

**THE EXPERIENCE OF THE PSYCHIATRIC
INTERVIEW FOLLOWING SELF-HARM: FACTORS
WHICH INFLUENCE THIS EXPERIENCE AND THE
POTENTIAL IMPACT OF IT.**

by

CHARLOTTE B NEVISON

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ABSTRACT

A proportion of individuals who are seen at accident and emergency following deliberate self-harm (DSH) are admitted to the medical wards where they are psychiatrically assessed. This exploratory study investigated the interaction between the psychiatrist who conducts this interview and the patient. A sample of 60 DSH patients were seen immediately following their interview with the psychiatrist. They completed questionnaires which assessed personality disturbance and were asked questions regarding their experience of the interview. At the same time the psychiatrist completed parallel measures which assessed their experience of the interview. The comparison group consisted of 30 new Psychology out-patients. They were recruited and assessed in the same way as the experimental group.

It was predicted that personality disorder / disintegration would be associated with poorer therapeutic alliance and a repetition of particular patterns of interactions (including avoidance, hostility or rescue). If demonstrated this would support the hypothesis that the experience of the psychiatric interview may inadvertently perpetuate the individual's view of the interpersonal world, which could then increase their likelihood of further dysfunctional coping and decrease the likelihood of them gaining constructive mental health.

The study also investigated the attitudes of staff working with this client group. Based on previous research it was predicted that staff would hold quite negative attitudes about deliberate self-harm. Within its theoretical framework, the study considered how such attitudes may be present and how they may contribute to the interaction patterns described above.

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DECLARATION

'This thesis has been composed by myself and the work contained herein is my own'.

Signed:

.....Charlotte B Nevison

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1 INTRODUCTION

1.1 Deliberate self harm

1.1.1 Overview

The term deliberate self-harm (DSH) is used to refer to any intentional act of self-poisoning (overdose) or self-injury, irrespective of the intended outcome. Although suicidal intent is present in many cases, it is also absent in a significant proportion which may involve complex, multiple motivation (Bancroft, Skrimshire, & Simkin, 1976; Hawton, Cole, O'Grady, & Osborn, 1982). The majority of cases are overdoses, with self-cutting being the next most frequent and most cases are seen within general hospitals (Hawton & Fagg, 1992a). The act of DSH can be conceptualised as 'a statement of suffering'; individuals who attempt suicide are overtly communicating at least two key messages - their desperation and their perceived lack of other alternative actions (McCaughey, Long, & Harrison, 1995). I have chosen to use the term 'deliberate self-harm' primarily, but this will be used interchangeably with the terms 'attempted suicide' and 'parasuicide'.

Historically there has been an escalation in the extent of DSH since 1960 when there were approximately 20,000 cases in the UK each year. The current estimate is that there are 100,000 cases (age 15 and over) referred to general hospitals per year in England and Wales as a result of DSH (Hawton & Fagg, 1992a). Roy (1999) states that DSH is the most common cause of hospital admission for people under the age of 50 years. The reasons for this increase are unknown, although it is acknowledged that it has occurred during a period of rising unemployment and divorce, and greater use of alcohol and drugs amongst young people (Charlton et al., 1993).

The United Kingdom has one of the highest rates of parasuicide in Europe. The parasuicide rates for 1989-92 vary from 48 per 100,000 for men in Padua, Italy, to 345 per 100,000 for

men in Helsinki, Finland (Williams, 1997). The UK's rate during this period was 264 per 100,000 for men (the second highest in Europe) and 368 per 100,000 for women (the highest) (Williams, 1997). Although there are fewer data available for North America, reported rates tend to be near the higher end of the European levels with annual rates in Canada estimated at 304 per 100,000 (Sakinofsky, 1996). Suicide rates are similar: from an international perspective, the highest rates are present in Germany, Scandinavia, Eastern Europe and Japan. Suicide rates are average and approximately equal for Great Britain, Canada and the United States, while the lowest suicide rates are found in traditionally Catholic countries (i.e. Italy, Spain and Ireland) (Sainsbury, 1986).

Data from the Central Statistical Office (HMSO, 1990) shows that 1 in 12,500 of the population in the UK is liable to commit suicide each year. Suicide is the third most common contributor to life years lost, after heart disease and cancer. The UK's 'Health of the Nation' White Paper has targeted reduction in suicide by the year 2000 (HMSO, 1992).

Females have higher rates of DSH than males, but mortality from suicide is lower for females than for males (Canetto & Sakinofsky, 1998). In the 1970's the female:male ratio for DSH was 2:1 but recent data from Leeds suggests that more men are attempting suicide and that the original sex bias is disappearing (Williams, 1997). Canetto and Sakinofsky (1998) explored this gender paradox to look at its validity and explanations. They concluded that although the gender bias is a real phenomenon it is more culturally bound than has previously been acknowledged. They found exceptions to this gender rule in certain cultural communities. For example in Helsinki, Finland they found that more males than females engage in DSH (Ostamo & Lonnqvist, 1994). They concluded that the gender gap may be more prominent in communities where different suicidal behaviours are expected of males and females. They suggest that these divergent expectations influence the choices individuals have and the interpretations made by others about the behaviour. They use the term 'scripts' to refer to the cultural model of gender and suicidal behaviour that people use

both to make choices and to make sense of others actions. They also noticed reporting biases and recording biases in these countries where scripts dictate.

Outcome after DSH is variable. Repetition occurs within one year after the initial episode in between 12% and 25% of cases (Morgan, Barton, Pottle, Pockock, & Burns-Cox, 1976; Platt, Hawton, Kreitman, Fagg, & Foster, 1988). DSH is also associated with an increased risk of suicide. In the year following an initial episode of self-harm 1-2% of these patients die of suicide (which is 100 times higher than in the general population), and approximately 3% die within the eight years following (Hawton & Fagg, 1988). The risk appears to remain high for at least ten years (Kreitman, 1977; Kreitman, 1989). Long-term follow-up suggests that one in ten people who self-harm may eventually die of suicide (Dahlgren, 1977).

In the United Kingdom, Oxford has been the site where attempted suicide has been the most carefully studied. These data will be described in order to gain a more detailed picture of patterns within the UK. (The data from Oxford has been compared with data from other UK centres and has been found to be representative (Williams, 1997).)

1.1.2 Oxford data in more detail

Oxford is a city composed of a diverse mix of people, ranging from the university population to residents from very deprived areas on the city outskirts. Figures show a marked increase in attempted suicide in the 10 years up until 1973, a decline towards 1980, a sharp increase in the early 1980's, followed by a decline then a relatively constant level over the 1980's, followed by an increase in the 1990's. The rate for women declined during the late 1970's and early 1980's but rose later. The rate for men has remained relatively stable. The peak age for women to attempt suicide is between 15 and 19, whilst the peak age for men is between 25 and 29 years. Most of the sample were single or divorced, one third of the group were unemployed, and the majority lived with either parents or partners

(Hawton et al. 1994, cited by Williams, 1997). Although the majority of the sample were single or divorced, only a small proportion of the sample (22%) reported living alone. (Sixty seven percent of 'single' individuals lived with parents or partners, whilst 52% of divorcees lived with parents). This was seen as corroborating the evidence that suicide attempts often occur in the context of relationship problems (Williams, 1997).

With regard to repetition, in this sample 15.5% of men and 12.8% of women repeated the attempt within the first year (Hawton et al., 1994, cited by Williams, 1997). It was found that a large proportion make repeated suicide attempts such that in any sample of parasuicide cases approximately 44% will have a history which includes a previous suicide attempt.

With regard to the nature of the DSH, the vast majority of cases involved self-poisoning (86% medicines and 3% other substances). Nine and a half percent of this sample self-cut (Hawton et al., 1994, cited by Williams, 1997). Though these proportions have remained relatively constant over the years, the types of substances used in overdoses have changed. Previously tranquillisers and sedatives were the most common but their use has dropped from 40% to 16% of overdoses. It is likely that this reflects changing prescribing patterns. In contrast, the use of paracetamol has increased from around 14% to 42% (Hawton & Fagg, 1992a). In the light of paracetamol's hepatic toxicity this is a worrying trend; often tablets are taken with alcohol (32% men and 20% women), or the tablets are taken under the influence of alcohol that has been ingested sometime earlier (56% men and 37% women) (Hawton et al., 1994, cited by Williams. 1997).

1.1.3 Factors predicting deliberate self-harm

Williams (1997) looked at three aspects of the formulation leading towards deliberate self-harm: long term vulnerability factors, short term vulnerability factors, and precipitating

factors. Long term vulnerability factors refer to early childhood experiences and relationships. He cites Maris (1981) who found that 83% of suicide attempters compared to 31% in a control group had experienced early loss either through the direct loss of a parent or indirect personal loss caused by drug abuse, mental illness or criminality (Maris, 1981 cited by Williams, 1997). Hawton and Catalan (1987) in their Oxford study of young people found that 12% of suicide attempters had been in care for some period, over half had problems with school-work or relationships with teachers, and three quarters had difficulties with their parents. Sexual abuse is another factor common in the histories of suicide attempters. Van Egmond, Garnefski, Jonker, and Kerkhov (1993) examined the extent of sexual abuse in a sample of 158 suicide attempters in the Netherlands. They found that 50% of subjects reported experiences of sexual abuse in the past. They also found that women who had been sexually abused, attempted suicide earlier and more often than other women who had no history of sexual abuse (van Egmond et al., 1993). Williams (1997) notes that this pattern is consistent with that of learned helplessness (Seligman, 1975).

Short-term vulnerability factors are factors present in the person's current situation. Life events are common in the months preceding attempts, more so than in either matched depressed patients or general population controls (Paykel, Prusoff, & Myers, 1975). In addition to such stressors, it has also been found that there is often an increased presence of physical illness (Williams, 1997). These factors contribute to a high proportion of attempters seeking advice from their General Practitioner (GP); Hawton and Catalan (1987) found that 57% of attempters contacted their GP in the month prior to their attempted suicide. Linke (1997) reported that 90% of successful suicides contact their GP or psychiatrists within one year before the suicide and 48% within a week before the suicide.

Employment status has also been considered influential in suicide risk (e.g. Platt & Kreitman, 1984). However Williams (1997) notes the need to acknowledge the many factors involved to ensure that any relationship (between employment and parasuicide) is not

caused by other factors e.g. drug abuse which is capable of predicting both unemployment and parasuicide.

In a comparative study looking at parasuicide in Edinburgh and Oxford, between 14% and 23% of males, and approximately 5% of females, were found to have alcohol dependence (Platt et al., 1988). In Hawton et al.'s (1994) study (cited by Williams, 1997) it was found that 41% men and 21% women were abusing alcohol and 16% men and 6% women were regularly abusing drugs. Alcohol and drug abuse can be regarded as affecting suicide risk in two ways: first they provide a readily available means of overdose and secondly they reduce inhibitions regarding this behaviour. As mentioned earlier, alcohol use usually precedes self-harming behaviour.

Precipitating factors are events that happen shortly before the episode of DSH. The most common events are interpersonal difficulties. Other examples include work or employment worries, financial difficulties, and physical pain or illness. Bancroft, Skrimshire, Casson, Harvard-Watts, and Reynolds (1977) found that in a general sample of patients the most common problems were interpersonal difficulties (72%), employment problems (28%), difficulties with children (26%), and financial worries (19%).

Particular dates can be another trigger for DSH. These dates include St Valentines Day, Christmas Day and New Year's Day. On these days the social pressure to be happy and enjoying life can exacerbate social isolation or personal difficulties. In their study Davenport and Birtle (1990) found that the number of parasuicides doubled on St Valentines Day (1983-8).

Kreitman and Foster (1991) examined significant factors in people admitted to hospital following attempted suicide. They found the following to be predictive;

1. Previous parasuicide
2. Clinical diagnosis of personality disorder

3. Heavy alcohol consumption (greater than 21 units a week for men and over 14 units a week for females)
4. Previous psychiatric treatment
5. Unemployment
6. Social class (V)
7. Drug abuse
8. Criminal record
9. Violence (received or given in the past five years)
10. Aged between 25 and 54
11. Single, widowed or divorced.

They found that those patients who had three or less of these factors had a repetition rate averaging 5%. Patients with between four and seven factors had a repetition rate of 20.5% and those with eight plus had a repetition rate of 41.5% (Kreitman & Foster, 1991).

1.1.4 Theoretical perspectives on suicidal behaviour

DSH is a form of suicidal behaviour which increases the likelihood of future eventual suicide (Hawton & Fagg, 1988). This section looks at suicidal behaviour generally to look at some theories which have been considered with respect to suicide. It includes some topics highlighted in Section 1.3.

1.1.4.1 Psychiatric factors

Research has indicated that suicide is closely linked to psychiatric illness and as such has often used the 'psychological autopsy' approach. This approach involves interviewing relatives and friends following a suicide in order to gain information on the person's mood and behaviour in the period preceding their suicide. In a classic study Robins, Warsrad, and Nemiroff (1959) demonstrated that 94% of individuals who committed suicide were

psychiatrically ill, mainly suffering from mood disorders or 'brought on by' alcoholism. This finding has been repeated more recently when Winokur and Tsuang (1990) in a review of completed suicides, found that 90% of these individuals were psychiatrically ill at the time of their death.

Mood disorders: Mood disorder is the psychiatric diagnosis most commonly associated with suicide. Studies show that the presence of mood disorder in persons who commit suicide is as high as 70% (Barraclough, Bunch, Nelson, & Sainsbury, 1974). It has been estimated that about 15% of patients with mood disorders will go on to commit suicide if certain factors, including a history of DSH, are present (Linke, 1997). Individuals with bipolar affective disorder have been found to have a long-term risk suicide risk of 20% (Goodwin & Jamison, 1990). Suicide is usually associated with the depressed rather than manic cycle but at times it can be linked to apparent improvement (Williams, 1997). Runeson, Beskow and Waern (1996) looked at suicide attempts as part of a range of suicidal behaviours including suicidal ideation, attempts, and completed suicides in young people (15 to 29 year olds). They viewed suicide as a progressive process occurring within the individual and their interactions with people around them. They found that depression and adjustment disorders had suicidal processes of short duration with few or no episodes of suicidal communication or attempts. The median interval from first suicidal communication to actual suicide was 3 months in major depression and under a month in adjustment disorders.

Chemical dependence: After mood disorders, alcohol or drug abuse is the next most common diagnosis among those who commit suicide (Marzuk & Mann, 1988). About 25% of people who commit suicide in the USA have been found to have alcohol dependency (Murphy & Wetzel, 1990). Linke (1997) reported that people who are alcohol dependent have a 15% lifetime risk of suicide. The mean age for suicide in alcoholic patients is 47 years following a 20 year history of alcohol abuse (Williams, 1997). Mixed substance abuse is considered to be most closely related to suicide. In a San Diego Suicide Study (Rich,

Young, & Fowler, 1986) found mixed substance abuse to be identified in 67% of youth suicides and 46% of suicides in adults age 30 years and over. The characteristics of chemically dependent people who commit suicide tends to be young males who use alcohol and other drugs concurrently, with a history of overdoses and comorbid psychiatric disorders, especially depression (Ghosh & Victor, 1999). In addition to the risk of suicidal behaviour due to the alcohol dependence itself, acute intoxication increases suicide risk by reducing disinhibition (as mentioned earlier) and removing constraints of self-care. In addition, disinhibition and poor judgement can lead to high risk behaviours resulting in car accidents and drug overdoses.

Schizophrenia: 1% of the general population suffers from schizophrenia (Williams, 1997). Linke (1997) reported that people with schizophrenia have an approximate 10% lifetime risk of suicide. In this group those most at risk include men, younger people, those who are socially isolated, unemployed, have a history of DSH, depression or anorexia, have high intellectual abilities and low achievement and those who have akathisia (involuntary movements caused by antipsychotic medication). Suicide risk is not at its greatest during the active hallucinatory phase. Rather individuals are most at risk when their psychosis is controlled and they are in the depressive recovery phase of the illness (Ghosh & Victor, 1999). Patients are also most at risk for suicide following discharge after a period of inpatient hospitalisation (Williams, 1997). Patients may then have better insight and may more clearly recognise the reality of their situation. Runeson, Beskow, and Waern (1996) found that patients with schizophrenia had longer suicidal processes with more suicidal communication and more severe psychological stressors and substance abuse. The median interval from first suicidal communication to suicide was 47 months.

Personality disorders: Personality disorder, especially borderline and antisocial personality disorder, is a risk factor. Recent evidence indicates that between 4% and 10% of individuals with BPD will eventually commit suicide (Williams, 1997). Individuals with

BPD frequently have co-existing Axis I disorders (DSM-IV, APA 1994) which may place them at particular risk. Corbitt, Malone, Haas, and Mann (1996) found that subjects with BPD and depression were more likely than other patients to have histories of DSH, including lethal suicide attempts. Personality disorder criteria were better predictors of past suicidal behaviour than was depressive symptomatology. Kernberg (1984) found that the particular characteristics of BPD which were associated with increased suicide risk included impulsivity, hopelessness, despair, antisocial characteristics and interpersonal aloofness. Runeson et al. (1996) found that individuals with personality disorders also had longer suicidal processes involving more suicidal attempts and more substance abuse. The median interval from first suicidal communication to the suicide was 30 months.

1.1.4.2 Social factors

Gibbs (1968) described how Emile Durkheim (1897) in his classic paper on suicide stated that the risk of suicide varied inversely to an individual's degree of connectedness with family and society as a whole. He found that suicide rates in European countries differed in relation to different social and demographic factors. He believed that the explanation of suicide rates existed in the nature of society, not in the psychological or biological attributes of individuals. Social integration and social regulation were considered to determine the types of social conditions which in turn determine the suicide rate. Durkheim (1897) considered there to be three types of suicide (egoistic, altruistic and anomic) which reflect three types of breakdown which may occur in the relationship between an individual and society. Egoistic suicide occurs when someone ends up with no concern for the community and no interest in being involved in it. This category would include people with physical or mental illness, or those suffering deprivation or bereavement. Altruistic suicide occurs when society has too strong a hold on the individual and the person has insufficient individuality.

In this case self-destruction is motivated by altruism and examples include the kamikaze pilots of the Second World War or people who are old or terminally ill and choose rather to die than be a perceived burden. Anomic suicide occurs when society has failed to regulate and integrate its members. Changes in family structure, unemployment, declining religious faith and divorce are all disturbances in collective organisation. This leads to a reduction in an individual's immunity against suicidal tendencies (Durkheim, 1897, cited by Gibbs, 1968). Much data on suicide is broadly consistent with the idea of anomie and societal disintegration as a major factor explaining differences in proneness to suicide (Williams, 1997). Risk factors known to increase suicide risk illustrate the importance of social factors: older age, living alone, unemployment or retirement, being single, separated or divorced, poor physical health and infrequent use of health agencies. The overall picture is that of a poor situation with few resources to sustain the individual. Significantly, there are a lack of social supports for the individual. Although Durkheim's theory has been criticised on many grounds, the value of social support remains acknowledged. It is now accepted that for a complete explanation, social factors require to be combined with an understanding of individual factors.

1.1.4.3 Psychoanalytic perspectives

Sigmund Freud gave the first psychological insight into suicide in his 1917 paper "Mourning and Melancholia." He saw suicide as the result of extreme depression precipitated by the loss of a significant other through either death, rejection, or disappointment. He believed that an emotional attachment with another leads to identification with them where they may become a "love object". Lost "love objects" may be identified with and introjected. Often, however, the person feels ambivalent towards these lost "love objects", that is, they both hate and love such people. When lost persons are introjected with ambivalent feelings, aggression becomes turned inward. He argued that suicide represented aggression turned inward against an introjected love object.

Freud saw suicide as the ultimate end point of this phenomenon and believed that there would be no suicide without the earlier repressed desire to kill someone. The main concept was that anger can become self-directed, lead to depression, and may be a motivating factor in suicide (Gibbs, 1968). Freud later introduced the concept of the death instinct (Thanatos). He defined this as a drive commonly seen in nature, to reinstate the former state of affairs, the return of all organic or living matter to its inorganic unorganised state. This view sees life as a preparation for death, and the death instinct as a drive to its end (Williams, 1997).

Karl Menninger elaborated upon Freud's ideas in "Man Against Himself" (Menninger, 1938) in which he conceived suicide as retroflected murder. This was a type of inverted homicide, the result of the patient's anger toward another person, which is either turned inward or used as an excuse for punishment. He argued that suicide involved the wish to kill and the wish to be killed. The first stems from introjection, which leads to the wish to be killed because "murder alone justifies in the unconscious the death penalty, even when both are acted out upon the self" (p.55). The wish to kill oneself is a strong tendency to use introjection as a defence mechanism, and the wish to be killed is generated by a punitive

superego that creates guilt, self-hatred and the need for self-punishment once introjection has occurred.

Contemporary experts on suicide are not persuaded of the value of one specific psychodynamic theory of suicide but do place importance on the fantasies of suicidal patients regarding the consequences of their suicide (Roy, 1999). Some patients talk about a wish to join a dead relative with whom they strongly identify. Reunion fantasies seem less driven by aggression and more related to pleasurable wishes. Other patients have rebirth fantasies and others seem to be seeking some sense of control or mastery. For some there is a feeling of revenge as they anticipate the distress their death may have on others (Williams, 1997).

1.1.4.4 Biological factors

Diminished central serotonin levels have been thought to play a causative role in suicidal behaviour. Low levels of the product of the metabolism of serotonin (5-HIAA) have been found in the cerebrospinal fluid (CSF) of a number of patients exhibiting violent and suicidal behaviour. Low levels of 5-HIAA in the CSF have been found to be related to suicidality and impulsivity (using behavioural and self-report measures) in patients with depression, personality disorders, schizophrenia and alcoholism (Coccaro et al., 1989). Nordstrom et al. (1994) found low CSF 5-HIAA concentrations to predict short-range suicidal risk in a high risk group of depressed patients with a history of DSH. Most researchers agree that there is some sort of association between serotonin function and violence and that the violence may be internally or externally directed (Williams, 1997).

1.1.4.5 Genetic factors

Suicidal behaviour is more common in the relatives of people who have completed suicide, which suggests a genetic component. However, relatives also share a similar environment. Looking at twin studies Roy, Segal, and Centerwall (1991) found that identical twins had a concordance rate for suicide of 13.2% compared with a rate of 0.7% in non-identical twins. Though some studies have not replicated this finding there was considered to be sufficient evidence to favour higher concordance rates for suicide in identical twins. Other useful studies are those that look for adoptees who commit suicide in later life. Schulsinger, Kety, Rosenthal, and Wender (1979) carried out a comprehensive adoption study in Denmark. They identified 57 people who were adopted and who later committed suicide and compared them with a sample of matched adopted controls. The incidence of suicide in the biological relatives of the control group was 0.7% compared to an incidence of 4.5% in the biological relatives of those who committed suicide. In the adoptive relatives of the controls and suicides there were no suicides.

1.2 Service Provision

1.2.1 General

The most common outcome for this group of patients is discharge. The second most common outcome is admittance to a medical ward for a short period followed by discharge (Sidley & Renton, 1996). The Department of Health's (1984) guidelines recommend that all of those who attempt suicide be referred for psychiatric assessment. Hawton (1989) provided support for this policy as he found a lower repetition rate in patients who were assessed, compared with those who were not. A major challenge in working with this client group is that they are notoriously difficult to engage (Maltsberger, 1994). Patients tend to default within the first three months of treatment and to utilise a series of services or therapists (Gunderson, Frank, Ronningstam, & Wachter, 1989). In several studies compliance rates of less than 50% have been reported in terms of attendance at initial out-patient sessions (Morgan et al., 1976; O'Brien, Holton, Hurren, Watt, & Hassanyeh, 1987).

The poor compliance may be partly related to the type of treatment offered, continuity of care being especially important. Patients are more likely to attend if they see the same person who conducted their assessment while in hospital (Moller, 1989). Kjellander, Bongar, and King (1998) also emphasise the importance of an ongoing therapeutic relationship with a problem-solving focus to prevent suicide. Other factors likely to influence motivation for attending are the enthusiasm of the clinician and the importance they appear to attach to the patient attending (Hawton, 1997). Compliance is also influenced by immediacy and location of treatment (Hawton et al. 1981).

Cognitive rigidity, dichotomous thinking and impaired problem-solving ability characterise individuals in acute suicidal crisis (Fermium, de Percel, & Ellis, 1990). Several studies have focused on using problem-solving therapy to help patients deal with their current problems. Hawton (1997) summarised the results from these studies and concluded that brief problem-

solving therapy may be beneficial for suicide attempters in terms of addressing specific problems and may be enhanced if cognitive strategies are a specific part of the treatment. However, there is some evidence that the benefits of this treatment are confined to females or possibly to patients with problems in an ongoing relationship. Results in this area are inconclusive as subject samples have been too small (Hawton, 1997).

Paris (1993) believes that the optimal treatment for more challenging patients, including patients with personality disorders, is a short-term admission with mutually agreed goals and a quick return to the community.

Litman (1995) states that hospitalisation is an acceptable option for patients who are a significant suicide risk but argues that since it is 'impossible' to identify those at most risk of completed suicide, the whole value of hospitalisation is questionable.

Links (1998) concludes that although expert opinion argues against the admission of patients with personality disorders, the little research there is in this area supports the value of hospital treatment as part of a service. He advocates a move towards less reliance on inpatient hospitalisation and a shift towards community programs. Whilst hospital admissions are likely still to be necessary he believes that this service should 'play a major role in engaging the patient'. He also advocates that these crisis admissions be seen as a series of interventions, which may be formulated and co-ordinated so that they remain therapeutically valuable.

1.2.2 Studies of services aiming to improve patient compliance

Some work has been conducted in attempting to improve the poor attendance of attempted suicide patients at follow-up appointments. Hawton, Gath, and Smith (1981) tried to address the problem by introducing a home-based treatment programme for deliberate self-harmers. They introduced a service composed of brief problem-solving therapy provided at home

with flexibly timed treatment sessions, and compared this with standard hospital based out-patient sessions provided by the same therapist. Patients in the home based treatment programme showed significantly better treatment compliance with almost twice as many completing treatment (83% compared to 42%). However there were no significant corresponding improvements in 'repetition' between the groups (15% of the out-patient treatment group and 10% of the home based treatment group repeated their suicide attempt within a year). There was evidence of better outcome within the home based treatment group for patients with problems in ongoing relationships. On the basis of these results the expensive home based intervention programme was stopped and modifications to follow-up treatment were offered. These included more flexibility in out-patient appointments rather than the restrictions of a weekly out-patient clinic, and better continuity of care between therapists (Hawton, Fagg, & McKeown, 1989).

Allard, Marshall, and Plante (1992) developed a treatment programme designed to improve compliance and provide treatment to a group of suicide attempters in Montreal. The experimental condition involved including the patient, therapist and patient's family (where appropriate) in drawing up a treatment plan. Treatment was provided weekly for the first month, then fortnightly for three months, and finally monthly for the last eight months. The social worker visited the patient at home at least once and patients with more chaotic lifestyles were provided with session reminders via letter or telephone. Treatment content was eclectic in comparison with standard treatment, but unfortunately this is not described in detail. Results showed reasonable compliance with the experimental treatment but two years after entry to the study, 35% of the patients in this group and 30% in the comparison group had made further suicide attempts.

A large study was conducted in Belgium, which also focused on improving motivation for treatment in a group of suicide attempters. The study involved offering all patients out-patient follow-up appointments and home visits to patients who failed to attend. Five

hundred and sixteen patients who had taken overdoses were allocated to either the experimental condition or the comparison group that consisted of standard out-patient treatment. Approximately 40% of both groups attended their out-patient appointments but attendance significantly improved after a home visit (van Heerington et al., 1995). Outcome data showed that although patients in the experimental group had a lower rate of repeat suicide attempts (including fatalities), when other factors such as gender, marital status, and suicide attempt history were considered the difference was non significant. Hawton (1997) remarks that although the sample size was large it was probably still not large enough to achieve the sufficient statistical power necessary.

A different approach has involved providing patients with a card which contained details of how to get emergency help from the psychiatric services. Preliminary results were promising but once again the lower suicide repetition rate in the experimental group (5%) compared to that of the comparison group (11%) was not statistically significant (Morgan, Jones, & Owen, 1993).

Hawton (1997) concludes that important factors for compliance in treatment of patients who attempt suicide include continuity of care and work on treatment motivation. It has also been shown that home based treatment can result in better compliance. Although none of these methods seems to influence the likelihood of future self-harm specifically, there have been some encouraging results.

1.2.3 Services for patients with a history of repeat suicide attempts

Patients who repeat suicide attempts are a group for whom there is a special need to develop an effective intervention, due to their risk of future self-harm or eventual suicide (Ovenstone & Kreitman, 1974; Hawton & Fagg, 1988). In an early study conducted in Edinburgh, patients were randomly assigned either to the experimental condition where

they were offered support from an aftercare service, or to routine care involving standard out-patient follow-up (Chowdhury, Hicks, & Kreitman, 1973). In the aftercare service patients were offered regular and frequent out-patient appointments, non-attenders were visited at home, an emergency phone service was provided, and home visits were arranged in response to emergency calls. Results showed no difference between the groups in terms of repetition rates within the six months following DSH. However, interview ratings reflected improvements in the social circumstances (housing, finance and employment) of the experimental group compared with those in the control group. This difference was apparently more noticeable among the women (76% improved compared with 36%) than among the men (42% improved compared to 26%).

Liberman and Eckman (1981) completed a different type of intervention program for repeat DSH in Los Angeles. They only included subjects who had attempted suicide in the two years preceding their recent act which had brought them into the study. Subjects were randomly assigned to one of two experimental conditions, both of which involved four hours of therapy a day for eight days in the same clinical unit. One experimental condition was behaviour therapy, which involved social skills training, anxiety management, and family negotiation skills. The other condition was insight-oriented therapy, which consisted of individual therapy, psychodrama, group therapy, and family therapy. Both groups were offered follow-up support after discharge. This was provided at regular intervals for up to 36 weeks. Results showed both treatment groups made significant improvements on all the assessment measures. However, the depression rating scores were significantly lower in the behaviour therapy group. Rate of repetition of suicidal behaviour was also lower in this group, but this did not reach statistical significance. At the 24- and 36- week follow-up assessments significantly fewer people from the behaviour therapy group reported suicidal thoughts (Liberman & Eckman, 1981).

1.2.4 Services for patients with personality disorders who deliberately self-harm

One of the most impressive studies done with patients with personality disorders is by Marsha Linehan, using dialectical behaviour therapy (DBT). This therapy combines behavioural, cognitive and supportive approaches and is usually delivered in an outpatient context. It addresses life-threatening and destructive behaviours while conceptualising them as learned problem-solving strategies. It uses the context of a stable therapeutic relationship to confront problematic behaviours (Linehan, 1987).

DBT also prioritises support for staff working with this patient group. It includes a consultation group which provides a forum where the therapist may openly discuss their dissatisfaction with a patient's behaviour. This group provides a safe outlet for the processing of the difficult feelings of frustration or anger that can be experienced towards this patient group (Linehan, 1987).

Marsha Linehan (Linehan, Armstrong, Suarez, Allmon, & Heard, 1991) conducted a randomised control trial to determine whether DBT could reduce parasuicidal behaviours more effectively than treatment as usual. Treatment as usual involved referral to an 'alternative individual therapy'. Comparisons were made between patients receiving DBT and control patients receiving individual therapy. The results were optimistic with the DBT group demonstrating fewer incidents of parasuicide (median of 1 per year verses 9 per year), fewer near-fatal parasuicides, requiring fewer days of hospitalisation, and having a lower attrition rate (16.7% verses 50%).

As the above review indicates, individuals who engage in DSH frequently utilise various health services, yet rarely engage in productive treatment. There is a high degree of discrepancy in services offered. Much work has been conducted aiming to improve the treatment and outcome of this patient group, but its success has been limited. There is some evidence of improved outcome but not regarding the reduction of future suicide attempts.

As mentioned, personality disorder is a risk factor for DSH (Kernberg, 1984). As indicated, the most successful treatment to date in reducing DSH has been that of Linehan which is designed specifically for those with BPD. However this treatment approach is very intensive and demanding and not necessarily practical for all service providers. This group continues to represent a large cost and challenge to the NHS and to be at high risk of permanent physical damage and eventual suicide. The following sections are concerned with considering personality disorder and DSH and the issues related to this in more detail.

1.3 Personality Disorders

1.3.1 An introduction to personality disorders

Studies indicate that 40-50% of Psychiatric outpatients have a personality disorder (PD) (Koenigsberg, Kaplan, Gilmore, & Cooper, 1985) and that between 10% and 13% of the general population have personality disorders (Lenzenweger, Loranger, Korfine, & Neff, 1997; Weissman, 1993). It has also been suggested that 15% of inpatients are hospitalised mainly for problems resulting from a PD (Loranger, 1990).

According to DSM-IV (APA, 1994) personality disorders are patterns of inflexible and maladaptive personality traits that cause subjective distress and significant impairment in social or occupational arenas or both. These traits must deviate markedly from the norm and manifest in more than one of the following areas: cognition, affectivity, impulse control and interpersonal functioning. The pattern should be stable and of long duration with an onset in adolescence or early adulthood. The dysfunction must be pervasive across a wide range of personal and social situations. Characteristics of presentation include problematic relationships with others, difficulty coping with everyday environmental changes, and a lack of resilience under stress.

Often their style of response serves to perpetuate and exacerbate existing difficulties, yet individuals are often unaware that their personality causes difficulties and they either deny existing problems or blame others for them (Phillips & Gunderson, 1999). Individuals with personality disorders have problems in family, academic, occupational and other roles. They have higher rates of separation, divorce, children in care, unemployment and homelessness (Caton et al., 1994). They also have higher rates of child abuse issues (Dinwiddie & Bucholz, 1993), emergency department visits, medical hospitalisations (Reich, Boerstler, Yates, & Nduaguba, 1989), violence (Raine, 1993), DSH (Hillbrand, Krystal, Sharpe, & Foster, 1994) and attempted suicide and suicide (Hawton, Fagg, Platt, & Hawkins, 1993; Brent et al., 1994). Although this group of patients use medical services frequently, they are usually unsatisfied with the treatment they receive (Kelstrup, Lund, Lauritsen, & Bech, 1993; Kent, Fogarty, & Yellowlees, 1995).

DSM-IV (APA, 1994) arranges personality disorders into three clusters, each sharing some common clinical features: Cluster A includes personality disorders with odd or eccentric features (schizotypal, schizoid, and paranoid); Cluster B includes personality disorders with dramatic or emotional features (borderline, histrionic, narcissistic and antisocial); and Cluster C includes personality disorders with anxious or fearful features (avoidant, dependent and obsessive compulsive). Although these clusters were originally only based on face validity, several studies have since provided empirical support (Kass, Skodol, Charles, Spitzer, & Williams, 1985; Zimmerman & Coryell, 1989).

An issue regarding personality disorder diagnosis is whether personality disorders should be classified as distinct categories, qualitatively different and distinct from normal personality traits and each other, or whether personality should be considered to be on a continuum where personality disorders represent extreme variants of the norm (Frances, 1982; Gunderson, Links, & Reich, 1991). The categorical model fits best with the medical model in terms of identifying pathological syndromes which are either present or not. The DSM-

IV uses the categorical model. However the dimensional model allows the potential use of many personality descriptors which may more comprehensively describe the presence of traits. It does not confine clinicians to a limited number of categories and is less absolute. Phillips and Gunderson (1999) note that most of the axis II disorders are present, albeit to a lesser degree, within healthy populations. Costa and McCrae (1990) in their “Big Five” theory of personality, argue for the existence of the dimensions of extroversion, neuroticism, openness, agreeableness and conscientiousness across the population. A classification model using both categorical and dimensional approach may be most useful to clinicians and several have been suggested (Gunderson, 1992). The debate continues and for now the categorical model dominates through the use of the DSM IV (APA, 1994) and the ICD10 (WHO, 1993) particularly by psychiatry.

1.3.2 Borderline personality disorder

The DSM-IV (APA, 1994) diagnostic criteria for borderline personality disorder (BPD) are listed in table 3.2a. Of all the personality disorders, BPD is the one which has received the most attention. A central feature of this disorder’s psychopathology is an impaired capacity for attachment and maladaptive behaviour patterns relating to separation (Gunderson, 1984). Even when borderline patients feel cared for or supported, depressive features (emptiness or loneliness) are usually present. When they perceive or experience threat regarding the loss of a relationship, their idealised perception of a loving care-giver is replaced by a hatefully devalued image of a cruel persecutor. This polarised way of experiencing relationships is known as splitting. Potential threats of separation can evoke intense abandonment fears. In order to minimise the expected hurt, they minimise the value of the relationship and become involved in angry self-destructive behaviours (Phillips & Gunderson, 1999).

A considerable body of research documents a high frequency of traumatic early experiences including physical abuse, sexual abuse or abandonment (Parris, 1992; Shearer, Peters, Quaytman, & Ogden, 1990; Zanarini, Gunderson, Marino, Schwartz, & Frankenburg, 1989). It is considered that the abuse exists within a context of neglect which elicits enduring rage and self-hatred in the child. The lack of stable attachments during childhood results in the inability of borderline patients to maintain a stable sense of themselves or others without ongoing contact (Gunderson, 1996).

Treatment sessions with borderline patients often evoke powerful counter-transference reactions in the therapists. These may result in therapists either attempting to reparent or reject these patients (Phillips & Gunderson, 1999). Kernberg's (1968) work initially looked at the value of exploratory psychotherapy for this group but later suggested that improvement may depend on the establishment of a stable, trusting therapeutic relationship with the therapist. (The topic of countertransference is discussed in detail later).

Table 3.2a DSM-IV diagnostic criteria for borderline personality disorder

A pervasive pattern of instability of interpersonal relationships, self-image and affects, and marked impulsivity beginning in early adulthood and present in a variety of contexts as indicated by five (or more) of the following;

1. Frantic efforts to avoid real or imagined abandonment.
 2. A pattern of unstable and intense interpersonal relationships characterised by alternating between extremes of idealisation and devaluation.
 3. Identity disturbance: markedly and persistently unstable self-image or sense of self.
 4. Impulsivity in at least two areas that are potentially self-damaging (e.g. sex, substance abuse, reckless driving, binge eating or spending).
 5. Recurrent suicidal behaviour, gestures, threats or self-mutilating behaviour.
 6. Affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability or anxiety lasting a few hours or rarely a few days).
 7. Chronic feelings of emptiness.
 8. Inappropriate or intense anger or difficulty controlling anger (e.g. frequent displays of temper, anger or recurrent physical fights).
 9. Transient stress-related paranoid ideation or severe dissociative symptoms.
-

1.3.3 Borderline personality disorder and deliberate self-harm

DSH is a characteristic feature of patients with BPD and is indeed one of the DSM-IV (APA, 1994) criterion. Research has shown that almost half (46%) of patients presenting to an emergency psychiatric service suffered from BPD compared to 4.8% of controls (Bongar, Peterson, Golann, & Hardimann, 1990). Gunderson (1984) found that 75% of inpatients with BPD had made at least one prior suicide attempt. Urwin and Gibbons (1979) found that in a sample of patients who had attempted suicide 25% of male patients and 10%

of females had personality disorders. Rates of suicide among patients with BPD range from 3% to 9.5% (Brodsky, Malone, Ellis, Dunlit, & Mann, 1997).

Brodsky et al. (1997) investigated the relationship between the characteristics of BPD and suicidal behaviour. They found the trait of impulsivity, rather than the severity of the personality disorder, to be related to suicidal behaviour within this group. This finding remained consistent after they controlled for lifetime prevalence of major depression and substance abuse. They conclude that whilst suicidal behaviour is a multi-determined phenomenon, aiming to reduce impulsivity may be valuable. They suggest that this may be done through psychotherapy or pharmacotherapy.

Unfortunately for the BPD group the frequency of their parasuicide attempts often results in clinicians underestimating the seriousness of their attempt (Kjellander, Bongar, & King, 1998). Although completion rates for suicide in this group have been found to be less than those with schizophrenia or affective disorder (Kjellander et al., 1998) 'any suicidal behaviour, regardless of severity, places a person at 10 to 100 times more than the normal risk for suicide' (Jacobs, 1989, cited by Kjellander et al., 1998).

1.3.4 Theories of borderline personality disorder and deliberate self-harm

The BPD construct originated from the observations of psychoanalytic psychotherapists in an attempt to understand a group of particularly disturbed patients who tended to disregard the usual boundaries of therapy and to fail to engage productively in analysis. Kernberg (1975) offered an account of BPD from a developmental and structural perspective. He suggested that characteristic BPD behaviour originates from an underlying lack of ego strength combined with the existence of primitive destructive and aggressive drives. He believed that these lead to the use of primitive defences including 'splitting' and

'repression'. The function of splitting is to protect good objects from hostile objects or forces. Repression is a defence mechanism where unacceptable impulses or ideas are rendered unconscious. They may continue to influence behaviour, but at an unconscious level. Psychoanalytical therapy with these patients involves looking at internal relations between objects. Intervention is confined to interpretations, where links are suggested between current thoughts or behaviour and unconscious motives and defences (Ryle, 1997). Ryle (1997) in his review of psychoanalytic treatment of BPD summarised by criticising its intensity, duration and success, but he valued the contribution it has made to the understanding of PD through the use of transference-countertransference interactions.

Campling (1996) uses attachment theory (Bowlby, 1960) in considering BPD. She describes the three typical attachment types; secure, insecure-avoidant and insecure-ambivalent. A fourth is found in only about 4% of infants and this is the insecure-disorganised type. These children 'freeze' on separation and are unable to maintain organised behavioural patterns. It has been demonstrated that this group has been subject to major parental failure such as physical abuse or gross neglect. She suggests that this group may become the future generation of people with BPD.

Interest in PD in the cognitive therapy (CT) field stemmed from a recognition of the limitations of conventional CT for the treatment of this patient group. Their lack of cooperation with the treatment process was explained as due to the existence of 'fixed underlying assumptions' about their self and the world, leading to pervasive behavioural patterns. Young (1990) developed an extension of Beck's CT (Beck, 1979) known as 'schema focussed therapy'. This approach describes the existence of early maladaptive schemas which are maintained through cognitive distortion, schema avoidance (conscious and unconscious) and schema compensation (involving the development of schemas strongly opposite to the original maladaptive schemas) (Young, 1990). Treatment involves identifying and describing harmful schemas leading to their eventual modification. This

approach avoids the intrusiveness of analytic practice considered harmful by some (Ryle, 1997) and emphasises the importance of the collaborative relationship. It has however been criticised for a failing to provide an explanation of the origins of BPD (Ryle, 1997).

Explanations regarding DSH within this group also encompass biological perspectives. One school of thought attributes DSH to a possible atypical depression consisting of intense, irregular depressive episodes lasting less than a week. The BPD person's inability to tolerate unpleasant affect could lead them towards suicide (Montgomery, Montgomery, Baldwin, & Green, 1989). Neurotransmitter imbalance has also been considered to underlie BPD, with the efficacy of certain psychotropic drugs in decreasing suicidality within this group being seen as supporting this theory (Montgomery et al., 1989).

Another explanation looks towards the role of trauma. Gunderson and Sabo (1993) assert that BPD can be considered the effect which trauma has on character structure whilst PTSD is the acute symptomatic reaction to trauma. The most common trauma associated with BPD is sexual abuse (Weaver & Clum, 1993). Retrospective studies on histories of female psychiatric emergency room users showed that women who were sexually abused as children were more likely to self-mutilate, abuse drugs, experience suicidal ideation, make suicide attempts and receive psychiatric diagnoses including BPD (Briere & Zaidi, 1989).

1.4 Staff attitudes

In this review the significance attached (e.g. by Linehan et al. 1991) to the need for a positive therapeutic relationship when working with individuals who engage in DSH (in particular those with a personality disorder) has been reported. At the same time, the difficulty in developing a positive relationship with this population has also been described. This would seem to highlight that the therapeutic relationship is a very important yet

difficult area. In the following section (Section 1.5) the related topics of staff attitudes and therapeutic alliance and empathy are considered in detail.

1.4.1 Attitudes of mental health staff toward patients who have committed deliberate self-harm

The attitudes of health professionals towards patients who have self-harmed have been the focus of a number of studies. It is clear that some professionals have difficulty in communicating with and caring for the person who has attempted suicide and their family (Evans, Cox, & Turnball, 1992; Dunleavey, 1992). A number of studies have found that nurses can have hostile and unsympathetic feelings towards suicidal patients compared with other patients (Patel, 1975; Ghodse, 1978). Other studies have shown that suicide attempters perceive themselves as being ignored (Pallikkathayil & McBride, 1986) and treated with indifference or with overt hostility (Welu, 1972). Goldney and Botrill (1980) and Patel (1975) found a significant lack of sympathy from staff towards suicide survivors, particularly amongst those for whom this was their first contact with such a group. Ramon (1980) claims that since medical staff are the first social contacts to meet someone after they have enacted a suicidal act, they are responsible for expressing socially desirable reactions to these patients.

In a study conducted with the Swedish organisation for suicide survivors (SPES) a high proportion of people voiced serious complaints regarding the psychiatric care provided to their now deceased relatives. Common concerns were that the attitudes of caregivers were hostile and that suicidal behaviour was not taken seriously enough (Akerberg, Samuelsson, & Asberg, 1994). Other UK studies have reported similar findings. Carrigan (1994) found that patients reported communication difficulties yet emphasised the desire to be listened to by someone trying to understand their problems. Dunleavey's (1992) findings are similar, as she reports interactions between patients and nursing staff to have been rare and generally restricted to either physical care or superficial social chats, often amounting to little more

than 'passing comments'. Patients in this study wanted more support and contact with staff, even without going into their problems in depth. Avoidance behaviours were also found in Pallikathayil and McBride's study (1986). This showed that patients felt emotionally overwhelmed and isolated through lack of communication. This study also documented patients' feelings of social isolation, embarrassment about not being ill, and feelings of stigmatisation.

Interviews and questionnaires completed by physicians and nurses in general hospitals have indicated that although both groups tend to have ambivalent attitudes toward this patient group, nurses tend to be more sympathetic and understanding (Ramon, Bancroft, & Skrimshire, 1975; O'Brien & Stoll, 1977). Sidley and Renton (1996) looked at the perceptions and attitudes of nurses on a general ward toward patients who self-harm. They found that staff possessed some knowledge regarding risk factors relating to future parasuicidal attempts and that they showed a professional attitude toward this group. They also found that nursing staff appeared to show negative personal reactions after looking after this people in this group. Half of the nurses reported that their colleagues disliked working with this patient group as they found it frustrating. Almost 20% reported that they found working with this patient group depressing.

In a study looking at the attitudes of staff working in emergency care, Suokas and Longqvist (1989) found attitudes amongst staff to be at their most negative within the emergency room and at their most positive for staff within intensive care.

Studies looking at the attitudes of psychiatric staff toward this patient group suggest that psychiatrists show more empathy than do other medical staff (Ghodse, 1978). Between nurses and psychiatrists Ramon and Breyter (1978) found nurses to be less accepting, less sympathetic and less ready to help than were psychiatrists.

Ramon (1980) investigated the attitudes of doctors and nurses towards self-poisoning patients in general and psychiatric hospitals in Britain and Israel. His findings indicate an 'ambivalent – yet stereotyped attitude' towards self-poisoning patients which is shown by all staff groups. He also found that physicians expressed more negative attitudes than did nurses regardless of their area of expertise (Ramon, 1980). The evidence he cites regarding the existence of an ambivalent attitude include a high degree of readiness to help, low levels of sympathy, negative attitudes to some suicide motives (e.g. to frighten people) and positive attitudes towards others (e.g. strong wish to die). He found attributions of 'really wanted to die' correlated positively with the highest degree of sympathy, readiness to help and understanding. The staff were able to acknowledge pragmatic reasons for disliking this patient group including financial and time costs, but still expressed the desire to help even those demonstrating unacceptable behaviour or motives. Ramon (1980) suggests this ambivalent attitude is a staff defence, protecting them against the need to resolve the ambiguity they are presented with, with every new parasuicide patient.

Samuelsson, Asberg and Gustavsson, (1997) examined the attitudes of psychiatric staff towards suicidal patients. They developed a scale they called the "Understanding of Suicide Attempt Patient Scale" and used this alongside clinical vignettes. They found that women tended to be more sympathetic than men, and that older personnel were more caring towards suicide attempters than were their younger colleagues. They also found that nurses who had more often worked with suicidal patients showed more empathy towards them. Their results suggest that factors relating to the background of psychiatric personnel (i.e. age, sex, previous experience and work setting) contribute to their general attitude towards suicide attempters. They also found that patient characteristics contributed toward staff attitudes. It was found that patients who had abused alcohol or drugs were afforded less sympathy than were other patients. This finding has been replicated elsewhere (Hawton et al., 1981; Suokas & Lonnqvist, 1989). The authors suggest that this may be attributed to the emotional

reactions (anger and uneasiness) more commonly felt by staff towards patients with drug and alcohol problems. They suggest more empathy can be felt for patients with whom staff more easily identify. They also found that staff were more sympathetic toward patients whom they thought were genuinely ill.

1.4.2 Explanations

Ramon (1980) attempts to explain the more negative attitudes of physicians compared to psychiatrists concerning this patient group. He suggests that the physician holds the self-poisoning patient responsible for their own harm, in distinct contrast to other physically ill patients whom they will treat. Ramon suggests that the self-poisoning patient detracts the physician's time and attention from other physically ill patients and as such 'challenges the basic professional values of the physicians'. In contrast the psychiatrist is primarily concerned with patients who are 'mentally ill' and physical complications are of a more secondary nature. Ramon (1980) goes further to suggest that the fact that a psychiatric assessment is deemed necessary for these patients relieves physicians of this task but also disempowers them. The physician then becomes an 'unwilling technician'. He also suggests that the physician feels disappointment in their lack of ability to introduce significant change in these patients' lives. This may also be the case for psychiatrists but they have more potential options and have longer opportunity for interventions.

Among nursing staff, nurses in the general hospital were more sympathetic than were their nursing colleagues at the psychiatric hospital (Ramon, 1980). Ramon suggests that this may be because of the differing emotional needs of a suicidal patient compared with the tasks involved in looking after physically ill patients. Ramon (1980) suggests that the need of this patient for empathic attention may be a 'reminder of the calling in nursing which often evaporates in the toil of menial work with the physically ill patient'. In contrast he suggests that the primary aim of nurses on psychiatric wards is to maintain the ward atmosphere, and

that this is severely challenged when faced with an acute crisis such as a self-harming patient.

Corley and Goren (1998) combine a social psychological perspective with ethical and organisational issues to provide an understanding of less caring types of nursing behaviour. They use the phrase 'the dark side of nursing' (Jameton, 1992) to refer to nursing behaviours which control, manipulate, distance or avoid patients who may be considered 'unpopular' (Johnson & Webb, 1995). The four main social psychological concepts which Corley and Goren (1998) say are relevant to the understanding of 'dark side behaviours' are marginalisation, stereotyping, labelling, and stigmatising.

Beauchamp and Childress (1994) state that within the NHS, allocation of resources is carried out according to whether the patient is perceived to be responsible for their own condition. This includes patients who have attempted suicide (Duffy, 1995; Pallikkathayil & McBride, 1996).

The working environment of staff has also been thought to play a role in influencing nurses' thinking and behaviour (Corley & Goren, 1998). Corley and Goren (1998) state that the reference group may support the use of stereotypes and patient stigmatising. They draw attention to the military origins of modern nursing with the emphasised importance of order and staff hierarchy. They also suggest that the rituals of care and emphasis on organisation serve to protect staff from emotional pain and stress associated with ward life (Chambliss, 1996; Wolf, 1988).

Long et al. (1998) suggest that nurses' difficulty in communicating empathy to this group of patients may be likened to 'cognitive dissonance' (Festinger, 1957). They suggest that a proportion of nurses will join the profession to help people and protect them from illness and preserve life. Their experiences of self-harm and death, including suicide, can be traumatic and may raise issues concerning their own and other peoples mortality.

Gibbs (1990) suggests that communication difficulties are attributable to professionals' own lack of awareness regarding their own feelings about suicide and death. He suggests that this results in their need to create barriers for self-protection resulting in treatment becoming focused on medical rather than psychological needs. Nurses have also been considered to avoid discussions with this group of patients because of their own feelings of insecurity and powerlessness (Dunleavey, 1992).

The high prevalence of negative attitudes among health staff towards this patient group give reason for concern and indicate the need for improved knowledge and understanding among their care givers. Samuelsson et al. (1997) suggest that the encounter between the nurse and the suicidal patient provides the potential basis for secondary suicidal prevention. They recommend more education in this area to optimise the use of this encounter.

1.4.3 Reactions in professionals evoked by people with personality disorders

Interactions with individuals with personality disorders can be most challenging. There are several reasons for this. First, these patients may be more strongly conditioned to expect aversive interpersonal experiences and may consequently respond more negatively in their interactions with others (Benjamin & Wonderlich, 1994). Their rigid or inflexible personality style may also be counterproductive to the requirements of the clinical situation (Wagner et al., 1999) and their difficulties adapting to situational constraints may elicit frustration or irritation within clinicians (Allen, 1997).

Transference is the phenomenon whereby the patient transfers (unconsciously) to the therapist, feelings, attitudes or reactions and conflicts experienced in childhood toward parents, siblings or other significant people. This idea was introduced by Freud in 1895. The patient behaves as though the analyst were their mother, father or brother etc. Counter-transference is the therapist's emotional response to a patient's presentation and is partly a

reaction to the transference response of the patient (Maltzberger & Buie, 1974). There are different types of counter-transference. In 'identifying counter-transference' the therapist has an emotional reaction similar to the patient (e.g. they both feel panicky and helpless) and in 'reciprocating counter-transference' the therapist has a response reciprocal to that of the patient (e.g. the therapist feels (or acts) paternal towards a patient who is weak and looking for help). Some of the therapist's counter-transference is due to the patient's behaviour in the therapeutic interaction and some stems from the therapist's predisposition to react in certain ways to either all patients or just patients of a certain type (Reich, 1951).

Countertransference is likely to be especially intense in interactions with 'borderline' and 'psychotic' presentations, particularly if these patients are prone to suicide (Chase & Hire, 1966, cited by Maltzberger & Buie, 1973). Maltzberger and Buie (1973) refer to a 'transference hate' in borderline patients. It involves a mix of aversion and malice that stems from a deep sense of abandonment (or fear of), a contradictory desire for, yet fear of, closeness, and other defense mechanisms which alienate them from others. Maltzberger and Buie (1973) believe that this 'transference hate' causes behaviour which in turn evokes a 'countertransference hate' in professionals interacting with them. They suggest that professionals may adopt a variety of positions to protect themselves against this uncomfortable affect. The first position they describe is 'repression of affect', which occurs when the therapist struggles to stay alert to the patient and tends to daydream or feel bored during the encounter. In this situation the message conveyed is 'I do not want to be with you' and the patient can feel rejected. The next response involves the therapist 'turning the hatred against the self'. The therapist does not feel good enough and may experience feelings of inadequacy, helplessness and hopelessness. In this case the therapist may give up or refer the patient elsewhere. A third potential reaction is over helpfulness. The therapist finds him/herself being excessively helpful, perhaps trying to be the omnipotent rescuer. This can lead to excessive, unhelpful interference in the patient's affairs. The fourth

potential position is 'a projection of countertransference hatred'. This involves the therapist feeling fear and perhaps hatred towards the patient. They may experience a dread that the person will carry out the suicidal act and there will be a tendency to take this act personally and feel helpless. This can result in a rejection of the patient or an attempt to over control their behaviour by imposing controls. The final position involves 'distortion and denial of reality for validation of countertransference hatred'. The therapist sees the patient as hopeless, bad, or dangerous and may feel pity, indifference or anger. In this case the patient may be sent away or discharged prematurely from hospital. Maltzberger and Buie (1973) suggest that the best way to protect against acting on countertransference hate is to acknowledge these difficult feelings and keep them in consciousness, so encouraging therapeutic objectivity.

Modern interpersonal theory can be a useful model for the study of social interactions and their relation to personality styles (Kiesler, 1996). It frames interpersonal interactions in terms of reciprocal causality of behaviours between interactants, such that each interactant's behaviour is both a cause and effect of the other's behaviour. According to this theory the interaction in a relationship will tend towards 'complementarity', which occurs on the basis of 'reciprocity' in respect to control, (dominance encourages submission, and submission encourages dominance) and in respect to affiliation, (friendliness encourages friendliness whilst hostility encourages hostility). Studies suggest that therapist-patient complementarity early in psychotherapy is related to the quality of the therapeutic alliance (Kiesler & Watkins, 1989) and outcome (Henry, Schacht, & Strupp, 1990).

Individuals learn interacting skills and style from significant others and develop a range of schemas for dealing with social relationships. People with a personality disorder (PD) are described as having rigid or extreme interpersonal patterns or perceptions (Kiesler, 1996). These patterns are considered to be highly restrictive. For example, a suspicious or paranoid person's expectation of danger or antagonism may lead them to misinterpret neutral social

behaviour as threatening. This may cause them to react in a hostile or attacking manner thereby distancing themselves from the perceived threat. This type of interaction can equally occur in the clinical situation. The inflexibility of a PD patient may constrain the clinician's style rendering them ineffective. It is therefore necessary for the clinician to be able to step back in order to provide the patient with a healthy interpersonal experience, which may develop into a healthy therapeutic relationship (Keisler, 1996; Safran & Segal, 1990).

As indicated, a large number of these patients have a personal history of childhood abuse. Unfortunately, as indicated above, their behaviour can elicit treatment from staff that confirms their expectation that carers will also become abusive. The clinician finds them self in an abusive role and both participants experience the encounter as abusive and damaging. It is from here that the clinician moves from a diagnostic stance to a moral evaluation and the individual is seen, for example, as bad or difficult (Hinshelwood, 1999). Hinshelwood attributes the reaction of the professional to the fact the patient 'does not complement the professional's helping role'. He hypothesises that the individual with a PD is unable to accept any help and re-interprets the offer as a threat of abuse or exploitation. This results in both the doctor and the patient clashing and feeling violated. Hinshelwood believes that the doctor, feeling exploited and rejected, reacts by stressing their identity. This reaction leads to them condemning, rejecting or discharging the patient, seeing them as untreatable. Ultimately the reactions of both are to the mutual detriment of the patient and the doctor and the experience further prolongs the patient's experience of abuse. (Hinshelwood, 1999).

Dawson (1996) believes that this interpersonal conflict characteristic of interactions with individuals with PD is an externalisation of the patient's self-system conflict. He believes that they take conflict from their own self-perception and enact it in dialogue with another. They may present one side (helpless or incompetent) and the professional will assume the

complementary position of competence by offering help, support or treatment. In doing so the clinician adopts the position of control and this is where Dawson believes the negotiation starts. He believes that when faced with this position the person with PD reacts to re-establish control by ensuring failure of the health care professional. This then makes the professional feel as though they have failed and are unable to help which leads them on towards feeling anger and rejection.

Dawson (1996) believes that the 'script is already written' regarding interactions with these patients. Because of this he believes that inpatient wards with their policies and rules are not beneficial places for these individuals. Though it may be with the best of intentions, Dawson believes that the experience of ward life and interactions with staff can mimic the cycle of abuse they have come to expect. He also goes so far as to suggest that the more extreme, dangerous behaviours manifested by these individuals may occur because of, not in spite of, professional care. Negotiations around issues of power and competence may result in more dramatic displays of helplessness. He advocates investigating these responses and changing social contracts with these patients.

Wagner et al. (1999) conducted a study to look at the interaction between the personality styles of outpatients and the pattern of their interactions with the clinician during their first outpatient appointment. They found that PD patients and clinicians had more constrained reciprocal interactions, which appeared to reflect less productive relationships characterised by hostility, distrust, suspicion and the lack of a working partnership. Generally they found that patients scoring higher on PD scales perceived clinicians to be more hostile. The authors were unable to establish whether this was due to the distortion of patient's perceptions or whether clinicians were actually more hostile to this patient group. The literature reviewed here would suggest both factors are relevant. Wagner et al. (1999) emphasise the importance of predicting difficult interpersonal relationships so that clinicians may employ compensatory mechanisms to improve these interactions and avoid

more negative experiences. This would guard against unproductive relationships, which could provoke difficult behaviours later.

1.5 The alliance

1.5.1 The therapeutic alliance

The therapeutic alliance involves the establishment of a bond between the therapist and the client and an agreement on tasks or goals. Bordin (1976) describes the working alliance as;

the complex understanding and attachments that are formed when one person in a state of personal crisis... turns to another for their expert help and a contract is made. This contract or alliance represents a subtle mixture of explicit and implicit understandings and acknowledged and unacknowledged attachments (pp.2).

He suggests that all working alliances have three common features: an agreement on goals, the assignment of tasks, and the development of bonds.

It has been widely accepted that a good relationship between the client and therapist enhances the effectiveness of therapy (Freud, 1958/1912; Goldfried, 1980; Rogers, 1957). There is substantial evidence that a good therapeutic alliance is the best predictor of good outcome in therapy (Frieswyk et al., 1986). Carl Rogers emphasised the importance of generic variables stating that the therapist's ability to provide the client with three basic interpersonal conditions (empathy, unconditional positive regard, and congruence) was necessary and sufficient to promote therapeutic improvement (Rogers, 1951; 1957). A good initial alliance is seen as a necessary precursor for the use of other interventions for therapeutic effect.

Hovarth (1994) summarised the impact of client pre-treatment characteristics on the alliance. He concluded that clients who have difficulty making social relationships or have

poor family relationships are less likely to develop strong alliances. Also patients with a pre-therapy pattern of negative expectation of success or poor object relations with high scores of defensiveness, hostility or dominance are more likely to have poor alliance scores. This is considered with the evidence and theories reviewed in Section 1.3. Henry and Strupp (1994) investigated the role of therapist variables in therapy alliance. They found that the therapist's internal representations of past relationships (introjects) have a strong influence on the quality of the alliance developed, at least with some patients. Their results also indicate that the therapist's ability to accept responsibility for his or her own relational struggles in therapy is a precursor of alliance improvement in the session.

Alliance concepts have been criticised for their lack of clarity (Hougaard, 1994). Hougaard (1994) presents a generic model as a heuristic means for clarifying the conceptual meaning of the therapeutic alliance. The model divides the alliance into two main areas, the personal relationship area consisting of the socio-emotional aspects of the relationship (i.e. mutual understanding and liking, agreement of intimacy, and amount of directiveness), and the collaborative relationship area consisting of the task related aspects of the relationship. Within both, distinctions are made between therapist contributions, patients contributions, and the collaborative relationship areas composed of task related aspects of the relationship. The therapist is considered to bring authenticity, warmth and acceptance and empathy to the personal relationship, whilst the patient brings confidence, friendliness, compliance and receptivity to the relationship. With regard to the collaborative relationship the therapist brings expertness and engagement, and the patient brings a working capacity, motivation, and positive expectations.

Between the late 1970's and early 1980's a number of measures have been devised which aim to measure the alliance (Horvarth, 1994). These measures mostly assess the relationship over the span of therapy. Research has found a moderate-to-strong relationship between

positive alliance and good therapy outcome (Horvath & Symonds, 1991; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985).

1.5.2 Therapeutic empathy and the alliance

Empathy has recently been subsumed within the concept of the therapeutic alliance (Bordin, 1979; Horvath & Greenberg, 1994). It is acknowledged as an important aspect of securing the bond in the therapeutic alliance or forming a helping therapeutic relationship. It promotes safety, facilitates patient openness and self-disclosure, can reduce resistance and may help to combat fear and denial (Bohart & Greenberg, 1997b). It is not, however, always seen as the primary agent of change. Nor is it valued equally across different therapeutic approaches. Some see empathy as little more than a kindly or supportive posture (Snyder, 1992) whilst others see it as a major component of the therapeutic process (Rogers, 1951). One of the difficulties in considering empathy is that it has multiple definitions. Basch (1983) defines empathy as an affective state within the therapist in response to the patient's appearance and behaviour. Book (1988) refers to empathy as the therapist's 'experiencing of the patient's conscious and unconscious emotional states' and 'requires from the therapist the essential ability to oscillate from being observer to being participant to being observer' (pp.421).

Bohart and Greenberg (1997b) conceptualise empathy as a multidimensional construct. They view empathy as including an understanding (cognitive) dimension, an experiential (affective) dimension and a communicative element. They define empathy as a way of being with someone in a relationship, with an overlap with the concept of interpersonal confirmation (validation).

Bohart and Greenberg (1997b) suggest that there are three types of empathy. They call the first 'empathic rapport' which involves kindness, global understanding and a tolerant

acceptance of the patient's feelings. The second type is 'experience-near understanding of the clients world'. Here the therapist aims to understand what is it like to be the patient at a deeper level. This would involve exploration of both conscious and unconscious processes and tends to be more characteristic of psychodynamic approaches. The third type is 'communicative attunement'. This involves immediate attunement and reflective understanding as used in client centred therapy. Of these, empathic rapport is the most global type and most useful in the therapeutic relationship building stage. It does not however involve understanding and interpersonal alignment at a deeper level as the other two types do.

Bohart and Greenberg (1997b) find it helpful to differentiate therapeutic empathy from empathy per se. They see the therapeutic empathy as an ongoing process of coming to know and understand another person to enable their development and problem resolution. It involves the therapist having regard and sincere respect for the patient. It also involves a belief that there is a certain validity to the patients feelings, experience and behaviour when looked at from their point of view. Secondly it is an experience involving the therapist perceiving and experiencing the patient in relation to themselves, themselves in relation to the client, and the relationship itself.

1.5.3 The therapeutic alliance with suicidal / borderline patients

As indicated, a good alliance with patients is a prerequisite for useful therapeutic work. This is particularly so when working with patients with personality disorders when it may be the only resource available to the clinician (Campling, 1996). However, as also indicated, this is particularly difficult to do with this client group. Campling believes that low self-esteem and feelings of worthlessness result in this group of patients finding it impossible to ask for help appropriately when they need it. This leaves them with few alternatives and they

frequently present in a crisis state, post suicidal behaviour, usually an overdose. This can prompt the clinician to adopt a defensive, reactive position where they become authoritarian and manage and judge the presenting behaviour rather than looking at the underlying distress. Patients can be left believing that their underlying beliefs about their despair and hopelessness are confirmed, so perpetuating their sense of distress. This results in anger on both sides, so making development of a healthy alliance virtually impossible (Campling, 1996).

Bordin (1979) believes that the establishment of a sustained collaboration with the therapist contributes to the patient's ability to experience the therapist's interventions and intentions as benevolent. This is particularly important when dealing with patients who struggle to develop relationships with others.

'Splitting' refers to the psychoanalytical concept where good and bad "objects" have to be kept separate in the mind and are idealised or denigrated accordingly. As mentioned earlier in Section 1.3.4, Kernberg (1975) considered this to be a defence used by individuals with BPD. Campling (1996) also argues that this is used by patients with severe PD, resulting in a polarisation of good and bad. In interactions with clinicians the patient with the personality disorder will see the clinician as either 'all good' (idealisation) and they will seek to be rescued, or 'all bad' (denigration) and they will try to destroy them.

Powell (1991) describes case histories where idealisation has been unrecognised and unwittingly encouraged. The subsequent breakthrough of negative feelings is often catastrophic and frequently leads to another suicide attempt. Campling (1996) emphasises the need to recognise the mixed feelings that borderline patients induce in the people trying to help them. She believes that it is essential to concentrate on surviving the hatred without either being destroyed and rendered impotent, or without resorting to revenge. The next step is to challenge their simplistic, polarised map of the world made up from the very good and

the very bad with no concept of people having both good and bad parts. Waldinger and Gunderson (1987) also note the need for a containing relationship that is able to withstand and endure the patient's destructive hostility.

Marsha Linehan (1993) in her treatment approach for suicidal patients, sees empathy as part of the validation process. Her approach, Dialectic Behaviour Therapy (DBT) (mentioned in Section 1.2.4), aims to accept patients just as they are, whilst encouraging change. Acceptance strategies are balanced by change strategies which include a range of problem solving approaches. Validation is considered to facilitate the therapeutic process through encouraging the development of the therapeutic relationship, acceptance (especially self-acceptance) and an understanding of one's behaviour. She believes therapist validation leads to client self-validation where the patients come to recognise that there is sense behind their own responses and that they are people worthy of attention. Linehan (1997) sees empathy as overlapping with validation in two ways. Firstly she considers empathic communication to be validating in its own right. Secondly, validation involves the accurate recognition, acknowledgement and authentication of that which is. Empathy is the process through which a person can understand another so well.

1.6 Cognitive Analytic Therapy

1.6.1 The model

Cognitive Analytic Therapy (CAT) is a structured, focused, time limited therapy developed by Anthony Ryle (1982; 1985; 1990; 1995). Its underlying model, the Procedural Sequence Object Relations Model (PSORM) is an integration of elements from cognitive, behavioural, and analytic forms of therapy. The model provides an account of how intentional, aim-directed behaviour is organised. One can identify parallels with theories previously discussed (e.g. Interpersonal Theory, (Kiesler, 1996)).

A central concept in CAT is that of reciprocal roles which draws on object relations theory. Reciprocal roles develop from the first interactions between the infant and their caregiver. In these the child learns their own role and also learns to enact the role of the other. They may enact the latter firstly in relation to the caregiver or others (e.g. other children) and then in relation to their self. Thus, early interactions lead to the learning of two reciprocal roles which will define the individual's options for relating to others and self-management (Ryle, 1995). A consequence of enacting a role is the provocation of the other person to enact the opposite, complementary role. For example, if an individual is indecisive or passive, they are likely to provoke others to be decisive and directive.

A second CAT concept is that of procedures or the procedural sequence. Procedures are seen to emanate from an individual's repertoire of reciprocal roles but to maintain or exacerbate the patient's problems.

A central feature of CAT is the early creation, with the patient's participation, of high-level descriptions of the patient's damaging strategies. These descriptions aim to demonstrate current, ineffective ways in which goals are pursued and relationships constructed. This conceptualisation is firstly written down in a letter which aims to identify individual procedures and describe how they represent how they cope with difficulties but how these strategies backfire (e.g. feeling worthless, they may avoid others, fearful of negative evaluation or rejection. This leaves them without the opportunity of social interactions which could challenge their view of themselves as worthless, therefore maintaining the status quo). As well as highlighting repeated procedures which can then become a focus of work, the giving of the letter is seen as an important part of developing therapeutic alliance. The formulation is also repeated in a diagrammatic form (the sequential diagrammatic reformulation, SDR). Here reciprocal roles are shown as being at a core with procedures emanating from, and returning to, different parts of this core.

The 'active' part of therapy involves monitoring enactments of both reciprocal roles and procedures and working on change. Therapy may draw on a range of approaches e.g. analytic, cognitive or behavioural, depending upon what seems most helpful.

1.6.2 Cognitive analytic therapy and borderline personality disorder

It is hypothesised that, in the context of normal development, a child's array of reciprocal roles and procedures will be elaborated, and originally separate ones for dealing with specific interactions will become integrated into complex interpersonal procedures that are mobilised according to context. Ryle (1994) hypothesised that this process of elaboration and integration will be impaired if the child is faced with inconsistent or traumatic early experiences, especially if these are accompanied by deficient or misleading accounts from caregivers. Adults who expose the child to these experiences are also likely to lack, and fail to offer the child, the kind of reflection from which the child's capacity for self-reflection (a meta-procedure) would develop. Defensive inhibition and avoidance about thinking about psychological processes of self or others may impair development further.

More recently, Ryle (1997) has proposed the Multiple Self States Model (MSSM) as a theoretical understanding of BPD. Ryle (1997) presents an understanding of BPD as being a consequence of childhood trauma (deprivation and/or abuse) located within the context of inconsistent, unreflective care giving. As indicated earlier, such individuals frequently do have a history of childhood sexual abuse. He proposes that this dysfunctional and traumatic early relationship context results in dysfunction at three levels. The first of which is at the level of very restricted and extreme repertoires of role relationships concerning intimacy and care-giving. For example, individuals frequently develop reciprocal roles involving an abusive other to a victimised other or idealised relationships involving an ideally caring other to an ideally cared for other. The second level of dysfunction involves splitting or

failure to integrate sets of reciprocal roles. It is considered that this may be a way of coping, or a consequence of the absence of a necessary environment for integration to occur. For example, if a child experiences the same adult as both abusive and loving, they could be left with two extreme and 'unintegrated' pairs of reciprocal roles involving abuse (abusive-abused) and love (loving-loved). These pairs of reciprocal roles are known as self-states. The third level of dysfunction involves an inability to reflect on, make sense of, revise and integrate the split roles and the related dysfunctional behaviour (including DSH).

In fact Ryle (1997) talks about the MSSM as a model of 'borderline personality functioning'. The same model may be used to understand narcissistic personality disorder. Here the individual's repertoire of dissociated self states are seen to include contemptuous-contemptible and admiring-admired self-states. CAT with individuals with such personality disturbance (relative to individuals with less poorly integrated personality structures) tends to focus more on the patients (and others) involvement in different self-states and movement between different self-states. Therapy is concerned with achieving change at all three levels of disturbance.

According to CAT, it is anticipated that patients will be biased to experience others (including the therapist) as being in a particular reciprocal role from their repertoire (e.g. critical or demanding) with them in the corresponding reciprocal roles (e.g. criticised or striving). Further there is a tendency for the client to (inadvertently) elicit feelings (countertransference) and behaviours in others (including the therapist) which reflect the reciprocal roles. It describes 'acting out' reciprocal roles as enactments. For example, a patient who has a directive-passive reciprocal role pair may elicit directive behaviours from the therapist by being passive.

In working with the patient with personality disturbance the transference and countertransference responses, together with the pressure to 'reciprocate' and become

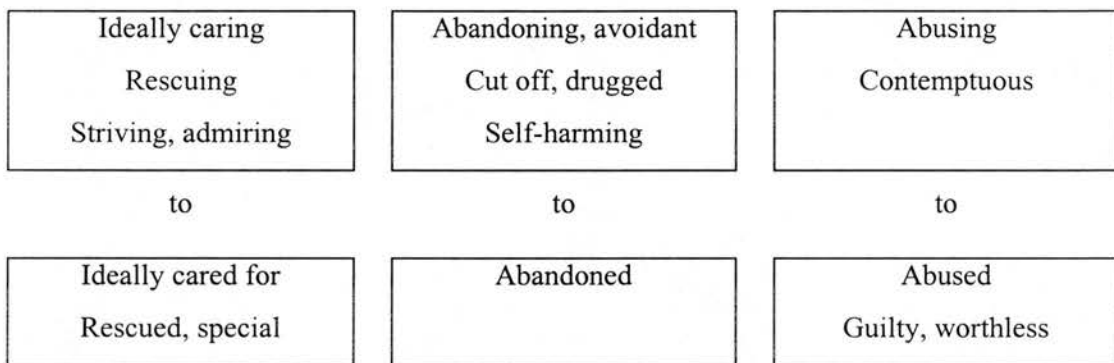
involved in an enactment, are seen to be much more powerful. This can be seen as being related to the extreme and unintegrated nature of the self states. Thus an individual who has poorly integrated self states involving abusive-abused reciprocal roles and ideally caring-cared for reciprocal roles respectively, may be quick to experience others as abusive or uncaring and to respond by becoming angry or abusive themselves (indeed they may do this if they perceive there to be forced choice between the two roles of abuser-victim). They may deliberately try to elicit rejection, because having their views confirmed is more reassuring. The other person, then feeling abused may respond by withdrawing or 'attacking' in some way (i.e. behaving in a way which appears to confirm expectations). Alternatively, this individual may perceive the other as being able to provide them with the answers, understanding, or care that no one else has and communicate this so that the other person hears a very seductive message. The other person believing that they (and perhaps no-one else) can help, then makes a special effort for this individual (thus reinforcing the individual's view of them). However such a position is unsustainable and if the 'choice' of relationship patterns involves either abuse or care – then the other person may go from being experienced as 'ideal' to 'abusive' with speed. One can see how individuals (the same or different persons) may occupy different roles and move between them.

This model illustrates how patients may unknowingly elicit intense feelings and behaviours in health professionals, which serve to strengthen their model of the interpersonal world. CAT actually uses reflecting upon the transference and countertransference responses and enactments as a source of information and a tool in therapy. (Therapists are encouraged to avoid becoming involved in enactments, but to do so completely is considered unrealistic).

Sheard et al. (2000) identified three different patterns of borderline and narcissistic coping based on their work with patients with personality disorders. Each are ways of trying to deal with unmanageable feelings: seeking resolution of feelings through rescue or a magical solution, seeking escape through avoidance, and trying to get rid of feelings through

inflicting them onto others. These may be broadly thought of as ‘rescue’, ‘avoidance’ and ‘hostility’. Rescue refers to seeking resolution through receiving ideal love or care from another. Avoidance may involve intoxication through substance abuse or overactivity or switching off into “zombie mode”. Hostility involves inflicting pain on others by identifying with the abuser role. (As discussed, Wagner et al. (1999) identified hostility as characterising interactions between clinicians and individuals with personality disorders). These self states or reciprocal roles are represented in figure 6.1.

Figure 6.1. Reciprocal roles demonstrated by borderline and narcissistic patients.



These three themes are seen to be on a circular continuum. “Core pain” drives the three forms of acting out (e.g. wanting to escape from feeling abused and worthless).

Sheard et al. (2000) also detailed the reciprocal roles that the therapist could get pressurised into taking which involve, collusively reciprocating a reciprocal role e.g. that of a rescuing problem solver, or adopting a fearful, powerless role in the face of patients’ aggression/contempt, or joining the patient in an emotionally avoidant rationalistic role.

1.6.3 Cognitive analytic therapy and deliberate self-harm

Cowmeadow (1994) used CAT to provide a course of brief psychotherapy to a group of deliberate self harmers. She first emphasised the need to focus on the patient’s distress. Kessel (1965) has described ‘distress’ in his classic study of three hundred and sixty five

self-harmers as the 'single common unifying factor' found in all patients admitted to a regional self-poisoning unit. This distress may be underestimated by professionals and may be made up of anxiety, rage and despair. Cowmeadow (1994) valued the process of spending time and attention on the nature of the emotional state associated with the self-harm act. She linked this to the CAT concept of 'core pain' that is central to the patient's long term difficulties. She reported finding that with persistence, patients will express very powerful feelings of anger, hopelessness, or despair especially believing that they will never receive acknowledgement of their distress or get help with their difficulties. Cowmeadow used the framework of CAT to establish meaning to the act of self-harm thus making it more understandable and manageable. She went on to identify 'target problem procedures' i.e. descriptions of the recurrent maladaptive patterns of behaviour, thinking or feeling which may give rise to the patient's problems. Patients were encouraged to understand how their behaviour may be eliciting certain unwanted behaviours from others which may leave them feeling unwanted, misunderstood or rejected. (Cowmeadow's work preceded the development of the Multiple Self States Model, (Ryle, 1997).)

Sheard et al. (2000) commented on the fact that although Cowmeadow's (1994; 1995) intervention appeared clinically valuable and acceptable to patients, the therapy was delivered by a therapist with a high level of experience in both CAT and psychoanalytical psychotherapy – a resource which is not routinely available to all individuals who engage in DSH, certainly not where they are initially seen. Sheard et al. (2000) devised a CAT based intervention for repeated self-harmers to be deliverable by staff who have not been trained in psychotherapy. They simplified the intervention into sequential tasks that are mediated through new CAT style standardised tools. The first tool is the 'Assessors Response File' which asks questions aimed at identifying counter-transference responses. More specifically, it is concerned with identifying which of the three possible themes described earlier (hostility, avoidance or rescue) is dominant. The second tool is a questionnaire (the

Self Harm Self Help File) which the patient completes. It contains questions aimed at identifying the patient's reciprocal roles, maladaptive behaviours, and their sense of integration, and also aims to identify dominant themes. The third tool is a set of eight standard diagrams – similar to SDR's. The diagrams all have a description of unmanageable feelings and trigger situations (antecedent) and a coping strategy (behaviour) leading to consequences that bring the patient back to the original situation and feelings. DSH is included as a crisis loop in parallel to everyday procedures. The psychiatrist chooses the most relevant diagram(s). (A personalised diagram can be created later). The Assessors Response File and the Self Harm Self Help File direct the Psychiatrist to diagrams which are anticipated to be most relevant as well as providing a guide for the session(s). The intervention follows the standard post overdose assessment and is for a maximum of three sessions. The first is conducted on the ward and the next two in out-patient clinics.

The aim of this intervention is firstly to provide a means of identifying the presence of, and naming of, unmanageable feelings, and also to show how the individual's behaviour represents an attempt to deal with these (and so is not being condemned) but that this strategy is 'backfiring'. This may encourage self-reflection and may then be used as a basis for identifying alternative ways of changing matters. Finally, the model and intervention may help avoid powerful and potentially damaging enactments between the psychiatrist and patient.

1.7 Aims

The aims of this study are;

- A. To adapt one of the assessment measures (the Assessors Response File) of Sheard et al. (2000) to produce two new measures which may assess the presence of avoidance, rescue, and hostility (as described by Sheard et al.) in the transference and countertransference in the "routine" post overdose psychiatric interview. (Existing measures of transference and countertransference have been developed for studying therapy sessions, rather than assessment sessions). This will include assessing the validity and reliability of the measures. These new measures will be named the 'Patient Response File' (PRF) and 'Clinician Response File' (CRF) respectively.
- B. To assess whether a lack of integration (as measured by the Personality Structure Questionnaire, PSQ (Broadbent et al., 2000)) is associated with the level of Personality disorder (as measured by the PDQ4 (Hyler, 1994). This will provide support for the validity of the PSQ and Ryle's model of borderline personality (Ryle, 1997).
- C. To assess whether there is a significant level of personality disorder and lack of integration (as measured by the PDQ4 and PSQ) amongst this population (individuals who have deliberately self-harmed).
- D. To assess whether the presence and intensity of the transference and countertransference (as measured by the PRF and the CRF) and the therapeutic empathy/alliance (as measured by the Empathy Scale, ES (Persons & Burns 1985)) is related to the level of personality disturbance.
- E. To assess whether repeated DSH is associated with a higher level of personality disorder, more intense transference and countertransference responses and lower empathy.

F. To replicate the findings that professionals generally hold quite negative views towards this client group (Ghodse, 1978; Patel, 1975). It is also expected that there will be some variation between different professional groups (Ghodse, 1978). It could be argued that these attitudes may both contribute to, and result from, aversive interactions.

1.8 Hypotheses

- A1. There will be a positive relationship (correlation) between the measures of transference and countertransference (as measured by the 'Patient Response File' (PRF) and the 'Clinician Response File' (CRF)) i.e. clients ratings of hostility, rescue and avoidance will correlate with clinician's ratings of hostility, rescue and avoidance, respectively.
- A2. There will be a positive relationship (correlation) between the ratings of rescue (as measured by the PRF and the CRF) and the measures of empathy (as measured by the Empathy Scale, ES).
- A3. There will be a negative relationship (correlation) between the ratings of avoidance and hostility (as measured by the PRF and the CRF) and the measures of empathy (as measured by the ES).
- B. There will be a positive relationship (correlation) between the scores on the PDQ4 (the borderline items and total score) and the PSQ.
- C. The level of personality disorder and lack of integration (as measured by the PDQ4 and PSQ) will be at least as high in the experimental group as that observed in a comparison group of individuals attending Psychology out-patient assessment appointments.
- D1. There will be a positive relationship (correlation) between the level of personality disorder and lack of integration (as measured by the PDQ4 and PSQ) and rescue, avoidance and hostility transference and countertransference (as measured by the PRF and the CRF).
- D2. There will be a negative relationship (correlation) between the level of personality disturbance (as measured by the PDQ4 and PSQ) and the level of empathy/alliance (as measured by ES).

- E1. The level of personality disorder and lack of integration (as measured by the PDQ4 and PSQ) will be highest in individuals with a history of repeated self harm and lowest in individuals who have never self-harmed.
- E2. The intensity of the transference and countertransference (as measured by the PRF and the CRF) will be highest in individuals with a history of repeated self harm and lowest in individuals who have never self-harmed
- E3. Empathy (as measured by the empathy scales) will be lowest during interactions with individuals presenting with a history of repeated self harm and highest during interactions with individuals who have never self-harmed.
- F1. Staff will hold negative attitudes towards this group.
- F2. There will be differences between the attitudes of different staff groups. In general, wards nurses will be more sympathetic and understanding than doctors, and psychiatrists will show more empathy towards this patient group than other medical staff.

2 METHOD

2.1 Preparation

Before the project commenced permission was sought to approach patients who had been referred for psychiatric assessment following deliberate self-harm (DSH), and to involve Psychiatry Senior House Officers (SHOs) who would be conducting the assessments. This was received from Dr Tom Brown and Dr James Hendry, Consultant Psychiatrists at St John's Hospital. Ethical approval was also sought and received from the Lothian Research Ethics Committee (December 2000).

2.2 Subjects

Subjects consisted of patients who presented to Accident and Emergency after self-harming and who were admitted into St John's Hospital, Livingston, and therefore seen for psychiatric assessment. Patients were excluded if they were under 16 years or over 65 years. Any patients unable to speak English or with a learning disability, were also excluded. Subjects with reading or writing difficulties were included; they were assisted to complete the questionnaires. In total, 60 patients consisting of 33 women and 27 men were recruited into the Experimental Group. There was a very low refusal rate with only 3 patients (two female and one male) choosing not to participate.

Before the patients had their standard post-overdose assessment they were individually approached by the researcher. They were given a verbal explanation of the study and a copy of an information sheet. Copies of the information sheet and consent form which all participants signed, are contained in Appendix I. Patients were allowed approximately two hours to make a decision regarding their participation. All patients were assured that they had the right to withdraw at any stage of the project. Some patients consented to participation but self-discharged before their psychiatric assessment. This happened

especially when circumstances necessitated an afternoon interview. Six patients (4 men and 2 women) withdrew in this way.

2.3 Comparison Group

The Head of the Psychology Department (Terry Griffiths) was approached regarding the department's possible participation in the study. The researcher then presented the study at a departmental meeting and requested participation from staff. Staff were asked to inform the researcher when they had new patients. For convenience, initially this consisted of patients seen within the department, then latterly it included patients seen within the community health centres. Staff were also educated regarding the questionnaires they would be required to complete for each subject.

The Comparison Group consisted of new out-patients attending Psychology. Thirty subjects were recruited, 22 women and 8 men. As with the Experimental Group, before their assessment interview they were approached by the researcher, given a verbal explanation of the study, a copy of an information sheet (Appendix II) and asked if they would be willing to participate. As with the Experimental Group patients were informed that they had the right to decline/withdraw participation at any stage of the project. Refusal rate was again low within this group; 3 females chose not to participate.

2.4 Materials, Measures and Rating Scales

- (i) Personality Disorder Questionnaire 4 (Hyler, 1994) (Appendix III)

Although self-report inventories are less accurate than clinician completed interviews, the Personality Disorder Questionnaire 4 (PDQ4) was chosen due to time and resource limitations. Structured interview schedules must be individually administered and generally require up to two hours to administer and score. This is demanding for both the researcher and the subject. Therefore a shorter self-report instrument was chosen. The PDQ4 (Hyler,

1994) is the most recent version of the PDQ (Hyler, Reider, Spitzer & Williams, 1983). The properties of the PDQ will be considered first before looking at the PDQ4.

The original PDQ (Hyler et al., 1983) is a self-administered personality disorder inventory. It is a true/false questionnaire, which requires approximately 20 minutes to complete. In contrast to other personality disorder inventories (e.g. the Minnesota Multiphasic Personality Inventory, MMPI (Hathaway & McKinley, 1989)) it represents a direct translation of DSM-III-R (American Psychiatric Association, APA, 1987) criteria for each personality disorder.

Test/retest reliabilities of between 0.63 and 0.75 were found for the original version of the PDQ following the Axis II disorders of borderline, avoidant, compulsive, paranoid, schizotypal and anti-social (Hurt, Hyler & Frances, 1984; Hyler, Reider, Williams, Spitzer, Handler, & Lyons, 1988).

The next version is known as the PDQ-Revised (Hyler & Reider, 1987). A review by Zimmerman (1994) found that both the PDQ and PDQ-R were widely used in research on personality disorders. However, both versions tend to have relatively low agreement with structured interviews when used as a diagnostic standard for Personality Disorder (PD) diagnosis and both tend to over-diagnose PD (Hyler, Skodol, Kellman, Oldham, & Rosnick, 1990; Reich, 1987). As it generates a very low rate of false-negative results, clinicians may have a generally high degree of confidence that significant Axis II pathology is not present in patients who do not meet threshold on any of the PDQ-R scales. The low positive predictive power indicates that a PD diagnosis may be a false positive. Because of this the authors suggest that PDQ-R may be useful for screening individuals for personality disorders in outpatient and inpatient psychiatric settings. They suggest that PDQ-R positive diagnoses should be verified for clinical significance by clinician administered interviews (Hyler, Skodol, Oldham, Kellman, & Doidge, 1992).

Research suggests that PDQ-R scales have different validities. Hyler et al. (1990) found that the schizoid and histrionic personality disorder sub-scales especially over-diagnose but they

found better specificity for antisocial personality disorder. The borderline personality disorder sub-scale has also provided better results, showing good concordance with clinician assigned diagnosis for individual patients (Hyler et al., 1989). It also gave a better performance than an alternative self-report measure, the Millon Clinical Multiaxial Inventory (MCMI) (Millon, 1987) when the Structured Interview for DSM-III Personality Disorders (SCID-II) (Spitzer, Williams & Gibbon, 1987) was used to diagnose personality disorder (Hyler et al. 1990). Hyler et al. (1990) suggest that although the PDQ-R may be no substitute for a structured interview, it may be a useful screening measure. They recommend that where possible, positive diagnosis according to the PDQ-R be verified for clinical significance by clinician-administered interviews. These findings, plus the advantage of a very brief completion time, result in Patrick (1996) recommending the PDQ-R's use as a screening measure.

The PDQ4 (Hyler, 1994) is the latest version of this self-report measure and is designed to assess the ten personality disorders of the DSM-IV (APA, 1994). The PDQ4+ includes the additional diagnoses of passive-aggressive personality disorder and depressive personality disorder that are included in the appendix of DSM-IV. The total PDQ4 score is an index of overall personality disturbance. Results suggest that a total score of 50 or more indicates a 'substantial likelihood that the patient had a significant personality disturbance'. Patients in therapy but without significant disturbance scored between 20 and 50 and normal controls scored less than 20 (Hyler, 1994). Since these values are from previous versions of the PDQ-R Hyler suggests that they be considered 'best approximations' for the PDQ4. To address the problem of over-diagnosis Hyler introduced a clinical significance scale in his latest version of the questionnaire. He recommends the assessment of clinical significance by either a clinician or trained rater. This involves the rater using the scale to check that each PDQ4 sub-scale that meets the threshold is confirmed. Through using the clinical significance scale Hyler hopes that the PDQ4 will generate personality disorder diagnoses which approximate to those obtained from structured interviews. He suggests that diagnosis generated without

the use of this scale should be sufficient for most screening purposes with the proviso that a fair number of false positives will be generated. Since this study is concerned with comparative levels of personality disturbance rather than absolute diagnoses the PDQ4 was used without the additional inclusion of the clinical significance scale.

(ii) Personality Structure Questionnaire (Broadbent, Clarke, & Ryle, 2000) (Appendix IV)

The Personality Structure Questionnaire (PSQ) is a self-report measure, composed of 8-items, (each a 5-point Likert scale). Items reflect features of Borderline Personality Disorder (BPD) as conceptualised by the Multiple Self-States Model (Ryle, 1997) and described in Section 1.6.2. The items relate to identity disturbance (considered to be present in BPD and dissociative identity disorder with greater disturbance being associated with the later) rather than DSM-IV (APA, 1994) criteria such as self-injury or impulsive aggression. The pathological end of the scales are indicative of an unstable sense of self, variation in subjective experiences, the presence of differing self-states (Items 1 to 4), changeability in moods (Items 5 and 6), and behavioural loss of control (Items 7 and 8). Initially this psychometric tool was developed to measure personality integration and its change over the course of Cognitive Analytical Therapy (CAT).

Pollock, Broadbent, Clarke, Dorrian and Ryle (2000) compared results from the PSQ for non-clinical and clinical samples. They found that a non-clinical sample (N=105) had a mean score of 20, the CAT patients (N=52) had a mean score of 26 whilst a sample of BPD sample (N=24) had a mean PSQ score of 34. Pollok et al. (2000) used several samples to investigate the psychometric properties of the PSQ. They found it to be a reliable self-report measure. Factor analysis showed it to be unidimensional and it was found to correlate with other measures of multiplicity and dissociation constructs related to identity disturbance. A Cronbach's alpha of 0.59 was obtained for the eight PSQ items across the total population. More specifically the PSQ had an alpha of 0.87 with a sample of BPD patients (N=24)

(Pollock et al. 2000). Test-retest reliability provided consistent results with a correlation of 0.75 demonstrating stability across time.

(iii) Clinician Response File (CRF) and Patient Response File (PRF) (Appendix V)

These measures were developed in order to study transference and countertransference responses in patients and clinicians respectively. New measures were devised since existing measures are often process oriented, time consuming and designed to assess change over the course of therapy rather than during a one off assessment. There are a number of such measures including 'The Core Conflictual Relationship Theme' (Luborsky, Crits-Cristop, & Mellon, 1986) and 'The Patient's Experience of the Relationship with the Therapist' (Gill & Hoffman, 1982). Beach and Power (1996) devised a measure of transference which involves the use of a coding system to code verbatim transcripts of therapy. Although this is a valuable measure this study was particularly concerned with the interactions of patients with personality disorders, in particular that three general themes of hostility, rescue and avoidance can be identified in the transference and countertransference (as proposed by Sheard et al. 2000). Further a brief, easily scored measure was required.

The CRF and PRF were developed by adapting a clinical tool devised by Sheard et al. (2000). Sheard et al. (2000) developed a CAT based intervention for people who repeatedly self-harm. Aspects of this are described in Section 1.6.3. The intervention is based around CAT oriented standardised tools which are used at specific points during the assessment interview. One of these is the 'Assessors Response File' (ARF) which is aimed at encouraging the psychiatrist to reflect on any counter-transference responses elicited by the interaction with the patient and to use this to guide the intervention. The ARF is composed of 32 items that are grouped under the three categories of hostility (9 items), rescue (16 items) and avoidance (7 items). As discussed in Section 1.6.3 these dimensions reflect common themes determined by clinical experience with borderline and narcissistic patients (Sheard et al., 2000). In the ARF each of the questions are followed by a series of guidelines designed

to assist the clinician in using their answers to guide their clinical intervention. As a first step in adapting this clinical tool to form a research tool, the 32 questions were listed alone (i.e. without the above mentioned guidelines). Steps to assess the reliability and validity were then taken and are described in the next chapter. This new measure was named the Clinician Response File (CRF).

For the purposes of this study a complementary measure called the 'Patient Response File' (PRF) was devised. The first step in doing this was to create a parallel item for each item in the CRF. For example, the parallel rescue item for 'I felt I did most/all of the work' (CRF) was 'I felt I did hardly anything through the interview' (PRF). As with the CRF steps to assess the reliability and validity were then taken. These are also described in the next chapter.

As mentioned the PRF and CRF were designed to measure the nature and intensity of the transference and counter-transference responses respectively, i.e. what is the main theme (hostility, rescue and avoidance) and how intense are these responses. The patient or clinician indicates how true they thought each statement was of the interview (using a 5-point scale ranging from "not at all" to "very true").

(iv) The Empathy Scales (Persons & Burns, 1985) (Appendix VI)

The Empathy Scales (ES) are 10-item questionnaires that may be used in research or clinical practice. There are two parallel versions, one to be completed by the patient (Patient Empathy Scale, PES) and the other by the therapist (Therapist Empathy Scale, TES). The measure was devised in 1985 and revised in 1991, 1992 and 1994. It was adapted from one originally developed by Jeffrey Young (Burns & Auerbach, 1996). Patients rate how warm, genuine, and empathic their therapists were during their most recent therapy session on the 10-items, (each a 4-point Likert scale). Patients record how strongly they agree with each item with response options ranging from "not at all" to "a lot". The first five items are

written so that a strong agreement indicates a good therapeutic relationship (e.g. “My therapist understands what I say to him/her”) while the second five items are worded so that strong agreement indicates a poor therapeutic relationship (e.g. “My therapist understands my words, but not the way I feel inside”). A total score is obtained by adding the five positively worded items and subtracting the five negatively worded items. Total scores range between -15 and +15. Burns and Nolen-Hoeksema (1992) found the ES to have a Cronbach’s coefficient alpha of 0.76 indicating a moderate degree of reliability and internal consistency.

(v) Deliberate Drug Overdose Questionnaire (Sidney & Renton, 1996) (Appendix VII)

This questionnaire is composed of 20 statements relating to patients who deliberately overdose. Clinicians are asked to indicate on a 4-point Likert scale, the degree to which they endorse each statement, from ‘strongly agree’ to ‘strongly disagree’. The statements in the questionnaire are designed to reflect the interviewee’s level of knowledge about this patient group (e.g. ‘Patients who kill themselves rarely mention their intention to anyone’). The questionnaire also investigates attitudes towards this patient group (e.g. ‘The taking of deliberate drug overdose is a display of attention seeking behaviour’). It also looks at personal reactions (e.g. ‘Working with patients who take deliberate drug overdoses is frustrating’), satisfaction with current services (e.g. ‘Current services for these patients are inadequate’) and training issues (e.g. ‘I believe I have adequate skills in dealing with the non-medical aspects of care for patients who take deliberate drug overdoses’). There is no reliability or validity information available regarding this questionnaire and therefore though it is not ideal, it was chosen due to its brief nature and ease of completion. Other research tools used to assess attitudes towards this patient group often involve reading lengthy case vignettes and answering related questions (Ramon, 1980).

2.5 Procedure

The researcher contacted Psychiatry reception daily to establish whether there had been any DSH admissions to be assessed by Psychiatry later that day. If so, secretarial staff collated the study forms with the referral papers and any case notes. The SHO then contacted the researcher when they were ready to do the assessment. Potential subjects were then approached by the researcher before their psychiatric assessment. Although they could take up to two hours to provide consent, usually this was given immediately. Providing consent was obtained, patients were seen following their post-overdose assessment with the SHO. The interview took approximately twenty minutes. The patient was first asked a series of questions to establish some basic demographic information; including, age, employment status, physical and mental health status and any history of deliberate self-harm. A copy of this itinerary is in Appendix VIII. Patients were then asked to complete the four questionnaires described in Section 2.4 (PDQ4, PSQ, PRF and PES). These questions were answered either verbally or on paper.

The procedure was almost identical for subjects in the Comparison Group. However, they were asked to provide slightly different demographic data, a copy of which is in Appendix IX.

For both groups the Clinician (Psychiatrist or Psychologist) completed the CRF and TES (also described in Section 2.4) immediately after the interview.

Before approaching staff to ask if they would complete the Deliberate Drug Overdose Questionnaire, the Ward Sister (of the medical ward where the patients were admitted) and the Medical Director (of A&E) were approached and the design and aims of the study were explained to them. Permission was sought from them to approach staff regarding completion of the questionnaire, as was their advice on how best this could be done. Both chose to distribute the questionnaires amongst their staff (doctors and nurses) and to ask for their staff's participation personally. Questionnaires were returned over the following two weeks

via internal mail. Information is unavailable regarding the number of potential staff and refusal rates between the groups. Ten members of staff (7 men and 3 women) from the medical ward returned questionnaires, 11 staff members (9 men and 2 women) from A&E. In addition, SHO's from psychiatry were asked to complete the questionnaire after being given a description of the study, either at the start of the study or the start of their placement. Nine psychiatrists completed the questionnaire (5 men and 4 women). In total 30 questionnaires were returned.

3 RESULTS

3.1 Validation exercise with the Clinician Response File and Patient Response File

Since the CRF and the PRF are new tools developed for research purposes it was felt important to assess their validity before use. Accredited CAT practitioners (N=150) were written to and asked to use the accompanying wheel (Appendix X) to rate each statement. The wheel represents the proposed circular continuum between hostility, rescue and avoidance (Sheard et al., 2000). CAT practitioners were asked to read each statement and consider its best position on the wheel. Each item was analysed individually to determine its loading on hostility, rescue or avoidance. Twenty-nine CAT practitioners responded. Their replies were anonymous so it is not possible to describe any of their demographics.

For the purposes of this study items were preferred if they measured a particular theme. Since the three themes (hostility, rescue and avoidance) are on a continuum, overlap was expected but ambiguous items (e.g. items with equal weight on avoidance and hostility) were removed. Items which were rated as being under a different theme (e.g. an item originally in the 'Rescue' scale rated as primarily measuring 'Avoidance') were moved to the corresponding sub-scale. Excluded examples include PRF Question Number 4 (hostility sub-scale) "I felt that I wanted the doctor to help me and provide care but they were not good enough" which was removed because the ratings given by CAT practitioners were almost equally divided between rescue and hostility. An example of an item excluded from the CRF is Question Number 21 "I felt threatened by the patient in a way which drew me into limiting what I said". CAT practitioners gave ratings which were almost equally divided between avoidance and hostility. The full results from this validity exercise are in Appendix XII. Table 3.1-1 describes the changes made to the items and the sub-scales following this exercise.

Table 3.1-1: Changes to the CRF and the PRF following the validation exercise

Measure	Ques. No.	Sub-scale	Consequence	
CRF	21	Hostility	Removed	
	19	Hostility	Moved to Avoidance Scale	
	15	Hostility	Moved to Avoidance Scale	
	32	Rescue	Moved to Avoidance Scale	
	29	Rescue	Moved to Avoidance Scale	
	7	Rescue	Moved to Hostility Scale	
	16	Rescue	Moved to Hostility Scale	
	4	Rescue	Moved to Avoidance Scale	
	14	Rescue	Removed	
	30	Avoidance	Moved to Rescue Scale	
	28	Avoidance	Moved to Hostility Scale	
	PRF	4	Hostility	Removed
		14	Hostility	Moved to Avoidance scale
13		Rescue	Moved to Avoidance Scale	
17		Rescue	Moved to Avoidance Scale	
30		Rescue	Moved to Hostility Scale	
8		Rescue	Removed	
2		Avoidance	Moved to Hostility Scale	
6		Avoidance	Moved to Rescue Scale	
10		Avoidance	Moved to Hostility Scale	

Table 3.1-2 summarises the number of items in each sub-scale of the CRF and the PRF before and after the exercise.

Table 3.1-2: Number of items in each sub-scale before and after the validation exercise.

	Clinician Response File		Patient Response File	
	Before	After	Before	After
Hostility	9	9	9	10
Rescue	16	11	16	13
Avoidance	7	10	7	7
Total	32	30	32	30

The two scales were analysed for reliability before and after the changes described above.

Table 3.1-3 shows the Cronbach's alpha for the sub-scales before and after the changes.

Table 3.1-3: Reliability analysis results for the sub-scales of the CRF and PFR before and after changes due to the validity exercise.

	Clinician Response File		Patient Response File	
	Alpha – before	Alpha - after	Alpha - before	Alpha – after
Hostility	0.800	0.867	0.922	0.892
Rescue	0.734	0.681	0.776	0.832
Avoidance	0.511	0.785	0.684	0.703

3.2 Demographics of the groups

(i) Age

The mean ages of the Experimental and Comparison Groups were analysed using an independent t-test. A significant difference was found between the two groups for age (Table 3.2-1). DSH has been found to be particularly common in young people; approximately two thirds of cases are aged under 35 years (Hawton, 1997). The results are therefore consistent with this as the Experimental Group was found to be significantly younger than patients attending out-patient psychology appointments. These results indicate the need to control for differences between the two groups, which may be attributable to age, in later analyses.

Table 3.2-1: Mean ages of the Experimental and Comparison Groups.

	Mean	SD	t-Value	Df	Probability
Experimental Group N=60	33.58	10.55	2.568	88	0.012
Comparison Group N=30	39.83	11.53			

(ii) Sex

The distribution of sexes in the two groups was analysed using a chi-square test. There was no significant difference between the groups for sex (Table 3.2-2).

Table 3.2-2: Sex composition of the two groups.

	Sex		Pearson chi-square	Df	Probability (2-tailed)
	Male	Female			
Experimental Group N=60	27	33	2.829	1	0.112
Comparison Group N=30	8	22			

(iii) Employment Status

The distribution of employment was analysed using a chi-square test. There was a significant difference between the two groups (Table 3.2-3). Platt and Kreitman (1984) found a highly significant correlation between unemployment and parasuicide amongst a male sample group in Edinburgh. The incidence of parasuicide was ten times higher among the unemployed compared to the employed (Platt & Kreitman, 1984).

This study supports this finding, as more subjects in the Experimental Group are unemployed compared to the Comparison Group. This group difference will need to be controlled for within later analyses.

Table 3.2-3: Employment status of patients within the two groups

	Employment status		Pearson chi-square	Df	Probability (2-tailed)
	Employed	Unemployed			
Experimental Group N=60	23	37	6.435	1	0.01
Comparison Group N=30	20	10			

General demographic information was taken for individuals in the Experimental and Comparison Groups. This data related to issues found to be relevant in this field. For the purposes of this study this data has not been analysed since it is an aside to the main aims of the study. The information obtained is in Appendix XI.

3.3 Exploratory results across the whole sample

3.3.1 Personality

The PDQ4 total scores of the “total patient population” (i.e. scores of both Experimental and Comparison Group) (N=88) were plotted to illustrate their distribution. They showed a normal distribution with low levels of skew (skewness=0.21, SE=0.26) and kurtosis (kurtosis=-1.05, SE=0.51) (Figure 3.3-1).

Figure 3.3-1: Distribution of PDQ4 total scores across the whole sample (N=88).

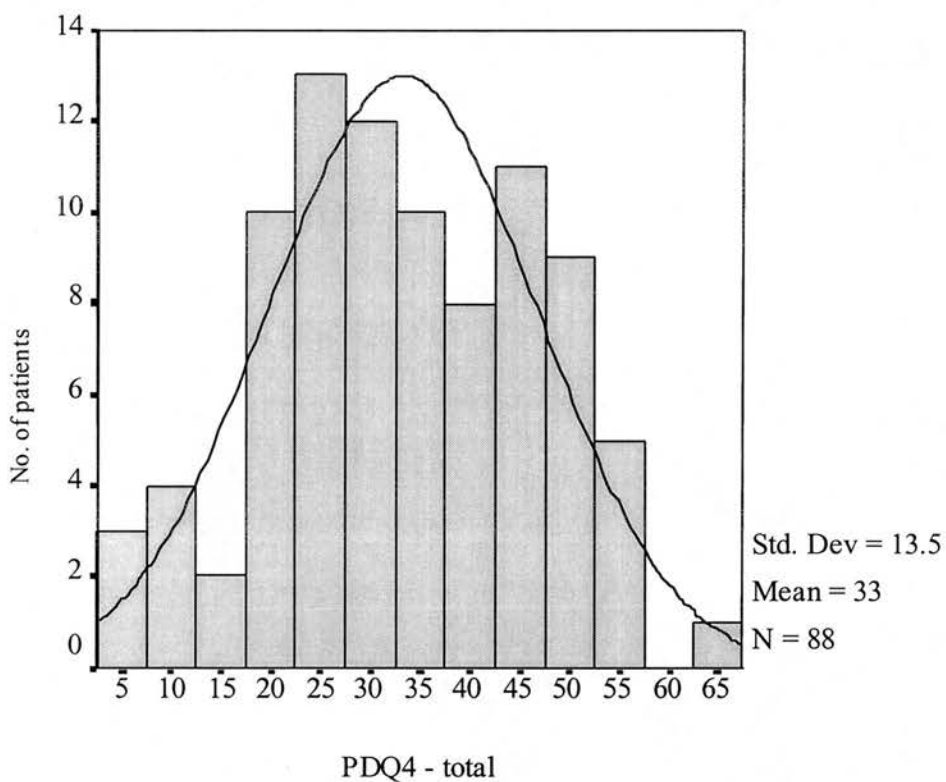
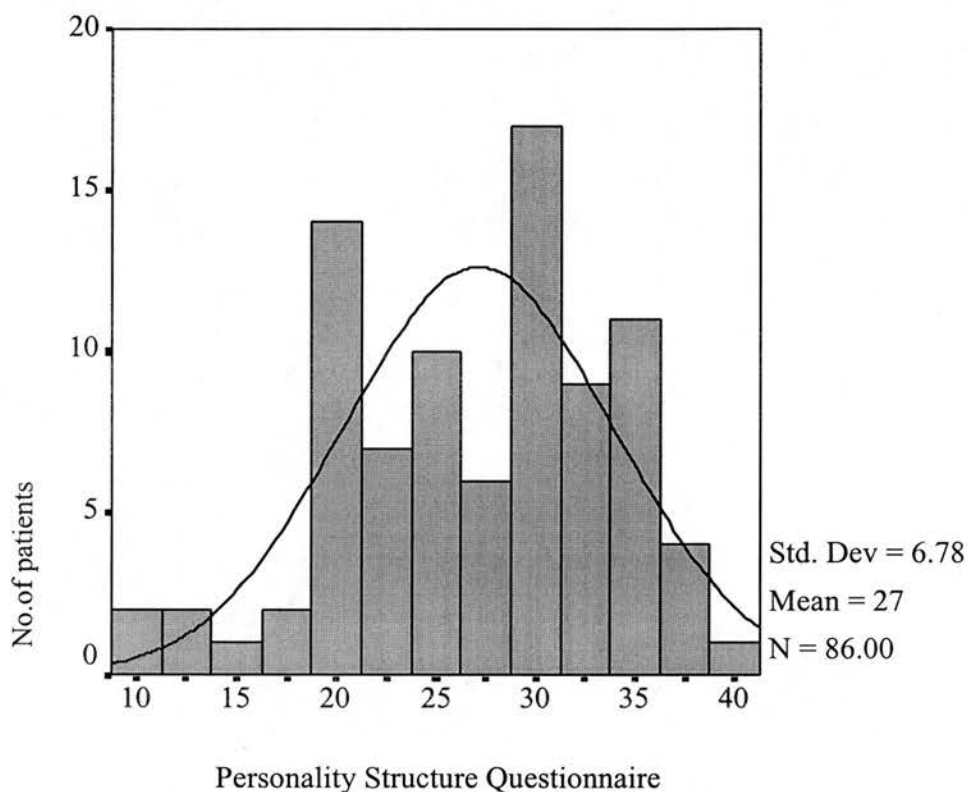


Figure 3.3-2 shows the distribution of the PSQ scores across the total patient population (N=86). This measure demonstrates low levels of skew (skewness=-0.20, SE=0.26) and kurtosis (kurtosis=-0.131, SE=0.51).

Figure 3.3-2: PSQ scores across the whole sample (N=86)



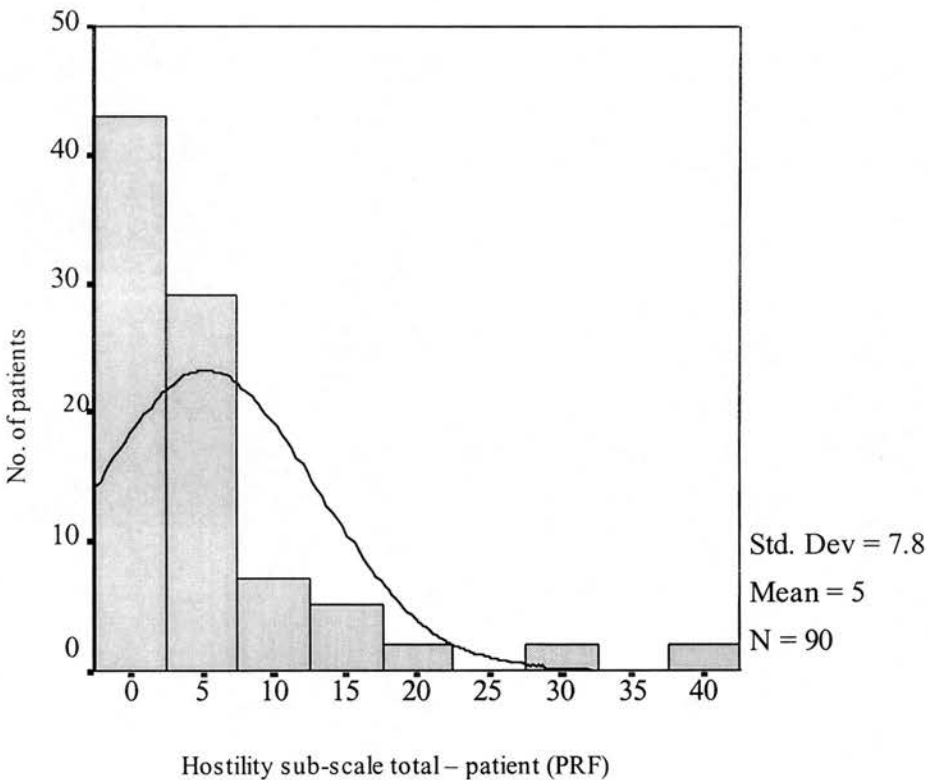
3.3.2 Transference

This section looks at the separate sub-scales of the transference measure, the Patient Response File (PRF). The distribution of the scores for each sub-scale was plotted for the total patient population (N=90).

a) Hostility

Figure 3.3-3 shows the hostility sub-scale scores of the PRF across the total patient population (N=90). The data had a positive skew (skewness=2.71, SE=0.25) and high level of kurtosis (kurtosis=8.09, SE=0.50). This 'floor effect' of the data is due to a high proportion of low hostility scores within the sample. The Kolmogorov–Smirnov test revealed a significant deviation from normality ($z=0.264$, $df=88$, $p<0.001$). This indicated that these data required transformation before parametric statistics were conducted. The data were transformed using a logarithmic transformation. Since there were a high number of zero scores the logarithmic of $x+1$ was used. Any analyses involving hostility (PRF-hostility) were performed on the transformed data.

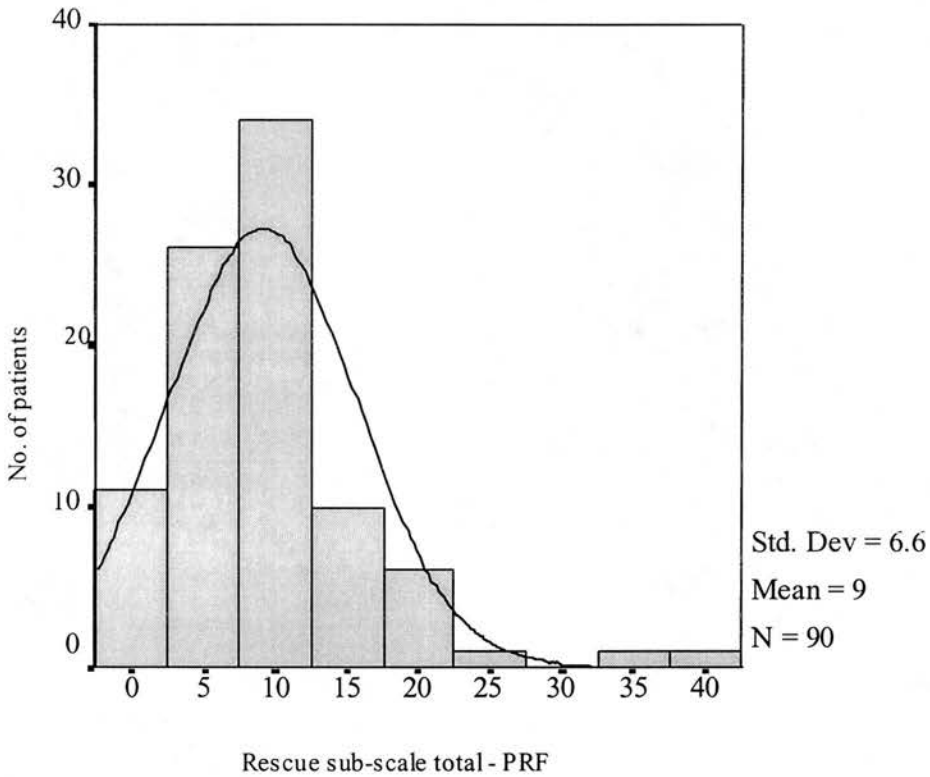
Figure 3.3-3: Total Hostility sub-scale scores on PRF for the total patient population (N=90)



b) Rescue

Figure 3.3-4 shows the total patient population (N=90) scores for the rescue sub-scale of the PRF. There was a positive skew (skewness=1.61, SE=0.26) and high level of kurtosis (kurtosis=4.52, SE=0.51). The Kolmogorov-Smirnov test demonstrates a significant departure from normality (z=0.13, df=88, p<0.001). This data was transformed to normalise distribution before using parametric statistics, by way of a logarithmic transformation (log (x+1)). Any analyses using this measure were on the transformed data.

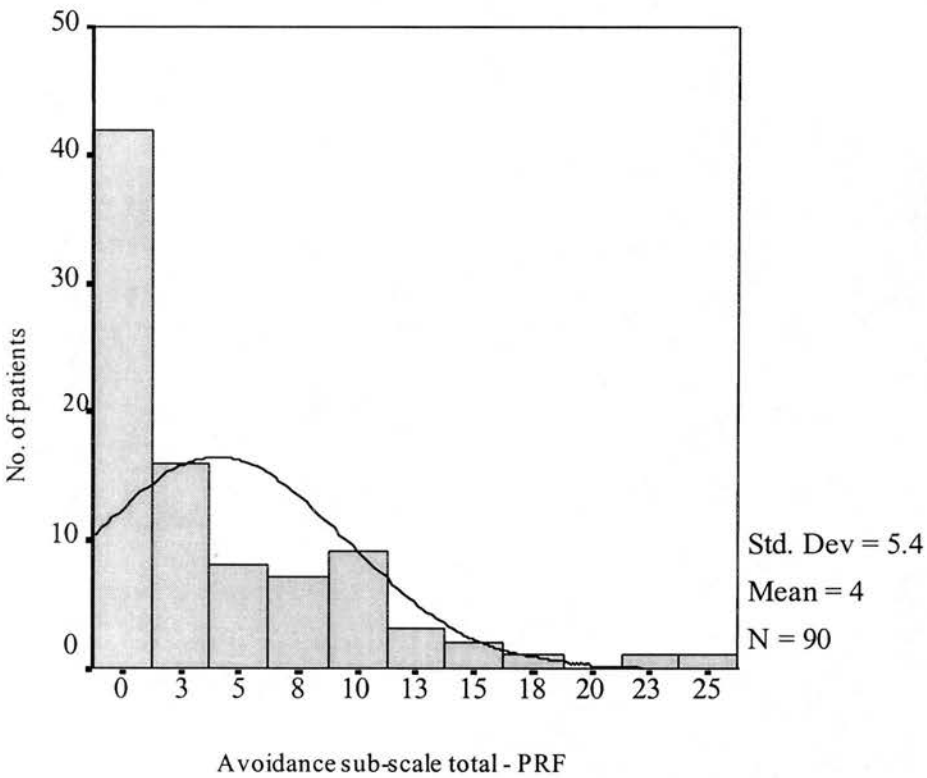
Figure 3.3-4: Rescue sub-scale scores on PRF for the total patient population (N=90)



c) Avoidance

Figure 3.3-5 illustrates the total patient population (N=90) avoidance sub-scale scores for the PRF. There is a positive skew (skewness=1.90, SE=0.26) and high level of kurtosis (kurtosis=3.93, SE=0.51). The Kolmogorov-Smirnov value shows significant deviance from the norm ($z=0.252$, $df=88$, $p<0.001$) so this data was transformed using the logarithmic transformation before parametric analysis ($\log(x+1)$).

Figure 3.3-5: Avoidance sub-scale scores on PRF for the total patient population (N=90)



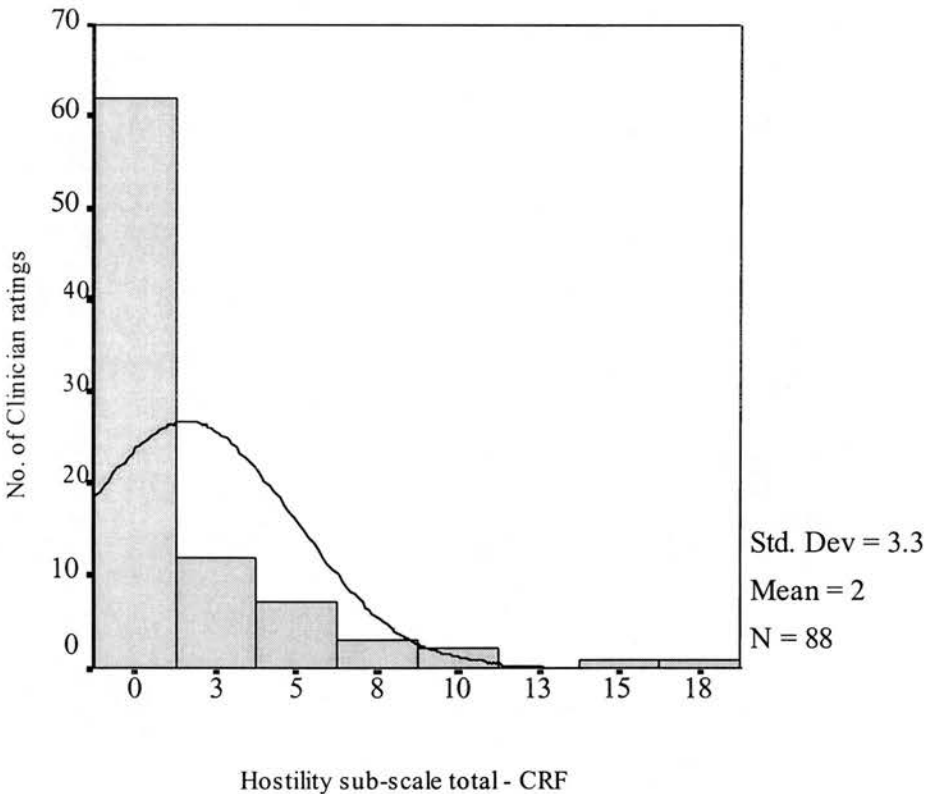
3.3.3 Countertransference

This section looks at the separate sub-scales of the countertransference measure, the Clinician Response File (CRF). The distribution of the scores for each sub-scale was plotted for the total Clinician population (the ratings of the psychiatrists and psychologists) (N=88).

a) Hostility

The total clinician population scores from the hostility sub-scale of the CRF are shown in Figure 3.3-6. The data shows a positive skew (skewness=2.86, SE=0.26) and a high level of kurtosis (kurtosis=9.38, SE=0.51). The Kolmogorov-Smirnov test reveals a significant deviation from normality ($z=0.35$, $df=88$, $p<0.001$). This indicates that this data requires transformation before parametric statistics can be conducted. The data was again transformed using a logarithmic transformation. As with the PRF there were a high number of zero scores so the data was transformed using the logarithmic of $x+1$.

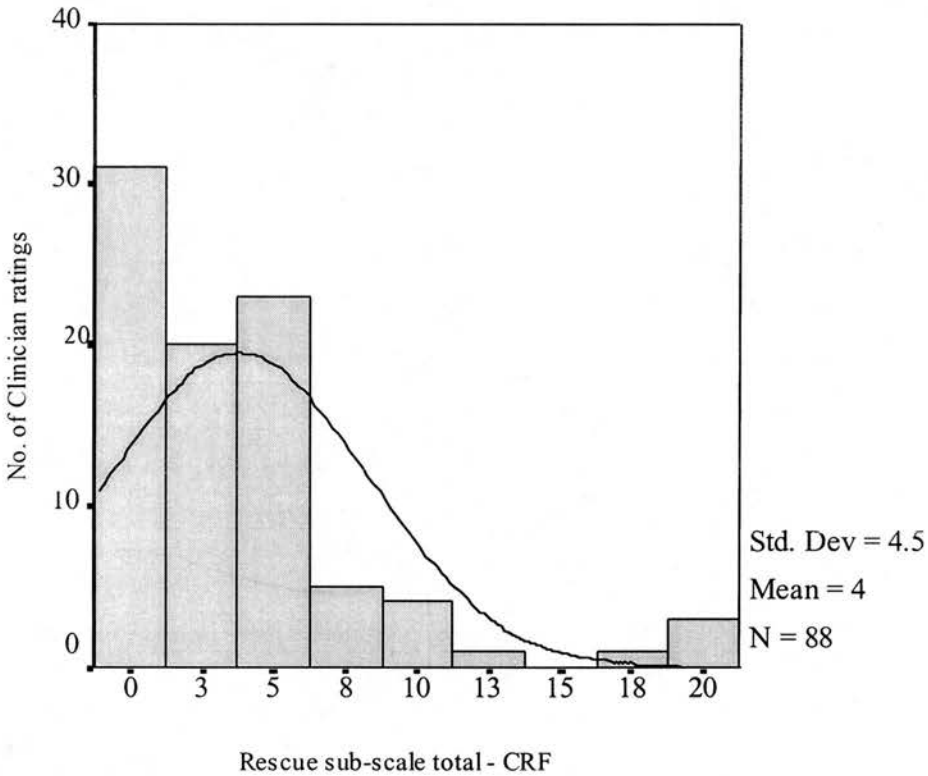
Figure 3.3-6: Hostility sub-scale scores on the CRF for the total clinician population (N=88)



b) Rescue

Figure 3.3-7 shows the rescue sub-scale scores of the CRF for the total Clinician population. There is a positive skew (skewness=2.07, SE=0.26) and high level of kurtosis (kurtosis=4.75, SE=0.51). The Kolmogorov-Smirnov test demonstrates a significant departure of normality ($z=0.20$, $df=88$, $p<0.001$). This data also required transforming to normalise distribution before using parametric statistics, and again a logarithmic transformation was used ($\log(x+1)$).

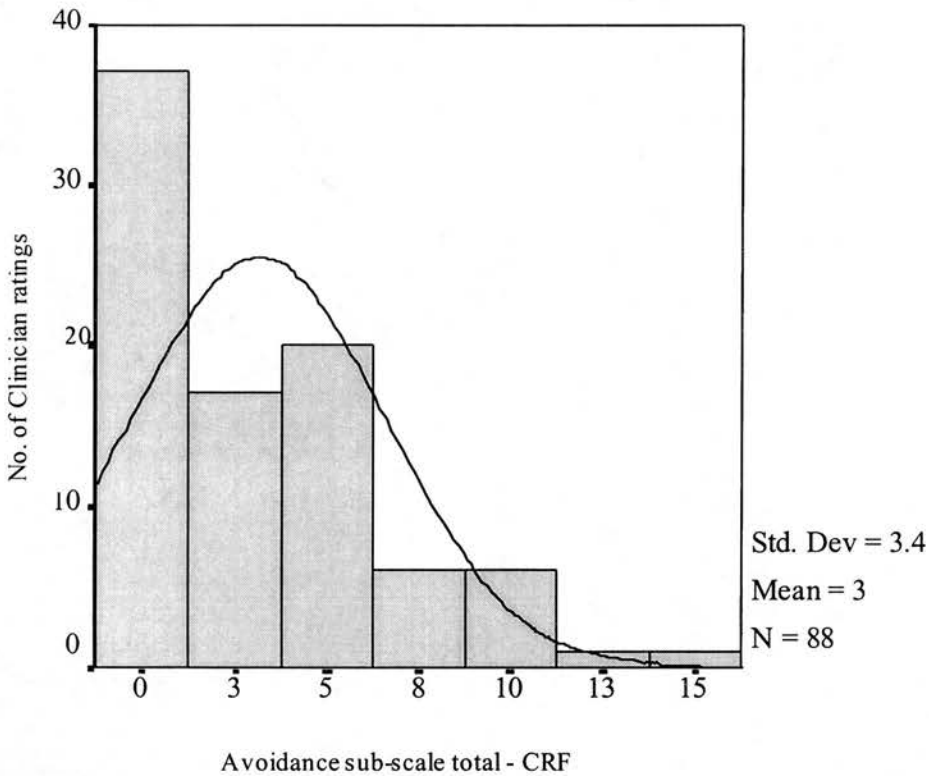
Figure 3.3-7: Rescue sub-scale scores on the CRF for the total Clinician population (N=88)



c) Avoidance

Figure 3.3-8 shows the avoidance sub-scale scores of the CRF for the total clinician population. There is a positive skew (skewness=1.20, SE=0.26) and high level of kurtosis (kurtosis=1.39, SE=0.51). The Kolmogorov-Smirnov value shows significant deviance from the norm ($z=0.20$, $df=88$, $p<0.001$) so this data was transformed using the logarithmic transformation ($\log(x+1)$) before parametric analysis.

Figure 3.3-8: Avoidance sub-scale scores on the CRF for the total Clinician population (N=88)

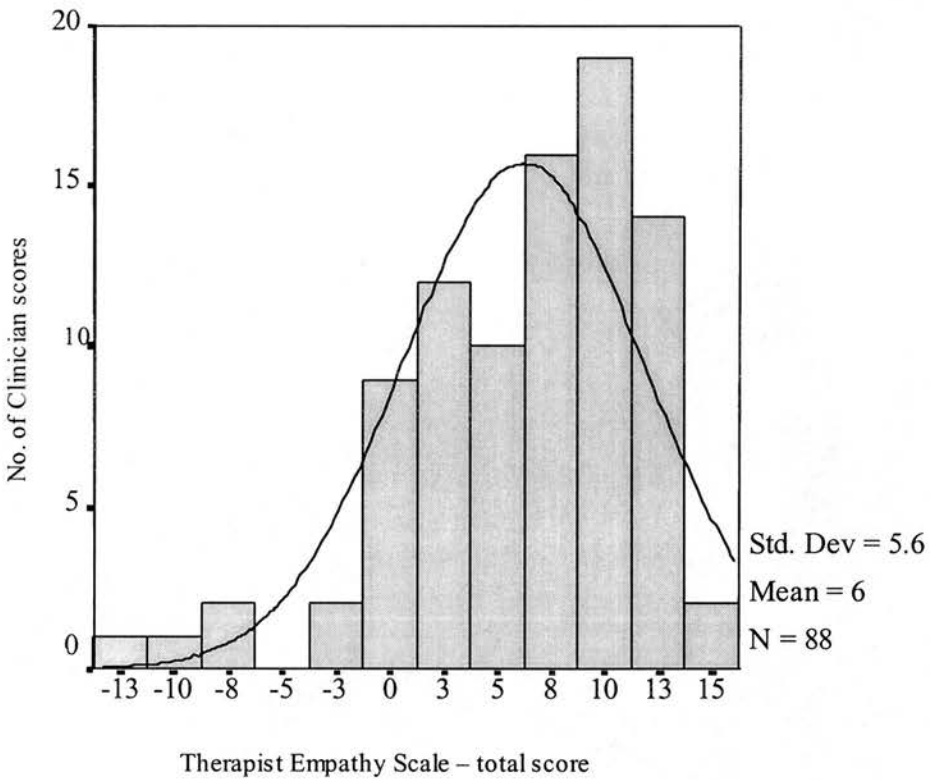


3.3.4 Empathy

a) Therapist empathy (Therapist Empathy Scale, TES)

Figure 3.3-9 shows total therapist empathy scores across the total clinician population (i.e. scores from the therapist empathy scale for both the psychiatrists and psychologists). Although there is evidence of a negative skew (skewness=-1.06, SE=0.25) and some kurtosis (kurtosis=1.13, SE=0.51) it was not severe enough to necessitate transformation.

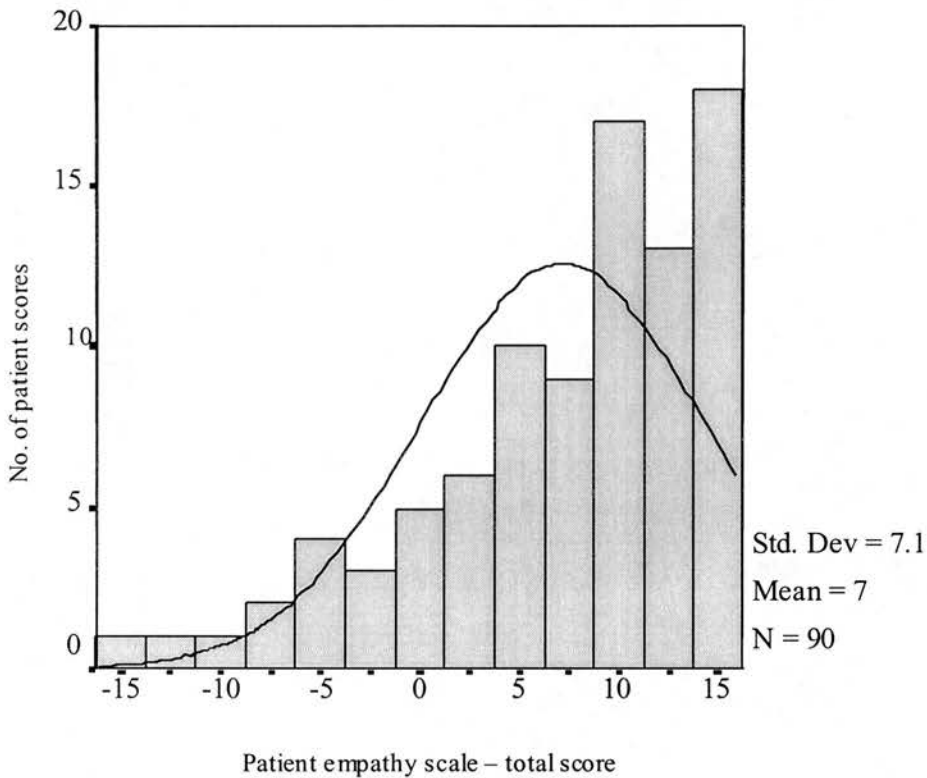
Figure 3.3-9: Total therapist empathy scores for the total clinician population (N=88).



b) Patient empathy (Patient Empathy Scale, PES)

Figure 3.3-10 shows total patient empathy scores across the total patient population (i.e. scores from the patient empathy scale for the Experimental and Comparison Group combined). Again there is some negative skew (skewness=-1.02, SE=0.26) and some kurtosis (kurtosis=1.13, SE=0.51) but as with the TES this data did not require transformation.

Figure 3.3-10: Total patient empathy scores for the total patient population (N=90)



3.4 Differences between the Experimental and Comparison Groups

3.4.1 Personality

Table 3.4-1 contains the results from the personality measures for the two groups. In order to test the hypothesis that the Experimental Group is at least as disturbed as the Comparison Group, an analysis of covariance was performed on the data from the PDQ4-total (Hyer, 1994) with age and employment status as the covariates. There were no significant differences between the groups ($F(1,84)=0.268$, $p=0.606$) and therefore this hypothesis was supported.

Data from the PDQ4 sub-scales was also analysed using an analysis of covariance with age and employment status as covariates. There were significant differences between the two groups for the borderline scale ($F(1,84)=7.95$, $p=0.006$) and the antisocial scale ($F(1,84)=5.36$, $p=0.023$), with the Experimental Group having more individuals with borderline and antisocial personality disorder. There were no other significant differences between the groups on the other sub-scales.

An analysis of covariance was performed on the data from the PSQ (Broadbent et al., 2000) with age as the covariate. There was a significant difference between the two groups ($F(1,83)=6.00$, $p=0.016$), with the members of the Experimental Group showing lower levels of personality integration when compared to the Comparison Group. When employment status was also added as a covariate the significant difference between the two groups disappeared ($F(1,82)=3.104$, $p=0.82$). This suggests that the differences between the Experimental and Comparison Group for personality integration are attributable to employment differences. Individuals who are unemployed have less personality integration than individuals in work. This data does not describe the direction of this relationship i.e. whether the personality disintegration results in lack of employment or whether lack of employment results in personality integration.

Table 3.4-1: Comparison of scores on personality tests between the two groups (significant differences in bold)

	Experimental Group (N=56)		Comparison Group (N=30)	
	Mean	SD	Mean	SD
PDQ4 – Total	34.17	13.12	31.23	14.23
PDQ4 – Borderline	5.76	2.24	4.07	2.29
PDQ4 – Narcissistic	2.43	1.72	2.70	1.66
PDQ4 – Schizotypal	3.66	2.26	3.77	2.58
PDQ4 – Dependent	3.19	2.31	2.67	2.26
PDQ4 – Histrionic	2.40	1.53	2.23	1.36
PDQ4 – Antisocial	2.52	1.90	1.30	1.53
PDQ4 – Obsessive compulsive	3.28	1.63	4.17	1.86
PDQ4 – Schizoid	2.76	1.84	2.80	1.52
PSQ	28.68	6.47	24.20	6.47

3.4.2 Transference

Table 3.4-2 shows the hostility, rescue and avoidance sub-scale scores of the PRF of the two groups.

Table 3.4-2: Hostility, rescue and avoidance sub-scale scores for the PRF for the two groups

	Experimental Group (N=60)		Comparison Group (N=30)	
	Mean	SD	Mean	SD
Hostility	6.28	8.94	3.27	3.91
Rescue	8.83	6.58	9.67	6.61
Avoidance	5.37	5.90	1.47	3.12

An analysis of covariance was performed on each sub-scale, with age and employment status as covariates. There were no significant differences between the two groups for hostility ($F(1,86)=0.054$, $p=0.82$), or rescue ($F(1,86)=1.02$, $p=0.32$). However, there was a significant difference between the two groups for avoidance with age and employment as covariates

($F(1,86)=8.05, p=0.006$). The Experimental Group had significantly higher scores on the avoidance sub-scale than did the Comparison Group.

3.4.3 Countertransference

Table 3.4-3 shows the mean values for hostility, rescue and avoidance as rated by clinicians (sub-scales of the CRF).

Table 3.4-3: Hostility, rescue and avoidance sub-scale scores for the CRF for the two groups

	Experimental Group (N=60)		Comparison Group (N=30)	
	Mean	SD	Mean	SD
Hostility	1.59	3.34	1.70	3.26
Rescue	4.10	5.05	3.17	3.10
Avoidance	3.41	3.69	2.67	2

An analysis of covariance was performed on each sub-scale, with age and employment status as covariates. There were no significant differences between the two groups for hostility ($F(1,84)=0.969, p=0.33$), rescue ($F(1,84)=0.093, p=0.76$) or avoidance ($F(1,84)=0.00, p=0.99$) with age and employment as covariates.

3.4.4 Empathy

Table 3.4-4 shows the values for the Therapist Empathy Scale (TES) and the Patient Empathy Scale (PES) between the Experimental and Comparison Groups.

Table 3.4-4: TES and PES scores between the two groups

	Experimental Group N=58		Comparison Group N=30	
	Mean	SD	Mean	SD
Therapist empathy, TES score	4.72	5.98	8.97	3.32
Patient empathy, PES score	5.45	7.71	10.67	4.08

An analysis of variance was performed on the empathy data. There were significant differences between the means of two groups on the TES when age and employment status were covariates ($F(1,84)=7.50, p=0.008$), with the therapists reporting feeling more empathic with the Comparison Group than with the Experimental Group. This remained significant when personality disorder was controlled for and introduced as a covariate. This group difference remained significant with age, employment status and borderline personality disorder (PDQ4-B) as covariates ($F(1,86)=6.06, p=0.016$). This was also the case when personality disintegration (PSQ) was controlled for ($F(1,79)=6.09, p=0.016$). This indicates that the significant difference in therapist empathy between the Experimental and Comparison Groups is not attributable to personality disorder or personality disintegration which is more prevalent in the Experimental Group.

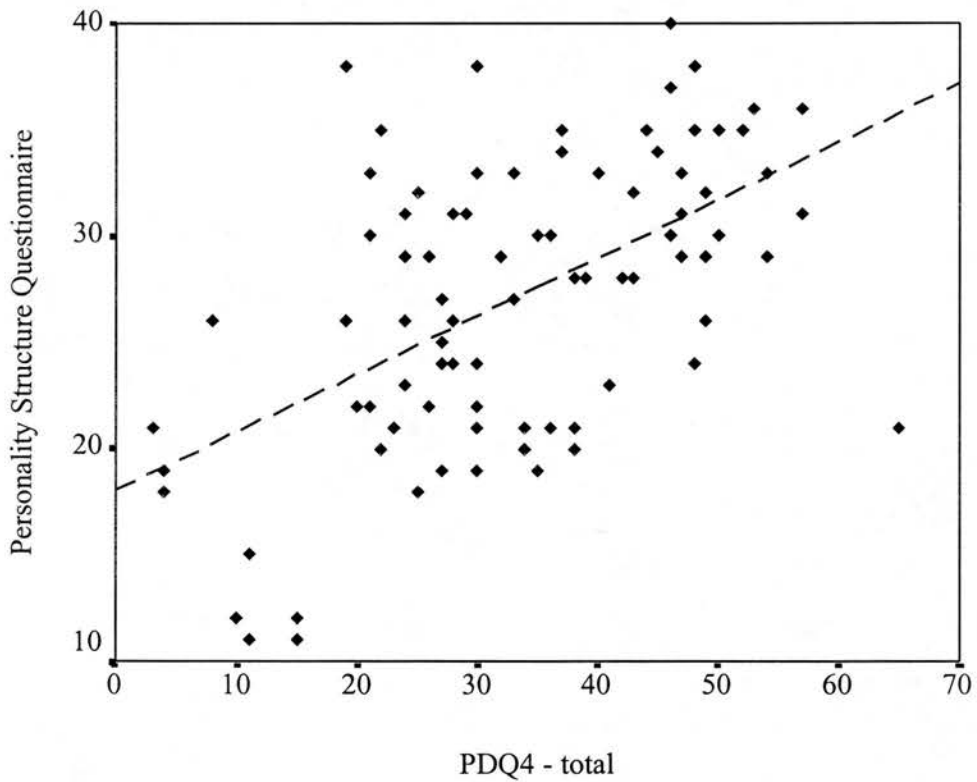
Using the same technique “patient empathy” (the ratings on the PES i.e. how empathic the patients believed the clinician was) was also found to be significantly different between the two groups when age and employment status were covariates ($F(1,86)=6.44, p=0.013$). The Experimental Group had a significantly lower mean PES score. This difference remained when personality disorder was controlled for (PDQ4-B) as a covariate ($F(1,83)=4.44, p=0.038$). It also remained when personality integration (as measured by the PSQ) was controlled for ($F(1,81)=4.99, p=0.028$). This indicates that the lower levels of patient empathy in the Experimental Group were not attributable to higher levels of personality disorder or lower levels of personality integration.

3.5 Correlations across the total sample

3.5.1 Personality measures

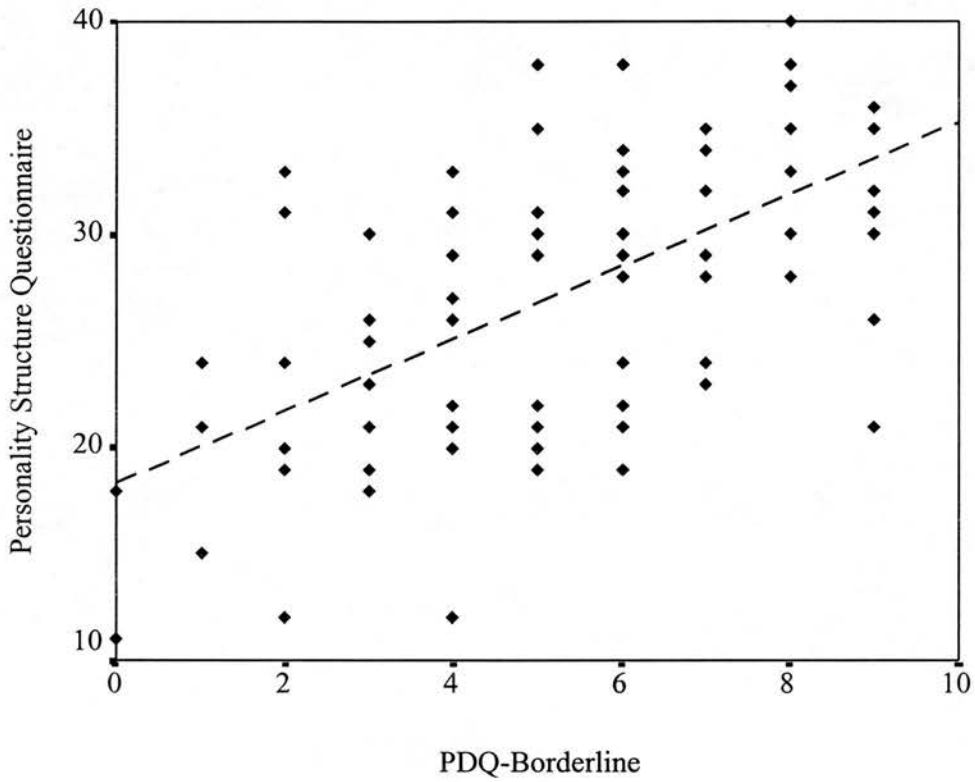
A Pearson correlation was carried out to establish the association between the two personality measures, the PDQ4-total and the PSQ. A significant positive correlation was found ($r=0.545$, $p<0.001$; 1-tailed, $N=86$). The correlation is represented graphically in Graph 3.5-1.

Graph 3.5-1: Correlation between PDQ-total and the PSQ



A Pearson correlation was also used to establish the relationship between the PDQ-borderline and the PSQ. There was a significant relationship between the two ($r=0.598$, $p<0.001$; 1-tailed, $N=86$). This is depicted in Graph 3.5-2.

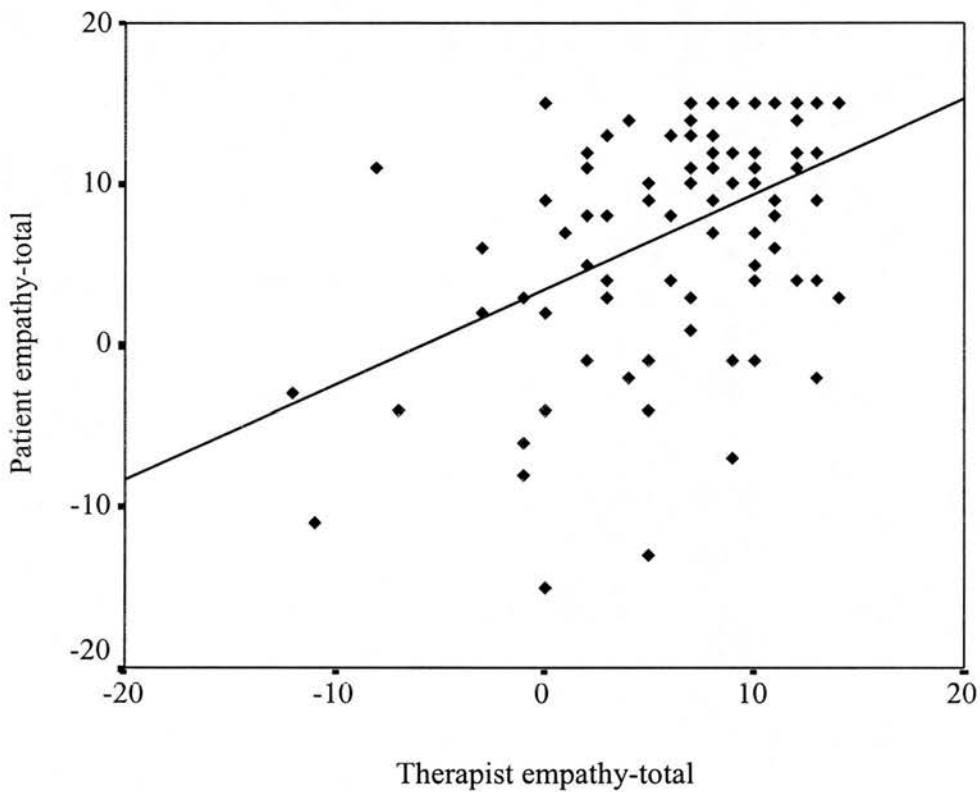
Graph 3.5-2: Correlation between the PDQ-borderline and the PSQ.



3.5.2 Empathy

A Pearson correlation was used to establish the presence and significance of the relationship between patient and therapist empathy (i.e. PES and TES scores) across the two groups. A significant positive relationship was found between patient and therapist empathy, ($r=0.458$, $p<0.001$; 1-tailed, $N=88$). This is shown in Graph 3.5-3.

Graph 3.5-3: Correlation between patient empathy and therapist empathy

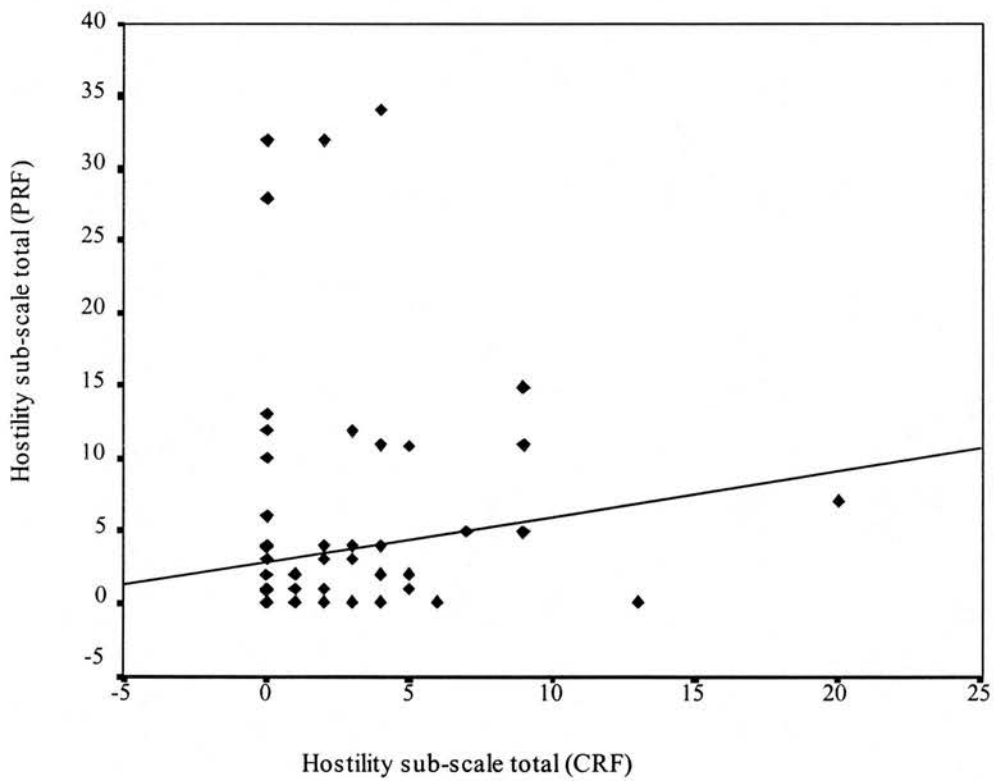


3.5.3 Transference / Countertransference

a) Hostility

A Pearson correlation was used to explore the relationship between ratings on the hostility sub-scales of the PRF and CRF. This was found to be significant ($r=0.309$, $p=0.002$; 1-tailed, $N=88$) and is shown in Graph 3.5-4.

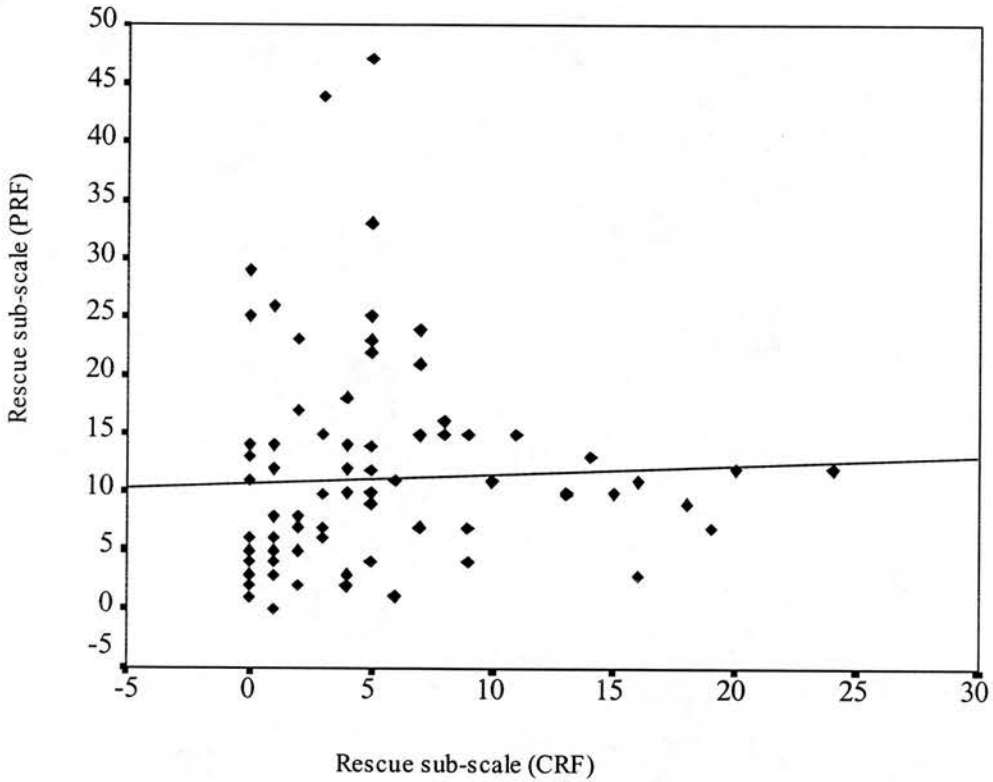
Graph 3.5-4: Correlation between patient and therapist hostility sub-scale scores across the two groups



b) Rescue

A Pearson correlation was used to explore the relationship between the ratings on the rescue sub-scales of the PRF and CRF. This was found to be significant ($r=0.182$ $p=0.044$, 1-tailed, $N=88$). It is represented in Graph 3.5-5.

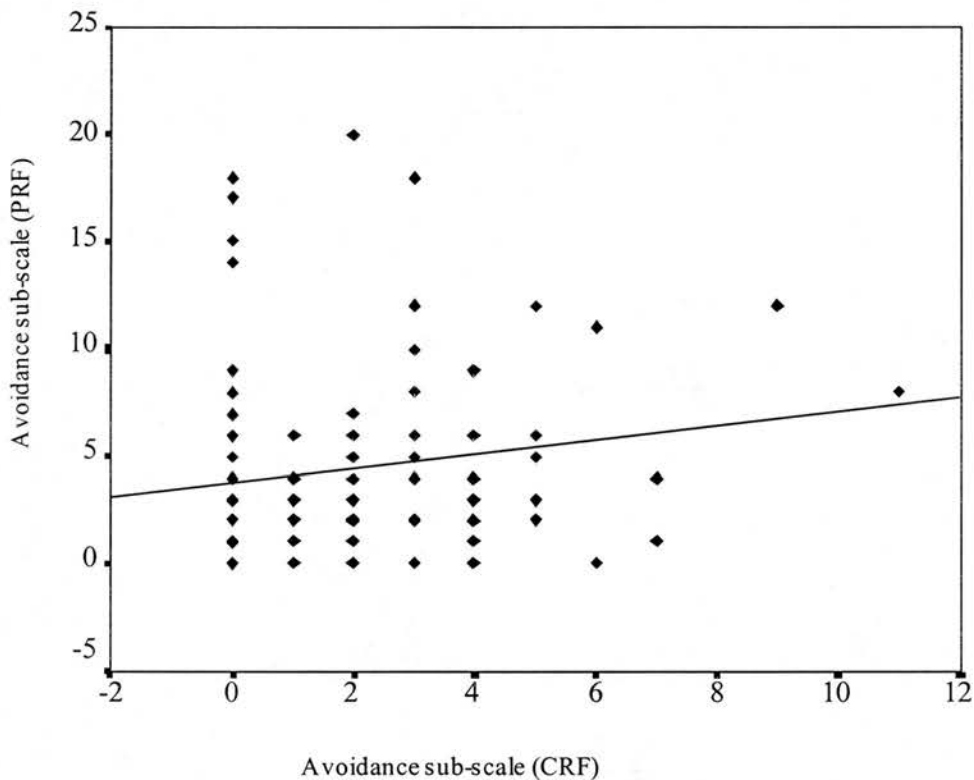
Graph 3.5-5: Correlation between patient and therapist rescue sub scale scores across the two groups



c) Avoidance

A Pearson correlation was used to explore the relationship between the ratings on the rescue sub-scales of the PRF and CRF. This was not found to be significant ($r=0.030$, $p=0.391$; 1-tailed, $N=88$). It is shown in Graph 3.5-6.

Graph 3.5-6: Correlation between patient and therapist avoidance sub-scores across the two groups



3.5.4 Personality and transference

Pearson correlations were used to investigate the relationship between the PRF sub-scale scores and the scores on the PDQ and PSQ.

Hostility – A significant relationship was found between “patient hostility” (i.e. scores on the hostility sub-scale of the PRF) and personality disturbance as measured by the PDQ4-

total, ($r=0.468$, $p<0.001$; 1-tailed, $N=88$), the PDQ4-borderline ($r=0.523$, $p<0.001$; 1-tailed, $N=88$) and the PSQ ($r=0.293$, $p=0.003$; 1-tailed, $N=86$).

Rescue – A significant positive relationship was present between “patient rescue” (i.e. scores on the rescue sub-scale of the PRF) and personality disturbance using the PDQ4-total ($r=0.482$, $p<0.001$; 1-tailed, $N=88$) and PDQ4-Borderline ($r=0.342$, $p=0.001$; $N=88$). However the correlation between “patient rescue” and the personality integration (PSQ) just failed to reach significance ($r=0.177$, $p=0.052$; 1-tailed, $N=86$).

Avoidance - A significant relationship was found between “patient avoidance” (i.e. scores on the avoidance sub-scale of the PRF) and personality disturbance as measured by the PDQ4-total ($r=0.450$, $p<0.001$; 1-tailed, $N=88$), PDQ4-Borderline ($r=0.504$, $p<0.001$, $N=88$) and the PSQ ($r=0.321$, $p=0.001$; 1-tailed, $N=86$).

3.5.5 Personality and countertransference

Pearson correlations were used to investigate the relationship between the transference (sub-scales of the PRF) and countertransference (sub-scales of the CRF) responses and the scores on the PDQ and PSQ.

Hostility – No significant relationships were found between “clinician hostility” (hostility sub-scale of the CRF) and personality disturbance as measured by the PDQ4-total, ($r=0.110$, $p=0.156$; 1-tailed, $N=86$), PDQ4-borderline ($r=0.104$, $p=0.171$; 1-tailed, $N=86$) and the PSQ ($r=0.169$, $p=0.062$; 1-tailed, $N=84$).

Rescue – No significant relationship was found between “clinician rescue” (i.e. scores on the rescue sub-scale of the CRF) and patient personality disturbance using the PDQ4-total ($r=0.156$, $p=0.076$; 1-tailed, $N=86$), PDQ4-Borderline ($r=0.098$, $p=0.186$; $N=86$) and the PSQ ($r=0.029$, $p=0.398$; 1-tailed, $N=84$).

Avoidance - A significant relationship was found between clinician rated avoidance (i.e. scores on the avoidance sub-scale of the CRF) and personality disturbance as measured by the PDQ4-total ($r=0.224$, $p=0.019$; 1-tailed, $N=86$). Correlations between “clinician avoidance” and patient personality disturbance as measured by the PDQ4-Borderline ($r=0.157$, $p=0.074$, $N=86$) and the PSQ ($r=0.160$, $p=0.073$; 1-tailed, $N=84$) approached significance.

3.5.6 Personality and empathy

A Pearson correlation was used to establish the relationship between patient personality disturbance and empathy. There were significant negative correlations between personality disorder (as measured by the PDQ4-total) and therapist empathy (as measured by the TES) ($r=-0.314$, $p=0.002$; 1-tailed, $N=88$) and patient empathy (as measured by the PES) ($r=-0.367$, $p<0.001$; 1-tailed, $N=88$). There were also significant correlations between the borderline personality disorder (sub-scale of the PDQ4) and therapist empathy ($r=-0.392$, $p<0.001$; 1-tailed, $N=86$) and patient empathy ($r=-0.335$, $p=0.001$; 1-tailed, $N=86$). This significant relationship between empathy and personality disturbance was repeated when the personality integration (PSQ) was correlated with therapist empathy ($r=-0.288$, $p=0.004$; 1-tailed, $N=84$) and patient empathy ($r=-0.315$, $p=0.002$; 1-tailed, $N=86$).

3.5.7 Transference and empathy

The sub-scales of the PRF (hostility, rescue and avoidance) were correlated with patient empathy scores (as measured by the Patient Empathy Scale, PES) to investigate the relationship between transference and how empathic the patient perceived the clinician to be. These analyses were conducted across the total patient population (both the Experimental and Comparison Groups) using Pearson Correlations.

Hostility and patient empathy – There was a significant negative relationship ($r=-0.639$, $p<0.001$; 1-tailed, $N=90$), i.e. higher scores on the hostility sub-scale of the PRF were correlated with lower scores on the PES.

Rescue and patient empathy – There was no significant correlation between scores on the rescue sub-scale of the PRF and scores on the PES ($r=-0.14$, $p=0.141$; 1-tailed, $N=90$).

Avoidance and patient empathy – There was a significant negative correlation i.e. higher scores on the avoidance sub-scale of the PRF were associated with lower scores on the PES ($r=-0.672$, $p<0.001$; 1-tailed, $N=90$).

3.5.8 Countertransference and empathy

Correlations were carried out to investigate the relationship between therapist countertransference (CRF) and empathy (as measured by the Therapist Empathy Scale, TES). Pearson correlations were used.

Hostility and therapist empathy – There was a significant negative correlation, ($r=-0.490$, $p<0.001$; 1-tailed, $N=88$) i.e. higher scores on the CRF were associated with lower scores on the TES.

Rescue and therapist empathy – No significant relationships were found between scores on the rescue sub-scale of the CRF and TES ($r=-0.049$, $p=0.324$; 1-tailed, $N=88$).

Avoidance and therapist empathy – A significant negative correlation was found ($r=-0.477$, $p<0.001$; 1-tailed, $N=88$) i.e. higher scores on the avoidance sub-scale of the CRF were associated with lower scores on the TES.

3.6 Differences between individuals with and without a history of deliberate self-harm

To analyse the data further, the total patient population (Experimental and Comparison Groups) was split into groups according to whether individuals had any previous history of deliberate self-harm. Since there were only five people in the Comparison Group with a history of DSH, these people were excluded because their numbers were too low to provide any meaningful information. Table 3.6-1 illustrates the numbers in, and the mean ages of, each sub-group.

Table 3.6-1: Age and composition of groups according to DSH history

Group	N	Mean age	SD
No DSH + no history	25	42.32	10.72
DSH + no history	30	32.23	9.81
DSH + history DSH	30	34.93	11.25
Total	85		

An analysis of variance was completed to see whether there was a significant age difference between the three groups; this was found to be significant ($F(1,82)=6.477$, $p=0.002$). The mean ages of the DSH groups (with and without a history of DSH) were significantly younger than those for the group who had never self-harmed. It was therefore necessary to control for age differences between the groups in further analyses.

Table 3.6-2 shows the sex composition between the three groups. A Chi-square test was used to establish whether there were any significant differences between sexes in the three groups. There were no significant differences between the groups, ($\chi^2=2.75$, $df=2$, $p=0.410$, $N=85$).

Table 3.6-2: Distribution of sexes between the three groups.

Group	Males	Females	Total
No DSH + no history	7	18	25
DSH + no history	12	18	30
DSH + history DSH	15	15	30
Total	34	51	85

Table 3.6-3 shows the employment status of members in the three groups. The distribution of employment was analysed using a chi-square test; this was also found to be significant between the three groups ($\chi^2=10.12$, $df=2$, $p=0.006$, $N=85$). It was also therefore necessary to control for differences attributable to differences in employment status in later analyses.

Table 3.6-3: Employment status across the three groups.

Group	Unemployed	Employed	Total
No DSH + no history	9	16	25
DSH + no history	14	16	30
DSH + history DSH	23	7	30
Total	46	39	85

Table 3.6-4 shows the mean values for the measures across the three groups.

Table 3.6-4: Summary values for the three groups

	GROUP 1 No DSH + no history (N=25)		GROUP 2 DSH + no history (N=29)		GROUP 3 DSH + history DSH (N=27)	
	Mean	SD	Mean	SD	Mean	SD
PDQ4-total	30.04	14.71	31.00	14.38	37.34	11.07
PDQ4-borderline	3.76	2.24	5.24	2.59	6.28	1.73
PSQ	23.56	6.76	27.17	7.03	30.30	5.48
Patient hostility (PRF)	2.84	3.77	3.10	4.07	9.47	11.18
Clinician hostility (CRF)	1.72	3.42	0.86	2.42	2.31	3.97
Patient avoidance (PRF)	1.60	3.37	3.80	4.68	6.93	6.62
Clinician avoidance (CRF)	2.40	2.83	3.14	3.84	3.69	3.58
Patient rescue (PRF)	9.52	6.58	7.80	7.36	9.87	5.64
Clinician rescue (CRF)	2.72	2.94	4.79	6.10	3.41	3.69
Therapist empathy	8.92	3.26	7.10	4.53	2.34	6.37
Patient empathy	10.92	4.36	8.10	5.65	2.80	8.62

3.6.1 Personality measures

Analyses were carried out to assess whether there were differences between the three groups in terms of personality disorder. An analysis of covariance was performed on the data from the PDQ4-total (Hyler 1994) with age and employment status as covariates. There were no significant differences between the three groups ($F(2,78)=0.98$, $p=0.379$). There were however significant differences between the groups on the PDQ-borderline using age and employment as covariates ($F(2,78)=3.57$, $p=0.033$). There were also significant differences between the three groups in terms of personality integration (PSQ) with age and employment as covariates ($F(2,76)=3.11$, $p=0.05$). Planned orthogonal contrasts showed that the effects

were due to significant differences between Group One (no DSH and no history of DSH) and Group Three (DSH and a history of DSH). Other contrasts were not significant.

3.6.2 Transference

Hostility – An analysis of covariance with age and employment status as covariates was used to determine whether there were significant differences between the groups in terms of their ratings on the hostility sub-scale of the PRF. Significant differences were present, with Group Three (DSH and a history of DSH) having the highest hostility transference ($F(2,80)=5.08, p=0.008$). Planned orthogonal contrasts identified significant differences between Group One and Group Three, with Group One (no DSH) having a significantly lower hostility rating than that for Group Three (DSH and history of DSH).

Rescue – There were no significant differences between the groups in terms of their ratings on the rescue sub-scale of the PRF. This was determined by an analysis of covariance, using age and employment status as covariates ($F(2,80)=1.80, p=0.171$).

Avoidance – An analysis of covariance with age and employment as covariates established significant differences between the groups on the avoidance sub-scale of the PRF ($F(2,80)=5.08, p=0.008$). A planned orthogonal contrast identified a significant difference between Group One (no DSH) and Group Three (DSH and history of DSH) where Group One had significantly less avoidance transference than Group Three.

3.6.3 Countertransference

Hostility – An analysis of covariance with age and employment status as covariates was used to determine whether there were significant differences between the groups in terms of clinicians' ratings on the hostility sub-scale of the CRF. There were no significant differences ($F(2,78)=2.27, p=0.110$).

Rescue – There were no significant differences between the groups regarding clinicians' ratings on the rescue sub-scale of the CRF. This was determined by an analysis of covariance, using age and employment status as covariates ($F(2,78)=1.003$, $p=0.997$).

Avoidance – An analysis of covariance with age and employment as covariates found no significant differences between the groups in terms of their ratings on the avoidance sub-scale of the CRF ($F(2,78)=0.298$, $p=0.743$).

3.6.4 Empathy

An analysis of covariance with age and employment as covariates found significant differences between the three groups in terms of therapist empathy (as measured by the Therapist Empathy Scale, TES) ($F(2,78)=8.18$, $p=0.001$). A planned orthogonal contrast identified a significant difference between Group One (no DSH) and Group Three (DSH and history of DSH). Therapist empathy was significantly greater in Group One compared with Group Three. There were significant differences between the three groups even when personality disturbance was controlled for; an analysis of covariance with age, employment status and PDQ-borderline as covariates remained significant ($F(2,75)=5.97$, $p=0.004$). Likewise, group differences of therapist empathy remained when personality disturbance using the PSQ was controlled for ($F(2,73)=6.10$, $p=0.004$).

There were also significant differences in patient empathy (as measured by the Patient Empathy Scale) between the groups with age and employment status as covariates ($F(2,80)=7.09$, $p=0.001$). A planned orthogonal contrast identified significant differences between Group One and Group Three, with higher patient empathy scores for the group without DSH compared to the group with DSH and a history of DSH. When personality disturbance (measured by the PDQ-borderline) was controlled for (age, employment and PSQ-borderline as covariates) differences in patient empathy remained ($F(2,77)=4.83$,

p=0.01). This was also the case for the PSQ; patient empathy remained significantly different across the three groups when age, employment and the PSQ were covariates ($F(2,75)=5.56$, $p=0.006$).

3.7 Results from the Deliberate Drug Overdose Questionnaire

A total of 34 professionals completed the Deliberate Drug Overdose Questionnaire (Sidney & Renton, 1996). Basic demographics of this sample are depicted in Table 3.7-1.

Table 3.7-1: Demographics of professionals who completed the questionnaire

	Total	Male	Female	Not reported	Doctors	Nurses	Other
Psychiatry	9	4	5		9	0	
Medical ward staff	13	3	10		2	8	3
A&E	12	2	9	1	6	6	

Results from the attitude questionnaire are shown in Table 3.7-2. Since numbers were relatively low, data from medical ward staff and A&E staff were merged to form a medical staff group to compare with the psychiatry staff group.

Table 3.7-2: Results from the attitude questionnaire

	Subject		Psychiatry	Medical
Q1	Patients who take deliberate drug overdoses (DDO) are more at risk of completing suicide in the future	Agree	9	20
		Disagree	0	5
Q2	Patients who kill themselves rarely mention their intention to anyone	Agree	3	14
		Disagree	6	8
Q3	Patients who survive a DDO cannot be serious about killing themselves otherwise they would have used more lethal means	Agree	0	4
		Disagree	9	21
Q4	The taking of a DDO is a display of attention seeking behaviour	Agree	7	12
		Disagree	1	12
Q5	Patients who take DDO should be considered less of a priority when working on a busy medical ward	Agree	1	1
		Disagree	8	21
Q6	Patients who take DDO have equal right to expensive medical treatment	Agree	8	19
		Disagree	0	2
Q7	A lot of my colleagues dislike working with patients who take DDO	Agree	9	18
		Disagree	0	6
Q8	Working with patients who take DDO is frustrating	Agree	8	16
		Disagree	1	8
Q9	Working with patients who take DDO is rewarding	Agree	2	3
		Disagree	7	19
Q10	Working with patients who take DDO makes me feel uncomfortable	Agree	0	6
		Disagree	9	19
Q11	Working with patients who take DDO makes me feel depressed	Agree	2	1
		Disagree	7	23
Q12	Current services for patients who take DDO are inadequate	Agree	4	11
		Disagree	5	8
Q13	Training for nursing staff regarding the non-medical management of patients who take DDO is inadequate	Agree	3	18
SIG		Disagree	6	6
Q14	I believe I have adequate skills in dealing with the non-medical aspects of care for patients who DDO	Agree	7	6
SIG		Disagree	2	19
Q15	Support should be routinely offered to nursing staff who work with patients who take DDO	Agree	7	21
		Disagree	2	2

The questions from the attitude questionnaire can be classified under four categories. Each of these will be discussed.

(i) Knowledge about DSH

Eighty five percent of all respondents recognised that these patients are at greater risk of completing suicide in the future. Eighty eight percent appropriately rejected the view that survivors can not be serious about killing themselves or they would have used more lethal means. More worryingly, 62% of staff believed that patients who kill themselves rarely mention their intention to anyone, suggesting that a patient's threat of suicide or DSH may not always be taken seriously. Nine of the 12 (75%) nurses who answered this question agreed while only 5 of the 15 (33%) doctors agreed. A chi-square analysis revealed a significance difference between the two professions ($\chi^2=4.64$, $df=1$, 2-tailed, $p=0.038$, $N=27$) demonstrating a better level of knowledge amongst the doctors than the nurses.

(ii) Attitudes to DSH

Attitudes towards DSH were generally positive. Ninety three percent disagreed with the statement that these patients should be considered less of a priority on busy medical wards and 93% endorsed the view that these patients have equal rights to expensive medical treatments. Fifty nine percent agreed that DSH is a display of attention seeking behaviour - a statement with clear negative connotations. These results are comparable to those of Sidney and Renton (1996).

(iii) Personal reactions to DSH

Eighty two percent of respondents agreed that their colleagues disliked working with this group, 73% reported finding the work frustrating. A higher proportion of doctors (86%) than of nurses (57%) reported that they found working with this patient group frustrating. This difference approached significance ($\chi^2=3.52$, $df=1$, 1-tailed, $p=0.071$, $N=30$). Eighty four percent disagreed with the statement that the work was rewarding. This suggests a negative

attitude to working with this patient group. However only 9% reported that they found working with this group depressing and only 8% reported feeling discomfort when working with this group.

(iv) Satisfaction with current services

Fifty four percent of respondents felt that current services for DSH patients are inadequate. Sixty two percent felt that they did not have the necessary skills to care adequately for this patient group and 64% felt that the training of nurses in the non-medical care of this patient group was insufficient. A chi-square was used to investigate whether there were significant differences between the two groups of staff (Psychiatric and Medical). Medical staff were more likely to feel that existing training for nurses to deal with this group was inadequate ($\chi^2=4.91$, $df=1$, 2-tailed, $p=0.036$, $N=33$), and to feel that they did not have adequate skills for this work ($\chi^2=8.10$, $df=1$, 2-tailed, $p=0.007$, $N=34$). When answers from the medical staff were considered alone, none of the doctors felt that they had adequate skills for dealing with the non-medical aspects of care for DSH patients while 42% of the nurses felt that they did have the necessary skills for this work. This difference approached, but just failed to reach, significance ($\chi^2=4.2$, $df=1$, 2-tailed, $p=0.055$, $N=21$). These results indicate that the medical staff group (particularly the doctors) felt significantly under-trained and lacking in the skills they deemed necessary to deal with this patient group, compared with psychiatry staff who felt more confident regarding their skills for this group.

A chi-square analysis revealed significantly more nurses than doctors reporting that they felt current training for nursing staff regarding the non-medical management of patients who take DDO is inadequate ($\chi^2=10.9$, $df=1$, 2-tailed, $p=0.001$, $N=29$).

Regarding staff support, 88% of staff agreed that support should be routinely offered to nursing staff who work with patients who DSH.

4 DISCUSSION

This chapter has an initial six sections discussing the results relating to the six listed aims of the study. These are followed by two sections summarising the findings and discussing their implications and possible future directions.

4.1 Development of the Clinician Response File (CRF) and Patient Response File (PRF)

The first aim of the study was to adapt a clinical tool (the Assessors Response File (Sheard et al., 2000)) to produce two new measures (the CRF and PRF) which could be used respectively to assess the intensity of hostility, rescue and avoidance within the countertransference / transference in a routine clinical interview. As indicated earlier in Chapter Two (Section 2.4), other measures of transference / countertransference did not seem suitable; they were often process oriented, time consuming and designed to investigate changes over the course of therapy rather than to look at events occurring during an assessment interview. As reported earlier Chapter Three (Section 3.1) steps were taken to establish the validity and reliability of the CRF and PRF. Hypotheses A1-A3 were concerned with using the data generated from using the measures with subjects to assess validity further. The steps taken to assess validity and reliability prior to the application of the measures will be briefly reviewed before the results relating to hypotheses A1-A3 are considered.

4.1.1 Preparatory assessment of reliability and validity

Since the tools were based on Cognitive Analytical Theory (Ryle, 1990) and particularly the work of Sheard et al. (2000) to establish the face validity of these measures, accredited CAT practitioners were asked to rate the potential questions for the PRF and CRF. Twenty-nine out of 150 (19%) CAT practitioners responded. Although this is a low response rate it is

close to the response rate of other mailed questionnaire based studies targeting psychologists (12% response rate) (Skinner & Baul, 1997) and general practitioners (36% response rate) (Murray, Caris, Ferguson, Kidd, & Sharp, 1999). Reasons for the low response rate may include the anonymity of a mailed request and the fact that the sample were clinicians often based in busy NHS hospitals with possibly little time for extra work. Nevertheless the low response rate reduces the strength of the results from this stage of the study.

CAT practitioners were chosen as the measures are based on CAT theory and there was a certain assumption that this group would have a good level of knowledge regarding CAT theory and practice. As this is only an assumption it can not be confirmed and people may have been without sufficient knowledge to perform this task adequately. Due to the low numbers of respondents and assumptions made as above, further validation exercises are recommended.

The results of this validation exercise involved the rejection of three items from the CRF and the PRF respectively, and the movement of items from one sub-scale to another in cases where they were considered to be measuring another theme. Consequently, sub-scales measuring hostility, rescue and avoidance were created for both the clinician CRF and the PRF. Although the response rate for the validation exercise was low (N=29) the data produced were considered to provide enough evidence to warrant the removal or movement of certain items between the sub-scales. Originally the ARF had been designed by a small research team purely for clinical purposes and its validity had not been previously established (Sheard et al. 2000). Although this was only a small step in establishing the validity of the measure, it was considered sufficient for the purposes of this pilot study.

Validation is done to assess the extent to which a measure measures what it purports to. CAT practitioners were asked to rate what theme they thought each item was measuring and changes were made on the basis of these results. Other validation procedures could have been used to report the content validity and construct validity of the measure. An exercise to

establish the content validity of the measure would have involved a comprehensive literature search on the concepts of hostility, rescue and avoidance, resulting in a comprehensive description of each theme (Carmines & Zeller, 1979). Items would then be constructed which reflect the meaning of each dimension. This is a difficult exercise when dealing with more abstract concepts such as avoidance. Further, there are no agreed criteria for determining the extent to which a measure has attained content validity (Carmines & Zeller, 1979). This exercise could not be completed since the measures devised were developed from an existing measure (the ARF devised by Sheard et al. (2000).) Construct validity is concerned with the extent a measure relates to other measures consistent with theoretically driven hypotheses. This was partly established through looking at the relationships of the CRF and PRF with measures of personality and the alliance of the relationship. These results will be discussed in Section 4.4.

To assess the reliability of the sub-scales, the consistency of the sub-scales (hostility, rescue and avoidance) within the measures (CRF and PRF) was assessed before and after the validation changes described above. Cronbach's alpha was used to assess the internal reliability of each sub-scale in the CRF and the PRF. The validation exercise resulted in an increase in the alpha values for the hostility sub-scale (CRF) (0.80 to 0.87) and avoidance sub-scale (CRF) (0.511 to 0.76). The avoidance scale improved reliability considerably due to the changes mentioned above. The alpha value for the rescue scale (CRF) reduced slightly (0.74 to 0.68) but remained sufficiently reliable for its inclusion. Changes to the PRF led to an increase in alpha score for the rescue sub-scale (0.77 to 0.83) and the avoidance sub-scale (PRF) (0.68 to 0.70). There was a slight drop in the alpha value for the hostility sub-scale (0.92 to 0.89) but this remained highly reliable. Other tests of reliability include the retest method, the alternative-form method and the split halves method (Carmines & Zeller, 1979). Due to the time limitations and nature of the study it was not possible to do these analyses. Further work using these measures would benefit from this exercise.

Prior to analysis results from the sub-scales of the PRF and CRF were plotted to show the pattern of their distribution (Figures 3.3-3 to 3.3-8). The data showed a high level of positive skew and kurtosis and hence the data were transformed. Following transformation some of the variables were still not normally distributed but because of the robustness of the tests parametric statistics were used in later analyses enabling age and employment status to be controlled for. Where possible results were confirmed by secondary non-parametric tests. The secondary non-parametric tests confirmed the results demonstrated by the parametric tests but for clarity are not reported.

4.1.2 Analysis of data generated by the use of the CRF and PRF to assess their validity.

Hypothesis A1: There will be a positive relationship between the measures of transference and counter-transference.

This hypothesis predicted the existence of a positive correlation between each theme for the measures of transference (PRF) and countertransference (CRF) i.e. client's ratings on the hostility, rescue and avoidance sub-scales of the PRF were expected to correlate with clinicians' ratings on the hostility, rescue and avoidance sub-scales of the CRF.

There were significant positive correlations between clinician and patient ratings for hostility (as measured by the hostility sub-scales of the CRF and PRF) and rescue (as measured by the rescue sub-scales of the CRF and PRF). For the avoidance sub-scale there was no significant relationship between the clinician and patient ratings. This may be partly attributable to a strong floor effect, particularly regarding the clinicians' ratings. Clinicians tended to choose conservatively low countertransference rating scores (often zero) particularly for the rescue and avoidance countertransference. This effect was also present in the patients' ratings but to a lesser degree. Thus the data would appear to offer some support of the hypothesis. There are good correlations between patient and clinician ratings for hostility and rescue.

Hypotheses A2 and A3 were concerned with investigating the relationships between hostility, rescue and avoidance with empathy.

Hypothesis A2: There will be a positive correlation between ratings of rescue and empathy.

This hypothesis predicted a positive correlation between rescue (as measured by the rescue sub-scales of the PRF and CRF) and the empathy measure (ES). The rescue theme refers to individuals seeking pain resolution through ideal care from another. It was expected that rescue reciprocal roles would correlate with increased empathy from the clinician in the interview.

Rescue transference and empathy: This was tested by correlating the rescue transference (as measured by the rescue sub-scale of the PRF) and patient empathy i.e. how empathic they considered clinicians to be (as measured by the PES). There was no significant relationship.

Rescue countertransference and empathy: This was tested by correlating the rescue countertransference (as measured by the rescue sub-scale of the CRF) and therapist empathy (as measured by the TES). As before there was no significant relationship. Thus this hypothesis was not supported.

The rescue theme was not significantly related to either patient or therapist empathy. This could be because rescue may have a more complex relationship with empathy. For some interactions, increased rescue transference could be associated with higher ratings of empathy reflecting an overly dependent patient-therapist alliance. In these cases rescue transference may encourage reciprocity. This would seem consistent with Powell's account, as mentioned in Chapter One (Section 1.5.3) of how idealisation may unwittingly be encouraged (Powell, 1991). Conversely, on other occasions, or for different clinicians, perhaps because the rescue theme is of a more demanding, insistent nature, a more intense rescue transference could lead to the clinician feeling less empathic. If these reactions exist they would cancel each other out and no relationship would be evident.

Hypothesis A3: There will be a negative correlation between ratings of avoidance and hostility with empathy.

Hostility transference and empathy: This hypothesis was tested by correlating hostility transference (as measured by the hostility sub-scale of the PRF) with patient empathy (as measured by the PES). There was a significant negative relationship. This demonstrates that increased hostility in the transference was associated with patients perceiving the clinician to be less empathic.

Hostility countertransference and empathy: This was tested by correlating hostility countertransference (as measured by the hostility sub-scale of the CRF) with the clinician empathy (as measured by the TES). As with the transference analysis, there was a significant negative relationship. Results were consistent between the patient and clinician populations with increased hostility transference and countertransference correlating with patients and clinicians rating the clinician as being less empathic. This finding is consistent with the findings of Hovarth (1994) as mentioned in Chapter One (Section 1.5.1). Hovarth (1994) looked at the impact of patient pre-treatment characteristics on the alliance. He found that patients with higher scores of hostility or defensiveness are more likely to form poorer alliances in therapy. Hougaard (1984) believed that the clinician should bring authenticity, warmth and empathy to the therapeutic relationship. When this is not present the alliance will suffer. The results of this study support these theories of alliance but fail to establish directly the direction of the relationship between hostile responses and reduced empathy.

Avoidance transference and empathy: Avoidance transference (as measured by the avoidance sub-scale of the PRF) was correlated with patient empathy (as measured by the PES). There was a significant negative relationship between the two. Increased avoidance transference was associated with patients rating the clinicians as being less empathic.

Avoidance countertransference and empathy: This was tested by correlating avoidance countertransference (as measured by the avoidance sub-scale of the CRF) and therapist

empathy (as measured by the TES). Once again there was a significant negative relationship between the two. Thus higher avoidance transference and countertransference were both associated with lower ratings on the Empathy Scales.

All four relationships were as predicted, thus supporting Hypothesis A3.

4.1.3 Summary of analyses of data generated

Exploratory analyses on data from the whole sample confirmed an expected correlation between the PRF and CRF for hostility and rescue but not for avoidance (although there was a trend in the predicted direction). The low ratings of the clinician were believed to reduce the impact of this measure sub-scale. There were strong negative correlations between hostility and avoidance transference and reduced patient empathy. There was a similar relationship between hostility and avoidance countertransference and therapist empathy; increased hostility and avoidance transference and countertransference correlated with lower empathy ratings by patients and clinicians respectively. Overall this analysis was considered to provide some support for the validity of these measures.

4.2 Relationship between personality disorder measures

The second aim of the study was to assess whether a lack of integration (as measured by the Personality Structure Questionnaire, PSQ (Broadbent et al., 2000)) is associated with the level of personality disorder (as measured by the PDQ4 (Hyler, 1994).) This would provide support for the validity of the PSQ and Ryle's model of borderline personality (Ryle, 1997). This aim generated Hypothesis B.

Hypothesis B: There will be a positive relationship (correlation) between the scores on the PDQ4 (the borderline sub-scale and total score) and the PSQ.

This hypothesis was tested by correlating personality disorder (as measured by the PDQ4-total and PDQ4-borderline) with personality integration (as measured by the PSQ) for all subjects. Both correlations were positive and significant, thus supporting the hypothesis. The PSQ (Broadbent et al., 2000) is a relatively new measure and this finding provides further support for its validity and hence its use in this study. It also provides support for the Multiple Self States Model (MSSM) (Ryle, 1997) as a theoretical model for understanding BPD. This states that BPD is a consequence of early trauma and dysfunctional interpersonal relationships. This is said to lead to the formation of a restricted and extreme repertoire of role relationships (particularly involving abuse and care) and a failure to integrate these sets of roles (self-states). The PSQ is a measure of personality integration, i.e. relates to the second level of BPD dysfunction as conceptualised by the MSSM. The study's findings provide support that personality disturbance (particularly borderline personality disorder) involves a poorer level of integration (as measured by the PSQ).

4.3 Personality disturbance across the two groups

A third aim of the study, generating Hypothesis C, was to investigate the prediction that individuals seen for psychiatric assessment following DSH are at least as disturbed as those referred for psychological intervention.

Hypothesis C: The level of personality disorder and lack of integration in patients who DSH will be at least as high as that observed in a Comparison Group of individuals referred to Psychology.

This hypothesis was tested by comparing the level of personality disorder (PDQ4-total and sub-scales) and personality integration (PSQ) between the Experimental and Comparison groups. There were no significant differences between the two groups regarding overall personality disorder (PDQ4-total). As indicated, comparisons were made between the two

groups for all the personality disorder sub-scales. Generally there were few differences between the two groups. The Experimental Group had slightly higher (but not significantly higher) levels of dependent and histrionic personality disorders whilst the Comparison Group had slightly higher (but not significantly higher) levels of narcissistic, schizotypal, schizoid and obsessive compulsive personality disorders. There were however significant differences between the two groups for borderline and antisocial personality disorder, with the Experimental Group having significantly higher borderline and antisocial personality disturbance compared with the Comparison Group.

These results support the hypothesis. Further, the results support previous research that found that individuals who are seen by out-patient services and those who present following DSH will have approximately similar levels of personality disorder; studies indicate that 40-50% of out-patients have a personality disorder (Keoingberg et al. 1985) and that approximately half (46%) of patients presenting to emergency psychiatric services suffer borderline personality disorder (Bongar et al. 1990). The fact that this population (individuals seen following DSH) are as disturbed as those being referred for treatment suggests that they have the same level of need. However, as reported in Chapter One (Section 1.2) the most common outcome for these individuals in discharge (Sidley & Renton, 1996). This supports research that their clinical needs are being unmet. But of course attempts to address these needs have generally been unhelpful (Hawton, 1997)

4.4 Assessment of relationships between measures of transference and countertransference and empathy with measures of personality disturbance.

The fourth aim of the study was to investigate the prediction that there would be relationships between measures relating to transference and countertransference and empathy and the measures relating to personality disturbance. This generated hypotheses D1 and D2.

Hypothesis D1: There will be a positive correlation between the level of personality disorder and lack of integration (as measured by PDQ4 and PSQ respectively) and rescue, avoidance and hostility transference and countertransference (as measured by the sub-scales of the PRF and CRF respectively).

Transference and personality disturbance: To test the hypothesis that there would be a relationship between transference and personality disturbance, correlations were conducted between hostility, rescue and avoidance transference and personality disorder measures across the total population. There were significant positive relationships between hostility (as measured by the hostility sub-scale of the PRF) and personality disturbance (as measured by PDQ4-total, PDQ4-borderline sub-scale and PSQ). There were also significant positive relationships between rescue (as measured by the rescue sub-scale of the PRF) and personality disorder (as measured by the PDQ4-total and PDQ4-borderline sub-scale). The correlation between rescue transference and personality integration (PSQ) showed a trend in the expected direction but just failed to reach significance. There were significant positive relationships between avoidance (as measured by the avoidance sub-scale of the PRF) and personality disturbance (as measured by the PDQ4-total, PDQ4-borderline and PSQ). Overall, the results would appear to provide evidence in support of the existence of more intense transference responses involving the themes of hostility, avoidance and rescue being associated with increased personality disorder and lower levels of personality integration.

Countertransference and personality disturbance: To test the hypothesis that there would be a positive relationship between countertransference and personality disturbance, correlations were done between hostility, rescue and avoidance countertransference (sub-scales of the CRF) and personality disorder measures across the whole population. No significant relationship was found between hostility and personality disturbance (as measured by the PDQ4-total, PDQ4-borderline and the PSQ). Results showed trends in the right direction but these failed to reach significance. This was also the case for the relationship between rescue

countertransference and personality disturbance (using the measures mentioned above). Again there were trends in the expected direction but they did not reach significance. A significant correlation was found between avoidance transference and personality disorder (as measured by the PDQ4-total), but correlations with other personality disorder measures (PDQ4-borderline and PSQ) just failed to reach significance.

The lack of significance between patient personality disturbance and countertransference may be due to the low scoring of clinicians for these countertransference sub-scales. Graphs 3.3-6, 3.3-7 and 3.3-8 in Section 3.3.3 illustrate the strong floor effect caused by a high proportion of zero scores for these countertransference themes. This may be because clinicians failing to attune to or notice feelings throughout the interview. This would seem consistent with the account by Powell (1991) of case vignettes where idealisation (which could be considered to be linked to rescue countertransference) has been unrecognised and at times encouraged. The possible failure of clinicians to either attune to, or report, feelings regarding clinical interactions may be due to training or working conditions. If the normality of such feelings is not emphasised in training, they may be less likely to notice them and they may feel uncomfortable about reporting them if they do (as if it is unprofessional to have such feelings). This may be particularly true for relatively junior staff (as SHO psychiatry staff could be considered to be). With regard to the role of working conditions, the clinicians may be under so much pressure that they may not have the 'space' to 'tune into' their countertransference responses. Another possible reason for the low scores on the CRF could be because clinicians seeing patients in the Experimental Group spent variable times conducting their assessments. The clinician would then have less opportunity to sense the more subtle dynamics of patient presentation and hostility, rescue or avoidance themes could go unnoticed.

To summarise the results relating to hypothesis D1, there was strong evidence for the existence of increased hostility, rescue and avoidance transference responses for patients

with higher levels of personality disorder, particularly borderline personality disorder. This was evident in both the Experimental Group and the Comparison Group. Sheard et al. (2000) described three themes (hostility, rescue and avoidance) as being dominant in interactions with individuals with personality disorders. The above results provide support for the three themes in the form of transference responses but only identifies an avoidance response in the countertransference response of the clinician. Reasons for this discrepancy have been discussed.

Hypothesis D2: There will be a negative relationship (correlation) between the level of personality disturbance (as measured by the PDQ4 and PSQ) and the level of empathy/alliance (as measured by ES).

This hypothesis was investigated by correlating personality disturbance with empathy across the total patient population (Experimental and Comparison groups). There were significant negative correlations between personality disorder (as measured by the PDQ4-total, PDQ4-borderline and PSQ) and therapist empathy (as measured by the TES). There were also significant negative relationships between personality disorder (as measured by the PDQ4-total, PDQ4-borderline and the PSQ) and patient empathy (as measured by the PES). Thus the hypothesis was supported with increased personality disorder and lower levels of personality integration being correlated with both patients and therapists perceiving the clinician to be less empathic.

The lower ratings of the clinicians on the empathy scale for individuals with higher levels of personality disturbance would suggest that these patients do elicit negative responses on the part of the clinician, despite the lower ratings made on the CRF. The results of the analyses relating to Hypothesis D2 would suggest that patients with personality disorders interact differently with clinicians resulting in lower levels of empathy and therefore poorer therapeutic alliance. As discussed earlier in Chapter One (Section 1.5.1) successful therapeutic work is dependent on a good patient therapist relationship (Horvarth & Symonds,

1991). This is particularly challenging but important when interacting with patients with personality disorders (Campling, 1996). This study identified particular transference responses (hostility and avoidance) to be higher amongst patients with personality disorders. Whilst these transference responses may be due to the level of PD, they may in turn influence how patients behave towards staff, which may lead to lower levels of empathy on the part of staff, which may then be perceived as confirming the individual's expectations of the interaction and hence perpetuate their view of the interpersonal world. Likewise this interaction can serve to 'confirm' negative attitudes of staff toward this group. An important point is that these results may suggest that transference and countertransference responses may be leading to enactments.

4.5 Group differences according to history of DSH

The fifth aim of the study concerned group differences. It led to hypotheses E1 to E3.

Hypothesis E1: The level of personality disorder and lack of integration (as measured by the PDQ4 and PSQ) will be highest in individuals with a history of repeated self harm and lowest in individuals who have never self-harmed.

Significant differences for borderline personality disorder (PDQ4-borderline) and personality integration (PSQ) were found between the three groups. Group Three (DSH and a history of DSH) had significantly more individuals with borderline personality disorder and poorer personality integration than did Group One (no DSH and no history of DSH). There were no significant differences found between the three groups in terms of general personality disturbance (PDQ4-total). Thus the hypothesis was partly supported.

Since DSH is one of the criteria for the diagnosis of borderline personality disorder (DSM-IV (APA, 1994) it is perhaps not surprising that there are more people with this personality

diagnosis within a group of people who all repeatedly self-harm. It is more surprising that there are no significant differences across the three groups for general personality disturbance and personality integration. This result may be due to the high level of personality disturbance and low levels of integration within the Psychology out-patient sample (Group One; no DSH and no history of DSH). It repeats the earlier finding that there are approximately similar levels of personality disturbance within the Psychology out-patient sample as compared to the sample of individuals admitted following DSH.

Hypothesis E2: The intensity of the transference and countertransference (as measured by the PRF and the CRF) will be highest in individuals with a history of repeated self harm and lowest in individuals who have never self-harmed.

Transference: There were significant differences between the groups in terms of hostility and avoidance transference. Group Three (DSH and a history of DSH) had significantly higher hostility and avoidance transference scores compared to Group One (no DSH and no history of DSH). There were no significant differences between the three groups in terms of rescue transference.

Countertransference: There were no significant differences in the ratings on the CRF (hostility, rescue or avoidance) between the three groups. Trends were present and in the predicted direction for hostility and avoidance, but these failed to reach significance. This is possibly due to the clinicians' tendency to give low or zero ratings for these themes. This effect is also consistent with the lack of correlation between patient and clinician ratings for avoidance (hypothesis A1). Therefore hypothesis E2 was only partly supported.

Patients in Group Three scored significantly higher on the hostility and avoidance sub-scales of the PRF as compared to Group One but these differences were not paralleled by clinicians ratings on the CRF (where scores relating to the three groups were equivalent). This repeats an earlier finding (involving hypothesis D1) and may be explained by clinicians not

reporting countertransference reactions for a variety of reasons. Higher transference responses are demonstrated by Group Three which also has the greatest number of individuals with borderline personality disorder. Therefore Sheard's prediction of specific themes within the interactions of people with PD was again supported.

Hypothesis E3: Empathy (as measured by the TES and PES) will be lowest during interactions with individuals presenting with DSH with a history of DSH and highest during interactions with individuals who have never self-harmed.

Therapist empathy: There were significant differences in therapist empathy between the three groups. Therapist empathy was significantly greater for Group One (no DSH and no history of DSH) compared to Group Three (DSH and a history of DSH). To establish whether this could be explained by differences in personality disturbance, personality disturbance (as measured by the PDQ4-borderline and PSQ) was controlled for. The significant differences between the groups remained, indicating reduced empathy and a weaker therapeutic alliance when clinicians interact with patients admitted following DSH, particularly when they have a history of DSH.

Patient empathy: There were also significant differences in patient empathy (i.e. how empathic the patient considered the clinician to be) between the three groups. As with the analyses regarding clinician empathy, the patients in Group Three (DSH and history of DSH) had significantly lower empathy scores and therefore poorer alliance than did those in Group One (no DSH and no history of DSH). To confirm that these differences were not attributable to personality disturbance, this was controlled for (by the PDQ4-borderline and the PSQ). The significant differences remained.

Empathy plays an important role in the development of the therapeutic alliance between the patient and the clinician (Horvarth & Greenberg, 1994). Bohart and Greenberg (1997) suggest that there are three types of empathy; 'empathic rapport', 'experience-near

understanding of the clients' world' and 'communicative attunement' as mentioned in Chapter One (Section 1.5.2). The PES and TES measure 'empathic rapport' which involves a global understanding and tolerant acceptance of the patient's feelings. This is most relevant for establishing a strong therapeutic alliance (Bohart & Greenber, 1997). Empathy is significantly reduced between the patient and clinician in Group Three. This was expected as there are more individuals within this group with borderline personality disorder and such individuals have difficulty forming relationships with others, as mentioned earlier in Chapter One (Section 1.3.2) and indicated by the results relating to Hypothesis D2. Also clinicians have been found to have more negative attitudes towards this patient group (Ghodse, 1978) and thus their capacity for 'empathic rapport' is likely to be compromised.

4.6 Staff attitudes

The sixth aim of the study was to replicate the previous findings regarding staff attitudes towards individuals who DSH. This was investigated by the administration of the Deliberate Drug Overdose Questionnaire (DDO) (Sidney & Renton, 1996) and generated two hypotheses.

Hypothesis F1: Staff will hold negative attitudes towards this group.

Attitudes towards patients who had committed DSH were generally positive. The majority of staff disagreed with the statement that these patients should be considered less of a priority on busy medical wards and they endorsed the view that these patients have equal rights to medical treatments. These results are comparable with those of Sidney and Renton (1996). However, on a more negative note, 73% of clinicians reported that they found working with this patient group frustrating and 82% reported that their colleagues disliked working with this patient group. These negative attitudes may be present before interactions (and may

influence the interactions) with this patient group and/or may be a result of discomfort when working with this patient group.

Over half of the staff group (62%) (significantly more nurses than doctors) believed that patients who kill themselves rarely mention their intention to anyone. This suggests that a patient's threat of DSH or suicide may not always be taken seriously. This was also found by Akererg et al. (1994).

Anecdotal remarks from staff in A&E suggested frustration and exasperation in dealing with this patient group. Staff on the medical ward also indicated some difficulties acknowledging or meeting the needs of this patient group. Occasionally patients would report feeling isolated and abandoned on a medical ward. This would seem consistent with the finding of Dunleavey (1992) that interactions between patients who had DSH and nursing staff were rare and often restricted to superficial social chats. A couple of patients reported feeling particularly ill-treated by staff on duty through the night.

The DDO questionnaire was chosen for its brevity and convenience. Although it yielded some interesting results, more subtle attitudes of clinicians may have been missed. However the results provided evidence indicating the existence of negative attitudes towards this patient group. Further, the lower ratings of empathy for patients who had self-harmed (as described in Section 4.5) supports the hypothesis that staff have negative attitudes towards this patient group.

Hypothesis F2: There will be differences between the attitudes of different staff groups. Nurses will be more sympathetic and understanding than doctors, and psychiatrists will show more empathy towards this patient group than other medical staff.

More doctors (86%) than nurses (57%) reported that they found working with this patient group frustrating. This difference reached significance supporting the first part of the hypothesis. This supports the findings of Ramon et al. (1975) who found that nurses were

more sympathetic and understanding than were physicians in medical wards, regardless of their area of expertise (Ramon, 1975). The second part of the hypothesis, that psychiatrists in particular show more empathy towards this patient group than do other staff was unsupported and hence does not support the findings of Ghodse (1978). This lack of significance may be due to the low number of psychiatrists within this group or due to the lack of sensitivity of the DDO questionnaire.

4.6.1 Training and services

Although no hypotheses regarding staff attitudes towards training and services were made, the results from the DDO regarding these topics would seem relevant to the study and therefore will be discussed.

Over 50% of questionnaire respondents reported that they felt that current services were unsatisfactory. A high proportion of staff (62%) felt that they did not have the necessary skills for dealing with this patient group. Sixty four percent of staff thought that existing training for nurses in caring for this patient group was insufficient. Medical staff felt this significantly more strongly than did the psychiatrists.

When answers from the medical staff were considered alone, none of the medical doctors reported feeling as though they had adequate skills for dealing with this patient group, while 58% of medical ward nurses felt that they lacked these skills also. A high proportion of staff, consisting of significantly more nurses than doctors, reported that they felt current training for nursing staff to manage the non-medical management of DSH patients was inadequate.

To conclude, the vast majority of staff (88%) in contact with this patient group thought that support should be routinely offered to staff. These findings clearly highlight the importance to staff of access to sources of psychological support and guidance in their continuing work with patients who DSH.

4.7 Summary and Implications of the study

Patients who DSH, especially when this is repeated, pose a particular challenge to the NHS. These patients are notoriously difficult to engage in therapy (Maltzberger, 1994) and reviews of treatment approaches have provided disappointing results (Hawton, 1997). The most successful treatment approach for this patient group has been Dialectical Behaviour Therapy (DBT) (Linehan, 1991). This approach emphasises the value of the therapeutic relationship and the importance of validating patients' feelings and behaviours. Since this approach has demanding training implications it is impractical for most services.

Using Cognitive Analytic Theory as a framework, this study attempted to develop a means of measuring difficulties (involving transference and countertransference responses) present in the interactions between this patient group and clinicians (which were subsequently applied). Initial results relating to the measures developed (the CRF and PRF) appeared to suggest that they are valid and reliable measures. However, this is a preliminary study with limitations and not all of the hypotheses regarding validity were fully supported. In particular the anticipated relationship between transference and countertransference measures of rescue and empathy was not apparent.

The significant relationship between the PDQ4 and PSQ provided support for the use of the PSQ as a measure of personality integration and also for Ryle's (1997) model of borderline personality as involving relatively poorly integrated personality structure.

The hypothesis that the Experimental Group would be at least as disturbed as the Comparison Group was supported. This has implications in that increased personality disturbance was predicted to lead to intense transference and countertransference responses. The fact that this may highlight individuals whose needs are not being met was discussed.

The hypothesis that the intensity of the transference responses would be associated with higher levels of personality disturbance was supported for all three dimensions (i.e. hostility,

rescue and avoidance). This again provided support for Sheard's model (Sheard et al., 2000). By contrast, the hypothesis that the intensity of countertransference responses would be associated with higher levels of personality disturbance was not supported for any of the three domains. Possible reasons were discussed. This is clearly an important area to investigate further.

The linked hypothesis that the level of empathy would be associated with the level of personality disturbance was supported and indicated that personality disturbance was associated with both patients and clinicians perceiving the clinician to be less empathic. The significance of this in terms of perpetuating a patient's difficulties was discussed. The fact that these results may indicate that transference and countertransference responses may be being acted on was also pointed out.

Analysis relating to the presence of DSH (repeated, first occasion and none) found that those individuals with a history of repeated DSH differed significantly; they were more likely to suffer from BPD, their hostility and avoidance transference responses were more intense (not simply as a result of their PD) and both the clinician and the patient perceived the clinician to be less empathic towards them.

The results regarding staff attitudes and beliefs were particularly tentative given the questionnaire used and the small sample. However, the results did support the presence of mixed attitudes including some negative (which is consistent with the results regarding empathy) and staff group differences (nurses were more sympathetic). Further the results identified a belief that they required more training and support.

4.8 Future directions and implications

More work is required on the new measures of transference and countertransference (the PRF and CRF) to further establish their reliability and validity. As reported in Chapter 4 (Section 4.1.1) it would be useful to consider content and construct validity and to carry out further reliability assessments. It would seem useful to repeat the study with a similar population to see if the significant and non-significant findings are replicated and if those approaching significance become significant. The study could also be repeated with a different population i.e. patients attending assessment or therapeutic interviews with a wide range of problems.

A second area for future investigation would be to investigate whether the transference and countertransference responses identified in the study are being acted upon. The PRF and CRF measure transference and countertransference respectively but they do not indicate whether patients and clinicians are acting upon their feelings. However, results regarding the empathy scales suggests that this may be the case. To study this area would probably require the use of process oriented methodology.

It would be valuable to investigate staff attitudes further and more comprehensively. This would involve using a more sensitive measure and a larger and wider staff sample. It would be interesting to investigate whether staff attitudes were directly related to staff countertransference and empathy. The pilot nature of this study did not enable this line of study to be pursued.

A further area for investigation is the study of clinicians as a separate variable. During this study the majority of the Experimental Group assessments were completed by two SHOs and the rest were done by a number of different SHOs. For the Comparison Group, assessments were done by a number of different psychologists. Ideally this variable would have been controlled for or only one clinician would have been involved. The fact that it was not is a

limitation of the study. A future study may be able to control for this factor. Alternatively - or in addition – it could be a variable studied. Studying the clinician as a variable could, for example, identify if for some a strong rescue transference leads to increased empathy, whilst for others it leads to decreased empathy.

Linked to the above, the theme of ‘rescue’ requires further study to establish whether it has a more complex relationship with transference and countertransference than the other themes or whether it is simply not there or not being measured. Evidence suggests that it is present, for example, there was a positive relationship between rescue transference response and personality disturbance (Section 4.4).

Further study of countertransference is recommended to establish whether the low levels are related to a reluctance to report or a lack of awareness. To this end, it would be worth investigating whether different results would be found with more experienced (and possibly more confident) clinicians and whether education would encourage more positive reporting.

This research provided evidence for the existence of mixed staff attitudes towards patients who DSH. Another part of the study identified significantly lower therapeutic empathy therefore presumably a poorer therapeutic alliance between clinicians and patients who DSH. It would be of interest to see whether the negative attitudes of staff correlate significantly with reduced empathy and negative countertransference. Such negative attitudes could both be a cause and effect of decreased empathy and negative countertransference responses.

Whilst this is only a pilot study, the results would appear to support the benefits of training and education regarding the nature of interactions with individuals who DSH (and have personality disorders). This would be relevant not only when these patients are seen by emergency services but also in routine mental health clinics. This education / training could involve teaching a clinical intervention such as that of Sheard et al. (2000) or educating

clinicians about the nature of transference and countertransference responses and the implications of avoiding becoming involved in enactments.

5 REFERENCES

Akerberg, H., Samuelsson, M. & Asberg, M. (1994). Suicide in psychiatric care as seen by the survivors. *Nordic Journal of Psychiatry*, **48**, 359-367.

Allard, R., Marshall, M., & Plante, M. (1992). Intensive follow-up does not decrease the risk of repeat suicide. *Suicide and Life-Threatening Behaviour*, **22**, 303-14.

Allen, D.M. (1997). Techniques for reducing therapy-interfering behaviour in patients with borderline personality disorder. *Journal of Psychotherapy Practice and Research*, **6**, 25-35.

American Psychiatric Association (1987). *Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised*. American Psychiatric Association, Washington DC.

American Psychiatric Association (1994). *Diagnostic and Statistical Manual of Mental Disorders, 4th Edition*. American Psychiatric Association, Washington DC.

Bancroft, J.H.J., Skrimshire, A.M., & Simkin, S. (1976). The reasons people give for taking overdoses. *British Journal of Psychiatry*, **128**, 538-48.

Bancroft, J., Skrimshire, A., Casson, J., Harvard-Watts, O., & Reynolds, F. (1977). People who deliberately poison or injure themselves: their problems and their contracts with helping agencies. *Psychological Medicine*, **7**, 289-303.

Bancroft, J., Hawton, K., Simkin, S., Kingston, B., Cumming, C., & Whitwell, D. (1979). The reasons people give for taking overdoses: a further enquiry. *British Journal of Medical Psychology*, **52**, 353-65.

Barraclough, B., Bunch, J., Nelson, B. & Sainsbury, P. (1974). A hundred cases of suicide: clinical aspects. *British Journal of Psychiatry*, **125**, 355-373.

Basch, M.F. (1983). Empathic understanding: A review of the concept and some theoretical considerations. *Journal of the American Psychoanalytic Association*, **31**, 101-126.

Beach, K. & Power, M. (1996). Transference: An empirical investigation across a range of cognitive-behavioural and psychoanalytic therapies. *Clinical Psychology and Psychotherapy*, **3**, 1-14.

- Beauchamp, T. & Childress, J. (1994). *Principles of biomedical ethics*. New York: Oxford.
- Beck, A.T., Rush, A.J., Shaw, B.F. & Emery, G. (1979). *Cognitive therapy of depression*. Guilford, New York.
- Benjamin, L.S. & Wonderlich, S.A. (1994). Social perceptions and borderline personality disorder: The relation to mood disorders. *Journal of Abnormal Psychology*, **103**, 610-624.
- Black, D.W. & Winokur, G. (1990). Suicide and psychiatric diagnoses. In S.J. Blumenthal & D.J. Kupfer, (Eds.), *Suicide Over the Life Cycle: Risk Factors, Assessment, and Treatment of Suicidal Patients*. pp.135-153.
- Bohart, A.C. & Greenberg, L.S. (1997). Empathy and Psychotherapy: An Introductory Overview. In A.C. Bohart & L.S. Greenberg (Eds.), *Empathy Reconsidered, New Directions in Psychotherapy*, pp. 3-32. American Psychiatric Association, Washington DC.
- Bohart, A.C. & Greenberg, L.S. (1997b). Empathy: Where Are We and Where Do We Go From Here? In A.C. Bohart & L.S. Greenberg (Eds.), *Empathy Reconsidered, New Directions in Psychotherapy*, pp. 419-449). American Psychiatric Association, Washington DC.
- Bongar, B., Peterson, L.G., Golann, S. & Hardimann, J.L. (1990). Self-mutilation of the chronically suicidal patient: An examination of the frequent visitor to the psychiatry examination room. *Annals of Clinical Psychology*, **2**, 217-222.
- Book, H.E. (1988). Empathy: Misconceptions and misuses in psychotherapy. *American Journal of Psychiatry*, **145**, 420-424.
- Bordin, E.S. (1976). The working alliance; Basis for a general theory of psychotherapy. Paper given at an A.P.A. Convention; Washington D.C. September 1976.
- Bordin, E.S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research and Practice*, **16**, 252-260.
- Bowlby (1960). Separation Anxiety. *International Journal of Psychoanalysis*, **41**, 89-113.

Brent, D.A., Johnson, B.A. Perper, J., Connolly, J., Bridge, J., Bartle, S. & Rather, C. (1994). Personality disorder, personality traits, impulsive violence, and completed suicide in adolescents. *Journal of American Academy Child and Adolescent Psychiatry*, **33**, 1080-1086.

Briere, J. & Zaidi, L.Y. (1989). Sexual abuse histories and sequelae in female psychiatric emergency room patients. *American Journal of Psychiatry*, **146**, 12, 1602-1606.

Broadbent, M., Clarke, S. & Ryle, A. (2000). *The Personality Structure Questionnaire*. C/o ACAT Office, Academic Department of Psychiatry, St Thomas' Hospital, London. Unpublished manuscript.

Brodsky, B.S., Malone, K.M., Ellis, S.P., Dunlit, R.A. & Mann, J.J. (1997). Characteristics of borderline personality disorder associated with suicidal behaviour. *American Journal of Psychiatry*, **154**, 1715-1718.

Burns, D.D. & Auerbach, A. (1996). Therapeutic empathy in cognitive-behavioural therapy: Does it really make a difference? In P.M. Salkovskis (Ed.), *Frontiers of Cognitive Therapy*, pp. 135-164. Guildford Press.

Burns, D.D., & Nolen-Hoeksema, S. (1991). Coping styles, homework compliance and the effectiveness of cognitive-behavioural therapy. *Journal of Consulting and Clinical Psychology*, **59**, 305-311.

Burns, D.D., & Nolen-Hoeksema, S. (1992). Therapeutic empathy and recovery from depression in cognitive-behavioural therapy. *Journal of Consulting and Clinical Psychology*, **60**, 441-449.

Campling, P. (1996). Maintaining the therapeutic alliance with personality disordered patients. *Journal of Forensic Psychiatry*, **7**, 535-549.

Canetto, S.S., & Sakinofsky, I. (1998). The Gender Paradox in Suicide. *Suicide and Life-Threatening behaviour*, **28**, 1-23.

Carmines, E.G. & Zeller, R.A. (1979). *Reliability and validity assessment*. Sage University Paper series on Quantitative Applications in the Social Sciences, 07-017. Beverly Hills and London: Sage Publications.

Carrigan, J.T. (1994). The psychosocial needs of patients who have attempted suicide by overdose. *Journal of Advanced Nursing*, **20**, 635-42.

Caton, C.L, Shrout, P.E., Eagle P.F. & Opler, L.A. (1994). Risk factors for homelessness among schizophrenic men: A case-control study. *American Journal of Public Health*, **84**, 265-270.

Charlton, J., Kelly, J.S., Dunnell, K., Evans, B., Jenkins, R. & Wallis, R. (1993). Suicide deaths in England and Wales: trends in factors associated with suicide deaths. *Population Trends*, **71**, 34-42.

Chambliss, D. (1996). *Beyond caring*. Chicago: The University of Chicago Press.

Chowdhury, N., Hicks, R.C., & Kreitman, N. (1973). Evaluation of an after-care service for parasuicide (attempted suicide) patients. *Social Psychiatry*, **8**, 67-81.

Coccaro, E.F., Seiver, L.J., Klar, H.M., Maurer, G., Cochrane, K., Cooper, T.B., Mohs, R.C. & Davis, K.L. (1989). Serotonergic studies in patients with affective and personality disorders. *Archives of General Psychiatry*, **46**, 587-99.

Corbitt, E.M., Malone, K.M., Haas, G.L., & Mann, J.J. (1996). Suicidal behaviour in patients with major depression and comorbid personality disorders. *Journal of Affective Disorders*, **39**, 61-72.

Corley, M.C. & Goren, S. (1998). The dark side of nursing: impact of stigmatising responses on patients. *Scholarly inquiry for nursing practice: An International Journal*, **12**, 99-118.

Costa, P. & McCrae, R. (1990). Personality disorders and the five-factor model of personality. *Journal of Personality Disorders*, **4**, 362-371.

Cowmeadow, P. (1994). Deliberate self harm and cognitive analytic therapy. *International Journal of Short Term Psychotherapy*, **9**, 135-150.

Dahlgren, K.G. (1977). Attempted suicides – 35 years afterwards. *Suicides and Life-Threatening Behaviour*, **7**, 75-79.

Davenport, S.M. & Birtle, J. (1990). Association between Parasuicide and St Valentine's Day. *British Medical Journal*, **300**, 783-4.

Dawson, D. (1996). The script is already written: system responses to patients with personality disorders. In P.S. Links (Ed.), *Clinical assessment and management of severe personality disorders*, pp.147-159. Washington, DC, American Psychiatric Press.

Department of Health (1984). *The management of deliberate self-harm*. London: Department of Health and Social Security. (HN(84)25).

Department of Health (1992). *The health of the nation. A Strategy for Health in England*. London: HMSO.

Dinwiddie, S.H. & Bucholz, K.K. (1993). Psychiatric diagnoses of self-reported child abusers. *Child Abuse and Neglect*, **17**, 465-476.

Duffy, D. (1995). Out of the shadows: A study of the special observation of suicidal psychiatric in-patients. *Journal of Advanced Nursing*, **21**, 944-950.

Dunleavy, R. (1992). An adequate response to a cry for help? *Professional Nursing*, **7**, 213-15.

Evans, M., Cox, C. & Turnball, G. (1992). Parasuicide response. *Nursing Times*, **88**, 34-36.

Fermium, W.J., de Percel, M., & Ellis, T.E. (1990). *Suicide risk: Assessment and response guidelines*. New York: Persimmon Press.

Festinger, L. (1957). *A theory of cognitive dissonance*. Evanston, IL: Row Peterson.

Frances, A. (1982). Categorical and dimensional systems of personality diagnosis: a comparison. *Comprehensive Psychiatry*, **23**, 516-527.

Frieswyk, S.H., Allen, J.G., Colson, D.B., Coyne, L., Gabbard, G.O., Horowitz, L., & Newson, G. (1986). Therapeutic alliance: Its place as process and outcome variable in dynamic psychotherapy research. *Journal of Consulting and Clinical Psychology*, **54**, 32-39.

Freud, S. F. (1958/1912). The dynamics of transference. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud*, vol. 12, pp.99-108. London: Hogarth Press.

Freud, S.F. (1956/1917). Mourning and Melancholia. In Jones, E. (Ed.), *Sigmund Freud, Collected Papers*, volume IV, pp.152-170. London: Hogarth Press.

Ghodse, A.H. (1978). The attitudes of casualty staff and ambulance personnel towards patients who take overdoses. *Social Science and Medicine*, **12**, 341-48.

Gibbs, J.P. (1968). *Suicide*. Harper and Row, New York.

Gibbs, A. (1990). Aspects of communication with people who have attempted suicide. *Journal of Advanced Nursing*, **15**, 1245-49.

Gill, M. & Hoffman, I. (1982). A method for studying the analysis of aspects of the patient's experience of the relationship in psychoanalysis and psychotherapy. *Journal of the American Psychoanalytic Association*, **30**, 137-167.

Goldfried, M.R. (1980). Toward the delineation of therapeutic change principles. *American Psychologist*, **35**, 991-999.

Goldney, R. & Botrill, A. (1980). Attitudes to patients who attempted suicide. *Medical Journal of Australia*, **2**, 717-720.

Goodwin, F.K. & Jamison, K.R. (1990). *Manic-Depressive Illness*. New York, Oxford University Press.

Ghosh T.B. & Victor, B.S. (1999). Suicide. In R.E. Hales, S.C. Yudofsky & J.A. Talbott (Eds.), *American Psychiatric Press Textbook of Psychiatry*, pp. 1383-1404, Washington, DC, American Psychiatric Press.

Gunderson, J.G. (1984). *Borderline Personality Disorder*. Washington, DC, American Psychiatric Press.

Gunderson, J.G. (1992). Diagnostic controversies. In A. Tasman & M. Riba (Eds), *American Psychiatric Press Review of Psychiatry*, **11**, 9-24.

Gunderson, J.G. (1996). The borderline patient's intolerance of aloneness: insecure attachment and therapist availability. *American Journal of Psychiatry*, **153**, 752-758.

Gunderson, J.G. & Sabo, A.N. (1993). The phenomenological and conceptual interface between borderline personality disorder and PTSD. *American Journal of Psychiatry*, **150**, 19-27.

Gunderson, J.G., Links, P.S. & Reich, J.H. (1991). Competing models of personality disorders. *Journal of Personality Disorders*, **5**, 60-68.

Gunderson, J.G., Frank, A., Ronningstam, E., Wachter, S., Lynch, V. & Wolf, P. (1989). Early discontinuance of borderline patients from psychotherapy. *Journal of Nervous and Mental Disease*, **177**, 38-42.

Hathaway, S. & McKinley. (1989). Minnesota Multiphasic Personality Inventory-2. Minneapolis, University of Minnesota.

Hawton, K. (1989). Controlled studies of psychosocial intervention following attempted suicide. In: Kreitman, N. & Platt, S.D. (Eds.), *Current research on suicide and parasuicide*, pp. 180-95. Edinburgh: Edinburgh University Press.

Hawton, K. (1997). Attempted Suicide. In Clark, D.M. and Fairburn, C.G. (1997), *Science and Practice of Cognitive Behaviour Therapy*, Oxford University Press.

Hawton, K. & Catalan, J. (1987). *Attempted Suicide: A practical guide to its nature and management*. Second edition, Oxford University Press.

Hawton, K. & Fagg, J. (1988). Suicide and other causes of death following attempted suicide. *British Journal of Psychiatry*, **152**, 359-66.

Hawton, K. & Fagg, J. (1992a). Trends in deliberate self-poisoning and self-injury in Oxford, *British Medical Journal*, **304**, 1409-1411.

Hawton, K. & Fagg, J. (1992b). Deliberate self-poisoning and self-injury in adolescents. A study of characteristics and trends in Oxford, 1976-89. *British Journal of Psychiatry*, **161**, 816-823.

Hawton, K., Gath, D., & Smith, E. (1979). Management of attempted suicide in Oxford. *British Medical Journal*, **2**, 1040-2.

Hawton, K., Fagg, J., & McKeown, S. (1989). Alcoholism, alcohol and attempted suicide. *Alcohol and Alcoholism*, **24**, 3-9.

Hawton, K., Bancroft, J., Catalan, J., Kingston, B., Stedeford, A. & Welch, N. (1981). Domiciliary and out-patient treatment of self-poisoning patients by medical and non-medical staff. *Psychological Medicine*, **11**, 169-77.

Hawton, K., Cole, D., O'Grady, J., & Osborn, M. (1982). Motivational aspects of deliberate self-poisoning in adolescents. *British Journal of Psychiatry*, **141**, 286-91.

Hawton, K., Fagg, S., Platt, S. & Hawkins, M. (1993). Factors associated with suicide after parasuicide in young people. *British Medical Journal*, **306**, 1641-1644.

Henry, W.P. & Strupp, H.H. (1994). The Therapeutic Alliance as Interpersonal Process. In A.O. Hovarth & L.S. Greenberg (Eds.), *The Working Alliance, theory, research and practice*, pp. 51-84. John Wiley and Sons, Inc. New York.

Henry, W.P., Schacht, T.E. & Strupp, H.H. (1986). Structural analysis of social behaviour: Application to a study of interpersonal process in differential psychotherapy outcome. *Journal of Consulting and Clinical Psychology*, **54**, 27-31.

Henry, W.P., Schacht, T.E., & Strupp, H.H. (1990). Patient and therapist introject, interpersonal process, and differential psychotherapy outcome. *Journal of Consulting and Clinical Psychology*, **58**, 768-774.

Hillbrand, M., Krystal, J.H., Sharpe, K.S., & Foster, H.G. (1994). Clinical predictors of self-mutilation in hospitalised forensic patients. *Journal of Nervous and Mental Disease*, **182**, 9-13.

Hinshelwood, R.D. (1999). The difficult patient. *British Journal of Psychiatry*, **174**, 187-190.

HMSO, (1990). *Annual report of the Chief Medical Officer*. Central Statistical Office, London.

Hougaard, E. (1994). The therapeutic alliance – A conceptual analysis. *Scandinavian Journal of Psychology*, **35**, 67-85.

Hovarth, A.O. (1994). Research on the Alliance. In A.O. Hovarth & L.S. Greenberg (Eds.), *The Working Alliance, theory, research and practice*, pp. 259-286. John Wiley and Sons, Inc. New York.

Hovarth A.O. & Greenberg, L.S. (1994). *The working alliance*. New York: Wiley-Interscience.

- Hovath, A.O. & Symonds, B.D. (1991). Relation between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counselling Psychology*, **38**, 139-149.
- Hurt, S., Hyler, S.E. & Frances, A. (1984). Assessing borderline personality disorder with self-report, clinical interview, or semi-structured interview. *American Journal of Psychiatry*, **141**, 1228-1231.
- Hyler, S.E. (1994). *Personality Diagnostic Questionnaire-4 (PDQ4)*. New York: New York State Psychiatric Institute.
- Hyler, S.E. & Reider R.O. (1987). *PDQ-R: Personality Diagnostic Questionnaire-Revised*. New York: New York State Psychiatric Institute.
- Hyler, S.E., Reider, R.O., Spitzer, R & Williams, J.B. (1983). *Personality Diagnostic Questionnaire (PDQ)*. New York: New York State Psychiatric Institute.
- Hyler, S.E., Reider, R.O., Williams, J., Spitzer, R., Handler, J. & Lyons, M. (1988). The Personality Diagnostic Questionnaire: Development and preliminary results. *Journal of Personality Disorders*, **2**, 229-237.
- Hyler, S.E., Reider, R.O., Williams, J.B.W., Spitzer, R.L., Lyons, M. & Handler, J. (1989). A comparison of clinical and self-report diagnoses of DSM-III personality disorders in 552 patients. *Comprehensive Psychiatry*, **30**, 170-178.
- Hyler, S.E., Skodol, A.E., Kellman, H.D., Oldham, J.M. & Rosnick, L.R. (1990). Validity of the Personality Diagnostic Questionnaire-Revised: Comparison with two structured interviews. *American Journal of Psychiatry*, **147**, 1043-1048.
- Hyler, S.E., Skodol, A.E., Oldham J.M., Kellman, H.D., & Doidge, N. (1992). Validity of the Personality Diagnostic Questionnaire-Revised: A replication in an outpatient sample. *Comprehensive Psychiatry*, **33**, 72-77.
- Jameton (1992). Nursing ethics and the moral situation of the nurse. In E.Freidman (Ed.), *Choices and conflict*, pp.101-109. Chicago: American Hospital Publishing.
- Johnson, M. & Webb, C. (1995). Rediscovering unpopular patients: The concept of social judgement. *Journal of Advanced Nursing*, **21**, 466-475.

- Kass, F., Skodol, A.E. Charles, E., Spitzer, R.L. & Williams, J.B.W. (1985). Scaled ratings of DSM-III personality disorders. *American Journal of Psychiatry*, **142**, 627-630.
- Kelly, M. & May, D.L. (1982). Good and bad patients: A review of the literature and a theoretical critique. *Journal of Advanced Nursing*, **7**, 147-156.
- Kelstrup, A., Lund, K., Lauritsen, B. & Bech, P. (1993). Satisfaction with care reported by psychiatric inpatients. Relationship to diagnosis and medical treatment. *Acta Psychiatrica Scandinavia*, **87**, 374-379.
- Kent, S., Fogarty, M. & Yellowlees, P. (1995). A review of studies of heavy users of psychiatric services. *Psychiatric Services*, **46**, 1247-1253.
- Kernberg, O.F. (1975). *Borderline conditions and pathological narcissism*. New York: Jason Aronson.
- Kernberg, O.F. (1968). Treatment of patients with borderline personality organisation. *International Journal of Psychoanalysis*, **49**, 600-619.
- Kernberg, O.F. (1984). *Severe Personality Disorders: Psychotherapeutic Strategies*. New Haven, CT, Yale University Press.
- Kiesler, D.J. (1983). The 1982 interpersonal circle: a taxonomy for complementarity in human transactions. *Psychological Review*, **90**, 185-214.
- Kiesler, D.J. (1996). *Contemporary interpersonal theory and research: Personality, psychopathology and psychotherapy*. New York: John Wiley and Sons, Inc.
- Kiesler, D.J. & Watkins, L.M. (1989). *Changing expectations. A key to explorative psychotherapy*. Pacific Grove, California, Brooks/Cole.
- Kjellander, C., Bongar, B. & King, A. (1998). Suicidality in borderline personality disorder. *Crisis*, **19**, 125-135.
- Koeingsberg, H.W., Kaplan, R.D., Gilmore, M.M. & Cooper, A.M. (1985). The relationship between syndrome and personality disorder in DSM-III: experience with 2,462 patients. *American Journal of Psychiatry*, **142**, 207-212.
- Kreitman, N. (1977). *Parasuicide*. John Wiley, London.

- Kreitman, N. (1989). Can suicide and life-threatening behaviour be prevented? *Journal of the Royal Society of Medicine*, **82**, 648-652.
- Kreitman, N. & Foster, J. (1991). The Construction and Selection of Predictive Scales, with Special Reference to Parasuicide. *British Journal of Psychiatry*, **159**, 185-92.
- Lenzenweger, M.F., Loranger, A.W., Korfine, L. & Neff, C. (1997). Detecting personality disorders in a nonclinical population. *Archives of General Psychiatry*, **54**, 345-351.
- Lieberman, R.P. & Eckman, T. (1981). Behaviour therapy vs insight-oriented therapy for repeated suicide attempters. *Archives of General Psychiatry*, **38**, 1126-30.
- Linehan, M.M. (1987). Dialectical behaviour therapy: a cognitive behavioural approach to parasuicide. *Journal of Personality Disorders*, **1**, 328-333.
- Linehan, M.M. (1993). *Cognitive behavioural treatment of borderline personality disorder*. New York: Guildford Press.
- Linehan, M.M. (1997). Validation and Psychotherapy. In A.C. Bohart & L.S. Greenberg, *Empathy Reconsidered, New Directions in Psychotherapy*, pp. 353-392. American Psychiatric Association, Washington DC.
- Linehan, M., Armstrong, H.E., Suarez, A., Allmon, D. & Heard, H.L. (1991). Cognitive-behavioural treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, **48**, 1060-1064.
- Linke, S. (1997). Assessing and Managing Suicide Risk. Coster, S. & Clifford, P. (Eds.) *Core Mini Guide Series*, April 1998, British Psychological Society.
- Links, P.S. (1998). Developing effective services for patients with personality disorders. *Canadian Journal of Psychiatry*, **43**, 251-259.
- Litman, R.E. (1995). Suicide prevention in a treatment setting. *Suicide and Life Threatening Behaviour*, **25**, 134-142.
- Long, A., Long, A. & Smyth, A. (1998). Suicide: a statement of suffering. *Nursing Ethics*, **5**, 3-15.

- Loranger, A.W. (1990). The impact of DSM-III on diagnostic practice in a university hospital. *Archives of General Psychiatry*, **47**, 672-675.
- Loranger, A.W., Susman, V.L., Oldham, J.M. & Russakoff, L.M. (1985). *Personality Disorder Examination (PDE): A Structured Interview for DSM-III-R Personality Disorders*. White Plains, NY: New York Hospital-Cornell Medical Centre, Westchester Division.
- Luborsky, L., Crits-Cristop, P. & Mellon, J. (1986). Advent of objective measures of the transference concept. *Journal of Consulting and Clinical Psychology*, **54**, 39-47.
- Luborsky, L., McLellan, A.T., Woody, G.E., O'Brien, C.P. & Auerbach, A. (1985). Therapist success and its determinants. *Archives of General Psychiatry*, **42**, 602-611.
- Maltsberger, T. (1994). Calculated risks in the treatment of intractably suicidal patients. *Psychiatry*, **57**, 199-212.
- Maltsberger, J.T. & Buie, D.H. (1974). Countertransference Hate in the Treatment of Suicidal Patients. *Archives of General Psychiatry*, **30**, 625-633.
- Marzuk, P.M. & Mann, J.J. (1988). Suicide and substance abuse. *Psychiatric Annals*, **18**, 639-645.
- McCaughey, J., Long, A. & Harrison, S. (1995). Suicide and parasuicide: a selected review of the liaterature. *Journal of Psychiatry and Mental Health Nursing*, **2**, 199-206.
- Menninger, K.A. (1938). *Man Against Himself*. New York: Harcourt, Brace and World.
- Millon, T. (1987). *Millon Clinical Multiaxial Inventory-II Manual*. Minneapolis, National Computer Systems.
- Moller, H.J. (1989). Efficacy of different strategies of aftercare for patients who have attempted suicide. *Journal of the Royal Society of Medicine*, **82**, 643-7.
- Montgomery, S.A. Montgomery, D., Baldwin, D. & Green, M. (1989). Intermittent 3-day depressions and suicidal behaviour. *Neuropsychobiology*, **22**, 128-134.
- Morgan, H.G., Jones, E.M, & Owen, J.H. (1993). Secondary prevention of non-fatal deliberate self-harm: the green card study. *British Journal of Psychiatry*, **163**, 111-12.

- Morgan, H.G., Barton, J., Pottle, S., Pocock, H. & Burns-Cox, C. (1976). Deliberate self-harm; a follow-up audit of 279 patients. *British Journal of Psychiatry*, **128**, 361-368.
- Murray, G., Caris, H., Ferguson, J., Kidd, G. & Sharp, K. (1999). A survey of general practitioner satisfaction with clinical psychology services. *Clinical Psychology Forum*, **132**, 22-25.
- Murphy, G.E. & Wetzel, R.D. (1990). The lifetime risk of suicide in alcoholism. *Archives of General Psychiatry*, **47**, 383-392.
- Nordstrom, P., Samuelsson, M., Asberg, M., Traskman-Bendz, L., Aberg-Wistedt, A., Nordin, C. & Bertilsson, L. (1994). CSF 5-HIAA predicts suicide risk after attempted suicide. *Suicide and Life Threatening Behaviours*, **24**, 1-14.
- O'Brien, S. & Stoll, K. (1977). Attitudes of medical and nursing staff towards self-poisoning patients in a London hospital. *International Journal of Nursing Studies*, **14**, 29-35.
- O'Brien, G., Holton, A.R., Hurren, K., Watt, L. & Hassanyeh, F. (1987). Deliberate self-harm and predictors of out-patient attendance. *British Journal of Psychiatry*, **150**, 246-7.
- Ostamo, A., & Lonnqvist, J. (1994). The epidemiology of attempted suicide in Helsinki, 1989-1993. In A. Kerkhof, A. Schmidtke, U. Bille-Brahe, D. De Leo, & J. Lonnqvist (Eds.), *Attempted suicide in Europe*, pp.137-158. Leiden, The Netherlands: DSWO Press.
- Ovenstone, I.M.K. & Kreitman, N. (1974). Two syndromes of suicide. *British Journal of Psychiatry*, **124**, 336-45.
- Pallikkathayil, L. & McBride, A.B. (1986). Suicide attempts. *Journal of Psychosocial Nursing*, **24**, 113-118.
- Parris, J. (1992). Social risk factors for borderline personality disorder: a review and hypothesis. *Canadian Journal of Psychiatry*, **37**, 510-515.
- Parris, J. (1993). The treatment of borderline personality disorder in light of the research on its long term outcome. *Canadian Journal of Psychiatry*, **38** (1 Suppl), 28S-34S.
- Patel, A.R. (1975). Attitudes towards self-poisoning. *British Medical Journal*, **2**, 426-30.

Patrick, J. (1996). Use of Psychological Tests in Personality Disorders. In P.S. Links (Ed.) *Clinical assessment and management of severe personality disorders*, pp. 49-76. Washington, DC, American Psychiatric Press.

Paykel, E.S., Prusoff, B.A., & Myers, J.K. (1975). Suicide attempters and recent life events: a controlled comparison. *Archives of General Psychiatry*, **32**, 327-33.

Persons, J.B. & Burns, D.D. (1985). Mechanisms of action of cognitive therapy: The relative contributions of technical and interpersonal interventions. *Cognitive Therapy and Research*, **9**, 539-551.

Phillips, K.A. & Gunderson, J.G. (1999). Personality disorders. In R.E. Hales, S.C. Yudofsky & J.A. Talbott (Eds.), *The American Psychiatric Press Textbook of Psychiatry*, pp.795-823. American Psychiatric Press Inc.

Platt, S. & Kreitman, N. (1984). Trends in parasuicide and unemployment amongst men in Edinburgh, 1968-1982. *British Medical Journal*, **289**, 1029-32.

Platt, S., Hawton, K., Kreitman, N., Fagg, J., & Foster, J. (1988). Recent clinical and epidemiological trends in parasuicide in Edinburgh and Oxford: a tale of two cities. *Psychological Medicine*, **18**, 405-18.

Pollock, P.H., Broadbent, M., Clarke, S., Dorrian, A., & Ryle, A. (2000). *The Personality Structure Questionnaire (PSQ): A measure of the Multiple Self States Model of identity disturbance in Cognitive Analytic Therapy*. Manuscript submitted for publication.

Powell, A.S. (1991). The idealisation of Therapy: Fantasy versus Reality in Clinical Practice. *British Journal of Psychiatry*, **159**, 850-6.

Raine, A. (1993). Features of borderline personality and violence. *Journal of Clinical Psychology*, **49**, 277-281.

Ramon, S. (1980). Attitudes of doctors and nurses to self-poisoning patients. *Social Science and Medicine*, **14**, 317-324.

Ramon, S. & Breyter, C. (1978). Attitudes towards self-poisonings among British and Israeli doctors and nurses in a psychiatric hospital. *Israeli Annals of Psychiatry and Related Disciplines*, **16**, 317-324.

Ramon, S., Bancroft, J. & Skrimshire, A. (1975). Attitudes towards self-poisoning amongst physicians and nurses in a general hospital. *British Journal of Psychiatry*, **127**, 257-64.

Reich, J. (1987). Instruments measuring DSM-III and DSM-III-R personality disorders. *Journal of Personality Disorders*, **1**, 220-240.

Reich, A. (1951). On Countertransference. *International Journal of Psychoanalysis*, **32**, 25-31.

Reich, J.H., Boerstler, H., Yates, W. & Nduaguba, M. (1989). Utilisation of medical resources in persons with DSM-III personality disorders in a community sample. *International Journal of Psychiatry in Medicine*, **19**, 1-9.

Rich, C.L., Young, D. & Fowler, R.C. (1986). San Diego Suicide Study, I: Young versus old subjects. *Archives of General Psychiatry*, **43**, 577-582.

Robins, E., Warsrad, G.M. & Nemiroff, R.A. (1959). Some clinical considerations in the prevention of suicide based on a study of 134 successful suicides. *American Journal of Public Health*, **49**, 888-899.

Rogers, C.R. (1951). *Client centred therapy*. Cambridge, Mass.: Riverside Press.

Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology*, **21**, 95-103.

Roy, A. (1999). Psychiatric Emergencies. Suicide. In B.J. Sadock, B.J. & V.A. Sadock, (Eds.), *Comprehensive Textbook of Psychiatry*, pp. 2031-40. Lippincott, Williams, & Wilkins.

Roy, A., Segal, N.L., Centerwall, B.S. & Robinette, D. (1991). Suicide in Twins. *Archives of General Psychiatry*, **48**, 29-32.

Runeson, B.S., Beskow, J. & Waern, M. (1996). The suicidal process in suicides among young people. *Acta Psychiatrica Scandinavica*, **93**, 35-42.

Ryle, A. (1982). *Psychotherapy: a Cognitive Integration of Theory and Practice*. London Academic Press.

- Ryle, A. (1985). Cognitive theory, object relations and the self. *British Journal of Medical Psychology*, **58**, 1-7.
- Ryle, A. (1990). *Cognitive Analytic Therapy: Active Participation in Change*. Chichester: Wiley.
- Ryle, A. (1994). Consciousness and psychotherapy. *British Journal of Medical Psychology*, **67**, 115-124.
- Ryle, A. (1995). *Cognitive Analytic Therapy: developments in theory and practice*. Chichester: Wiley.
- Ryle, A. (1997). *Cognitive Analytic Therapy and Borderline Personality Disorder*. Chichester: Wiley.
- Safran, J.D. & Segal, Z.V. (1990). *Interpersonal process in cognitive therapy*. New York: Basic Books.
- Sainsbury, P. (1986). The epidemiology of suicide. In R.A. Baltimore (Ed.), *Suicide*, pp.17-40, Williams & Wilkins.
- Sakinofsky, I. (1996). The epidemiology of suicide in Canada. In A. Leenaars, S. Wenckstern, I. Sakinofsky, M. Kral, R. Dyck & R. Bland (Eds.), *Suicide in Canada*, University of Toronto.
- Samuelsson, M., Asberg, M. & Gustavsson, J.P. (1997). Attitudes of psychiatric nursing personnel towards patients who have attempted suicide. *Acta Psychiatrica Scandinavia*, **95**, 222-230.
- Schulsinger, F., Kety, S.S., Rosenthal, D. & Wender, P.H. (1979). A Family Study of Suicide. In M. Schou & E. Stromgren (Eds.), *Prevention and Treatment of Affective Disorders*, Academic Press, New York.
- Seligman, M.E.P. (1975). *Helplessness: On depression, development, and death*. San Francisco: W.H. Freeman.
- Sheard, T., Evans, J., Hicks, J., King, A., Nereli, B., Rees, H., Sandford, J. Slinn, R. & Ryle A. (2000). A CAT derived one to three session intervention for repeated deliberate self

harm. Part one: The model, its rationale and development. Manuscript submitted for publication.

Shearer, S.L., Peters, C.P., Quaytman, M.S. & Ogden, R.L. (1990). Frequency and correlates of childhood sexual and physical abuse histories in adult female borderline inpatients. *American Journal of Psychiatry*, **147**, 214-216.

Sidley, G. & Renton, J. (1996). General nurses' attitudes to patients who self-harm. *Nursing Standard*, **10**, 32-36.

Skinner, A. & Baul, J. (1997). Clinical psychologists' caseloads and waiting lists: the DCP survey. *Clinical Psychology Forum*, **110**, 40-46.

Snyder, M. (1992). The meaning of empathy: Comments on Hans Strupp's case of Helen R. *Psychotherapy*, **29**, 318-322.

Spitzer, R.L., Williams, J.B.W. & Gibbon, M. (1987). *Structured Clinical Interview for DSM-III-R (SCID-II)*. New York: New York State Psychiatric Institute, Biometrics Research.

Suokas, J. & Lonnqvist, J. (1989). Work stress has negative effects on the attitudes of emergency personnel towards patients who attempts suicide. *Acta Psychiatrica Scandinavia*, **79**, 474-480.

Urwin, P. & Gibbons, J.L. (1979). Psychiatric diagnosis in self-poisoning patients. *Psychological Medicine*, **9**, 501-7.

van Egmond, M., Garnefski, N., Jonker, S. & Kerkhov, A. (1993). The relationship between sexual abuse and female suicidal behaviour, *Crisis*, **14**, 129-39.

van Heeringen, C., Jannes, S., Buylaert, W., Henderick, H., De Bacquer, D. & Van Remoortel, J. (1995). The management of non-compliance with referral to out-patient after-care among attempted suicide patients: a controlled intervention study. *Psychological Medicine*, **25**, 963-70.

Wagner, C.C., Riley, W.T., Schmidt, J.A., McCormick, M.G.F. & Butler, S.F. (1999). Personality disorder styles and reciprocal interpersonal impacts during outpatient intake interviews. *Psychotherapy Research*, **9**, 216-231.

Waldinger, R.J. & Gunderson, J.G. (1987). *Effective psychotherapy with borderline patients: Case studies*. New York: Macmillan.

Weissman, M.M. (1993). The epidemiology of personality disorders: A 1990 update. *Journal of Personality Disorders*, 7, supplement 1, 44-62.

Welu, T.C. (1972). Psychological reactions of emergency room staff to suicide attempters. *Omega*, 3, 103-109.

Williams, J.M.G. (1997). *Cry of Pain. Understanding suicide and self-harm*. Penguin Books Ltd, London.

Winokur, G. & Tsuang, M. (1975). The Iowa 500: suicide in mania, depression, and schizophrenia. *American Journal of Psychiatry*, 132, 650-651.

Wolf, Z. (1988). *Nurses' work: The sacred and the profane*. Philadelphia: University Press.

World Health Organisation (WHO) (1993). *The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research*. Geneva: World Health Organisation.

Young, J.E. (1990). *Cognitive therapy for personality disorders: A schema-focussed approach*. Sarasota, FL: Professional Resource Exchange.

Yuen, N., Andrade, N., Nahulu, L., Makini, G., McDermott, J.F., Danko, G., Johnson, R., & Waldron, J. (1996). The rate and characteristics of suicide attempters in the Native Hawaiian adolescent population. *Suicide and Life-Threatening Behaviour*, 26, 27-36.

Zanarini, M.C., Gunderson, J.G., Marino, M.F., Schwartz, E.O. & Frankenburg, F.R. (1989). Childhood experiences of borderline patients. *Comprehensive Psychiatry*, 30, 18-25.

Zimmerman, M. (1994). Diagnosing personality disorders. A review of issues and research methods. *Archives of General Psychiatry*, 51, 225-245.

Zimmerman, M. & Coryell, W. (1989). DSM-III personality diagnoses in a non-patient sample: demographic correlates and comorbidity. *Archives of General Psychiatry*, 46, 682-689.

Appendix I. Subject information sheet and consent form

Information sheet: An investigation of the experience of a psychiatric interview following self-harm

INTRODUCTION

We are trying to look at the experiences of people who have harmed themselves in West Lothian with a view to making recommendations for improved care.

We are inviting all patients who have self-harmed to take part. We are keen to know what they are like and how they experience their post-overdose assessment.

WHAT IS INVOLVED?

The research psychologist will ask you to complete a questionnaire and ask you a few questions. She will remain with you to offer any assistance. This will take approximately half an hour.

The study is entirely voluntary and though we hope you will be happy to take part there is no obligation to do so. You will have up to two hours to decide whether you would like to participate in this study. If at any time you feel uncomfortable with participating in the study you may withdraw anytime. Not taking part will in no way influence your current or future treatment.

If you agree to participate you will meet the researcher Charlotte Nevison who is a final year Clinical Psychology trainee.

All the information you give will be confidential and anonymous. Records will be identified by a research number, not by name, and all records will be kept in a locked filing cabinet.

You may take time to decide whether you would like to participate and the researcher will be available to answer questions regarding any concerns you may have.

MANY THANKS FOR YOUR HELP

If you have any further questions, please contact:

Principal researcher

Charlotte Nevison
Psychology Department
St John's Hospital at Howden
Tel; 01506 422769

Independent advisor

Dr Tom Brown
Consultant Psychiatrist
St John's Hospital at Howden
Tel; 01506 419666 Ex. 2676

Consent form

An investigation of the experience of a psychiatric interview following overdose or other type of self-harm.

PERMISSION OF PATIENT

I have read the Information sheet and consent form and have had the opportunity to ask questions about them.

I give permission for the researcher to have access to my medical notes and to inform my GP of my participation in this study.

I understand that whether I participate or not will have no bearing on my treatment.

I understand that I have the right to withdraw from the study at any stage.

I agree to participate in this study

Signature of respondent.....

Date.....

Name of respondent (please print)

Signature of researcher;

Independent advisor; Dr Tom Brown, Consultant Psychiatrist, St John's Hospital, Livingston. Tel; 01506 419666 Ex. 2676

GP;

Appendix II. Comparison group information sheet

INTRODUCTION

We are trying to look at the experiences of people in Psychiatry and Psychology during their assessment interview with a view to making recommendations for improved care.

We are inviting all patients to take part. We are keen to know what they are like and how they experience their assessment.

WHAT IS INVOLVED?

The research psychologist will ask you to complete a questionnaire and ask you a few questions. She will remain with you to offer any assistance. This will take approximately half an hour.

The study is entirely voluntary and though we hope you will be happy to take part there is no obligation to do so. If at any time you feel uncomfortable with participating in the study you may withdraw anytime. Not taking part will in no way influence your current or future treatment.

If you agree to participate you will meet the researcher Charlotte Nevison who is a final year Clinical Psychology trainee.

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Tel; 01506 419666 Ex. 2676

Over the last several years.....

- | | | | |
|-----|--|---|---|
| 1. | I avoid working with others who may criticise me | T | F |
| 2. | I can't make decisions without the advice or reassurance of others | T | F |
| 3. | I often get lost in the details and lose sight of the big picture | T | F |
| 4. | I need to be the centre of attention | T | F |
| 5. | I have accomplished far more than others give me credit for | T | F |
| 6. | I'll go to extremes to prevent those I love from leaving me | T | F |
| 7. | I've been in trouble with the law several times (or would have been if I was caught) | T | F |
| 8. | Spending time with family or friends just doesn't interest me | T | F |
| 9. | I get special messages from things happening around me | T | F |
| 10. | I know that people will take advantage of me, or try to cheat me, if I let them | T | F |
| 11. | Sometimes I get upset | T | F |
| 12. | I make friends with people only when I am sure they like me | T | F |
| 13. | I prefer that other people assume responsibility for me | T | F |
| 14. | I waste time trying to make things to perfect | T | F |
| 15. | I am sexier than most people | T | F |
| 16. | I often find myself thinking about how great a person I am, or will be | T | F |
| 17. | I either love someone or hate them, with nothing in between | T | F |
| 18. | I get into a lot of physical fights | T | F |
| 19. | I would rather do things by myself than with other people | T | F |
| 20. | I have the ability to know that some things will happen before they actually do | T | F |

Over the last several years....

- | | | | |
|-----|--|---|---|
| 21. | I often wonder whether the people I know can really be trusted. | T | F |
| 22. | Occasionally I talk about people behind their backs | T | F |
| 23. | I am inhibited in my intimate relationships because I am afraid of being ridiculed | T | F |
| 24. | I fear losing the support of others if I disagree with them | T | F |
| 25. | I put my work ahead of being with my family or friends or having fun | T | F |
| 26. | I show my emotions easily | T | F |
| 27. | Only certain very special people can really appreciate and understand me | T | F |
| 28. | I often wonder who I really am | T | F |
| 29. | I have difficulty paying bills because I don't stay at any one job for very long | T | F |
| 30. | Sex just doesn't interest me | T | F |
| 31. | I can often sense or feel things that others can't | T | F |
| 32. | Others will use what I tell them against me | T | F |
| 33. | There are some people I don't like | T | F |
| 34. | I am more sensitive to criticism or rejection than most people | T | F |
| 35. | I find it difficult to start something if I have to do it by myself | T | F |
| 36. | I have a higher sense of morality than most people | T | F |
| 37. | I use my "looks" to get the attention I need | T | F |
| 38. | I need very much for other people to take notice of me or compliment me | T | F |
| 39. | I have tried to hurt or kill myself | T | F |
| 40. | I do a lot of things without considering the consequences | T | F |
| 41. | There are few activities that I have any interest in | T | F |
| 42. | People often have difficulty understanding what I say | T | F |

Over the last several years....

- | | | | |
|-----|---|---|---|
| 43. | I keep alert to figure out the real meaning of what people are saying | T | F |
| 44. | I have never told a lie | T | F |
| 45. | I am afraid to meet new people because I feel inadequate | T | F |
| 46. | I want people to like me so much that I volunteer to do things that I'd rather not | T | F |
| 47. | I have accumulated lots of things I don't need that I can't bear to throw out | T | F |
| 48. | Even though I talk a lot, people say that I have trouble getting to the point | T | F |
| 49. | I expect other people to do favours for me even though I do not usually do favours for them | T | F |
| 50. | I am a very moody person | T | F |
| 51. | Lying comes easily to me and I often do it | T | F |
| 52. | I am not interested in having close friends | T | F |
| 53. | I am often on guard against being taken advantage of | T | F |
| 54. | I never forget, or forgive, those who do me wrong | T | F |
| 55. | A nuclear war may not be such a bad idea | T | F |
| 56. | When alone I feel helpless and unable to care for myself | T | F |
| 57. | If others can't do things correctly I would prefer to do things myself | T | F |
| 58. | I have a flair for the dramatic | T | F |
| 59. | Some people think that I take advantage of others | T | F |
| 60. | I feel that my life is dull and meaningless | T | F |
| 61. | I don't care what others say about me | T | F |
| 62. | I have difficulties relating to others in a one-to-one situation | T | F |
| 63. | People have often complained that I did not realise they were upset | T | F |
| 64. | By looking at me, people might think that I'm pretty odd, eccentric or weird | T | F |

Over the last several years....

65.	I enjoy doing risky things	T	F
66.	I have lied a lot on this questionnaire	T	F
67.	I have difficulty controlling my anger, or temper	T	F
68.	Some people are jealous of me	T	F
69.	I am easily influenced by others	T	F
70.	I see myself as thrifty but others see me as being cheap	T	F
71.	When a close relationship ends, I need to get involved with someone else immediately	T	F
72.	I suffer from low self-esteem	T	F
73.	I waste no time in getting back at people who insult me	T	F
74.	Being around people makes me nervous	T	F
75.	In new situations I feel embarrassed	T	F
76.	I am terrified of being left to care for myself	T	F
77.	People complain that I'm stubborn as a mule	T	F
78.	I take relationships more seriously than do those who I'm involved with	T	F
79.	Others consider me to be stuck up	T	F
80.	When stressed things happen. Like I get paranoid or just black out	T	F
81.	I don't care if others get hurt so long as I get what I want	T	F
82.	I keep my distance from others	T	F
83.	I often wonder whether my partner (wife, husband, girlfriend, boyfriend) has been unfaithful to me	T	F

84. I have done things on impulse (such as those below) that can get me into trouble T F

Tick any that apply to you:

- Spending more money than I had
- Having sex with people I hardly know
- Drinking too much
- Taking drugs
- Eating binges
- Reckless driving

85. When I was a kid (before age 15) I was somewhat out of control, doing some of the things below T F

Tick any that apply to you:

- I was considered a bully
- I used to start fights with other kids
- I used a weapon in fights that I had
- I robbed or mugged other people
- I was physically cruel to other people
- I was physically cruel to animals
- I forced someone to have sex with me
- I lied a lot
- I stayed out at night without my parents permission
- I stole things from others
- I set fires
- I broke windows or destroyed property
- I ran away from home overnight more than once
- I began skipping school, a lot, before age 13
- I broke into someone's house, building or car

Appendix IV. Personality Structure Questionnaire (Broadbent, Clark, & Ryle, 2000)

The aim of this questionnaire is to obtain an account of certain aspects of your personality. People vary greatly in all sorts of ways: the aim of this form is to find out how far you feel yourself to be constant and 'all of a piece' or variable and made up of a number of distinct 'sub-personalities' or liable to experience yourself as shifting between two or more quite distinct and sharply differentiated states of mind.

Most of us experience ourselves as somewhere between these contrasted ways. A state of mind is recognised by a typical mood, a particular sense of oneself and of others and by how far one is in touch with, and in control of, feelings. Such states are definite, recognisable ways of being; one is either clearly in a given state or one is not. They often affect one quite suddenly; they may be of brief duration or they last for days. Sometimes, but not always, changes of state happen because of a change in circumstances or an event of some kind.

Please indicate which description applies to you most closely by shading the appropriate circle

Please complete all questions and shade only one circle per questions.

	Very True	True	May or True may not be true	True	Very true	
1. My sense of myself is always the same	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	How I act or feel is constantly changing
2. The various people in my life see me in much the same way	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	The various people in my life have different views of me as if I were not the same person
3. I have a stable and unchanging sense of myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I am so different at times that I wonder who I really am
4. I have no sense of opposed sides to my nature	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I feel I am split between two (or more) ways of being, sharply differentiated from each other
5. My mood and sense of self seldom change suddenly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	My mood can change abruptly in ways which make me feel unreal or out of control
6. My mood changes are always understandable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I am often confused by my mood changes which seem either unprovoked or quite out of scale with what provoked them
7. I never loose control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I get into states in which I lose control and harm to myself and/or others
8. I never regret what I have said or done	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	I get into states in which I do and say things which I later regret

Thank-you for your help. All information will be treated as private and confidential.

Appendix V. Clinician and Patient Response File

Clinician Response File (CRF)

Please rate each statement on a scale of 0-4.

(0 -not at all, 1-slightly agree, 2-agree, 3- strongly agree, 4-very strongly agree).

1. I felt hurt and rejected by this patient, perhaps as though my attempts to care and be helpful were thrown back in my face, weren't good enough	
2. I felt the patient was trying to please me, be compliant and avoidant of any conflict with me	
3. I felt parental towards the patient, as though they were a child and lacking adult resources	
4. I felt the patient was compliant, trying to please me, and avoidant of any conflict with me	
5. I felt anxious, maybe threatened when we got near feelings	
6. I did most / all of the work	
7. I felt disabled, incompetent, paralysed, lost and so I felt a failure and very self-critical about this interview	
8. I felt critical / despising of the patient, feeling I wanted to label them in an insulting or demeaning way	
9. I felt blocked / frustrated in getting to any feelings, anything real, any contact between us	
10. I felt irritated or angry with the patient	
11. I felt drawn into wanting to make a big effort to help the patient in practical ways, e.g. setting up support	
12. I felt overwhelmed emotionally: myself wanted rescuing by a senior colleague. Help!! Reached for the phone at the end of the interview	
13. I felt like harming the patient or shouting at the patient	
14. I felt the patient was passively blocking "yes but"	
15. I felt the patient was passively blocking	
16. I felt hurt and rejected by this patient, perhaps as though my attempts to care and be helpful were thrown back in my face, weren't good enough	
17. I felt bored by the patient	
18. I gave a lot of advice to the patient who was very passive	
19. I wanted to finish and get out of the interview as quickly as possible	
20. I felt the patient was trying to look after or protect me	
21. I felt threatened by the patient in a way which drew me into limiting what I said	

22.I felt idealised by the patient	
23.I felt cut off from and felt no feeling for the patient as a human being	
24.I felt a special sympathy for the patient who moved me into wanting a wonderful solution for all of his or her pain so s/he can go on to live happily ever after	
25.I felt disabled, incompetent, paralysed, lost and so I felt a failure and very self-critical about the interview	
26.I feel pity for the patient as though s/he is pathetic	
27.I felt very powerful and effective and the patient seemed weak and powerless	
28.I felt dismissed / invalidated as a human being by the patient (treated as if I am a faceless professional)	
29.I felt overwhelmed by complexity or detail	
30.I felt fascinated / enchanted by the patient	
31.I felt fear / tension / beaten up by the patient's aggression / anger or hostility	
32.I felt ignored or marginalised as the patients attention was focused on someone or something else	

Patient Response File (PRF)

Please rate each statement on a scale of 0-4.
(0 -not at all, 1-slightly agree, 2-agree, 3- strongly agree, 4-very strongly agree).

1. I felt the doctor was completely useless though the interview	
2. I saw the doctor as just another worker who didn't care for me as a person.	
3. I felt I needed the doctor to put things right and felt that he/she were not good enough because he/she could not do this.	
4. I felt that I wanted the doctor to help me and provide care but they were not good enough.	
5. I felt the doctor had hostile feelings toward me.	
6. I wanted the doctor to look after me so I had to be nice and not mention any of my feelings of rage and anger.	
7. I felt cut-off / distanced from my feelings and the doctor.	
8. I felt I had to be nice to the doctor to be worthy of their care as I know I'm not worth it. If they saw the real me they would not help.	
9. I felt like the doctor was paternal towards me and treated me as a child.	
10. I was aware of getting very upset and angry when we talked about my feelings.	
11. I gave all of my problems to the doctor to sort out, they were too much for me.	
12. I felt that the doctor really cared about me and that he/she would have the answer to take away all of my pain.	
13. I did hardly anything through the interview.	
14. I felt there was no point being open and honest with the doctor, he/she could not understand or help me.	
15. I felt the doctor really understood me better than anyone else. They could put things right.	
16. I felt quite hostile. If the doctor had mentioned certain things I would have got very angry / upset/ emotional.	
17. I felt disinterested in the doctor as my thoughts were elsewhere. My thoughts were on the thing/person in my life that I need, that I cannot cope without.	
18. I felt that I kept the doctor happy. I felt that I put on a front for the doctor and that he/she didn't see the real me.	
19. I felt that the doctor was willing to really work to put things right for me.	
20. I felt angry / aggressive / hostile towards the doctor.	
21. I felt the doctor cut-off as though they were unable to bear/hear my story. I felt that the doctor consciously switched off as they could not face hearing my story.	

22.I felt weak and hopeless and that the doctor recognised this and felt sorry for me. That he/she wanted to put things right for me.	
23.I felt the doctor was irritated or angry with me, that I was annoying.	
24.I wanted the doctor to solve my problems but I knew they did not have the answer.	
25.I felt it was up to the doctor to help me and I said little through the interview.	
26.I felt the doctor felt negatively towards me, looked down on me.	
27.I gave all of my problems to the doctor to sort out, they were too much for me.	
28.I felt weak and powerless while the doctor seemed effective and powerful.	
29.I felt that the doctor wasn't really interested. I felt distanced from the doctor.	
30.I felt the doctor or the whole system were not doing enough to help me. I felt angry.	
31.I felt rejected or disliked by the doctor.	
32.I felt I had to look after or protect the doctor. Perhaps if I did this, then they would look after me.	

Appendix VI. The Empathy Scales (Persons & Burns, 1985)

The Empathy Scale (Patients version)

Put a check (✓) in the box to the right to indicate how strongly you agree with each of the following 10 statements concerning your appointment.	Not at all	Somewhat	Moderately	Alot
1. I felt that I could trust my therapist during today's session.				
2. My doctor felt I was worthwhile.				
3. My doctor was friendly and warm toward me.				
4. My doctor understood what I said today.				
5. My doctor was sympathetic and concerned about me.				
6. Sometimes my doctor did not seem to be completely genuine.				
7. My doctor pretended to like me more than he or she did.				
8. My doctor did not seem to care about me.				
9. My doctor did not understand the way I felt inside.				
10. My doctor acted condescending and talked down to me				
Total score				

The Empathy Scale (Therapist's version)

Put a check (✓) in the box to the right to indicate how strongly you agree with each of the following 10 statements concerning your appointment.	Not at all	Somewhat	Moderately	Alot
1. I felt that he or she could trust me during today's session.				
2. I felt this patient was worthwhile.				
3. I appeared warm and friendly during the appointment.				
4. My patient felt understood during the session.				
5. I appeared sympathetic and concerned about this patient.				
6. Sometimes I did not seem completely genuine.				
7. I pretended to like this patient more than I did.				
8. I did not always appear to care about him or her.				
9. I did not always understand how he or she felt inside.				
10. Sometimes I appeared condescending and talked down to the patient.				
Total score				

Appendix VII. Deliberate Drug Overdose Questionnaire (Sidney & Renton, 1996)

Sex; Male / Female Profession

Experience of working with individuals who deliberately self-harm; none / a little / quite a lot / a lot

Please endorse the statements listed below;

	Strongly agree	Agree	Disagree	Strongly disagree
1. Patients who take deliberate drug overdoses are more at risk of completing suicide in the future.				
2. Patients who kill themselves rarely mention their intention to anyone.				
3. Patients who survive a deliberate drug overdose cannot be serious about killing themselves, otherwise they would have used more lethal means.				
4. The taking of a deliberate drug overdose is a display of attention seeking behaviour.				
5. Patients who take deliberate drug overdoses should be considered less of a priority when working on a busy medical ward.				
6. Patients who take deliberate drug overdoses have equal right to expensive medical treatment.				
7. A lot of my colleagues dislike working with patients who take deliberate drug overdoses.				
8. Working with patients who take deliberate drug overdoses is frustrating.				
9. Working with patients who take deliberate drug overdoses is rewarding.				
10. Working with patients who take deliberate drug overdoses makes me feel uncomfortable.				
11. Working with patients who take deliberate drug overdoses makes me feel depressed.				
12. Current services for patients who take deliberate drug overdoses are inadequate.				
13. Training for nursing staff regarding the non-medical management of patients who take deliberate drug overdoses is inadequate.				
14. I believe I have adequate skills in dealing with the non-medical aspects of care for patients who take deliberate drug overdoses.				
15. Support should be routinely offered to nursing staff who work with patients who take deliberate drug overdoses.				

Thank-you for taking time to complete this questionnaire

Appendix VIII. Subject demographic information sheet (experimental group)

Study number;

Age;.....

Sex;

Ethnic group;

Marital status;

Current employment;

If unemployed / retired for how long;

Physical health;

Mental health;.....

Living arrangements (alone / shared);.....

Date of admission;

Time of arrival to A&E;

Time of interview with SHO;.....

Means of deliberate self-harm;

Nature of DSH; impulsive or planned;

Did you mean to kill yourself?

Use of suicide note;

Use of alcohol in suicide attempt;

Use of alcohol heavily over the past week;

Number of previous episodes of deliberate self-harm;

Are you currently receiving any mental health treatment?.....

If so what?

Have you received any mental health treatment in the past?.....

If so in-patient or out-patient treatment?.....

Appendix IX. Subject demographic information sheet (comparison group)

Demographics

Study number;

Age;.....

Sex;

Ethnic group;

Marital status;

Current employment;

If unemployed / retired for how long;

Physical health;

Mental health;.....

Living arrangements (alone / shared);.....

Date of appointment;

Clinical psychologist / SHO;

Time of interview;.....

Referral problem;

Use of alcohol heavily over the past week;

Have you received any mental health treatment in the past?.....

If so in-patient or out-patient treatment?.....

Any history of deliberate self-harm?.....

If so, what and when?

Appendix X. Validation exercise with CAT practitioners; letter and wheel

Dear CAT Practitioner,

I would be grateful if you could help me in developing measures for my D.Psych thesis by completing the attached "Draft Questionnaire". Below is an explanation of the research and instructions for completing the questionnaire.

I am a third year clinical psychology trainee. My research is being supervised by Allison Ridley/Shanks, CAT Practitioner, and Prof Mick Power of Edinburgh University.

If you have any questions regarding the questionnaire or research, please contact me, either by phone at St. John's Hospital (01506 422769) or via e-mail at CBN@onet.co.uk

Section A is an outline of the research which may, or may not, be of interest to you. Section B contains directions for completion of the questionnaire.

I would welcome any comments you have on the project or questionnaire.

Thank you in advance for your help.

yours sincerely,

Charlotte Nevison

Please return completed forms to;

Charlotte Nevison
Psychology Department
St John's Hospital at Howden
Howden Road West
Livingston,
EH54 6PP

Section A - Outline of Research

Individuals who deliberately self-harm (DSH) pose a large clinical challenge and UK service provision for these patients varies greatly. Many of these patients do not have a major mental illness, but do suffer from personality disorder. Studies suggest multiple repetition of self-harm is frequent and suicide levels of up to 10% have been found in this group (Nordentof et al 1996). Patients are often offered follow-up appointments, yet attendance is notoriously poor (approximately 40 - 50%). The literature stresses the importance of developing a therapeutic alliance, and the challenges of this. This client group are often seen as difficult and manipulative and health service staff can feel they have little to offer this patient group. This group does however have a lot of contact with services through "crisis presentation". To make optimum use of resources and identify how best to help this patient group, research into the nature of this contact is worthwhile.

My study is concerned with testing hypotheses regarding the interaction between the patient and psychiatrist in the psychiatric assessment interview following an overdose. It is based upon the work of Tim Sheard et al (in press) (which you may be familiar with from presentations at CAT Conferences).

It is hypothesised that - as with any individual - the way the individual construes the interpersonal world will be reflected in the transference and counter-transference in the psychiatric interview. Sheard et al believe that the three particular themes which are common in the transference and counter-transference in this situation are HOSTILITY, AVOIDANCE, and RESCUE and that these are on a continuum.

Because of the pressure to reciprocate, the psychiatrist may easily be drawn into an enactment of reciprocal roles. Thus, one can see how the interaction may reinforce the client's view of the world.

Sheard et al's work is concerned with developing standardised SDR's which can be used by workers with relatively limited training (i.e. not CAT practitioners) as a basis for a brief intervention with this client group. One of the measures they have developed is a measure of counter-transference (the Assessor's Response File). This aims to help the worker to identify their counter-transference response, which they may then use to guide them towards which standardised SDR would be most helpful. More specifically, it focuses upon which themes are dominant in the counter-transference (hostility, avoidance or rescue).

The measures I am developing are based upon the above measure. First there will be a measure adapted from the Assessor's Response File which will be renamed the Clinician Response File. Secondly there will be a measure named the Patient Response File, which will be composed of parallel items to those in the Clinician Response File and will form a measure of the patient's response. Together, the Clinician Response File and the Patient Response File are concerned with measuring the nature and intensity of the transference and counter-transference responses i.e. what are the main themes (hostility, avoidance or rescue) and how intense is this response.

In the project I will interview patients after they have been seen by the psychiatrist for psychiatric assessment. (They will have been seen beforehand when I will have informed them about the research and sought their consent for participation). They will be asked to complete a number of questionnaires, including the one I am asking your assistance in developing. The other measures will be the Personality Diagnostic Questionnaire 4 (Hyler 1994), Personality Structure Questionnaire (Broadbent, Clark and Ryle in press) and the Empathy Scale (Burns 1994). The psychiatrist will complete a brief version of the Assessor Response File.

It is predicted that higher levels of personality disturbance and lower levels of integration (as measured by Broadbent et al's measure) will be associated with poorer therapeutic alliance and more intense transference and counter-transference responses. If supported, this will highlight how this interview may inadvertently be perpetuating difficulties, and the usefulness of trying to avoid this, whether through the use of an intervention such as that of Sheard et al, or through teaching (perhaps using a CAT model). The latter would be aimed at increasing awareness and understanding of this client group's difficulties.

Further, if the measure we are developing correlates with the standardised measures, and if there is correlation between the patient and therapist ratings, then this would support Sheard's model.

References:

Broadbank, M., Clark, S. and Ryle, A. (In press) The Personality Structure Questionnaire. c/o ACAT Office, Academic Department of Psychiatry, St Thomas' Hospital, London.

Burns (1994). Therapeutic Empathy in Cognitive Behavioural Therapy: Does it really make a difference? In Salkovskis, P. (1996) *Frontiers of Cognitive Therapy: The State of the Art and Beyond*, 138-140. Guildford Press.

Campling, P. (1996). Maintaining the therapeutic alliance with personality disordered patients. *The Journal of Forensic Psychiatry*, 7, 3, 535-550.

Casey, P.R. (1989). Personality disorder and suicide intent. *Acta Psychiatrica Scandinavica*, 79 (3), 290-5.

Hyer S.E. (1994) The Personality Diagnostic Questionnaire 4 and Instructions for Use. Unpublished manuscript.

Nordentoft, M. Breum, L. Munck, LK. Nordestgaard, AG. Hunding, A. Bjaeldager, PAL. (1993) High mortality by natural and unnatural causes: a 10 year follow up study of patients admitted to a poisoning treatment centre after suicide attempts. *British Medical Journal* 306 6893: 1637-41.

Ryle, A. (1997) The structure and development of borderline personality disorder: a proposed model. *British Journal of Psychiatry* 170 82-87.

Sheard, T. (in press) A CAT derived one to three session intervention for repeated deliberate self-harmers: part one the model and its rationale.

Sidley, G. and Renton, J. (1996) General nurses attitudes to patients who self-harm. *Nursing Standard*, 10, 32-36.

Urwin, P. & Gibbons, J.L. (1979) Psychiatric diagnosis in self poisoning patients. *Psychological Medicine*, 9 501-8.

Section B - Completing the Questionnaire

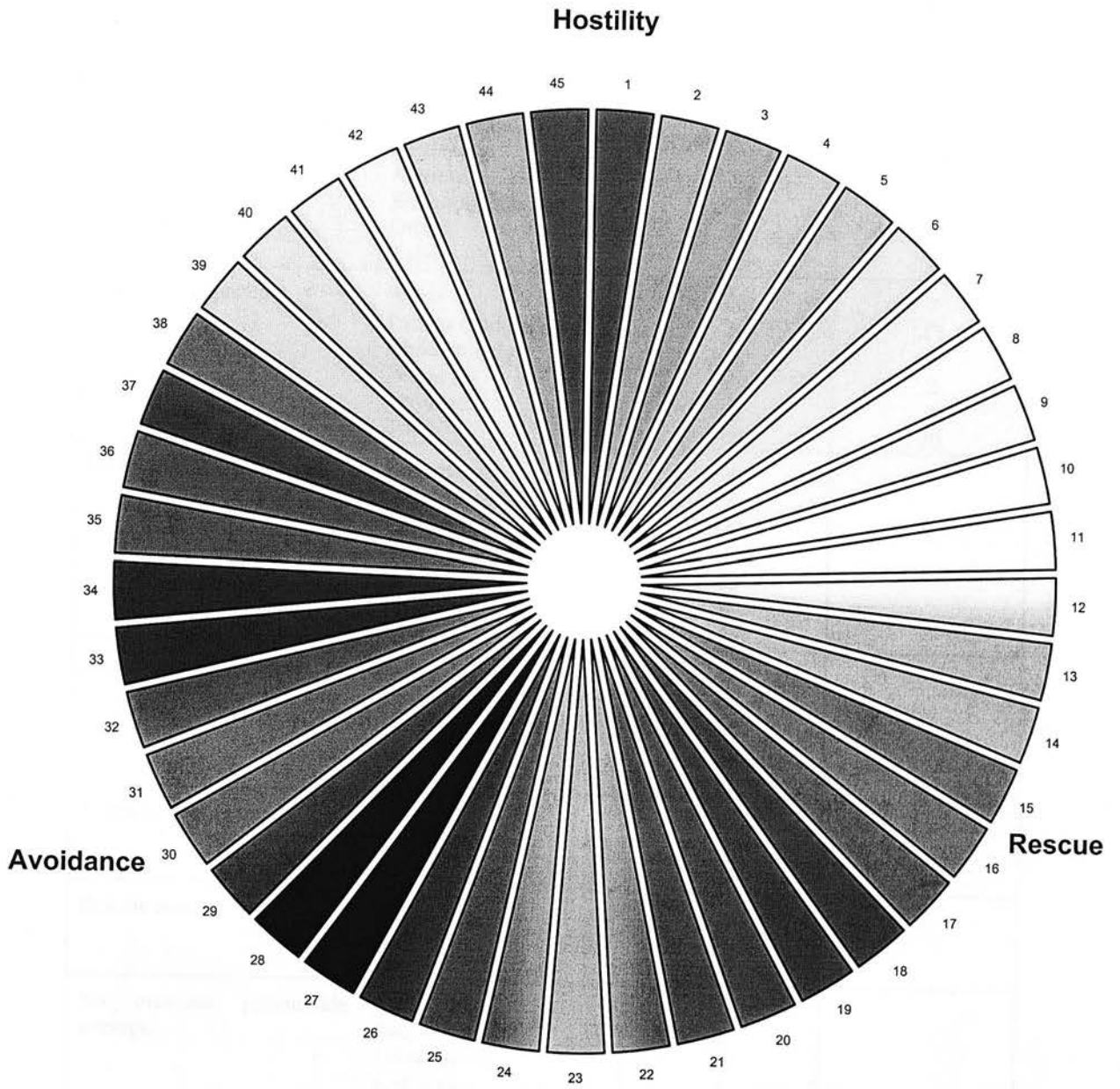
As mentioned there are to be two parallel measures, one to be completed by the psychiatrist, aimed at assessing counter-transference, and one by the patient, aimed at assessing transference.

Currently Sheard's measure is composed of 32 items and your help is required to reduce the number of items in this measure. This is necessary so that it is less time-consuming for the patient and doctor.

What I wish to do is to assess where each statement could be placed on the continuum of hostility-rescue-avoidance. This will allow me to select 12 statements for each measure which will cover the whole continuum as best as possible. The final measure will involve the psychiatrist / patient indicating how true they they thought the statement was of the interview.

In the attached Draft Questionnaire there are two parts relating to the two measures being developed,- the Client Response File and the Clinician Response File.

What I would ask you to do is to use the accompanying wheel to rate each statement. The wheel is composed of 45 parts. It represents the proposed continuum between hostility, rescue and avoidance. You are asked to read each statement and consider its best position on the chart. For example if you think statement "I felt it was up to the doctor to help me and I did little through the interview" is an example of a transference response involving rescue and hostility you may choose a rating of say 9.

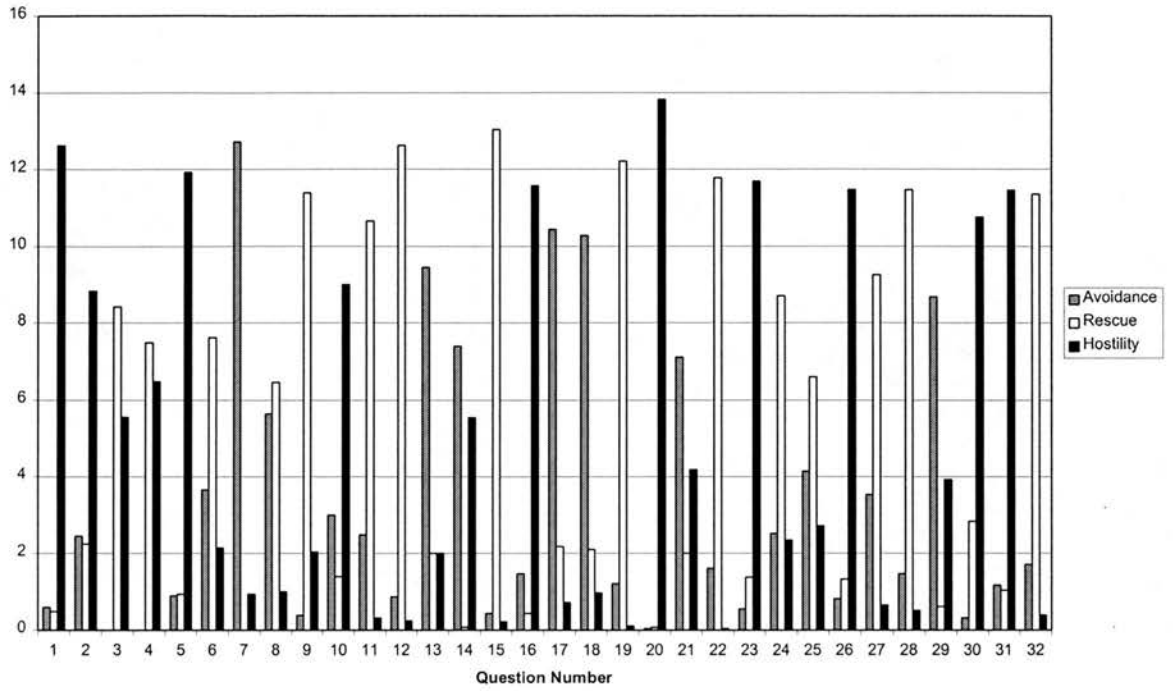


Appendix XI. Demographic characteristics of experimental and comparison groups

		Exp. group	Com. group
Marital status	Single	28	10
	Married	15	13
	Separated	9	2
	Divorced	6	4
	Widowed	<u>2</u>	<u>1</u>
	Total	60	30
Physical health	No problems	38	20
	Significant problems	<u>22</u>	<u>10</u>
	Total	60	30
Mental health	No problems	15	5
	Depression	35	12
	Anxiety	5	6
	Schizophrenia	3	3
	Other	<u>2</u>	<u>3</u>
	Total	60	30
Living arrangements	Alone	14	7
	Partner (and children)	21	17
	Children only	8	4
	Parent (s)	13	2
	Flatmates	<u>3</u>	<u>0</u>
	Total	60	30
Method of self-poisoning	Paracetamol	5	
	Other analgesics	8	
	Tranquillizers	4	
	Antidepressants	8	
	Mixture	30	
	Other	<u>1</u>	
	Total	56	
Amount taken	0-10	8	
	10-20	11	
	20-30	11	
	30+	<u>26</u>	
	Total	56	
Intent to kill oneself	Yes	31	
	No	<u>29</u>	
	Total	60	
Suicide note	Yes	9	
	No	<u>51</u>	
	Total	60	
No previous parasuicide attempts	None	30	
	One	8	
	1-5 times	10	
	5-10 times	9	
	10 and more	<u>3</u>	
	Total	60	
Use of alcohol whilst overdosing	Yes	36	
	No	<u>24</u>	
	Total	60	
Excessive alcohol use in preceding week	Yes	22	3
	No	<u>38</u>	<u>27</u>
	Total	60	30

Appendix XII. Results from validation exercise

Patient Response File



Clinician Response File

