.105	-.071	.539	1.857
	ASBS	.181	.139	.119	1.305	.194	.545	.113	.076	.407	2.455
	BPNIGRSSSE	.319	.244	.090	1.307	.193	.350	.113	.076	.718	1.394
	BPNIVUHTS	-.179	.226	-.064	-.792	.430	.444	-.069	-.046	.520	1.921
	BPNIVUD	.519	.229	.165	2.264	.025	.432	.194	.132	.640	1.562
6	(Constant)	-4.227	8.526		-.496	.621					
	OAS	.144	.121	.126	1.187	.237	.609	.103	.069	.302	3.306
	ESS	.238	.082	.307	2.907	.004	.657	.245	.169	.304	3.286
	ASPSNSE	-.284	.223	-.147	-1.276	.204	.567	-.110	-.074	.256	3.906
	ASPSEXT	.589	.298	.140	1.980	.050	.409	.170	.115	.676	1.480
	ASPSEMD	.717	.399	.176	1.799	.074	.592	.155	.105	.356	2.811
	ASCS	-.118	.100	-.094	-1.181	.240	-.432	-.102	-.069	.540	1.854
	ASBS	.178	.139	.117	1.287	.200	.545	.111	.075	.408	2.453
	BPNIGRSSSE	.287	.240	.081	1.196	.234	.350	.104	.070	.737	1.357
	BPNIVUD	.466	.219	.148	2.129	.035	.432	.182	.124	.700	1.429
7	(Constant)	-13.183	3.904		-3.377	.001					
	OAS	.144	.121	.126	1.191	.236	.609	.103	.069	.302	3.306
	ESS	.240	.082	.310	2.933	.004	.657	.246	.171	.305	3.284
	ASPSNSE	-.220	.216	-.114	-1.018	.311	.567	-.088	-.059	.272	3.674
	ASPSEXT	.550	.296	.131	1.856	.066	.409	.159	.108	.684	1.462
	ASPSEMD	.687	.398	.168	1.725	.087	.592	.148	.101	.357	2.799
	ASBS	.243	.128	.159	1.898	.060	.545	.162	.111	.481	2.077
	BPNIGRSSSE	.290	.241	.082	1.207	.229	.350	.104	.070	.737	1.357
	BPNIVUD	.462	.219	.147	2.106	.037	.432	.180	.123	.700	1.429
8	(Constant)	-11.989	3.724		-3.220	.002					
	OAS	.099	.113	.087	.879	.381	.609	.076	.051	.349	2.862
	ESS	.222	.080	.286	2.778	.006	.657	.233	.162	.320	3.128
	ASPSEXT	.542	.296	.129	1.831	.069	.409	.156	.107	.685	1.461
	ASPSEMD	.527	.366	.129	1.440	.152	.592	.123	.084	.424	2.359
	ASBS	.228	.127	.150	1.793	.075	.545	.153	.105	.488	2.050
	BPNIGRSSSE	.316	.239	.089	1.318	.190	.350	.113	.077	.745	1.342
	BPNIVUD	.450	.219	.143	2.054	.042	.432	.175	.120	.702	1.425
9	(Constant)	-12.968	3.550		-3.653	.000					
	ESS	.258	.069	.333	3.761	.000	.657	.308	.219	.433	2.308
	ASPSEXT	.592	.290	.141	2.041	.043	.409	.173	.119	.711	1.406
	ASPSEMD	.515	.365	.126	1.411	.160	.592	.121	.082	.424	2.356
	ASBS	.258	.122	.169	2.107	.037	.545	.178	.123	.525	1.903
	BPNIGRSSSE	.314	.239	.089	1.314	.191	.350	.112	.077	.745	1.342
	BPNIVUD	.492	.214	.156	2.306	.023	.432	.195	.134	.738	1.356
10	(Constant)	-10.854	3.173		-3.421	.001					
	ESS	.271	.068	.349	3.976	.000	.657	.323	.232	.442	2.262
	ASPSEXT	.518	.285	.123	1.814	.072	.409	.154	.106	.740	1.352
	ASPSEMD	.633	.355	.155	1.784	.077	.592	.151	.104	.452	2.214
	ASBS	.235	.121	.154	1.936	.050	.545	.164	.113	.536	1.866
	BPNIVUD	.585	.202	.186	2.893	.004	.432	.241	.169	.827	1.209

a. Dependent Variable: DASS21_T

APPENDIX X Full Stepwise Regression Table – Wellbeing (WEMWBS)

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients			Correlations			Collinearity Statistics	
		B	Std. Error	Beta	t	Sig.	Zero-order	Partial	Part	Tolerance	VIF
1	(Constant)	30.637	6.699		4.573	.000					
	OAS	-.038	.095	-.049	-.398	.691	-.435	-.035	-.026	.292	3.429
	ESS	-.056	.066	-.107	-.859	.392	-.439	-.076	-.057	.283	3.539
	ASPSNSE	.360	.182	.274	1.985	.049	-.424	.173	.131	.230	4.349
	ASPSEXT	-.413	.243	-.145	-1.697	.092	-.260	-.149	-.112	.602	1.661
	ASPSEMD	-.294	.314	-.106	-.938	.350	-.416	-.083	-.062	.342	2.924
	ASCS	.183	.078	.214	2.344	.021	.490	.204	.155	.526	1.902
	ASBS	-.256	.110	-.248	-2.327	.022	-.550	-.202	-.154	.385	2.595
	BPNIGREXP	.237	.179	.105	1.327	.187	.112	.117	.088	.700	1.429
	BPNIGRSSSE	.140	.222	.058	.630	.530	-.067	.056	.042	.515	1.940
	BPNIGRGF	.293	.158	.157	1.849	.067	.004	.162	.122	.610	1.640
	BPNIVUCSE	-.166	.193	-.097	-.861	.391	-.367	-.076	-.057	.342	2.920
	BPNIVUHTS	-.316	.178	-.166	-1.774	.078	-.413	-.156	-.117	.497	2.010
	BPNIVUD	-.474	.207	-.221	-2.290	.024	-.293	-.199	-.152	.468	2.135
	BPNIVUER	.278	.212	.129	1.312	.192	-.072	.116	.087	.456	2.195
2	(Constant)	30.799	6.665		4.621	.000					
	ESS	-.065	.062	-.123	-1.050	.296	-.439	-.092	-.069	.316	3.161
	ASPSNSE	.337	.172	.256	1.966	.051	-.424	.171	.130	.256	3.913
	ASPSEXT	-.432	.238	-.151	-1.812	.072	-.260	-.158	-.120	.625	1.600
	ASPSEMD	-.272	.308	-.098	-.884	.378	-.416	-.078	-.058	.353	2.832
	ASCS	.184	.078	.214	2.356	.020	.490	.204	.155	.526	1.902
	ASBS	-.264	.108	-.255	-2.438	.016	-.550	-.211	-.161	.397	2.520
	BPNIGREXP	.236	.178	.104	1.323	.188	.112	.116	.087	.700	1.429
	BPNIGRSSSE	.145	.221	.060	.658	.512	-.067	.058	.043	.517	1.933
	BPNIGRGF	.286	.157	.153	1.822	.071	.004	.159	.120	.617	1.620
	BPNIVUCSE	-.174	.192	-.102	-.909	.365	-.367	-.080	-.060	.346	2.890
	BPNIVUHTS	-.321	.177	-.169	-1.815	.072	-.413	-.158	-.120	.500	1.999
	BPNIVUD	-.480	.205	-.225	-2.337	.021	-.293	-.202	-.154	.471	2.122
	BPNIVUER	.278	.212	.129	1.315	.191	-.072	.115	.087	.456	2.195
3	(Constant)	31.459	6.574		4.785	.000					
	ESS	-.066	.062	-.126	-1.074	.285	-.439	-.094	-.071	.317	3.158
	ASPSNSE	.330	.171	.251	1.929	.056	-.424	.167	.127	.257	3.894
	ASPSEXT	-.455	.235	-.159	-1.938	.055	-.260	-.168	-.128	.640	1.563
	ASPSEMD	-.225	.299	-.081	-.754	.452	-.416	-.066	-.050	.373	2.681
	ASCS	.181	.078	.211	2.332	.021	.490	.201	.153	.527	1.897
	ASBS	-.269	.108	-.260	-2.496	.014	-.550	-.215	-.164	.399	2.507
	BPNIGREXP	.258	.174	.114	1.478	.142	.112	.129	.097	.726	1.377
	BPNIGRGF	.317	.149	.170	2.122	.036	.004	.184	.140	.678	1.474
	BPNIVUCSE	-.153	.188	-.089	-.811	.419	-.367	-.071	-.053	.356	2.807
	BPNIVUHTS	-.310	.176	-.164	-1.766	.080	-.413	-.154	-.116	.505	1.982
	BPNIVUD	-.487	.205	-.228	-2.379	.019	-.293	-.205	-.157	.473	2.116
	BPNIVUER	.310	.206	.143	1.506	.135	-.072	.131	.099	.480	2.084
4	(Constant)	31.375	6.563		4.781	.000					
	ESS	-.073	.061	-.139	-1.206	.230	-.439	-.105	-.079	.324	3.084
	ASPSNSE	.286	.161	.218	1.782	.077	-.424	.154	.117	.289	3.455
	ASPSEXT	-.497	.228	-.174	-2.184	.031	-.260	-.188	-.144	.678	1.474
	ASCS	.178	.078	.208	2.300	.023	.490	.198	.151	.528	1.892
	ASBS	-.284	.106	-.275	-2.692	.008	-.550	-.230	-.177	.414	2.418
	BPNIGREXP	.261	.174	.115	1.497	.137	.112	.130	.098	.726	1.377
	BPNIGRGF	.305	.148	.163	2.059	.042	.004	.178	.135	.686	1.458
	BPNIVUCSE	-.143	.188	-.084	-.761	.448	-.367	-.067	-.050	.358	2.793
	BPNIVUHTS	-.336	.172	-.177	-1.952	.053	-.413	-.169	-.128	.524	1.908
	BPNIVUD	-.468	.203	-.219	-2.306	.023	-.293	-.198	-.152	.480	2.083
	BPNIVUER	.301	.205	.139	1.467	.145	-.072	.128	.096	.482	2.077

5	(Constant)	31.377	6.552		4.789	.000					
	ESS	-.081	.060	-.154	-1.362	.176	-.439	-.118	-.089	.334	2.990
	ASPSNSE	.253	.154	.192	1.639	.104	-.424	.142	.108	.313	3.195
	ASPSEXT	-.449	.218	-.157	-2.057	.042	-.260	-.177	-.135	.735	1.361
	ASCS	.183	.077	.214	2.376	.019	.490	.203	.156	.532	1.879
	ASBS	-.292	.105	-.283	-2.783	.006	-.550	-.236	-.183	.418	2.395
	BPNIGREXP	.265	.174	.117	1.524	.130	.112	.132	.100	.727	1.375
	BPNIGRGF	.293	.147	.157	1.991	.049	.004	.171	.131	.694	1.441
	BPNIVUHTS	-.363	.168	-.191	-2.157	.033	-.413	-.185	-.141	.547	1.828
	BPNIVUD	-.469	.202	-.219	-2.315	.022	-.293	-.198	-.152	.480	2.083
	BPNIVUER	.245	.191	.113	1.281	.202	-.072	.111	.084	.553	1.808
6	(Constant)	31.485	6.567		4.794	.000					
	ESS	-.070	.059	-.134	-1.187	.237	-.439	-.103	-.078	.342	2.927
	ASPSNSE	.244	.154	.186	1.580	.116	-.424	.136	.104	.314	3.189
	ASPSEXT	-.432	.219	-.151	-1.974	.050	-.260	-.169	-.130	.738	1.356
	ASCS	.186	.077	.217	2.404	.018	.490	.205	.158	.533	1.878
	ASBS	-.303	.105	-.293	-2.887	.005	-.550	-.244	-.190	.420	2.380
	BPNIGREXP	.290	.173	.128	1.674	.097	.112	.144	.110	.736	1.358
	BPNIGRGF	.326	.145	.174	2.245	.026	.004	.192	.148	.716	1.397
	BPNIVUHTS	-.367	.169	-.193	-2.175	.031	-.413	-.186	-.143	.547	1.827
	BPNIVUD	-.348	.180	-.163	-1.937	.055	-.293	-.166	-.127	.612	1.633
7	(Constant)	30.482	6.523		4.673	.000					
	ASPSNSE	.156	.136	.118	1.149	.253	-.424	.099	.076	.408	2.449
	ASPSEXT	-.451	.218	-.158	-2.064	.041	-.260	-.176	-.136	.742	1.348
	ASCS	.189	.077	.220	2.438	.016	.490	.207	.161	.533	1.876
	ASBS	-.339	.100	-.328	-3.376	.001	-.550	-.281	-.222	.459	2.177
	BPNIGREXP	.249	.170	.110	1.464	.146	.112	.126	.096	.767	1.304
	BPNIGRGF	.303	.144	.162	2.102	.037	.004	.179	.138	.729	1.372
	BPNIVUHTS	-.397	.167	-.209	-2.380	.019	-.413	-.202	-.157	.560	1.785
	BPNIVUD	-.325	.179	-.152	-1.815	.072	-.293	-.155	-.120	.620	1.614
8	(Constant)	31.787	6.431		4.943	.000					
	ASPSEXT	-.360	.204	-.126	-1.766	.080	-.260	-.151	-.116	.852	1.174
	ASCS	.163	.074	.190	2.199	.030	.490	.187	.145	.580	1.724
	ASBS	-.305	.096	-.295	-3.174	.002	-.550	-.264	-.209	.504	1.985
	BPNIGREXP	.224	.169	.099	1.326	.187	.112	.114	.087	.780	1.283
	BPNIGRGF	.309	.144	.165	2.145	.034	.004	.182	.141	.730	1.370
	BPNIVUHTS	-.340	.160	-.179	-2.132	.035	-.413	-.181	-.141	.615	1.627
	BPNIVUD	-.315	.179	-.147	-1.761	.081	-.293	-.150	-.116	.621	1.610
9	(Constant)	33.636	6.296		5.343	.000					
	ASPSEXT	-.323	.203	-.113	-1.593	.113	-.260	-.136	-.105	.869	1.151
	ASCS	.165	.074	.192	2.211	.029	.490	.187	.146	.580	1.724
	ASBS	-.334	.094	-.323	-3.567	.001	-.550	-.293	-.236	.532	1.879
	BPNIGRGF	.356	.140	.191	2.542	.012	.004	.214	.168	.777	1.287
	BPNIVUHTS	-.319	.159	-.168	-2.005	.047	-.413	-.170	-.133	.621	1.611
	BPNIVUD	-.278	.177	-.130	-1.570	.119	-.293	-.134	-.104	.636	1.571
10	(Constant)	33.759	6.329		5.334	.000					
	ASPSEXT	-.405	.197	-.142	-2.062	.041	-.260	-.174	-.137	.932	1.073
	ASCS	.168	.075	.196	2.245	.026	.490	.189	.149	.581	1.722
	ASBS	-.336	.094	-.326	-3.573	.000	-.550	-.293	-.238	.532	1.879
	BPNIGRGF	.285	.133	.152	2.137	.034	.004	.180	.142	.869	1.150
	BPNIVUHTS	-.396	.152	-.209	-2.604	.010	-.413	-.218	-.173	.686	1.458

a. Dependent Variable: WMWBS_T

APPENDIX Y Tests of Normality for Multiple Regression – all variables on Wellbeing (WEMWBS)