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### Relationship of patient shame to working alliance and satisfaction: a preliminary investigation

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**Relationship of Patient Shame to Working Alliance and Satisfaction: A Preliminary Investigation**

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# Relationship of Patient Shame to Working Alliance and Satisfaction: A Preliminary Investigation

## Abstract

### *Purpose*

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

### *Design/Methodology/Approach*

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

### *Findings*

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

### *Practical Implications*

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

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3 *Originality/Value*  
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5 The findings from this preliminary study suggest that internal and external shame are  
6 important factors to consider in the provision of medical care to maximise the quality of  
7  
8 patient experience and working alliance.  
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17 *Keywords:* working alliance; patient satisfaction; internal shame; external shame; mediation  
18 analysis  
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## Introduction

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

As patient-centred care increasingly becomes a driver of policy in various healthcare disciplines (Kitson et al., 2013), research attention has turned to the physician-patient relationship. Although the therapeutic relationship has been recognised throughout history (Bordin, 1979), it is only more recently that this relationship has been measured empirically using various research instruments, some of which are used for official purposes in the recertification of medical credentials. For example, in the United Kingdom doctors undergoing periodic revalidation are required to obtain patient evaluations of the concrete aspects of practising medicine as well as their ability to “put [the patient] at ease” and to “involv[e] [the patient] in medical care” (Roland et al., 2013). The United Kingdom National Health Service (NHS) Outcomes Framework specifically names “patient experience” as one of the key factors of quality in healthcare (Darzi, 2014). This includes metrics such as patient

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3 satisfaction with care provided, as well as satisfaction with logistical factors affecting access  
4 to care (e.g. access to parking and administrative matters) (Roland et al., 2013) Similar  
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6 initiatives are currently under review by the Australian Health Practitioner Regulation  
7 Agency (AHPRA) and are likely to be adopted in future (Medical Board of Australia, 2015,  
8 Medical Board of Australia, 2016). In the present study, the physician-patient relationship  
9  
10 was operationalised in terms of “working alliance”, a construct which has attracted increased  
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12 research interest in medicine over the last ten years (Fuertes et al., 2015, Fuertes et al., 2007,  
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14 Doyle et al., 2013, Sturgiss et al., 2016).  
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24 The concept of a practitioner-patient alliance has been central to psychotherapy since its  
25 inception, beginning with Freud (1912) and later Greenson (1965), who first used the term  
26  
27 “working alliance”. Although these researchers were undoubtedly influential, the modern  
28  
29 understanding of working alliance owes much of its conceptual basis to Bordin (1979), who  
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31 developed a new definition of working alliance that was broadly applicable in healthcare  
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33 settings.  
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40 Bordin’s definition of working alliance comprises three factors: patient-provider agreement  
41 on the specific goals of treatment; patient-provider agreement regarding which tasks are best  
42  
43 suited to achieve these goals; and the relational bond between the patient and provider,  
44  
45 including feelings of liking, trust and empathy present in the relationship. Specifically,  
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47 “[a]lliance describes the degree to which the therapy dyad is engaged in collaborative,  
48  
49 purposive work.” (Hatcher and Barends, 2006, p. 293). In psychological research, working  
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51 alliance has gradually come to be understood as one of the most reliable predictors of  
52  
53 successful therapeutic interventions (Arnd-Caddigan, 2011, Martin et al., 2000), without  
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55 which effective therapy may be impossible.  
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6 Providing care for primarily physiological illnesses has a fundamentally different character to  
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8 the treatment of psychological problems, such that interventions may be undertaken without  
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10 the patient being awake, aware or (technically, in cases of clinical death; Safar, 1988) even  
11  
12 alive. However, there are several crucial components of medical care that require patient  
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14 action, such as adherence to medication regimens, disclosure of symptoms, continued  
15  
16 attendance, and making lifestyle changes. Each of these factors respectively has been  
17  
18 demonstrated to be influenced by working alliance in past research across a range of illness  
19  
20 categories (Bar-Sela et al., 2016, Fuertes et al., 2015, Fuertes et al., 2007). Significant  
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22 empirical research has also emphasised that working alliance is strongly related to patient-  
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24 rated satisfaction with treatment, in the provision of both psychological and medical care  
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26 (Martin et al., 2000, Horvath and Greenberg, 1989, Tetzlaff et al., 2005, Bennett et al., 2011,  
27  
28 Fuertes et al., 2015). In general, patients who rate their alliance with their provider poorly are  
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30 correspondingly unlikely to be satisfied with the treatment they receive, irrespective of the  
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32 type or efficacy of that treatment.  
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40 Based on this understanding of the importance of working alliance in healthcare and its  
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42 relationship with a range of outcomes, the present study investigated a variable that is not yet  
43  
44 well understood in the context of working alliance. Specifically, this research targeted  
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46 potential relationships of patient-rated alliance with patient shame, which may have an  
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48 impact on the formation and maintenance of a functional, high quality alliance.  
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54 Although the character of the physician-patient relationship is demonstrably influenced by  
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56 the actions of the healthcare professional (Dolezal, 2015), certain patient characteristics, such  
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58 as dispositional shame, arguably have a part to play in the development of a good working  
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3 relationship (Tangney, 1995). There is some debate about the precise nature of dispositional  
4 shame (Leeming and Boyle, 2004), but most theorists conceptualise it as the tendency to  
5 experience shame (or not) in situations which are recognised as shame-provoking (i.e.  
6 “shame proneness”), as well as longstanding or frequent generalised feelings of shame  
7 (Andrews, 1998).  
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17 When discussing shame in a healthcare context, it is important to consider the related concept  
18 of ‘stigma’. Although the two are often conflated, and substantial variation in definitions  
19 exists (Link and Phelan, 2001), there are important theoretical differences. Weiss et al. (2006)  
20 described stigma as “a social process, experienced or anticipated, characterised by exclusion,  
21 rejection, blame or devaluation” (p. 280), which they linked to a feature of an individual’s  
22 identity (e.g. a health problem), sometimes described as a “social abnormality” (Goffman,  
23 2009). For example, Health-related stigma is commonplace (Scambler, 2009) and medical  
24 conditions (e.g. HIV/AIDS) are unfortunately routinely regarded as ‘shameful’ (Parker and  
25 Aggleton, 2003), both by society and by individuals affected by the disease. By contrast,  
26 dispositional shame need not be related to any ‘social abnormality’ - it is conceptually  
27 admissible that persons belonging to no stigmatised category can nevertheless experience  
28 high levels of shame-proneness, and vice-versa. Having said this, Goffman (2009) also made  
29 the important point that the experience of stigma is highly probable to result in shame, and as  
30 such the two experiences are likely to co-occur in a variety of situations.  
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51 Shame is best regarded as a self-conscious emotion with a strong interpersonal dimension –  
52 that is, it is most likely to arise in relation to or through comparison to other people. In  
53 shame, the entire self is subjected to intense negative evaluation - by oneself or by the  
54 presumed mind of others. Feelings of worthlessness and negative self-appraisals result in  
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3 actions such as withdrawing from others, or self-isolation (Tangney et al., 1996). Shame is  
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5 almost universally recognised as an emotion which can be destructive and painful, and is  
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7 often described as being overpowering and incapacitating (Wicker et al., 1983).  
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12 Shame in doctor-patient consultations has received little scientific scrutiny since the  
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14 publication of Lazare's (1987) article *Shame and Humiliation in the Medical Encounter*  
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16 (Dolezal, 2015). This is surprising, given that the experience of attending a doctor's surgery  
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18 has been recognised as a particularly intense venue for shame-inducing experiences (Stevens,  
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20 1996, Dolezal, 2015). These occasions often involve the revealing of normally private parts  
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22 of the body, as well as the acknowledgement of illness, which can sometimes be interpreted  
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24 as a personal deficiency or failure (Lazare, 1987, Harris and Darby, 2009). This is especially  
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26 true in cases in which patients are fearful the ailment may be viewed as self-inflicted, such as  
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28 smoking-related illnesses (Harris and Darby, 2009, Gilbert and Miles, 2014).  
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35 It is useful to make a theoretical distinction between two different subtypes of shame –  
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37 *internal* and *external* shame (Goss and Allan, 2009). The former refers to self-evaluative  
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39 experiences, where an individual may judge *themselves* to be deeply personally flawed,  
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41 powerless, physically and mentally unattractive, and as a failure (Gilbert, 1998b). By  
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43 contrast, those experiencing external shame are likely to be fearful of negative evaluations  
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45 and beliefs on the part of some real or theoretical "other(s)", but may not necessarily evaluate  
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47 themselves negatively. In this way, the shamed person believes that other people view them  
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49 as being inadequate, valueless and inferior, and may be fearful of social rejection, which may  
50  
51 in turn be related to concealing certain sources of bodily or emotional shame from others  
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53 (Lewis, 1995). Meta-analyses (Kim et al., 2011, Căndea and Szentágotai-Tătar, 2018) have  
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3 demonstrated that external shame is a stronger predictor of depressive symptoms and social  
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5 anxiety symptoms than internal shame.  
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10 External shame, although not always explicitly acknowledged, is frequently identified as a  
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12 barrier to effective treatment in medicine (Zinn, 1993, Stevens, 1996). In these cases, patients  
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14 may demonstrate behaviours congruent with responses to external shame, such as concealing  
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16 (partially or wholly) the true nature of their illness from physicians, refusal to expose parts of  
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18 the body of which they may fear judgement, or misleading healthcare professionals regarding  
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20 behaviours for which they risk condemnation (e.g. smoking or unsafe sex practices) (Zinn,  
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22 1993, Dolezal, 2015, Gilbert and Miles, 2014). Harris and Darby (2009) found that one in  
23  
24 five participants reported that they had stopped seeing a physician as a direct result of a  
25  
26 shaming event. High levels of shame may also be related to non-productive behaviour in a  
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28 healthcare setting, such as withdrawal, anger, deflection and externalisation of blame (Black  
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30 et al., 2013, Tangney et al., 1996), although this has yet to be demonstrated explicitly.  
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38 Fortunately, there are measures to assess internal and external shame. The Other as Shamer  
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40 Scale (Allan et al., 1994, Goss et al., 1994) is a measure of external shame which prompts  
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42 participant ratings based on statements about others' perceptions of them. This can be  
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44 contrasted with the TOSCA-III (Tangney and Dearing, 2003), which measures a propensity  
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46 to experience shame in common situations and is concerned with shame-related behaviours  
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48 and negative self-evaluations by oneself (Kim et al., 2011). Given the presumed value of  
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50 identifying different subtypes of shame, both of these measures were included in the present  
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52 investigation, as well as the Experience of Shame Scale (Andrews et al., 2002), which  
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54 assesses a broad variety of shame-provoking areas.  
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3 It is not difficult to imagine that a high degree of shame – especially external shame – may be  
4 related to the formation of a less effective working alliance. Furthermore, by restricting the  
5 development of the alliance, shame might then have the indirect effect of reducing patient  
6 satisfaction with treatment. Despite the intuitive appeal of this proposition, few studies have  
7 linked shame, working alliance, and satisfaction, and those studies are marked by  
8 methodological shortcomings, such as small sample sizes and overreliance on post-hoc  
9 reviews of data not initially intended to assess this relationship (Black et al., 2013).  
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21 Although it has long been recognised that empathy on the part of physicians is valuable in  
22 patient consultations (Zinn, 1993), it may well be that patients may require a different  
23 interpersonal approach according to their level of dispositional shame. This is not simply a  
24 matter of compassion on the part of healthcare providers; tailored approaches may be  
25 essential for the treatment to be effective, delivered in a timely manner, and for instructions  
26 to be followed correctly (Harris and Darby, 2009).  
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38 In the current study, it was hypothesised that *there would be at least small, negative*  
39 *correlations between measures of dispositional shame and patient-evaluated working*  
40 *alliance. Furthermore, that external shame would prove a greater barrier to building an*  
41 *effective alliance with a physician, and therefore would show stronger negative correlations*  
42 *with measures of both alliance and patient satisfaction than measures of internal shame.*  
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49 Finally, it was hypothesised that *shame would be negatively related to patient satisfaction*  
50 *indirectly through working alliance.*  
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## Methods

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

The University population was chosen in recognition of the fact that the University campuses contain no fewer than three GP clinics (in which care is available for free for staff and students) and that high levels of educational attainment have previously been associated with higher health literacy, which in turn increases the likelihood of regular GP visits (Von Wagner et al., 2007). Regular visits were considered essential for participants in the present study, given that psychotherapy research has demonstrated that working alliance develops over time (Kivlighan Jr and Shaughnessy, 2000). Accordingly, inclusion criteria included the stipulation that participants had “regularly seen the same GP for the past year”, with the minimum acceptable regularity being bimonthly.

## Measures

### *General Practice Assessment Questionnaire (GPAQ-R)*

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

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

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

The WAI is a measure of working alliance as defined by Bordin (1979), divided into the three key areas of agreement on tasks, agreement on goals and the therapeutic bond. It has been

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2  
3 exhaustively validated, reliability tested and used with a huge variety of populations,  
4 including dozens of languages and ethnic groups. The Hatcher and Gillaspay variant of the  
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6 WAI (Hatcher and Gillaspay, 2006) demonstrates excellent internal consistency reliability  
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8 (subscale alphas ranging from .85 to .90, total score alphas from .91 to .92), as well as very  
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10 strong correlations (.94 to .95) with the original Working Alliance Inventory developed by  
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13 Horvath (Hatcher and Gillaspay, 2006, Tracey and Kokotovic, 1989).  
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19 Following the example set by Fuertes et al. (2007), the present study employed a modified  
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21 WAI-SR-C to refer to working alliance with general practitioners, rather than to  
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23 psychotherapists. Participants were asked to rate their answers on a 5-point Likert-type scale  
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25 ranging from 1 (*Seldom*) to 5 (*Always*). Items included; “*I feel that the things I do as a result*  
26  
27 *of consultations with my doctor will help me to improve my health.*” (*Tasks*); “*My doctor and*  
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29 *I collaborate on setting goals for my health care.*” (*Goals*) and; “*My doctor and I respect*  
30  
31 *each other.*” (*Bond*). Internal consistency reliability for our modified instrument was high  
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33 both for full-scale (Cronbach’s  $\alpha = .95$ ) and subscale scores ( $\alpha = .87$  to  $.90$ ).  
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#### 41 *Test of Self-Conscious Affect, Shame Subscale (TOSCA-3-Shame).*

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43 The Test of Self-Conscious Affect-3 (Tangney and Dearing, 2003) is designed to assess  
44  
45 dispositional emotions. Participants are prompted with 16 scenarios, each of which is  
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47 followed by four descriptions of thoughts or behaviours to which participants must then  
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49 respond on a scale ranging from 1 (*Not likely*) to 5 (*Very likely*). For example, for the  
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51 scenario “*You break something at work and then hide it.*”, respondents are asked to rate the  
52  
53 likelihood of the following statement: “*You would think about quitting.*” The TOSCA is  
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55 considered an industry standard and is used very frequently in studies concerned with shame  
56  
57 and guilt (Andrews et al., 2002). In the present study, only the 11 items pertaining to shame  
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3 were included. The TOSCA-3-Shame subscale showed an internal consistency reliability of  
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5 .80. This measure was used to assess internal shame; pecifically, context-dependent  
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7 dispositional shame.  
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#### 10 11 12 13 *Other As Shamer Scale (OAS).*

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16 Allan et al. (1994) and Goss et al. (1994) developed the Other as Shamer scale in order to  
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18 assess global judgements of how participants think others view them. It contains 18 items  
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20 which are scored by participants on a 5-point scale ranging from 0 (*Never*) to 4 (*Almost*  
21  
22 *Always*). These items are worded in the first person, and invite participants to rate their  
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24 thoughts and feelings, e.g. “I feel other people see me as not good enough.” or “I think others  
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26 are able to see my defects.” Goss et al. (1994) reported a very high degree of internal  
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28 consistency for this scale (Cronbach's  $\alpha = .92$ ). This scale was used to assess individual levels  
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30 of external shame.  
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#### 37 *Experience of Shame Scale (ESS).*

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40 The Experience of Shame Scale (Andrews et al., 2002) is comprised of 25 items which are  
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42 divided into eight conceptual areas of shame, including shame related to; personal habits;  
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44 manner with others; sort of person you are; personal ability; doing something wrong; saying  
45  
46 something stupid; failure in competitive situations; and bodily shame. Each item is rated by  
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48 participants on a 4 point Likert-type scale, ranging from 1 (*Not at all*) to 4 (*Very much*).  
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50 Items ask respondents to rate the extent to which they have had certain experiences, e.g.  
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52 “Have you worried what other people think of the sort of person you are?”, “Do you feel  
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54 ashamed when you do something wrong?”. Andrews et al. (2002) report that this scale has a  
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56 high level of test-retest reliability over a time of approximately 11 weeks ( $r=.83$ ) and strong  
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3 internal consistency (Cronbach's  $\alpha=.92$ ). This scale has a primarily internal focus, and has  
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5 previously been classified as a measure of contextual shame (Kim et al., 2011), however it  
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7 does include some items relating to others' perceptions. For the purposes of this study, it was  
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9 treated as a measure of internal shame.  
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### 14 *Planned Analyses*

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17 In order to examine hypotheses 1 and 2, concerning the relationship of various shame  
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19 measures to patient-rated working alliance and satisfaction with treatment, examination of  
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21 correlations was planned. Variables to be included in these analyses included WAI total  
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23 scores, WAI subscale scores, OAS, ESS, and TOSCA-3 scores, and Communication  
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25 (Satisfaction) scores. Given that both WAI and Communication subscale ratings were  
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27 positively skewed, non-parametric Spearman's Rank-Order Correlation was selected as the  
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29 appropriate methodology.  
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35 Similarly, non-parametric bootstrapping analyses were chosen to test the hypothesised  
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37 indirect relationship between external shame and patient satisfaction through working  
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39 alliance. This type of analysis is recommended in cases in which the sample size is small or  
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41 there is non-normality in the data (Preacher and Hayes, 2004).  
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### 46 **Results**

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51 Table 2 presents the means, standard deviations and inter-correlations for all primary  
52  
53 measures. There were several statistically significant differences between participants who  
54  
55 identified as male or female on three variables. Independent samples *t*-tests revealed that  
56  
57 there was a significant difference in TOSCA-Shame between female ( $M=36.19$ ,  $SD=8.59$ )  
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3 and male ( $M=32.39$ ,  $SD=7.54$ ) participants,  $t(125)=-2.12$ ,  $p=.036$ , with female participants  
4  
5 scoring higher. Similarly, examination of overall WAI scores suggested that female  
6  
7 ( $M=45.19$ ,  $SD=10.06$ ) participants rated the alliance higher on average than their male  
8  
9 counterparts ( $M=40.71$ ,  $SD=11.31$ ),  $t(125)=-2.02$ ,  $p=.045$ . A similar result was evident in the  
10  
11 Bond subscale of the WAI, with females ( $M=15.74$ ,  $SD=3.38$ ) giving higher ratings than  
12  
13 males ( $M=13.86$ ,  $SD=4.27$ ),  $t(125)=2.45$ ,  $p=.016$ . There were no other differences on any of  
14  
15 the variables of interest based on sex, age, recruitment status or regularity and recency of GP  
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17 visits.  
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24 Because WAI and Communication ratings were positively skewed, non-parametric  
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26 Spearman's rho values are reported in Table 2. No significant correlations were evident  
27  
28 between overall working alliance ratings and shame as assessed by the TOSCA-3 or the ESS.  
29  
30 In contrast, there was a small, negative correlation between scores on the OAS and overall  
31  
32 WAI scores. As such, the hypothesis that external shame would be more related to working  
33  
34 alliance than other assessed forms of shame was supported. Similarly, OAS and ESS scores  
35  
36 were modestly negatively correlated with Communication, but TOSCA-Shame scores  
37  
38 showed no significant correlation. This suggests that context-dependent shame (as assessed  
39  
40 by the TOSCA (Kim et al., 2011) is not as relevant to patient satisfaction as other types of  
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42 shame.  
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49 As anticipated, the averaged Communication rating showed a moderate, positive correlation  
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51 with overall WAI score, suggesting that participants who rated their satisfaction with their  
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53 GP's performance highly were correspondingly more likely to report a greater working  
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55 alliance. Similarly, all three measures of shame showed moderate-to-strong positive  
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intercorrelations, lending convergent validity to these as measures suitable for assessing shame.

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

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

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

## Discussion

The hypotheses that shame would be negatively related to measures of patient satisfaction and working alliance were partially supported. It is noteworthy that the only measure of shame to evince *any* correlation with both working alliance *and* patient satisfaction was the

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2  
3 OAS, which assesses external shame. Thus, these results provide evidence of a modest  
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5 relationship between levels of external shame and retrospective evaluations of working  
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7 alliance. They also reinforce decades of research which suggest that patient satisfaction –  
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9 although empirically distinct from working alliance - is strongly related to it, such that a  
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11 patient reporting a poor alliance is highly unlikely to be satisfied with treatment (Martin et  
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13 al., 2000, Fuertes et al., 2015, Tetzlaff et al., 2005). Indeed, these findings demonstrated that  
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15 part of the relationship between external shame and satisfaction was accounted for *by*  
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17 alliance, which further underscores the importance of attending to working alliance in  
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19 provider-patient consultations.  
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26 The results of this study suggest that those patients who enter a consultation with feelings of  
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28 fearfulness regarding the judgement of others may be less likely to develop a good  
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30 relationship with their doctor, and more likely to be unsatisfied with treatment. This  
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32 relationship may hold – to a lesser extent – with feelings of shame in general. This  
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34 corresponds well with existing research evidence, which indicates that patients may exhibit  
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36 withdrawal and avoidant behaviours when dealing with high levels of shame, and that fear of  
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38 condemnation is a powerful motivator to remain silent, not disclose, and not engage well with  
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40 treatment (Lazare, 1987, Dolezal, 2015, Black et al., 2013, Stevens, 1996). Such findings  
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42 should be of particular interest to general practitioners, especially those who see the same  
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44 patients on a regular, ongoing basis (e.g. the “family doctor”). Such professionals have the  
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46 scope to develop meaningful, long-term alliances with their patients, and a failure to do so  
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48 effectively may have flow-on effects that are not yet fully understood.  
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56 It is important to be aware of the limitations imposed by the preliminary state of these  
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58 findings. Most notably, the retrospective nature of the study and its correlational design limit  
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3 the possibility of inferences regarding causal relationships. Although it is reasonable to  
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5 suppose that propensity towards shame temporally precedes consultations with doctors, it  
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7 cannot be assured that its effects on patient-rated satisfaction and alliance are unidirectional.  
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9  
10 Future research should address this issue by ensuring that the variables under consideration  
11  
12 are assessed in a temporally logical way, with dispositional measures being administered  
13  
14 either preceding consultations with physicians, or before and after. Satisfaction and working  
15  
16 alliance measures would also ideally be obtained after each session, rather than a single,  
17  
18 global alliance rating. This is particularly important given that past research suggests that  
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20 alliance levels fluctuate throughout treatment (Kivlighan Jr and Shaughnessy, 2000).  
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23 Similarly, it was not possible to collect assessments of physician-rated working alliance.  
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26 Although it is common in alliance research to obtain a unilateral assessment of alliance  
27  
28 (generally from the client perspective) (Fuertes et al., 2015, Fuertes et al., 2007, Doran,  
29  
30 2016), research suggests that provider-patient disparity in alliance rating often occurs (Meier  
31  
32 and Donmall, 2006), and this information would be desirable to provide a more complete  
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34 picture of the treatment landscape.  
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40 The present sample was a convenience sample, recruited through the university, which limits  
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42 the generalisability of our findings to a young, relatively well-educated, and affluent  
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44 population. Information regarding participants' illness category, duration of illness or ethnic  
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46 background was not collected, each of which may influence levels of shame (Tang et al.,  
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48 2008), working alliance reports (Doran, 2016, Walling et al., 2012) and patient satisfaction  
49  
50 (Chung et al., 2014, Hall and Dornan, 1990). It would be important to assess ethnic and  
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52 socioeconomic status and to expand the diversity of participant samples in future research in  
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54 order to broaden the generalisability of findings.  
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## Conclusions

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

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

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

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6 Regardless of the means of identification, when high levels of shame *are* identified, it is  
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8 generally recommended that practitioners provide patients with opportunities to express  
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10 feelings of dissatisfaction or discomfort (Gilbert, 1998a). Receiving statements about shame  
11  
12 and humiliation with empathy may also be helpful in reducing the impact of shame-inducing  
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14 experiences, and it is noteworthy that empathy, acceptance and validation are also  
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16 recommended for repairing ruptures in working alliance (Safran and Muran, 1996).  
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22 Finally, these results once again underscore the importance of developing and maintaining a  
23  
24 good working alliance in healthcare (Horvath and Symonds, 1991, Bar-Sela et al., 2016,  
25  
26 Doran, 2016, Fuertes et al., 2015), given its important relationship with patient satisfaction.  
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28 They also suggest that it may be useful to administer the WAI routinely in practice. This  
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30 simple, 12-item measure may provide doctors with important insights regarding patients'  
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32 perception of the healthcare relationship, and help them address patient concerns in a way  
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34 that reaches a satisfying resolution for all parties.  
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#### 40 **Ethical Approval**

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42 This study was approved by the University of Adelaide Human Research Ethics Psychology  
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44 Sub-Committee, approval #1681.  
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**Table 1**  
**Participants' demographic information and reports regarding GP visits. (N = 127)**

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

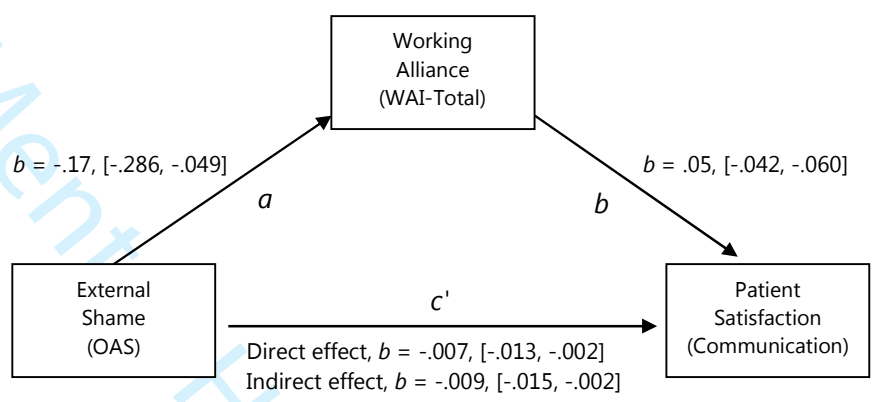
*\* Participants enrolling in the study from Undergraduate Psychology courses were eligible for course credit for participation.*

**Table 2**  
**Means, standard deviations and correlations (Spearman's rho) among study variables. (N=127, except**  
**Communication, where N=122).**

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

\* $p < 0.05$

\*\* $p < 0.01$



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

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