Shame and Self Harm in Axis II Disorders

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Submitted in part fulfilment for the degree of Doctorate in Clinical Psychology

University of Edinburgh
August 2004

<u>Declaration</u>

"This thesis has been composed by myself and the work herein is my own"

Signed

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Acknowledgements

I would like to thank Adeline Graham, Suzanne O'Rourke and Arthur Still for their advice and support during the planning and write up of this thesis.

I would also like to thank the individuals who participated in this study, and acknowledge their dedication and motivation to help others who experience difficulties similar to their own.

ABSTRACT

Self harm is a challenging clinical problem within the health services. Although it has attracted a great deal of research attention, the majority of this research would appear to be descriptive in nature, with limited knowledge relating to the actual experience and function of self harm. It is suggested that one of the reasons that individuals engage in self harm is to be relieved of negative emotions (Brown, 2003). One emotion that is thought to play a significant role in self harm is shame (Wise, 1989). Further to this, self harm behaviour is found to be prevalent in the Axis II disorder (Personality Disorder) client group (Dulit et al., 1994). However, the fact that not all individuals engage in self harm behaviour, would suggest that certain mediating factors may exist.

The hypotheses that were explored stated that individuals who have a personality disorder and who self harm, will experience higher levels of internal shame, and report more active shame schemas than those with a personality disorder who do not self harm. It was also hypothesised that in those who self harm, the frequency of self harm would be related to the levels of shame.

The results of the study were analysed, and are discussed with reference to related theories and literature. Two case examples are also reported. The findings of this study suggested that there were no differences in shame between individuals with a personality disorder who self harm and those who do not self harm. The findings also indicated that there was no relationship between the frequency of self harm and shame. However, during the course of analysis, there was some evidence of a relationship between the recency of self harm and the level of shame. Methodological issues and conclusions are discussed.

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Chapter 1: Introduction

1. Introduction

Research suggests that there has been a marked increase in self injurious behaviour (SIB) since the 1960's (Walsh and Rosen, 1998). In addition, it is also thought that the incidence of SIB in adolescents and young adults is on the increase (Darche, 1990). However it is difficult to establish whether this increase is due to greater public awareness and openness about SIB, or an actual increase in the incidence itself.

SIB is an important issue at both a clinical and service delivery level. This is due to the high risk that this behaviour places on those who engage in it, and also the demands on the healthcare services that provide treatment. With regard to the cost implications for health services, the demand placed on these services is considered to be quite significant, with an estimated 150,000-170,000 attendances at accident and emergency departments per year as a result of SIB (Yeo & Yeo, 1993). What is particularly interesting, is the way in which professionals assess and respond to this client group, as this is considered to be a significant factor in the prevention of repeated SIB (Hawton, 1998).

Despite the risk and service implications, our understanding of SIB is relatively limited. There has been a growing body of research that aims to increase our understanding of SIB within various populations and clinical groups. However, the majority of the literature has been primarily descriptive in nature. This inevitably creates a barrier in the effectiveness of working practice, as we have little evidence based knowledge of the psychological mechanisms that operate, and experiences that occur, within this clinical problem. (Himber, 1994).

1.1 Self Harm

i) Definition

SIB is not a new phenomenon. Attempts to define SIB were first demonstrated by Menniger in 1938, when he used the term "wrist cutting syndrome". Menninger discussed the relationship between SIB and suicide, and saw SIB as a conflict between the human drives of the life instinct and the death instinct. He saw the act of SIB as partial suicide, which as a consequence avoided total suicide.

During the 1960's our modern understanding of the definition of SIB was furthered by the work of Graff and Mallin (1967), when they also explored the differences between SIB and suicide. Their work involved observing the characteristics of individuals who engaged in non suicidal wrist cutting whilst on an inpatient ward.

More recently, SIB has been defined by the World Health Organisation (1993) as;

> "An act with non-fatal outcome, in which the individual deliberately initiated non-habitual behaviour that, without intervention from others, will cause self harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes within the subject desired via the actual or unexpected physical consequences" (Platt, Bille-Brahe, Kerkhof, 1992).

The current understanding of SIB is changeable, with no universally accepted definition. Within research, one of the most frequently cited definitions is that of Favazza (1996);

> "the deliberate harm to ones own body resulting in tissue damage, without conscious intent to die".

For the purposes of this research, Favazza's definition of SIB shall be used.

ii) Epidemiology

It is difficult to estimate the exact prevalence of SIB within the general population, this is partly due to the majority of studies focusing on clinical populations. However, another barrier in gaining accurate prevalence data lies within the shame associated with the behaviour, and the tendency for individuals to hide the fact that they engage in it. One study, completed by Briere and Gil in 1998, estimated that 4% of the general population (from a sample of 927) and 21% of a clinical sample (321 inpatients and outpatients) had self injured. However, although this provides us with some insight into the prevalence of SIB in a general population, this data was taken from national sampling for a trauma symptom inventory, that included one item on SIB. Our knowledge of more specific information about SIB e.g. type and frequency, remains limited.

SIB behaviour has also been found to differ across age groups, peaking during late adolescence/early adulthood. It must be kept in mind, however, that these findings were the result of a study that explored SIB in a psychiatric inpatient population, the sample does not therefore represent the general population (Sansone, Gaither and Songer, 2002).

iii) Comorbidity

Psychiatric disorders and personality disorders are believed to be common in those who self injure. A study by Haw, Hawton, Houston & Townsend (2001), which involved a structured clinical interview of 150 general hospital patients who presented with SIB, found that 92% had a co-morbid psychiatric disorder and 45.9% had a co-morbid personality disorder. The findings of this study were

strengthened by the use of self report diagnostic and personality questionnaires, as well as follow up interviews. In addition to this, it also included a relatively large number of males within the subject group (over a third). The definition of SIB used did however, include self-poisoning and wrist cutting. Therefore attempted suicides were potentially included in the grouping of self injurious behaviours. The function of the self-harm in these instances may have been different to those who engaged in milder forms of SIB e.g. cutting. In addition, self cutting that was considered to be part of a repetitive pattern was excluded from analysis. This would seem to remove an important and core group of individuals who engage in SIB.

The prevalence of SIB is reported to be particularly high in patients with a diagnosis of Borderline Personality Disorder (BPD; Schaffer, Carroll & Abramowitz, 1982; Dulit, Fyer, Leon, Brodsky & Frances, 1994). However, as SIB is part of the diagnostic criteria for BPD, it has been suggested that BPD can be overdiagnosed in those who self harm (Johnstone, 1997).

It has also been shown that high levels of depression are experienced by those who self harm (Brittlebank, Cole, Hassanyeh, Kenny, Simpson & Scott, 1990). However, it is suggested that this link is not primarily due to depressive affect causing individuals to self harm, as several studies have demonstrated that depression does not predict the frequency of self mutilation (Comtois et al.,1998 cited in Brown, 2002; Simeon, Stanley, Frances, Mann, Winchel & Stanley, 1992) and that depression does not characterize SIB solely (Kingsbury et al. 1999). It has also been suggested (Brown, 2001) that exploring the *emotions* involved in

depression (e.g. shame), would provide a better understanding of the relationship between SIB and depression.

1.1.2 The Experience of Self Harm

One of the earliest attempts to research the experience of SIB was that of Rosenthal, Rinzler, Walsh & Klausner (1972). From interviews of male and female 'wrist cutters' it was concluded that the majority of cutting behaviour was in response to separation or rejection, as a result of which the individual experienced feelings of being numb and feelings linked to earlier experiences of physical trauma. It was also found that the individual felt relieved and satisfied following the cutting.

One area of research into SIB has involved exploring the negative emotions experienced by those who engage in it. This has played a role in helping us understand the experience of SIB further. It has been suggested that quite often, those who engage in SIB may be doing so in order to be relieved of negative emotions (Brown, 2002). One such emotion that has been said to be acute in those who self injure is shame (Wise,1989). The emotion of shame can also create barriers within a therapeutic relationship, as it often prevents disclosure (Calof, 1995). A fuller understanding of the emotions experienced by self injurers would further our insight into the experience and function of SIB for this client group, and allow us to work towards more effective treatments and service provision.

Despite our continued interest in SIB, literature and research exploring the inner experience of SIB remains minimal. However, it is generally thought that the

sequence of behaviours and the experience of self injury is surprisingly similar for those who engage in it (Babiker & Arnold, 1997).   Firstly, the individual is thought to experience a situation or trigger which is, or which they perceive to be, loss, abandonment, rejection or failure (Herpertz, 1995). As a result of this individuals tend to experience feelings of emotional pain or anger, as well as feelings of negativity towards themselves. Due to the distress of these painful emotions, individuals have difficulty tolerating or managing them, particularly on a cognitive level (Calof, 1995). As well as this, they may have difficulty communicating emotional distress to others (Suyemoto, 1998). They therefore seek self injury as a means of regulating their emotions and ending the distress (Haines, Williams, Brain & Wilson 1995; Briere and Gil, 1998; Linehan, 1993). There is no universal understanding of the psychological mechanisms involved in the experience of SIB, and various theoretical and clinical discussions have attempted to provide an understanding. These will be discussed in the course of this introduction.

A study by Liebenluft, Gardner and Cowdry (1987) led them to identify five stages that are involved in self injury. They considered these to be 1) a precipitating event, 2) escalation of dysphoria, 3) attempts to forestall the self-injury 4) self-injury and 5) the aftermath. On a positive note, this study provides us with some insight into the function and experience of SIB. Despite this, the stages identified are based on a small sample of patients with BPD. Further research is needed to explore and confirm these findings.

Another study, by Weber (2002) explored the meaningfulness of an individuals experience of self injury using qualitative methods. From this, four

themes/linkages were identified. These included 1) pleas to be listened to and receive help, 2) specific triggers for self abusive behaviour, 3) causes of self abusive behaviour and 4) how to stop abuse. Within these links various aspects of qualitative information were identified, these included; 1) reasons for self abuse being sexual abuse, powerlessness, self-punishment, feelings of exploitation, anger loneliness, environmental cues and flashbacks 2) triggers as being noise and profanity in a ward setting, anger, feeling lonely and feeling dirty 3) the women interviewed identified someone talking to them at a time of crisis, the use of distraction and a slow, gentle approach as helpful ways of enabling them to stop self harming. These findings would appear to be in keeping with previous descriptions and functions of SIB by this client group. However, as with many studies exploring SIB, these findings were based on interviews with inpatients in a secure inpatient setting. It is therefore difficult to generalise these findings within the SIB population, as the clinical problems and level of SIB is likely to be more extreme in this inpatient setting.

In addition to the triggers and experience of high emotional intensity during the sequence of SIB, dissociation during these stages has also been identified as a significant factor within the experience of SIB. Dissociation associated with SIB refers to breaks in connectedness (usually as a result of extreme stress; Strong, 2000). This can be experienced as a sense of detachment from an individuals own surroundings or from their body. It can be seen as a psychological defence that keeps distressing memories, sensations and/or feelings out of conscious awareness. It has been found that there is a strong association between levels of dissociation and increased frequency of SIB in individuals who have experienced

childhood trauma (Low, Jones, MacLeod, Power & Duggan, 2000). It has also been reported that dissociation peaks during self-injury and that decreased dissociation, as well as mood elevation, follows self injury (Kemperman, Russ & Shearin,1997; Miller and Bashior, 1974; Liebenluft, Gardner & Cowdry,1987). Research in this area does not appear to have compared the experience of dissociation in individuals who engage in SIB and have a history of childhood trauma, and those who engage in SIB and do not have a history of childhood trauma. The inner experiences of the client group who do not have a history of childhood trauma is relatively neglected within research.

1.1.3 Predisposing factors/Reasons for SIB

There are many factors that have been explored and suggested as having a link to an individual engaging in SIB. Although we can consider these in turn, the experience of each individual is likely to be varied and complex. It is unlikely, therefore, that there is a single pathway that leads an individual to engage in SIB. However, understanding the types of factors that have been found to have a significant link with SIB, may help us to develop our understanding of it's nature and development.

i) Childhood Factors

The most commonly researched and suggested predisposing factor linked to SIB is sexual abuse, however maltreatment, bereavement and loss have also been suggested as significant early life factors (Hawton, Rodham, Evans & Weatherall,2002; Meltzer Harrington, Goodman & Jenkins, 2002; Briere and Gil, 1998). Favazza (1993) explored the links between a number of early life

experiences and SIB among a group of 250 self injurers. He suggested that there is a link between SIB and stressful situations in early life, particularly physical and sexual abuse and a history of early medical procedures or hospital treatment. In another study, van der Kolk, McFarlane & Weisaeth (1991) found that 79% of individuals who engaged in self destructive behaviours had a history of significant childhood trauma, and that 89% had experienced major disruption in the childcare that they received. Van der Kolk et al. also argued that the severity and type of self destructive behaviour was related to the age at which child abuse or maltreatment occurred, in that the younger the age the more severe the behaviour.

Walsh and Rosen (1988) also explored factors of childhood and adolescence in relation to SIB. They found that those who self injured were more likely to have lost a parent or have been placed outside the family home, experienced childhood illness or surgery, been the victim of physical or sexual abuse, or witnessed impulsive or destructive behaviour in the home e.g. domestic abuse. With regard to experiences in adolescence, Walsh and Rosen found that individuals were more likely to have experienced loss, been isolated from their peers or experienced conflict with their peers. However, what is different about their interpretation, is that they considered these childhood experiences to mediate characteristics that make an individual prone to self injury, these include; vulnerability to loss, role of victim, distorted body image, predilection towards impulsive behaviour and destructive behaviour.

ii) Experiences in Adulthood

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A small amount of research has also explored adult experiences that may lead an individual to engage in SIB. It has been suggested that the factors which are linked to SIB are similar to those in childhood e.g. rape, sexual abuse (Babiker & Arnold, 1997). One study found that some individuals began to engage in SIB following an experience of rape or trauma, and that this factor was independent of childhood experiences (Arnold, 1995). Miscarriage, loss of a child or the inability to have a child were also said to be significant factors. In addition to this, research that has explored adults who have been victims of war trauma, have found that self injury may follow this type of experience (Pitman, 1990; Lyons, 1991).

1.1.4 Theories of Self Injurious Behaviour

As well as there being a number of accounts of the experiences and predisposing factors related to SIB, various theoretical understandings also exist.

i) Psychoanalytic

Psychoanalytic theories relate SIB to concepts of personality development and unconscious motivations. It is said that early failure to master the first developmental stages during childhood leads to conflict within the individual. SIB is seen as an individual's primitive and concrete attempt to work out these conflicts. The ego stage of development is the stage at which the child is first thought to begin to recognise that they are separate to the mother (Hibbard, 1994). The skin therefore presents the first boundary of the self. Consequently, the way in which the child is touched and handled at this stage forms their early understanding of their own self. Loving and nurturing care would therefore lead to the individual experiencing a secure and positive view of the self, whilst cold and

abusive handling would cause the individual to experience a negative self. The function of SIB, according to psychoanalytic theories, often relates to the injurious behaviour being used to redefine the individuals own boundaries e.g. self/other, inside/outside. It is suggested that the self that becomes conflicted and split by early experiences, is reintegrated by the stimulation of SIB (Cooper, 1988).

Another area of psychoanalytic thinking that contributes to the theoretical understanding of SIB, is the idea of individuals internalising negative feelings towards the self, in an attempt to believe that the parents are good and ideal (Bollas, 1995). By punishing the bad self through SIB, individuals gain temporary relief from feelings of blame, shame and guilt. This enables the individual to cope and return to a manageable level of emotion. Related to this is the understanding based upon object relations theory (Mahler, 1968). Object relations theorists explore how individuals develop a sense of self from what they learn from their attachment figures, the environment and fantasies. van der Kolk (1996) describes the abused child's experience of their parent as conflicting, as their parent is experienced as untrustworthy, but also as their only source of love and care. As a result, this individual learns that love is inconsistent and unstable, as well as it being something that can hurt. They therefore internalise this and are unable to love and care for themselves consistently. This represents the conflict of the bad self, with SIB as the punishment.

Psychoanayltic theories have also been applied to understanding SIB in children who have experienced serious illness. Walsh and Rosen (1988) propose that through medical procedures and physical faults children, become confused about

their own bodies and see them as flawed and unacceptable. Their bodies become separate from the self, and body alienation is experienced. SIB therefore functions as a means of reintegrating this split self/body or experiencing sensations of the physical body (Cooper, 1988).

ii) Learning Theory

Learning theories understand SIB as a cycle of behavioural reinforcement. As part of normal development, we learn during infancy that our caregivers provide us with comfort when we experience pain. Thinking of reinforcing experiences in cases of childhood trauma, survivors of abuse may have experienced pain along with care via the conflicting role of parent and abuser. It is possible therefore, that experiencing pain becomes associated with care and comfort via classical conditioning. Further to this, learning theory also describes reinforcement in relation to SIB via operant conditioning because as the consequent relief that individuals gain from negative emotions and tension can be experienced as rewarding and reinforcing (Linehan, 1993). It has also been suggested that additional positive reinforcement occurs via the social support that an individual receives following self injury e.g. comforting remarks, positive attention (Carr, 1977)

iii) Biological

Biological understandings of SIB have also been explored. Van der Kolk (1996) is one author who argues for a link between childhood experiences, biology, and self harm. It is argued that an individual may have a biological predisposition to self injury, arising from early experiences altering the brain structures and chemistry

involved in the regulation of emotional stress. This is thought to occur as a result of neural pathways being developed in response to extreme stress experiences in infancy.

iv) Neurocognitive

Neurocognitive explanations of SIB relate to the processing of information related to trauma. There are two main structures thought to be involved in the processing of such information, the amygdala and the hippocampus.

The amygdala is automatically activated when faced with emergency situations. It is thought that the amygdala processes sensory information related to a perceived threat, as well as creating its own unique imprint and memory of the threat.

The hippocampus is believed to be involved in the integration of information (Kolb & Wishaw, 1996). It is thought that the hippocampus has difficulty processing traumatic memories due to the amount of physiological arousal that they cause.

Inefficient processing of traumatic memories may result in the individual continuing to experience these memories as overwhelming. The individual may be seen to self harm as a means of relieving negative emotions, or as a way of providing stimulation or self soothing (Herman, 1992).

v) Neurochemical

Stimulation and mood regulation as a consequence of the increased release of endorphins in the body as a result of pain, has also been considered as a possible explanation as to why individuals self injure (Simeon et al. 1992; Coid, 1983). The endogenous opiates, released as a result of pain, are thought to become a positive

reinforcer for SIB (Konicki & Schulz, 1989). It is also thought that the opiate system of self harmers may be impaired, and that an increased release, stimulated by SIB, is necessary to maintain levels (Russ, 1992). However, in studies which explore levels of endogenous opiates in self harmers, it is difficult to establish whether higher levels of opiates are a result of a healing response to SIB rather than a causal or precipitating factor (Favazza, 1996; Coid, 1983).

Serotonin is a neurotransmitter which facilitates the passage of impulses between a small number of nerves in the brain. Serotonin has been implicated as having a function in SIB (Konicki and Shulz,1989) as it is thought to be related to mood regulation, but also to impulsivity. The highest concentration of serotonin is found in the raphe nuclei, where most of the nerves connect to the hypothalamus (the hypothalamus is the brain structure thought to be responsible for impulsivity and aggression). A chemical called 5-hydroxyindoleacetic acid (5-HIAA) is responsible for metabolising serotonin. It has been suggested that low levels of 5-HIAA may reflect low serotonin activity in individuals who engage in impulsive and aggressive behaviour toward the self and others (Brown et al, 1982; Asberg, Traskman & Thoren, 1976). Simeon et al (1992) conducted a study which compared serotonin activity levels in self harming and non self harming individuals with a personality disorder. It was found that those who self harmed had significantly more personality pathology, greater lifetime aggression, more antisocial behaviour and lower levels of serotonin activity. However, the relationships and causal relationships between these factors remains unclear.

vi) Biosocial

Linehan's Biosocial theory of Borderline Personality Disorder (1993), offers an understanding of SIB within this client group by suggesting that individuals experience emotional dysregulation, combined with an invalidating childhood environment. More specifically, Linehan refers to a heightened sensitivity to emotions, with increased emotional intensity, and a slower return to an emotional baseline. SIB is considered to be a modulating behaviour, as a means of coping with the emotional experiences. She identifies shame, anger and contempt as the main emotional risk factors for individuals seeking an escape or attack on the self. However, coping behaviours like this are thought to be maladaptive in that they evoke further invalidation within interpersonal relationships e.g. from their family, friends and social environment.

vii) Developmental Psychopathology

Applying a developmental understanding to SIB can help us to explain how and why this behaviour might manifest in some but not in others. Psychopathology, according to developmental understandings, is seen as a developmental deviation from otherwise normative developmental processes and pathways (Yates, in press).

Recently, Yates (in press) has attempted to provide a review of the current position in understanding self harm behaviours using a developmental psychopathology approach to understanding SIB in those who have experienced childhood trauma. Yates argues that the experience of childhood trauma has a negative impact on the development at various levels of competence. Such individuals therefore experience vulnerability within areas of adaptive

functioning, and consequently turn to SIB as a compensatory regulatory and relational strategy.

Five core levels of competence, relevant to normal development, were previously identified by Sroufe, Egeland and Carlson (1999). Within these levels the individuals' foundations for adaptive functioning are formed. The various levels of competency are described in the following table;

Table 1.1 Levels of competence – Summarised from Yates (in press)

Level	What this level represents	Normative development
Motivational level	Positive expectations of others	Motivated to seek out interpersonal connections. Confidence in relying on others. Takes pleasure from social relationships
Attitudinal level	Favourable representations	View of self as worthy of care and responsiveness from important others
Instrumental level	Skills to negotiate developmental issues effectively	Able to elicit and engage in support necessary for successful adaption
Emotional level	Ability to regulate emotion, arousal and impulse	Exercises flexibility and effective arousal, impulse control and adaption of emotions to cope with environmental demands
Relational level	Capacity to engage in reciprocal and empathic relationships	Clear understanding of self/other boundaries and is able to form reciprocal and empathic relationships

Failure to achieve these competencies is therefore thought to cause the child to use SIB as a means of compensating. For example, a child who fails within the Emotional level may not have the competency of controlling or adapting their emotions in response to environmental stressors. As a result, they may engage in SIB as an adaptive way of managing the emotions that they experience.

1.2. Shame

It would seem that within many of the current understandings of SIB the experience and role of negative emotions, and views of the self, are suggested to be an important component. One negative emotion that is particularly relevant to psychopathology, and more specifically SIB, is shame. The emotion of shame has become an area of much clinical and theoretical research within the field of psychology. More specifically, the impact of shame on psychopathology has received a great deal of attention.

1.2. 1. Definitions of shame

Attempts to define and understand shame has been the focus within much of the literature. Shame has been described as an emotion of self conscious affect (Tangney & Fischer, 1995) which motivates individuals to conceal themselves or escape from shame-inducing interpersonal situations (Lindsay-Hartz, 1984; Lindsay-Hartz, 1995). The experience of shame is understood to encompass feelings of helplessness and an inherent sense of badness (Gilbert, 1998; Tangney et al. 1996; Wicker, Paynes and Morgan, 1983). Shame is also considered to be related to the evaluation of the self in the eyes of others, as it is thought that we take our standards and ideals about ourselves from others (Suls & Wills, 1991).

Social comparison is therefore considered to be a significant factor in the development and cognitive understanding of shame. Mascolo and Fischer (1995), describe shame as being related to appraisals of having failed to live up to standards of worth in the evaluation that others may place on them. Shame is therefore considered to cause us to become aware of behaviours that threaten our honour or self worth.

1.2.2 External and Internal Shame

Within social psychology, it has been repeatedly demonstrated that attention can focus on an internal or external self (Gibbons, 1990). This idea of an internal and external focus of attention can also be applied to shame (Gilbert, 1998).

i) External Shame

External shame can be understood as being related to the negative judgements made by others about the self (Gilbert, 1998). Therefore the focus of this type of shame is on the external world, rather than the internal world. It refers to how one can be seen by others and how one comes across in the eyes of others (Gilbert, 1998). More specifically, the experience of shame can be attached to a number of external scenarios – the evaluation of others, failure to create a positive image in the eyes of others, not being 'chosen' or lacking talent, ability or appearance. This may have the feared consequence of being ignored or rejected (Gilbert, 1998). Lewis (1982) suggests that our potential to feel shame comes to the fore when we take on the role of 'object to others'. Lewis considers the extent to which we feel shame to be related to how important the views of others are to the self. This is

therefore considered to be influenced by cognitions about desirability and judgement in the eyes of others.

ii) Internal Shame

The concept of internal shame was introduced by Cook (1994) and this led to the development of his shame measure, the Internalised Shame Scale. Internal shame is thought to be different from external shame, as it is related to how the self judges the self, therefore potentially seeing the self as bad, flawed, worthless or unattractive. Gilbert (1998) also describes internal shame as often being related to an awareness of not meeting internal ideals or standards.

iii) The relationship between internal and external shame

As might be expected, internal and external shames are often found to be highly correlated (Gilbert & Andrews, 1998; Cook, 1994). In one study Goss, Gilbert and Allan (1994) attempted to measure the relationship between negative self judgement and how individuals consider themselves to be externally judged by others. They found that this is highly correlated, with those who negatively judged the self tending to make the assumption that others would judge them negatively too. However, the point is also made that it is possible to separate the internal and the external. For example, by concealing what is thought to be externally bad, socially unacceptable, and potentially shameful, the individual may not experience internal shame (Cook,1994) . If an individual's behaviour is to be solely influenced by external shame, then they may be of the assumption that they might avoid discovery, and will therefore engage in behaviours that would be considered socially shameful e.g. sex offending. Despite the body of literature separating

internal and external shame, most current psychometric measures of shame do not separate the two.

1.2.3. The Origins of Shame

The origins of shame have been explored using various theoretical bases, including evolutionary and developmental approaches. The findings of research within these areas have increasingly shown that early parenting experiences are an important factor in the development of shame vulnerability.

i) Evolutionary Origins

Understanding shame in the context of its evolutionary origins has mainly focused on the role of shame as a submissive emotion in relation to social ranking and status behaviour in groups. Evolutionary understandings of groups view acceptance and status as being related to attractiveness and the approval of others. Shame behaviours, such as avoiding eye contact, are seen to reflect submission and inferiority (Greenwald & Harder, 1998). These types of behaviours have also been observed in non-human primates (Byrne, 1996). Given that shame is triggered by rejection or social demotion and results in removing the self from the situation, theorists have suggested that the evolutionary function of shame is to limit the damage that can be done in a social situation, via socially unacceptable behaviour (Greenwall & Harder, 1998).

ii) Innate Origins

The argument for shame as an innate emotion has been supported by the findings of research looking at temperament in children. A study by Kagan & Reznick

(1986) for example, found that some children showed temperamental characteristics, such as being anxious and timid. Nathanson (1994) is a leading author on understanding shame using the concept of 'innate affect scripts'. In his writings he explores shame in the context of innate affect theory, originally proposed by Tomkins (1963). Tomkins observed that newly born babies have the ability to cry, and therefore express emotion in the same way that adult humans do. This led him on to develop his theory of innate scripts of human emotion, which he believed to be pre-cognitive. Tomkins explained that there are nine basic affects;

Positive:	Interest – Excitement Enjoyment – Joy
Neutral:	Surprise-Startle
Negative	Fear-Terror Distress-Anguish Anger-rage Dismell Disgust

These are primarily labelled to indicate the mildest and most intense presentation of each. Tomkins suggests that for each affect, a pattern of expression and specific information is triggered in response to stimuli e.g. facial expression. These innate affect scripts are thought to provide a baseline temperament of the individual. Life experience then allows us to build upon this cognitively, by creating a library of scripts from experiences of affect. When we are then faced with stimuli, this is processed and responded to by reference to these scripts and innate responses.

With specific reference to shame, Nathanson (1994) goes on to detail the affect system surrounding this emotion. He considers shame to have a physiological

basis, which is an inborn script. This script is believed to modulate affective communication. Shame is considered to be the most recent of the affects to have developed. This is because shame exists in terms of other affects, and has the function of interrupting affect states e.g. interest, enjoyment. As life experiences then build our library of scripts to manage 'scenes' of shame, the cognitive phase of shame is, according to Nathanson, entirely dependent on our own history and personal experience of shame.

Nathanson goes on to identify a 'compass of shame'(see below). He sees this as a system of the affect management, and a set of strategies by which an individual has learned to handle shame.

Compass of shame (Nathanson, 1992)

WITHDRAW

ATTACK OTHER   ATTACK SELF

AVOIDANCE
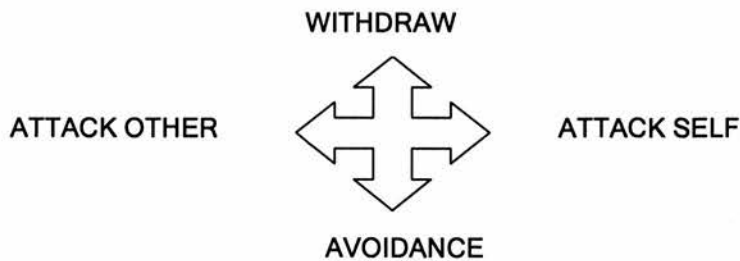
Nathanson believes that at different times different strategies will be used to deal with shame. However, individuals will be inclined to favour one type of strategy. The four types of strategies are follows;

Withdraw	This type of strategy refers to the individual who is willing to experience the physiological manifestation and the cognitive phases of shame as it provides an escape from situations.
Attack self	This type of strategy is a result of the individual finding the isolation and withdrawal resulting from shame intolerable. As a result, they take control of the experience of shame by attacking the self. They are therefore willing to experience the shame, as long as others understand that they have done so voluntarily, with the intention of fostering their relationships.
Avoidance	This type of strategy involves going to the extremes to avoid or limit shame affect e.g. substance abuse, plastic surgery
Attack other	The aspect of shame that results in this type of strategy, is the cognitive phase that discloses information about the individuals inferiority to others. As a response, they are inclined to attack others e.g. vandalism

The concept of innate scripts is an interesting theoretical basis to understand the interaction between our innate emotional drives, and our life experiences and cognitive development.

iii) Developmental understanding of shame

As our understanding of shame, and shame development, continues to grow, our knowledge of how normal and pathological shame develops is becoming increasingly more informed. One area of understanding related to the developmental origins of shame is that of infant development and the beginning of emotional regulation. It has been suggested that the initial experience of shame in infants occurs at approximately 14-16 months (Schore, 1998). At this stage the caregiver is involved in undertaking a significant role in socializing a child within their environment, and consequently models and teaches the infant to regulate their own emotions. Shame has a significant role in teaching infants to inhibit behaviours that are considered to be socially deviant e.g. tantrums, lack of bladder/bowel control. This is achieved by caregivers inhibiting the positive emotions that an explorative behaviour induces in a child, by giving negative non verbal responses. In response to this, the child experiences a stressful situation, during which de-escalation in positive emotion occurs, and the child withdraws from the interaction. This change in affect is considered to be shame. Non verbal communication from caregivers to inhibit behaviour includes gaze aversion rather than reciprocal gaze behaviour. This is a key form of non verbal communication in attachment (Bowlby, 1988). In addition to this, Lewis (1982) found that disgust facial expressions are widely used by caregivers during the socialization of

children, but that caregivers are often unaware of using it. The caregivers response following such an interaction is also crucial, as a responsive and emotionally sensitive caregiver will help the child re-engage in positive affect, and consequently shift from the negative affective experience. In doing this, the ability to self regulate is developed, along with an internal model of secure attachment. It is also suggested (Schore, 1998) that experiences such as this are thought to influence the psychobiological development of the infant's brain. This is thought to occur via the biochemical changes that occur within the individual at times of stress. More specifically, the psychobiological patterns of hormones and neurotransmitters occurring in the brain, are thought to alter the brain biochemistry and induce a neurobiological reorganisation of the developing brain.

In situations in which an infant experiences a caregiver who is unresponsive to their affect during socialization, for example if a child is met with rejection at times of distressing affect, an internal model of parental rejection, and also a view of self as unworthy of help or comfort is formed. It is therefore considered that unsuccessful infant attachment is a key point in the development of shame and shame vulnerability in the development of the self (Kaufman, 1989). Although the shame experienced during the process of socialization is based on external interactions, it is eventually thought to become internalised (Morrison, 1989). As shame is considered to inhibit the expression of emotion (Scheff, 1988), managing emotion internally is considered to be an important stage of development (Morrison, 1989), as it also allows for the regulation of a spectrum of positive and negative affect. Infants, who have not successfully developed an efficient ability

to regulate emotions, may therefore experience a disposition to shame and psychopathology (Lewis, 1982).

It would appear, therefore, that across the theories of shame, there is a general agreement that shame is a powerful emotion, evoked by our social and interpersonal environment. It would also seem to be implicated in mediating the internal biological and psychological organisation of an individual.

We can summarise our understanding of the development of shame as follows;

Figure 1. Summary of developmental understanding of shame
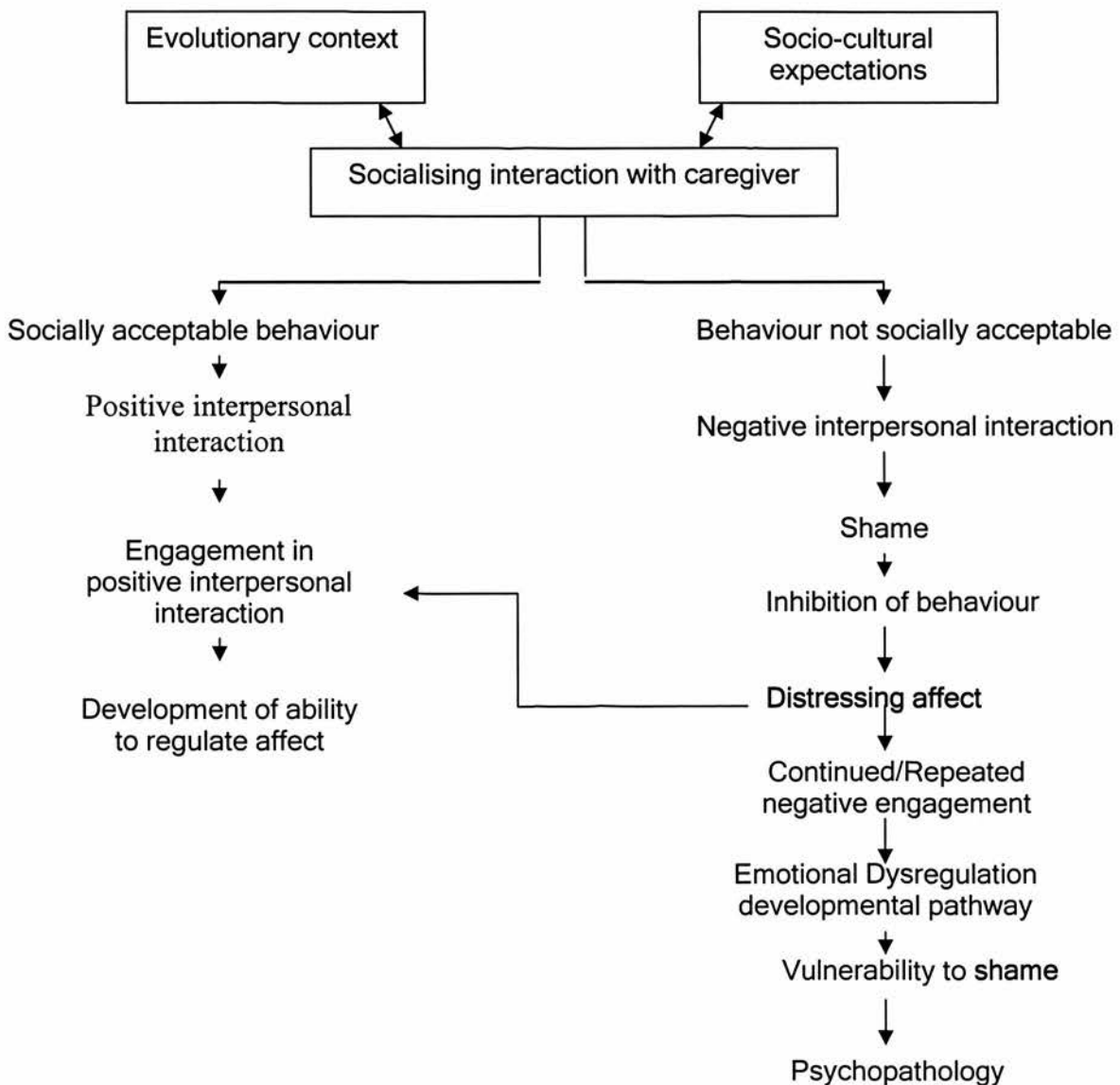
1.2.4. Shame and guilt

Within literature, the concept of shame is often considered along with guilt. However, it is possible to differentiate guilt from shame by understanding it to be related to a specific behaviour, that may have harmed another (Weiss, 1993), rather than a global evaluation of the self as defective or worthless. It is also suggested that guilt is related to a moral act that generates a need to make amends (Lindsay – Hartz, 1995), whereas shame is thought to motivate an individual to conceal something. However, much of our distinction between shame and guilt is dependent on how they are measured.

1.3. The Relationship Between Shame, Cognition and Emotion

1.3.1 Understanding Emotion

The emotional basis to shame is considered to be a complex area, with several key theoretical understandings to the development of emotion and shame. Tangney & Fisher (1995) considers shame-proneness to be related to a tendency to experience certain emotional states. These include anxiety, disgust and anger. The example of shame about sexual abuse is given, with the associated emotions including anger and disgust towards the body (Gilbert, 1998).

1.3.2. Cognition and Emotion

Understanding emotions using a cognitive framework is a complex and developing area of psychological theory. Traditional cognitive theories of emotion would suggest that some form of cognitive operation activates affect in an individual. Therefore, emotions are considered to be elicited following meaning being attached to the experience an individual might have (Beck et al.,1985). This

supposes therefore, that emotion follows cognition. However, this has been criticised as failing to encompass the often complex relationship between cognition and emotion that is seen clinically (Power and Dalgleish, 1997). Teasdale and Bernard (1993) elaborate upon this and suggest that a sub system is involved in our cognitive processing. According to Teasdale, the *meaning* that someone attributes to a cognition, rather than the cognition itself, leads to the emotion. They therefore argue that emotional reactions are mediated by schematic appraisal.

In agreement with Teasdale and Bernard's understanding of cognition and emotion, Power and Dalgleish go on to develop this understanding in their Schematic, Propositional, Analogical and Associative Representation System (SPAARS model) (1997) . Within this they suggest that all emotion derives from five basic emotions: sadness; happiness; anger; fear; and disgust. Shame is considered to derive from the emotion of disgust. When an event (internal or external) is experienced by an individual, it is first thought to be experienced via the Analogical system which is modality specific (modalities include olfactory, auditory, gustatory, visual, proprioceptive and tactile). The representations that occur within these modalities do not require linguistic interpretation. The processing is then thought to follow two possible cognitive routes to emotion. The first route involves processing via routes that involve schematic and propositional interpretation. The second route, referred to as the associative level, allows emotion to be experienced without schematic interpretation. This is thought to occur when a direct link between a schematic interpretation and an emotion is established due to them being repeatedly paired through life experiences and

events. This therefore creates direct access, in which schematic interpretation is no longer necessary. The complex emotional base of shame, can therefore be understood to be activated by two possible routes.

1.3.3. Shame: Self schema and cognitions

i) Schema Theory

Beck (1967) describes schemas as cognitive structures that screen, code and evaluate the stimuli that an individual encounters. The schemas that an individual develops, enables them to make sense of themselves in relation to their environment and experiences, by allowing them to categorise and interpret this information in a meaningful way. Beck also suggests that schemas may play a role in consistently biasing the interpretations that individuals make, such as those seen in psychopathology e.g. unrealistic goals and expectations, distorted attitudes.

However, paralleling the more recent developments in theories of cognition and emotion, Young (1994, 2003) in his clinical work and writings on Schema Therapy has developed our clinical understanding of schemas further. He describes schemas as complex representations of meaning comprising memories, cognitions, bodily sensations and emotions. He identifies eighteen Early Maladaptive Schema (see appendix 1). These were developed to encompass themes observed in clinical practice, and have been empirically tested (Schmidt, Joiner, Young & Telch, 1995). He considers most individuals who experience chronic psychopathology to have more than one core schema. The schemas are

grouped into five domains, each corresponding to the five developmental needs of children (see appendix 1).

ii) Shame: Self Schema

Cognitive based psychotherapies suggest that early shame experiences, are associated with the development of an individuals basic self-other schema (Beck et al., 1995). Negative self evaluation has been linked to vulnerability to experience emotional disorders (Segal and Blatt, 1993). Despite the fact that negative self evaluation schema appear to be seen as a central feature of both internal and external shame, it would seem that little literature has focused on understanding the relationships between shame and self schema. Gilbert (1992), suggests that self other schema, especially shame based schema, often arise from direct early emotional experiences, and function like conditioned responses (Ferster, 1973; Gilbert, 1998). Related to earlier discussions, Nathanson (1994) suggests that early experiences, such as negative responses from a caregiver to a child's interaction, elicit the first shame responses (such as distress and gaze aversion) in infants, followed by the development of cognitive competencies to recognise shame experiences.

iii) Shame Related Schema in Schema Theory

With regard to shame, the schema of 'Defectiveness/Shame' is identified. This is described by Young (2003) as;

> "The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed. May involve hypersensitivity to criticism, rejection and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one's perceived flaws. These flaws may be *private* (e.g.

selfish, angry, impulses or sexual desires) or *public* (e.g. undesirable physical appearance, social awkwardness)"

The Defectiveness/Shame schema is grouped within the 'Disconnection and Rejection' domain, outlined as the;

"Expectation that one's needs for security, safety, stability, nurturance, empathy, sharing of feelings, acceptance, and respect will not be met in a predictable manner. Typical family origin is detached, cold, rejecting, withholding, lonely, explosive, unpredictable, or abusive"

Individuals who have not successfully negotiated these developmental tasks are therefore considered to have difficulty functioning within this domain.

1.3.4 Shame in Psychopathology

Shame, and its relation to the formation and maintenance of psychopathology has received an increasing amount of attention within clinical and theoretical discussions (Harder, Cutler & Rockart, 1992). The shame experienced by individuals, is believed to be linked to early aversive experiences and a resulting vulnerability to experience shame and psychopathology (Gilbert at el., 1995; Kaufman, 1989; Nathanson 1994). In a study that looked at a population of female students, Gilbert, Allan & Goss (1996) found a relationship between early shaming experiences and increased psychopathology in interpersonal problems. The relationship between shame and specific psychological problems has also been demonstrated within literatature e.g. depression (Andrews, 1995; Brown, Harris & Hepworth, 1995; Gilbert, Pehl & Allan, 1994; Allan, Gilbert & Goss, 1995; Tangney et al., 1992), social anxiety (Gilbert & Trower, 1990) personality disorders (Kinston, 1987; Lewis, 1987; Wurmser, 1987). Clearly the relationship

between shame and these specific disorders is complex, and an area of ongoing research.

1.3.5 Shame and Self Harm

In considering the literature surrounding self harm, the concept of shame is implicated in many of our conceptual understandings of the behaviour. An association between negative attitudes towards the self and self injurious behaviour has been demonstrated (Friedman, Glasser, Laufer, Laufer & Whol, 1972). 'Self conscious' emotions and self blame are seen as important reasons for self harm (Brown, 2002; Breed, 1972; Rothberg and Jones, 1987; Walsh and Rosen, 1988) SIB has also been reported as a punishment of the self (Walsh and Rosen, 1988; Briere & Gil, 1998; Favazza & Conterio, 1988; Herpertz, 1995). Those who engage in SIB also attribute their self injury to anger at the self rather than anger at others (Bennum & Phil, 1983). Linehan (1993), within her Biosocial Theory, also recognises the role of shame in self harm. She describes shame related emotions as directly leading to self attack, self punishment and/or an extreme desire to hide or disappear.

Wise (1989) explores SIB in adult survivors of child sexual abuse. Wise discusses the role of a shame bound family systems and also the intertwined relationship between shame, denial and self injury. Wise considers survivors of abuse to internalise the effects of the victimisation that they have encountered. Self harm is seen as further violation of the self as well as a simultaneous survival response pattern to internalised victimisation. Fossum and Masson (1986) are also discussed in Wise's writings. Fossum and Masson describe a "control-release"

cycle. Within this, victims of shame bound family systems try to express control by attempting to control the self or others. This may be achieved by attitudes and behaviours such as being self critical, rigid, blaming or pleasing. The excessive nature of this control phase is thought to lead to a "breakout" phase, which provides an escape from the pressures of shame and control. Self mutilation is one behaviour that may occur within this phase, other behaviours may include abuse of alcohol, drugs, food, sex and money.

Shame is therefore implicated in many psychological disorders, and is recognised as a significant area of interest and continued research. Early research findings also suggest a link between shame and SIB.

1.4. Personality Disorders (Axis II Disorders)

As previously mentioned, one client group that SIB is particularly prevalent in, is Personality Disorders. Individuals presenting with Personality Disorders typically show significant levels of distress and dysfunction, particularly in interpersonal functioning. Not surprisingly, they are considered to pose a challenge to mental health services.

1.4.1 Diagnostic Criteria for Personality Disorders

A personality disorder (Axis II disorder), is defined by the Diagnostic and Statistical Manual – IV (DSM-IV) as an;

> "enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment" (DSM-IV-TR, 2002,p685)

Ten specific personality disorders are described within the DSM-IV. These are summarised in table 1. Fuller diagnostic criteria are shown in appendix 2.

Table 2. Description of Personality Disorders as defined in DSM-IV

Personality Disorder	Description
Paranoid Personality Disorder	A pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent
Schizoid Personality Disorder	A pattern of detachment from social relationships and a restricted range of emotional expression
Schizotypal Personality Disorder	A pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behaviour
Antisocial Personality Disorder	A pattern of disregard for, and violation of, the rights of others
Borderline Personality Disorder	A pattern of instability in interpersonal relationships, self-image, and affects, and marked impulsivity
Histrionic Personality Disorder	A pattern of excessive emotionality and attention seeking
Narcissistic Personality Disorder	A pattern of grandiosity, need for admiration, and lack of empathy
Avoidant Personality Disorder	A pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation.
Dependent Personality Disorder	A pattern of submissive and clinging behaviour related to an excessive need to be taken care of
Obsessive Compulsive Personality Disorder	A pattern of preoccupation with orderliness, perfectionism, and control

(DSM-IV-TR,2002, p685)

These Personality Disorders are also grouped into diagnostic clusters which are based on descriptive similarities. These are;

Cluster A: Paranoid, Schizoid and Schizotypal Personality Disorders (odd or eccentric)

Cluster B: Antisocial, Borderline, Histrionic and Narcissistic Personality Disorders (dramatic, emotional or erratic)

Cluster C: Avoidant, Dependent and Obsessive-Compulsive Personality Disorders (anxious or fearful).

However, although this system is adapted for clinical and research purposes it is not empirically-based. There are also questions regarding its reliability and validity, with many patients fulfilling criteria for different diagnoses and across different clusters (Livesey, 2000; Klonsky, 2000).

1.4.2. Issues Related to the Concept of Personality Disorder

The concept of a personality disorder has attracted differing views about its validity (Ryle, 1997). One of the central features in identifying a personality disorder is that individuals who are considered to fit diagnostic criteria are thought to differ from those with a 'normal personality' by having a physical, biological or genetic abnormality. Many argue against the distinction between a 'normal' and 'abnormal' personality, and hold the view that personality can be more accurately describing using a dimension of personality traits.

1.4.3. Personality Disorder as a Developmental Disorder

There has been considerable interest surrounding the personality disorder diagnostic criteria. However, a further related area of discussion centres around our understanding of personality development. Discussions on the topic have suggested that a *developmental* perspective in understanding the disorders may be a more useful way of conceptualising them. Connections between personality disorders and our current understandings of personality development have been suggested (Ryle,1997; Paris, 1993; van der Kolk et al, 1991). Early experiences and relationships are instrumental in shaping our personality development. Damaging or disruptive experiences and relationships are therefore likely to have a negative impact on this. The internal representations that we form of our self and

others in our early attachment relationships are thought to be central to the developmental understanding of personality disorder psychopathology (Crittenden, Parridge & Clauseen, 1991).

1.5 Aims of current research

There has been limited research exploring the relationship between shame and self harm. Individuals who fit criteria for a personality disorder provide an interesting client group to facilitate our understanding of this area, given that self harm is prevalent in this group and both self harm and personality disorders are associated with developmental trauma. However, despite self injury presenting as a common behaviour in this client group, not all individuals engage in it. In addition, the experience of intense emotions and view of the self as bad or flawed associated with those who self injure, would suggest that shame plays a key role in SIB. It could therefore be proposed that shame is a mediating factor in the development of SIB in personality disorders. To explore this, two hypotheses will be tested.

1.5.1 Hypotheses

1. Individuals who meet criteria for a personality disorder and who self harm, will report higher levels of internal shame and shame related schema than individuals who meet criteria for a personality disorder and do not self harm.

2. In individuals who self harm, levels of shame and shame related schema will be positively related to the frequency of SIB. Therefore, those who report higher levels of shame will also report higher frequencies of SIB.

Chapter 2: Methodology

2. Methodology

2.1 Preparation

A meeting with a representative from a local support group, for those who engage in self injurious behaviour, took place. This was conducted in order to integrate the views of the client group in the planning of the research. The procedure of the data collection and the questionnaires that were going to be used were discussed. Overall the representative felt that the procedure and questionnaires were appropriate. However, she did suggest that in the participant information sheet, under the heading of 'What are the possible disadvantages and risks of taking part?', the last word in the paragraph (distressing) should be replaced with 'triggering'. This was therefore changed.

Prior to commencing the project, ethical approval was sought and received from Grampian NHS Trust Research Ethics Committee (see appendix 3).

2.2 Subjects

Subjects consisted of patients who were seen by clinical psychology or psychiatry at the Royal Cornhill Hospital, Aberdeen. The hospital is a psychiatric hospital which provides inpatient and outpatient treatments for a wide range of psychiatric disorders and mental health problems. The majority of referrals to the hospital come via general practitioners and other medical hospital bases covered by the local health board.

Participants in the study were recruited via clinicians. An information sheet (appendix 5), a copy of the clinician consent form (appendix 6) and a copy of the

participant information sheet were sent to clinical psychologists and psychiatrists within the hospital. Clinicians were given the opportunity to contact the researcher to discuss the project or ask any questions.

If a clinician was able to identify a patient that was potentially suitable for the study, a participant information sheet (appendix 7) was given to the patient by their clinician, and they were given the option to partake in the study or not. The information sheet aimed to ensure that patients fully understood what their participation would involve. Patients were also given the opportunity to contact the researcher if they had any questions or required any further information. Patients were made aware that they were free to withdraw from the study at any point.

Subjects included in the study

- Met criteria for a Personality Disorder (Axis II Disorder) according to the DSM-IV.
- Were aged between 18 and 65

Individuals excluded from the study

- Were unable to speak English
- Had a learning disability
- Had a diagnosis of a psychotic illness

If a patient agreed to participate in the study, they were asked to complete a participant consent form (see appendix 8), and were then able to take part in the study by following one of three routes;

1. Completing a set questionnaires out with the session on their own
2. Completing a set questionnaires with their clinician
3. Completing a set questionnaires with the researcher

The option that was most suitable for the client was decided upon by their active clinician. This was to minimise the risk of participants being placed in a situation that caused them any distress.

From those included in the study, two groups were identified

1. Those with an Axis II disorder who engaged in SIB
2. Those with an Axis II disorder who did not engage in SIB

Individuals who met the criteria for the SIB group, answered 'yes' to any of the following questions as identified by the Self Harm Inventory (see appendix 14; discussed below; Sansone, Sansone & Wiederman, 1995).

Have you ever ....

2. Cut yourself on purpose?
3. Burned yourself on purpose?
4. Hit yourself?
5. Banged your head on purpose?
8. Scratched yourself on purpose?
9. Prevented wounds from healing?

(Sansone et al, 1995)

2.3 Questionnaires

The questionnaires that participants were asked to complete included;

- Personal & self harm frequency information sheet (Appendix, 9)

- Hospital Anxiety and Depression Scale (Appendix, 10; Zigmond & Snaith, 1983)
- Internalized Shame Scale (Appendix, 11; Cook, 1994)

- Personality Disorder Questionnaire 4+ (Appendix, 12; Hyler, 1994) *and follow up clinical significance sheets*

- Young Schema Questionnaire (Appendix, 13; shame section, Q.55 – Q.69 ; Young & Brown, 1990)

- Self Harm Inventory (Appendix, 14; SHI: Sansone et al,1995)

2.4 Description and properties of measures

i) Personality Disorder Questionnaire 4+ (Hyler, 1994)

One of the main inclusion criteria for the project was that individuals would fit the diagnostic criteria for an Axis II disorder. Research has suggested that there is some inconsistency in the diagnosis of personality disorders, and that standardised assessments are more reliable than clinician's judgements (Davidson, 2002). It was decided that an Axis II diagnostic questionnaire would strengthen the validity of the diagnosis.

The assessment and diagnosis of personality disorders can be problematic due to the fluctuation of personality traits as a result of a clinical syndrome (Klein, 1993). Diagnostic measures for Axis II disorders are available in the format of a clinician interview or a self report questionnaire. The most commonly measures listed below in table 2.1.

Table 2.1 Measures of Personality Disorder

Measure	Authors	Type of meaure
International Personality Disorder Examination Revised (PDE-R)	Loranger et al, 1987, 1994	Interview
Structured Clinical Interview for DSM (SCID-II)	Spitzer et al 1990	Interview (self report as screen)
Structured Interview for DSM-III-R Personality (SIDP-R)	Pfohl et al, 1989	Interview
Personality Assessment Schedule (PAS)	Tyrer et al , 1988	Intreview
Personality Diagnostic Questionnaire Revised (PDQ-R/PDQ4/PDQ-4+)	Hyler et al 1988; Hyler 1994	Self report
Millon Clinical Multiaxial Inventory (MCMI-III)	Millon et al 1994	Self report
Schedule for Nonadaptive and Adaptive Personality (SNAP)	Clark, 1993	Self report

It could be argued that self report methods can be less accurate than measures completed by clinicians. This is due to the fact that an experienced interviewer is likely to be able to limit the rate of false positives by asking additional questions, therefore establishing a greater understanding of the severity and extent of the personality trait (Davidson, 2002). In addition to this, self report measures require a degree of literacy, require individuals to be able to self reflect and assume that individuals are able to identify the presence and duration of problematic personality traits (Davidson, 2002).

Despite this, it was felt that a self report measure was most suited for this study for the following reasons;

- To avoid placing participants in a situation in which they had to answer questions and discuss personal information with someone who was not clinically involved in their care
- To prevent therapeutic relationships from being affected by difficult questions being asked with a non therapeutic goal.
- To reduce administration and scoring time for participants, clinicians and the researcher
- The researcher did not have enough clinical experience to conduct and score a clinical interview assessment, and it felt that asking clinicians to complete this would be impractical and time consuming

Due to resource availability, short administration time and evidence of the PDQ-4's being widely used in research , it was decided that the PDQ4 was a suitable measure for the purposes of this study.

The Personality Disorder Questionnaire 4+ (PDQ-4+) is a self report inventory developed by Hyler (1994). It comprises a series of true and false questions and takes approximately 20 minutes to complete. The inventory is based on the diagnostic criteria for the ten DSM-IV personality disorder diagnoses. It also provides the option to include the additional diagnoses of passive aggressive personality disorder and depressive personality disorder as described in the appendices of the DSM-IV. However, for the purposes of this study the ten main personality disorders were the focus of the measure and clinician feedback. On completion, the PDQ-4+ provides an assessment of which of the personality disorders the individual would meet a positive diagnosis for. In addition to this, it also provides a total score, which reflects the "personality disturbance" of an individual. However, as the PDQ-4+ is being used as a screening tool for personality disorders, the positive personality disorder diagnoses will be used in analysis, rather than the total score. The PDQ-4+ is the latest version of the Personality Disorder Questionnaire (PDQ; Hyler, Reider, Spitzer & Williams, 1983). Previous revisions have included the PDQ-Revised (Hyler & Reider, 1987) and the PDQ4 (Hyler, 1994). The original version of the PDQ was found to have test/retest reliabilities of between 0.63 and 0.75 (Hurt, Hyler & Frances, 1984; Hyler, Reider, William, Spitzer, handler & Lyons, 1988). In previous research, the PDQ has been criticised for being overly sensitive to criteria which may indicate the presence of personality disturbance, therefore causing it to over-diagnose (Hyler, Skodol, Kellman, Oldman & Rosnick, 1990). It is suggested that the tool should be used as a screening tool in inpatient and outpatient psychiatric settings (Hyler & Reider, 1987). In order to address the problem of over diagnosing, Hyler introduced the clinical significance scale (see appendix 15) with

the PDQ-4. He recommends that this is administered, preferably by a clinician or researcher, to confirm that the personality disorders which meet positive diagnosis are confirmed. The clinical significance sheets test that the clusters of answers, that indicate a positive personality diagnosis, remain true and that they fit criteria for DSM-IV Personality Disorder diagnosis confirming that the participant;

- Has experienced these difficulties for most of their life or since before the age of 18
- That these items are true all of the time and not only when the individual is depressed, anxious, using drugs/alcohol or are physically ill
- That the factors have had a significant impact on certain aspect of the individuals life e.g. work, relationships **or** that the individual is bothered about themselves because of the items they recognise as true

ii) Shame Measures

The measurement of shame is an ongoing area of development. The nature and definition of shame remains an area that lacks clear definition. This presents significant difficulty in the measurement of shame in research. One criticism of the literature surrounding shame, is the suggestion that the findings of research are dependent on the measure that has been used (Tangney, 1996). The majority of the measures which exist, focus on the relationship between shame and guilt. For the purposes of this discussion, the focus will primarily be on the shame components of available measures.

In a discussion paper on the topic of conceptual and methodological issues in the assessment of shame and guilt, Tangney (1996) reviews some of the current

advantages and limitations of the measures of shame and guilt commonly used. The most common formats of shame measures are outlined below;

Global Adjective Checklists - This type of shame measure uses a checklist of shame related adjectives, and the respondent is asked for a global rating of how well the adjective describes them. Adjective checklist measures include the Revised Shame-Guilt Scale (RSGS: adapted from Gioiella's, 1991 Shame/Guilt Scale), the Personal Feelings Questionnaire (PFQ) and the revised PFQ -2 (Harder & Lewis, 1987; Culter & Rockart, 1992). The PFQ-2 lists shame and guilt related affective descriptions, and individuals are asked to rate the frequency that they experience them. The advantage of this type of measure is that it is easily administered and it also has high face validity. However, it also brings several disadvantages. Firstly, it is suggested by Tangey (1996) that advanced verbal skills are necessary to be able to complete the measure. In addition to this, respondents are expected to make distinctions between shame and guilt in an abstract context. Research has found that well educated adults have difficulty providing meaningful definitions of shame and guilt in abstract terms (Lindsay-Hartz, 1984; Tangney,Wagner & Cramzow, 1989). With specific reference to the Axis II client group, particularly Borderline Personality Disorder, it is suggested that this client group have difficulty labelling and identifying emotions accurately (Linehan, 1993). Therefore, it is possible that this would further complicate the accuracy of responses to this type of measure.

Scenario based measures – This type of measure presents respondents with a series of common scenarios. Each scenario is also followed by a specific

phenomenological description of shame and guilt. Respondents are asked to rate the descriptions with reference to their own experience of shame and guilt. One of the most frequently used scenario based measures is the Test of Self Conscious Affect (TOSCA; Tangney et al, 1989). One advantage of this type of measure is the way in which it allows for the distinction between guilt and shame experienced in a situation. In addition to this, it does not depend on respondents being able to distinguish between abstract concepts of shame and guilt. Despite this, disadvantages to using the measure have also been recognised. Firstly, this type of measure only identifies a small amount of everyday scenarios. It does not account for specific and less common shame enduring scenarios. In relation to this, the more intensive maladaptive emotion of shame, common in psychopathology, is not overtly represented. Kugler & Jones (1992) also criticise this type of measure, and suggest that measures which refer to specific scenarios invite moralistic values and standards into the judgement, rather than specific emotion. The TOSCA has also been criticised due to the fact that it was constructed from subject generated scenarios, and the subject group used were young adult college students. The scenarios are not based, therefore, on a clinical population.

iii) Internalised Shame Scale (ISS; Cook, 1994)

The measure that was selected for use during this study was the Internalised Shame Scale (ISS; Cook, 1994), Cook (1994) argues that scenario based measures are less effective, as shame can be triggered in an individual without interpersonal situations. He views shame as being something that is the product of multiple scenarios being experienced and internalised over time. It is then integrated as part of the self concept. To access shame Cook believes that a measure should include

items which are globally related to the self. The Internalised Shame Scale (ISS; Cook, 1994) is a measure that was developed by Cook (1994) and was based largely on data from clinical populations. The focus of the measure is primarily on shame. Within the measure there are 24 items based on phenomenological descriptions of shame. These are presented in language that characterises the description of a shame experience e.g. *I would like to shrink away when I make a mistake*. Respondents are asked to indicate, on a five point scale, the frequency of the experience for them. In addition to the 24 shame items, 6 positively worded items from the Rosenberg Self-Esteem Inventory (Rosenberg, 1965) are also used. This provides a measure of positive self esteem (PSE). The first version of the ISS was developed in 1984. There have been five revisions since this. Cook (1996) reports that the unidimensionality of the measure was confirmed in large population studies by Novak (1986) and Chang (1988), when factor analysis did not show any factors as being sufficiently independent of each other. In addition to this, reliability data from both clinical and non clinical studies has been collected (Cook, 1984). This data has come from a total of 370 subjects, with clinical samples including diagnoses of alcohol dependence, depression, PTSD, eating disorders and adjustment disorders. The non clinical sample comprised of undergraduate and graduate students. The following reliability data was presented by the authors;

Table 2.2 Reliability studies of the ISS (Cook, 1994)

	No. of subjects	Mean age	SD	Cronbach's Alpha Shame Items	Cronbach's Alpha Self Esteem Items
Non clinical sample	645	24	8	0.95	0.90
Clinical sample	370	38	11	0.96	0.87

iv) Schema Measures

In addition to looking at a specific measure of shame, the study also aimed to explore the shame related schema experienced by participants. In order to do this, Young's Schema Questionnaire, long form (YSQ; Young & Brown, 1990) was selected as a suitable schema based questionnaire. This was developed by Young as a clinical tool in relation to his schema theory. The long form of the questionnaire has 205 questions, and is time consuming to complete. Feedback from the ethics board included the observation that participants had to complete an excessive amount of questions. In order to reduce the number of questions, and because the focus of the research is primarily on shame, the questions relating to shame and defectiveness were the only items administered. This gave a total of 15 questions from the YSQ (see appendix 13).

Although the YSQ is a non standardised measure, the psychometric properties of the questionnaire have been investigated within various studies. One of the most comprehensive of these was completed by Schmidt et al. (1995). The alpha coefficients for each of the early maladaptive schema identified and included in the YSQ, were found to range from .83 (Enmeshment/Undeveloped self) and .96 (Defectiveness/Shame). In addition, test-retest coefficients in a non-clinical sample were found to range from .50 to .82. The YSQ's measurement of Defectiveness /shame schema would therefore appear to be a reliable assessment.

v) Self Harm Measure

As discussed earlier, a universal definition of SIB has not been agreed upon within research. In addition to this, participants are likely to have differing

understandings of the meaning of SIB. In order to gain a measure of SIB, and also to be able to have clearly defined inclusion criteria of what SIB refers to for the purposes of this study, it was considered important that a screening tool for SIB was used.

The Self Harm Inventory (SHI) was developed for use with both psychiatric (Sansone, Wiederman & Sansone, 1998) and non-psychiatric (Sansone, Sansone, & Wiederman, 1995) populations. The measure provides a score of 0 – 22, which indicates the range of self harm behaviours that an individual engages in. The author recognises that the inventory does not encompass all form of self injurious behaviour, however it does provide a comprehensive list of possible behaviours with the opportunity for respondents to add their own experiences to this list.   The author also reports that, in using a cut off score of 5 or above, the inventory can also be used as a screening measure for   Borderline Personality Disorder. Research has demonstrated satisfactory convergent validity with self-report measures of borderline personality (Sansone, Gage, & Wiederman, 1998). However, for the purposes of this study the SHI shall be used as a screening inventory of the self harm methods used by participants. The inventory will also be used to establish the inclusion criteria for the study with an answer of 'yes' to engaging in any of the following behaviours ;

Have you ever;
2. Cut yourself on purpose? 3. Burned yourself on purpose? 4. Hit yourself? 5. Banged your head on purpose? 8. Scratched yourself on purpose? 9. Prevented wounds from healing?

These behaviours were selected as they represent self harm which is a direct attack on the self, rather than less direct behaviours e.g. drinking alcohol to the excess, having lots of sexual partners. The full inventory was administered to all participants, with a view to potential post hoc exploration of the group.

vi) Measure of Depression and Anxiety

Due to the link that research has shown between shame and depression and shame and anxiety (Gilbert & Andrews, 1998), it was considered necessary to measure anxiety and shame in order to test whether any significant correlation was a result of depression or anxiety rather than between shame and self harm.

In order to minimise the time commitment required from participants, it was felt that a brief screening measure for anxiety and depression was necessary. The Hospital Anxiety Depression Scale (HADS; Zigmond & Snaith, 1983) was considered to be an appropriate measure for the purposes of this study.

The HADS is a 14 item self report measure of anxiety and depression which was developed by Zigmond and Snaith (1983). The measure was originally developed for use in medical out-patient clinics, and is now widely used within research and clinical assessment (Herrmann, 1997). Internal consistencies between 0.76 and 0.41 for anxiety items and between 0.60 and 0.30 for depression items were reported by Zigmond and Snaith. The authors recommend that cut off scores are used for its interpretation, with scores of 8-10 indicating mild cases, 11-15 indicating moderate cases and 16 and above indicating severe cases. The authors also suggest a separate cut off of score of 14/15 for "severe" disorders, however they do not supported this with empirical evidence. In addition, the authors also

reported a significant Spearman correlation between their diagnosis of a client's depression and scores on the HADS (0.79) and likewise for anxiety (0.54). Silverstone (1994) however, found that the HADS performed poorly in the diagnosis of major depression in medical and psychiatric populations.

vii) Participant Information Questionnaire

In addition to the measures used in the study, it was also essential for analysis that personal information and information on self harm frequency was collected on each participant. A participant information sheet (appendix 9) was therefore designed and administered for completion. It covered the following areas;

- Age
- Sex
- Marital status
- Current contact with mental health professionals
- Most recent inpatient hospital contact
- Participants were asked to indicate whether they self harmed and asked to describe their most frequent methods of self harm
- Participants were asked to select one of the following as an estimate of their frequency of self harm
  More than weekly, weekly, once a fortnight, once a month, every 2-3 months, every 3-6 months, once a year
- Participants were asked to select one of the following as an estimate of their frequency of self harm
  In the past week, in the past fortnight, in the past month, in the past 2-3 months, in the past 6 months, over six months ago

2.5 Participation in a follow up interview

Participants were given the option to complete a sheet in which they volunteered to participate in a short follow up interview. The purpose of this interview was to explore the participant's experience of shame and self harm. The questions covered during the interview are shown in appendix 16. In addition to this, a sheet was prepared showing a definition of shame (items adapted from the ISS descriptions of shame; see appendix 4). This was used to help participants

understand the definition of shame relevant to the study. This was shared with the participant following a discussion about their own understanding of shame. A total of 2 participants were interviewed.

2.6 Ethical Considerations

Due to the vulnerable nature of this client group, one of the main priorities of the study was to ensure that both participants and clinicians were not placed in situations that caused distress. It was considered important that the clinicians were fully informed of all aspects of their clients' involvement, and also included in sharing the responses given by their patients within the questionnaires. This was to prevent disclosure of information that may be important to the therapeutic intervention, and to ensure that the therapist was aware of any behaviour that was placing the client, or anyone else, at risk. The client was fully aware that their clinician was reviewing their completed questionnaires. In addition to this, the clinician was able to make the decision as to how the client participated in the project. This was aimed at reducing the possibility of the participant being placed in a situation that they felt uncomfortable with, but also to reduce the potential impact of participation on the therapeutic process.

2.7 Data Analysis

i) Statistical Analysis

The Statistical Package for the Social Sciences for Windows (SPSS v10.0) was used to perform statistical analysis on the data.

Due to the small and uneven numbers in the two groups ($n_1 = 21$, $n_2 = 9$), and skewed distributions for some of the variables, non parametric statistics were

appropriate for all analyses comparing the self harm and no self harm groups. It has been suggested that parametric statistics are not robust when used with uneven sample sizes (Howell, 1997). The Mann Whitney test was used to examine the significance of differences in median levels of various factors, for example, age and shame score, between the two groups.

In order to test the second hypotheses, only data from the self harm group was used. Although there were only 21 participants in this group, scores on the ISS and the YSQ Shame Schema section had been previously shown to be normally distributed, as had the variables frequency and recency of self harm. Therefore, Pearson correlation coefficients were calculated to assess the linear association between measures of shame and both self harm frequency and recency. The magnitude of the correlation coefficients was assessed using a one-sided significance level since the hypothesis stated a one-directional effect. In addition, since a strong association between self harm frequency and recency was noted, partial correlation coefficients between measures of shame and frequency (after adjusting for recency) were then calculated.

In all statistical analyses, a p-value of 0.05 was used to denote statistical significance.

ii) Power Calculation

The original power calculation was based on the t-test. In order to achieve a large effect size, at a two-sided 5% significance level with 80% power, 26 participants would be necessary (Cohen, 1992).

Figure 2.1. Summary of the procedure for participation in questionnaire component of research

```
┌──────────────────────────────────────────────────────────────────────┐
│         Clinicians contacted via information/clinician information sheet │
└──────────────────────────────────────────────────────────────────────┘
                                    │
                                    ▼
┌──────────────────────────────────────────────────────────────────────┐
│  Participants identified by their clinician, provided with participant │
│         information sheet and asked to consider participating          │
└──────────────────────────────────────────────────────────────────────┘
                                    │
                                    ▼
┌──────────────────────────────────────────────────────────────────────┐
│ Participant agrees to take part in study, clinician identifies which route to │
│                     participate is most appropriate                    │
└──────────────────────────────────────────────────────────────────────┘
                                    │
                                    ▼
              ┌────────────────────────────────────────┐
              │      Researcher notified by clinician    │
              └────────────────────────────────────────┘
                                    │
                                    ▼
         ┌────────────────────────────────────────────────────┐
         │ Consent forms completed by clinician and participant │
         └────────────────────────────────────────────────────┘
```

Route 1	Route 2	Route 3
Participant Completes Questionnaires alone	Participant completes questionnaires with researcher	Participant meets with researcher to complete questionnaires

Questionnaires returned to researcher

PDQ-4 clinical significance sheets administered by researcher

Questionnaires marked and PDQ-4+ clinical significance sheets prepared

Clinical Significance sheets and scored questionnaires returned to clinician

Scored questionnaires and completed PDQ-4+ clinical significance sheets returned to clinician

Clinical significance sheets completed by clinician with participant

Questionnaires reviewed by clinician and returned to researcher with completed diagnosis sheet

Data entry & Statistical Analysis

Chapter 3: Results

3. Results

3.1 Demographic Data

A total of 30 participants were included in the study, 4 (13.3%) males and 26 (86.7%) females. 21 (70%) of the participants met criteria for the self harm group, and 9 (30%) met criteria for the non self harm group. A total of 5 participants were excluded from all subsequent analysis due to one of the following reasons;

1. They indicated on the participant information sheet that they did not engage in self harm, but did fit the criteria for self harm on the Self Harm Inventory. These subjects were excluded as data on the frequency of self harm behaviour was not provided.

2. Individuals indicated that they did not self harm, but also indicated that they self harmed over 1 year ago. It was felt that participants who had not self harmed within the last year may have 'contaminated' the results of the self harm group, as they were not actively self harming.

The 2 inpatients who participated in the study both met criteria for the SIB group. In total, the researcher met with 18 of the participants to complete questionnaires. The remaining 17 completed the questionnaires alone or with their clinician.

In the self harm group there were 17 females and 4 males, whilst in the non self harm group there were 9 females and no males, a difference that was not statistically significant (p= 0.287, Fisher's exact test, two-tailed).

Table 3.1. Summary of participants by group and sex

	Self Harm Group	Non Self Harm Group	Total
Males	4	0	4
Females	17	9	26

i)**Age**

Summary statistics of age are shown in table 3. 2, and the distribution of age by group is shown in figures 3.1 and 3.2. They suggest that participants in the self harm group may be more likely to fall within the under 40 age group. This would be consistent with research findings on this population (Hawton, 1997). To test whether there was a significant difference in median age between the two groups, a Mann Whitney U test was carried out. The test gave a p-value of 0.007 and showed that the median age among the self harm group was significantly lower than among the non-self harm group (table 3.3)

Table 3. 2. Descriptive Statistics for age of participants

	N	Mean	Standard Deviation	Median	IQR*	Minimum	Maximum
Self Harm group	21	33.76	11.21	33	22.5-40	20	59
Non-self harm group	9	46.78	12.6	47	36.5-57.5	27	64
Total Participants	30	37.67	12.4	37	27- 47.25	20	64

*Interquartile range

Figure 3. 1. Age distribution among the self harm group

Participant age
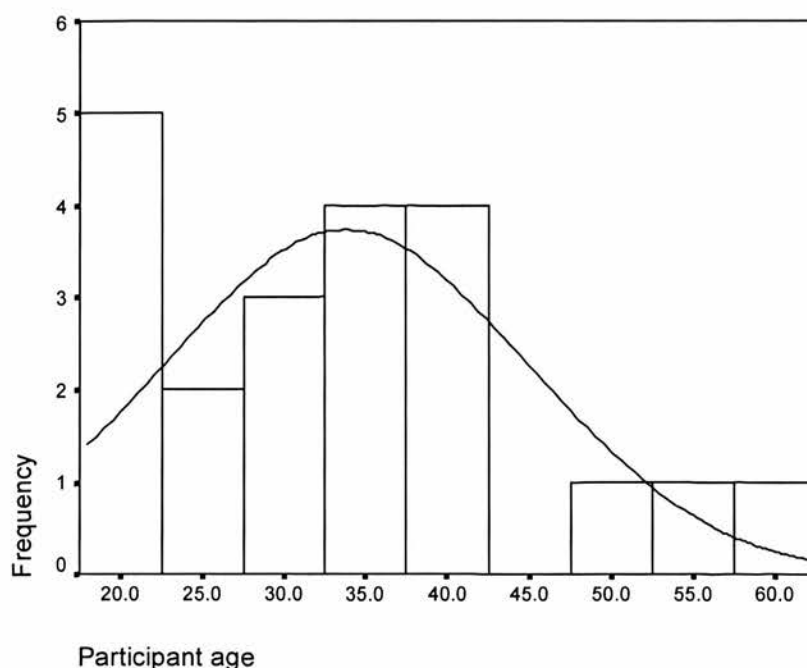
Figure 3.2. Age distribution among the non self harm group
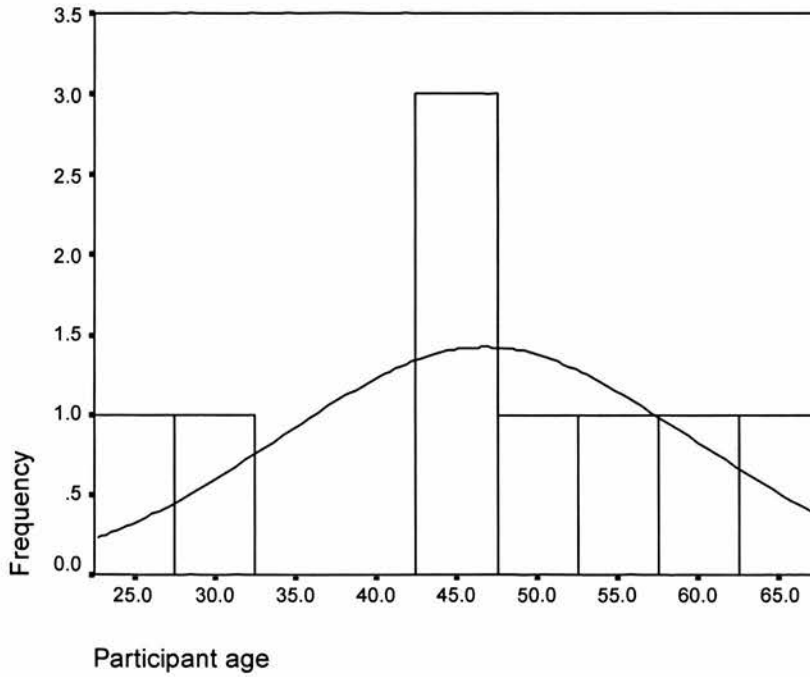
Participant age

Table 3.3 Mann-Whitney results for age between self harm groups

	Median	**IQR***	*U*	*Z*	*p-value*
Self harm	33	22.5-40	40.0	-2.469	.007
Non-self harm	47	36.5-57.5			

*Interquartile range

3. 2 Marital Status

The marital status of participants in the self harm and non self harm group is shown in figure 3.3. Overall, a higher percentage of the self-harm group were single (43% versus 33%). The category of 'single' does not include those in the 'divorced', 'separated' or 'living with someone' category.

Figure 3.3. Marital status across the total sample
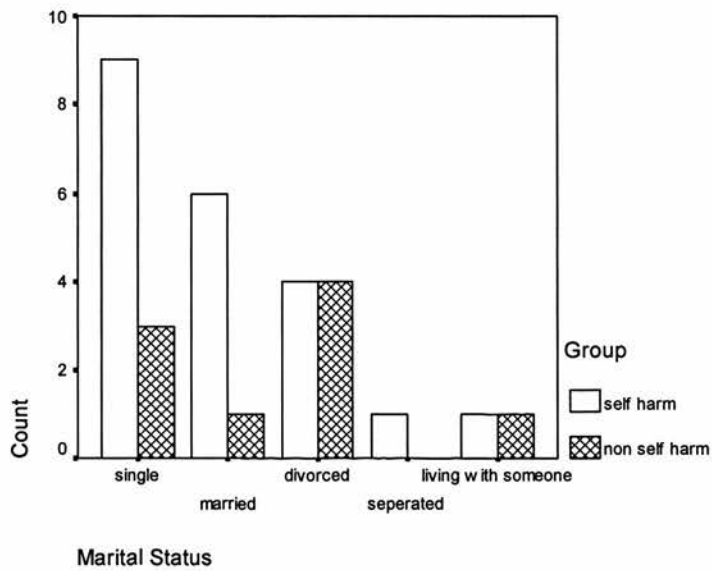
iv) **Inpatient contact – total sample**

The most recent inpatient contact for each participant is represented in figure 3.4.

11 (52%) of the self harm group had no inpatient contact within the past year and

the remaining 10 subjects had contact sometime in the past month to 6-12 months.

Figure 3.4. Most recent inpatient contact within past year
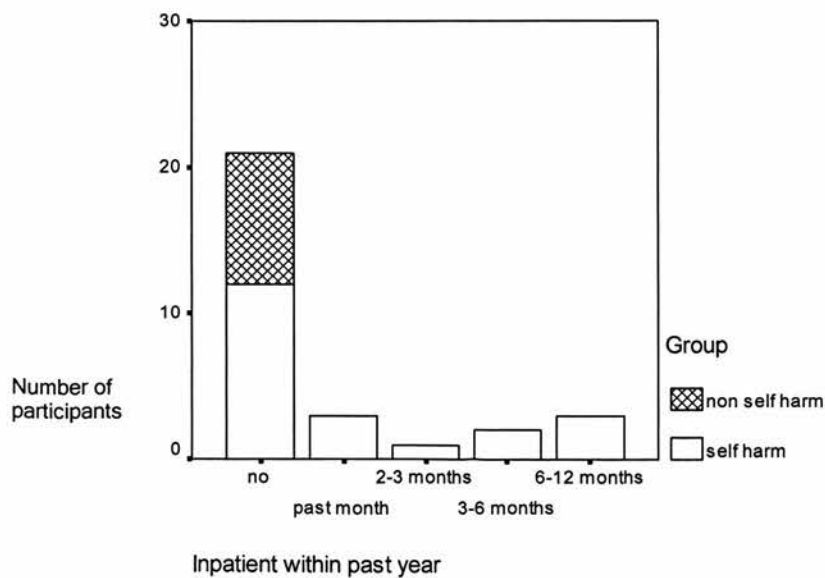
v) Personality Disorder Diagnosis

The PDQ4+ was administered to all participants to elicit personality diagnoses. In addition, clinicians were asked to classify subjects according to DSM-IV personality disorder diagnosis criteria. Tables 3.4 and 3.5 demonstrated the positive diagnoses by clinician and by PDQ-4+ for each of the 10 personality disorders.

Table 3.4. PDQ4+ Positive Personality Diagnosis across both groups***

	Self Harm Group (n=21)	Non Self Harm Group (n=9)	Total (n=30)
Paranoid	12 (57 %)	4 (44%)	16(53%)
Schizoid	7 (33%)	2 (22%)	9 (30%)
Schizotypal	6 (29%)	3 (33%)	9 (30%)
Histrionic	0	0	0
Narcissistic	1 (5%)	2 (22%)	3 (10%)
Borderline	12 (57 %)	2 (22%)	14 (46 %)
Antisocial	1 (5%)	0	1 (3%)
Avoidant	17 (77.5 %)	9 (100%)	26 (87%)
Dependent	7 (33 %)	3 (33%)	10 (33%)
Obsessive Compulsive	11(53 %)	5 (55%)	16 (53 %)

*participants may have a more than one personality disorder diagnosis
** These figures are based on all participants including those who did not complete the clinical significance sheets

Table 3. 5. Personality Disorder Diagnosis by Clinician across both groups*

	Self Harm Group (n=21)	Non Self Harm Group (n=9)	Total
Paranoid	1 (5%)	1 (11 %)	2 (6%)
Schizoid	0	2 (22 %)	2 (6%)
Schizotypal	0	0	0
Histrionic	1 (5%)	1 (11%)	2 (6%)
Narcissistic	1 (5%)	0	1(3%)
Borderline	15 (71.4%)	1 (11 %)	16 (53%)
Antisocial	0	0	0
Avoidant	8 (39%)	9 (100 %)	17 (56 %)
Dependent	1 (5%)	1 (11%)	2 (6%)
Obsessive Compulsive	2 (10%)	2 (22 %)	4 (12%)

* Participants may have a more than one personality disorder diagnosis

From the PDQ4+, the most common personality disorders in the self harm group were avoidant (77.5%), paranoid (57%) and borderline (57%). Among the non-self harm group, it was avoidant (100%). This was across the clinician diagnosis and the PDQ4+.

To look at whether there was a significant difference in diagnosis of personality disorders between the clinicians and the PDQ-4+, McNemar's test was run on each personality disorder diagnosis. Due to the small number in the non self harm group (n=9), the McNemar test was only run on the self harm group. The results of this are shown in table 3.6 below. These analyses suggest that, in the self harm group, there was a significant difference between the clinician diagnosis and the PDQ4+ diagnosis of paranoid, dependent and obsessive compulsive personality disorders.

Table 3.6. Agreement between PDQ4+ and clinician for personality disorder diagnosis in the self harm group

Personality Disorder			Questionnaire Diagnosis		McNemar p-value
			+ve	-ve	
Paranoid	Clinician Diagnosis	+ve	-	1	0.003
		-ve	12	8	
Schizoid	Clinician Diagnosis	+ve	-	-	*
		-ve	7	14	
Schizotypal	Clinician Diagnosis	+ve	-	-	*
		-ve	6	15	
Histrionic	Clinician Diagnosis	+ve	-	1	*
		-ve	-	20	
Narcissistic	Clinician Diagnosis	+ve	-	1	1.000
		-ve	1	19	
Bordeline	Clinician Diagnosis	+ve	10	5	0.453
		-ve	2	4	
Anti-social	Clinician Diagnosis	+ve	-	-	*
		-ve	1	20	
Avoidant	Clinician Diagnosis	ve	7	1	0.120
		-ve	10	3	
Dependent	Clinician Diagnosis	+ve	1	-	0.031

		- ve	6	14	
Obsessive Compulsive	Clinical Diagnosis	+ve	1	1	0.012
		-ve	10	9	

* Not possible to perform statistical test due to zeros in two or more categories

3.2. Comparison of groups on Questionnaire data

i) Internalized Shame Scale

Internal Shame Score (ISS)

The results of the ISS are shown below. Table 3.8 presents the summary statistics of the internal shame scores in the self harm group and in the non self harm group, whilst figures 3.5 and 3.6 show their overall distributions. These results will be explored further under hypothesis driven analyses.

Table 3.7. Summary statistics for internal shame scores for both groups

	N	Mean	Std. Deviation	Median	IQR*
Self harm	21	72.81	12.64	73	65-83.5
Non self harm	9	71.78	10.426	74	59.5-80
Total sample	30	72.50	11.849	73	63.5-82.25

* Interquartile range

Figure 3.5. Distribution of ISS shame scores across the self harm group

ISS total shame score
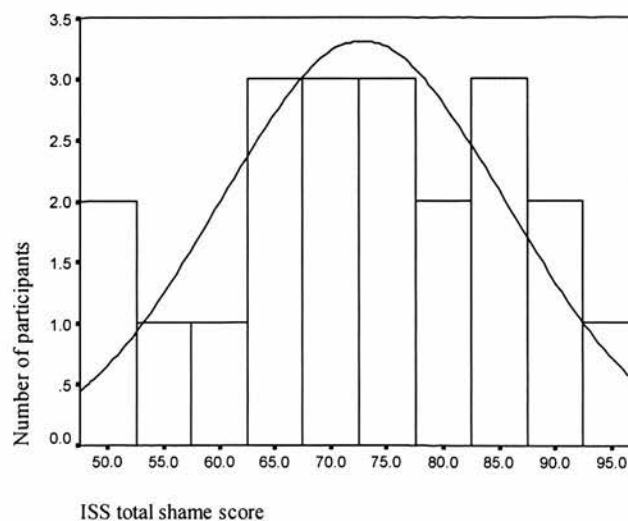
Figure 3.6. Distribution of scores across the non self harm group

ISS total shame score
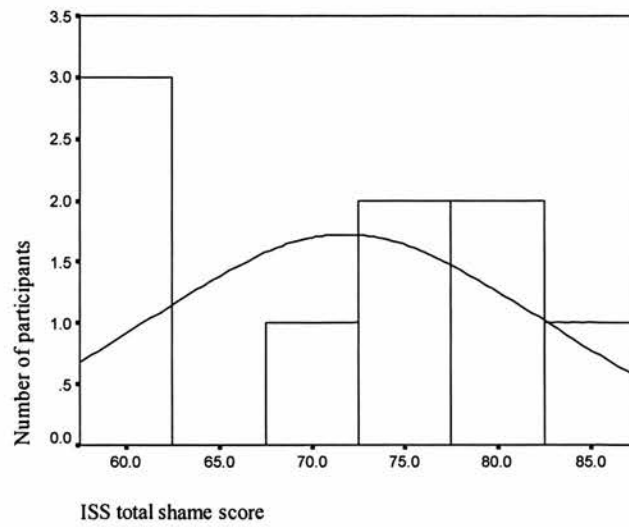
ii) ISS Positive self esteem scores

The summary statistics of the positive self esteem scores for the self harm and non self harm group are shown in table 3.9. The distribution of positive self esteem scores are represented in figures 3.7 and 3.8. There was no significant difference between the self harm group and the non-self harm group on the median ISS positive self esteem score ($U = 64.0$, $p = 0.165$, two tailed)

Table 3.8. Positive Self Esteem Scores for both groups

	N	Mean	Standard Deviation	Median	IQR*
Self harm	21	5.86	4.693	6	2-8.5
Non self harm	9	8.44	4.035	7	5.5-11.5
Total sample	30	6.63	4.597	7	3.75-9

*Interquartile range

Figure 3.7. Distribution of ISS positive self esteem across the self harm group

ISS total positive self esteem score
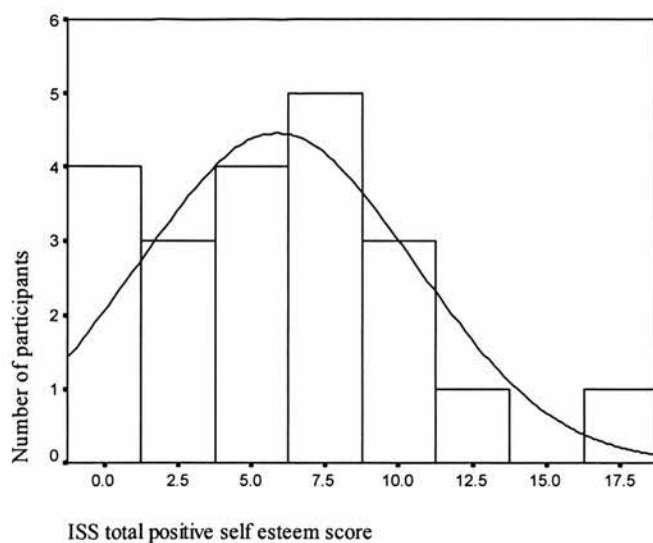
Figure 3.8. Distribution of positive self esteem scores across the non self harm group

ISS total positive self esteem score
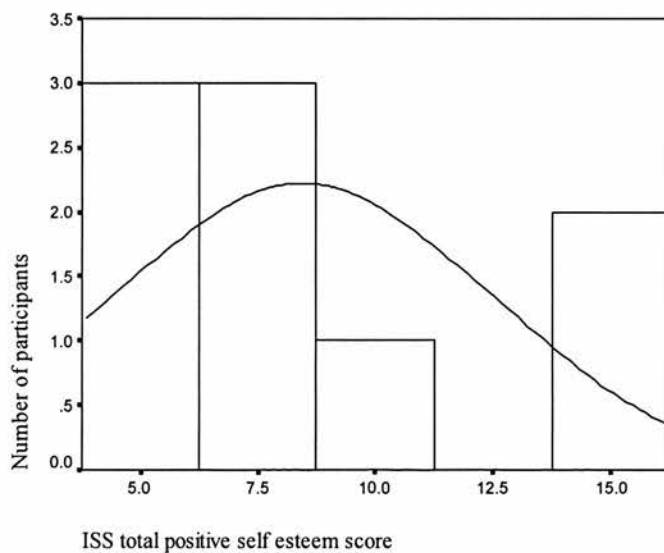
iii) YSQ Total active shame schema items

The summary statistics for the shame schema items on the YSQ are presented in table 3.10. The distribution of active schema items for each group are shown in

figures 3.9 and 3.10. These results will be explored further during hypothesis driven statistical analyses.

Table 3.9. Number of active shame schema items

	N	Standard. Deviation	Mean	Median	IQR*
Self harm	21	3.875	8.71	8	6-12.5
Non self harm	9	4.387	6.33	8	1-9.5
Total sample	30	4.11	8	8	5.75-11.25

*Interquartile range

Figure 3.9. Number of active shame schema items reported in self harm group

Number of active shame schema
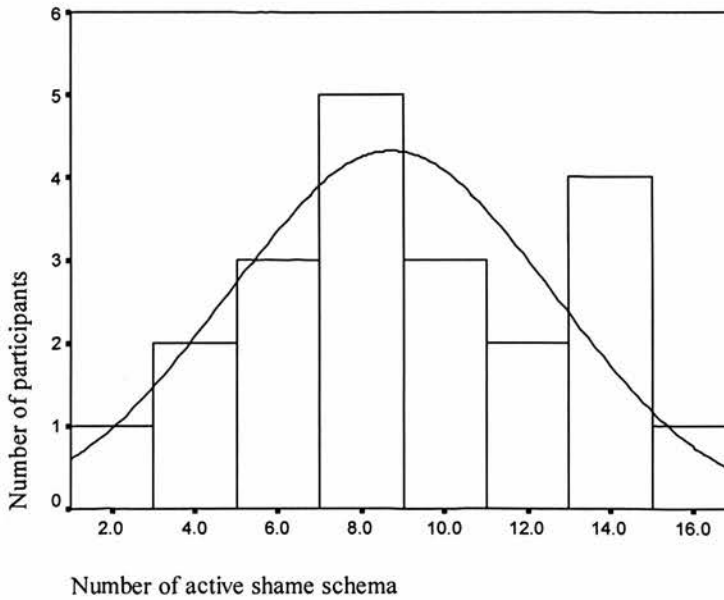
Figure 3.10 . Number of active shame schema items reported by the non self harm group

Number of active shame schema
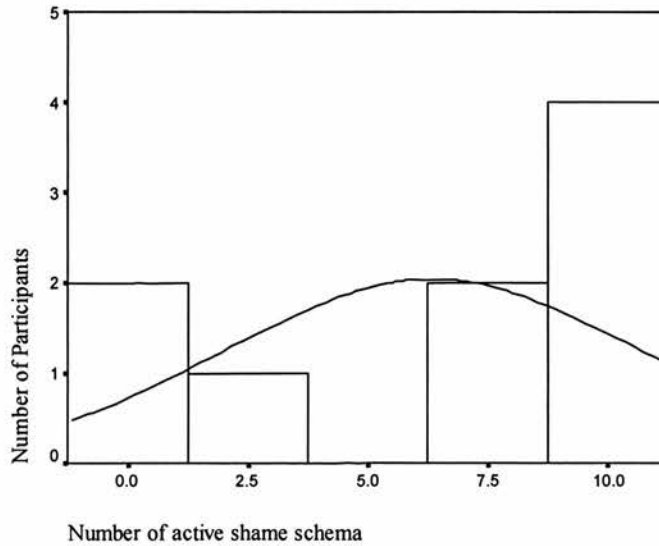
iv) Self Harm Inventory – Total Score

The total scores on the Self Harm Inventory, across the two groups, are summarised in table 3.11 and their distributions plotted in figures 3.11 and 3.12. There was a highly significant difference between the self harm group and the non-self harm group on the median total score of the self harm inventory (U = 14.000 , $p < 0.001$, two tailed), the self harm group had higher levels The total score includes the 6 inclusion criteria questions identified for the study.

Table 3.10. Self Harm Inventory Total Score – across both groups

	N	Mean	Standard Deviation	Median	IQR
Self harm	21	10.90	3.39	11	9-13
Non self harm	9	4.44	3.13	4	2-7.5
Total sample	30	8.97	4.44	9.50	5.75-12.25

* Interquartile range

Figure 3.11. Distribution of Self Harm Inventory Total Score in the self harm group

Self Harm Inventory - total
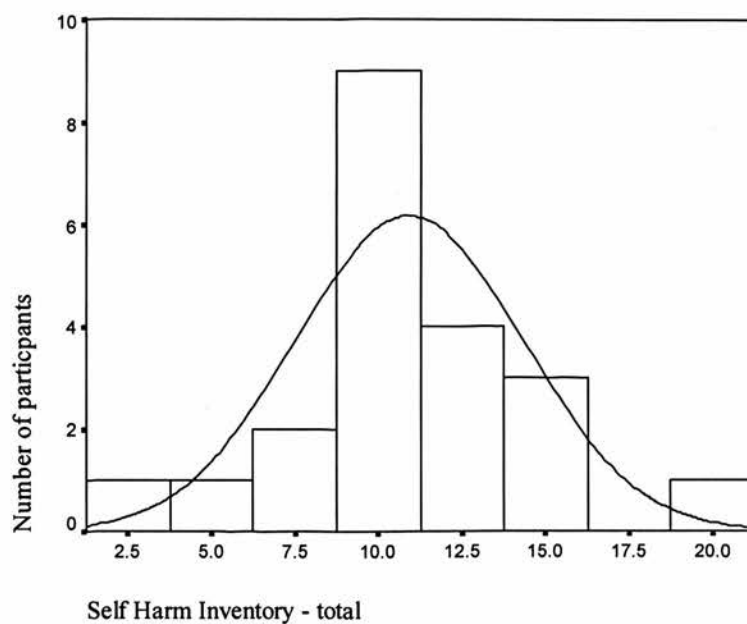
Figure 3.12. Distribution of Self Harm Inventory Total Score in the non self harm group

Self Harm Inventory - total
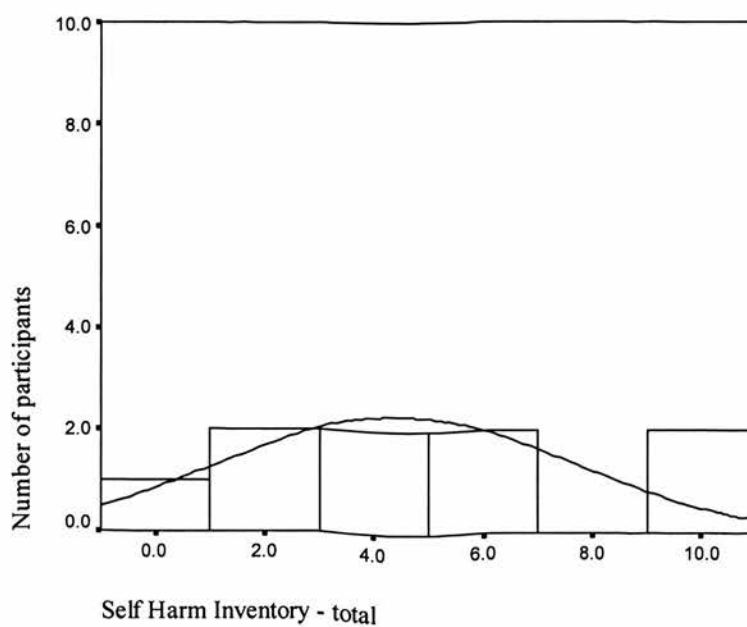
v) Hospital Anxiety Depression Scale

Tables 3.12 and 3.13 summarise the descriptive statistics for the anxiety and depression subscales of the HADS. The distribution of anxiety scores for both groups are shown in figures 3.13 and 3.14, and the depression scores in figures 3.15 and 3.16. There was no significant difference between the self harm group and the non-self harm group on the median HADS anxiety score ($U = 70.0$, $p = 0.265$, two tailed) or the HAD depression score ($U=81.5$, $p = 0.554$, two tailed). Further to this, there was found to be no significant correlation between the ISS shame score and the HADS depression score ($r_s = 0.125$, $p = 0.511$, two tailed) or the YSQ shame score and the depression score on the HADS ($r_s = 0.240$, $p = 0.202$, two tailed). With regard to the HAD anxiety score, no significant correlation was found between this score and the YSQ shame score ($r_s = 0.357$, $p = 0.053$, two tailed). However, there was found to be a significant relationship between the ISS shame score and the HADS anxiety score ($r_s = 0.399$, $p<0.05$, two tailed).

Table 3.11. HADS anxiety scores across both groups

	N	Mean	Standard Deviation	Median	IQR*
Self harm	21	14.81	4.094	15	13.5-18
Non self harm	9	13.22	4.295	13	10-17.5
Total sample	30	14.33	4.147	15	11.75-18

  * Interquartile range

Figure 3.13. Distribution of HADS anxiety in the self harm group
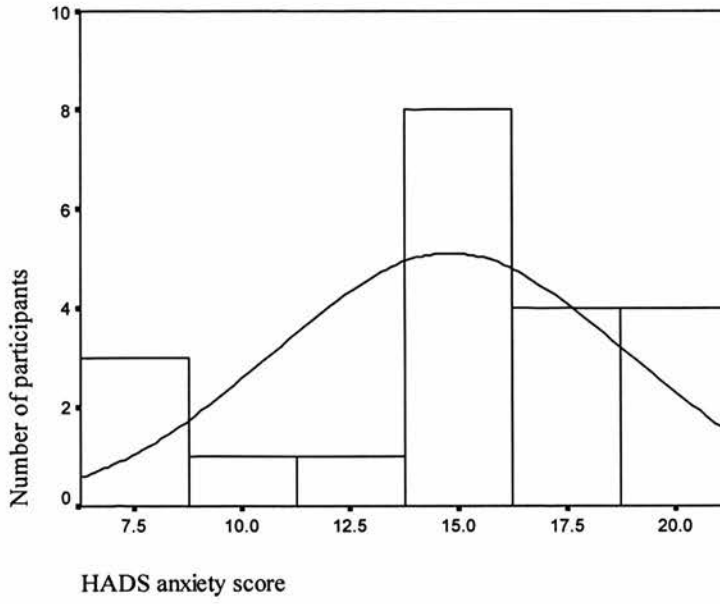
HADS anxiety score

Figure 3.14. Distribution of HADS anxiety in the self harm group

HADS anxiety score
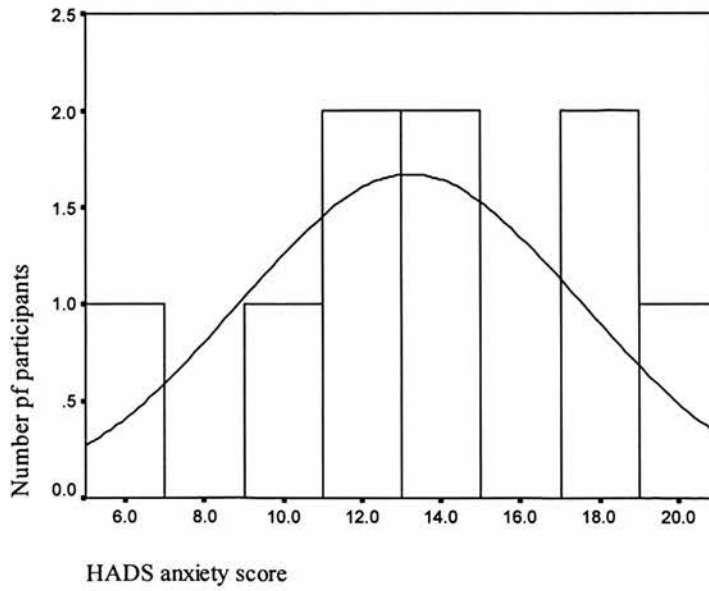
Table 3.12. HADS depression scores across both groups

	N	Mean	Standard Deviation	Median	IQR*
Self harm	21	11.62	3.814	11	9-14.5
Non self harm	9	10	5.431	11	5.5-13.5
Total sample	30	11.13	4.33	11	8-14.25

* Interquartile range

Figure 3.15. Distribution of HADS depression score in the self harm group

HADS depression score
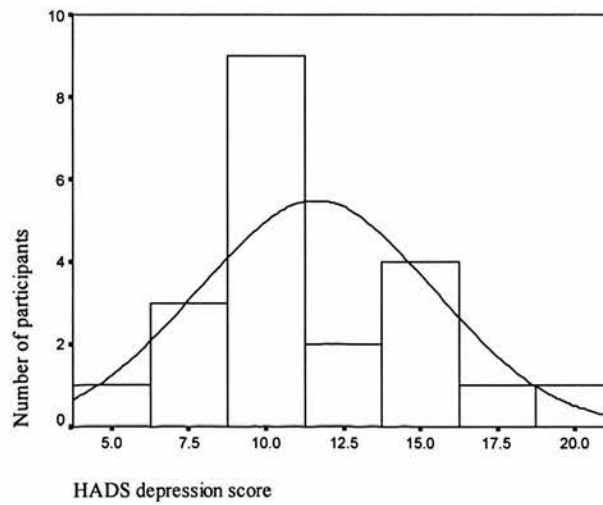
Figure 3.16. Distribution of HADS depression score in the non self harm

Std. Dev = 5.43
Mean = 10.0
N = 9.00

HADS depression score
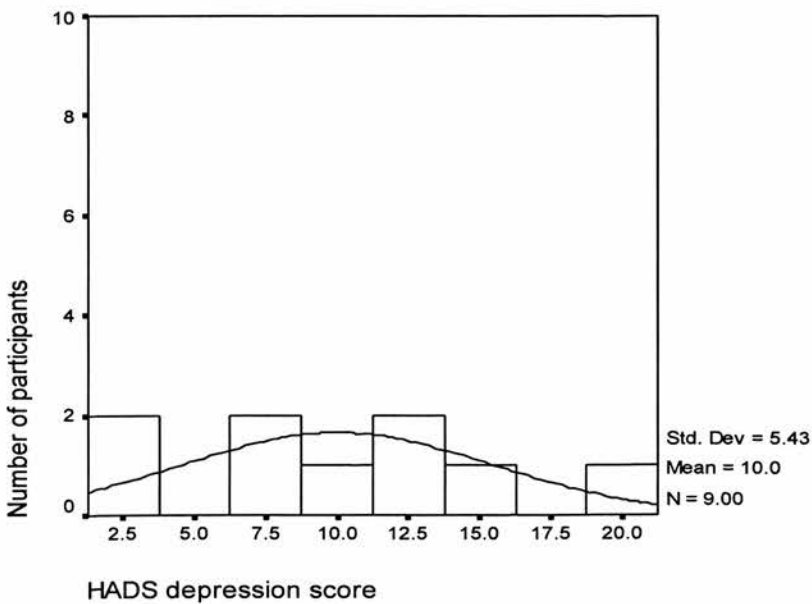
3.3. Correlation between Shame Measures

As the ISS and the YSQ shame schema section were selected as measures of shame, a Spearman's rank correlation coefficient was calculated to explore whether these two measures correlated with each other. The two measures were significantly linearly correlated ($r_S = 0.56$, $p < 0.01$), and this is demonstrated graphically in figure 3.17.

Figure 3.17. Scatterplot of positive correlation between two shame measures
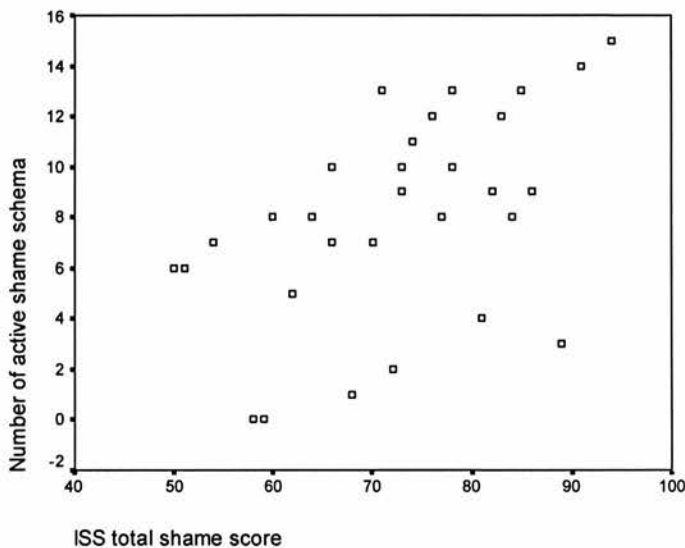
3.4. Hypothesis driven statistical analysis

i) Hypothesis 1

Individuals who meet criteria for a personality disorder, and self harm, will report higher levels of internal shame and shame related schema than individuals who meet criteria for a personality disorder and do not self harm.

In order to test Hypothesis 1, Mann-Whitney U tests were carried out to compare the median scores of the two groups on the ISS internalised shame score and the

total YSQ shame schema item score (score 5>; see table 3.14). This non parametric statistic was selected due to the fact that the group sizes were small and uneven, consequently normal distributions can not be assumed. From the results of this calculation, it can be seen that no significant differences in the shame scores between the groups were found, therefore this hypothesis was not upheld.

Table 3.13. Results of Mann-Whitney U test comparing shame scores across the two groups

	Median	IQR*	*U*	*Z*	*p-value*	*Effect size*
ISS Shame - self harm	73	65-83.5	90.5	-0.181	.856	0.03
ISS Shame - non self harm	74	59.5-80				
YSQ Shame - self harm	8	6-12.5	71.0	-1.07	.286	0.04
YSQ Shame- non self harm	8	1-9.5				

* Interquartile range

ii) Hypothesis 2 - *In individuals who self harm, levels of shame and shame related schema will be positively associated with the frequency of SIB. Therefore, those who report higher levels of shame will also report higher frequencies of SIB.*

In order to test this hypothesis a Pearson correlation was calculated, looking at the correlation between the frequency of self harm, and the reported level of shame on the ISS and the YSQ shame schema items.

The results of this are presented in table 3.14. In figure 3.18, the frequency of self harm behaviour was shown to have a weak, but significant, negative correlation with the total shame score on the ISS ($r = -0.381$, $p < 0.05$). The number of active YSQ shame schema item' was not significantly correlated with frequency of self harm ($r = -0.19$; figure 3.21). The recency of self harm behaviour correlated highly with frequency of self harm ($r = 0.85$, $p < 0.01$) and also showed a strong negative correlation with the ISS shame score ($r = -0.57$, $p < 0.01$). However,

recency and 'YSQ active shame schema items' did not show a significant correlation (r = -0.23).

Figure 3.18. Scatterplot between frequency of self harm and ISS shame score
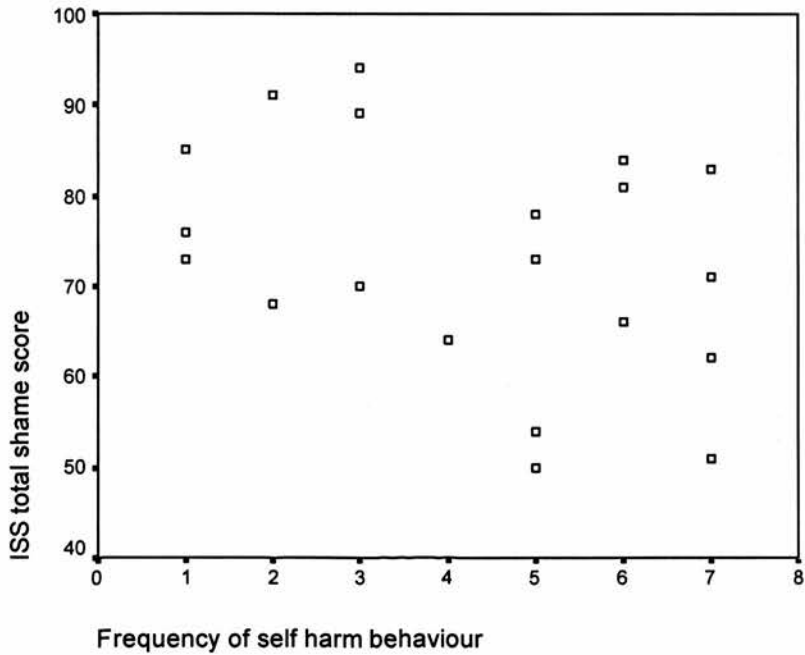
Figure 3.19. Scatterplot between frequency of self harm and YSQ active shame schema items
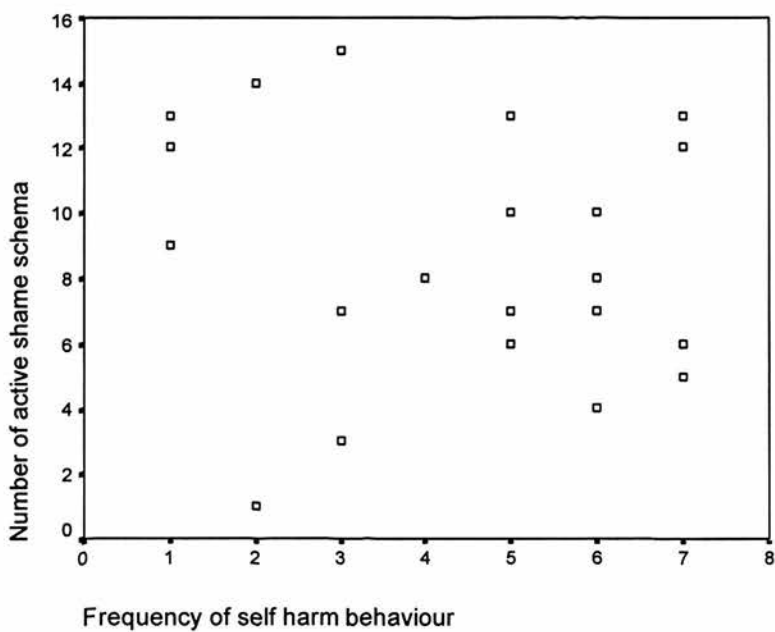
Figure 3.20. Scatterplot between most recent self harm episode and ISS shame score
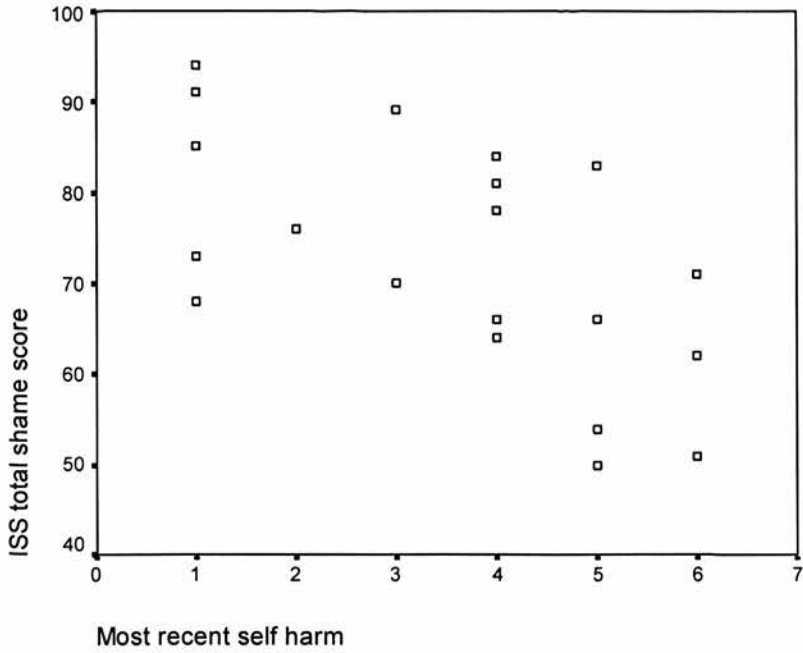
Figure 3.21. Scatterplot between most recent self harm episode and YSQ active shame schema
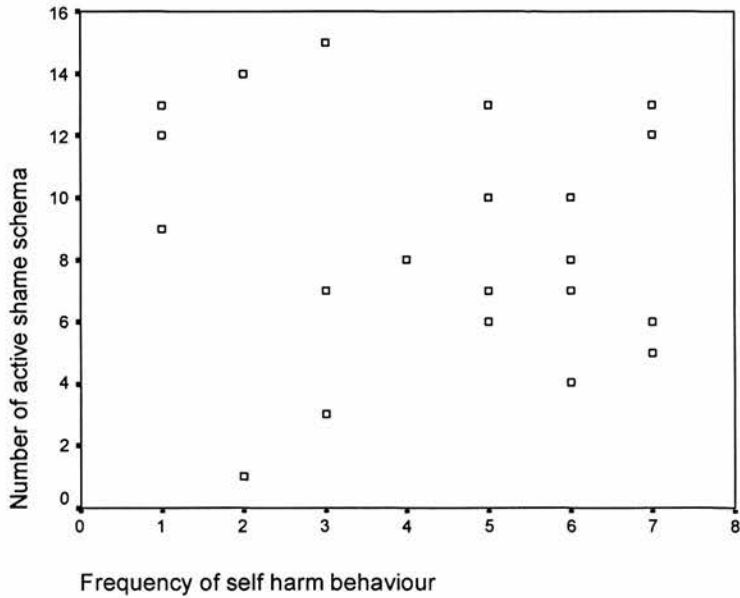
As the 'frequency of self harm' and 'ISS shame score' both significantly correlated with 'recency', it is possible that the key factor is 'recency' rather than

'frequency'. To test for this the confounding of 'recency' was removed using a partial correlation coefficient. As a result, 'frequency of self harm' and the 'ISS shame score' no longer showed a significant correlation. However, the original correlation did change from a negative correlation (r = -0.38, p = 0.044) to a positive partial correlation (r = 0.24, p = 0.298). Therefore, the original correlations between 'frequency' and 'ISS shame score' were confounded by their association with 'recency'.

Table 3.14. Hypothesis 2 - Correlation results and effect size

	Correlation	Effect size
Frequency / ISS	-0.381	0.15
Frequency / YSQ shame	-0.192	0.06

When a partial correlation between 'recency of self harm' and 'ISS shame score', controlling for 'frequency of self harm', was performed, the partial correlation between 'recency of self harm' and 'ISS shame score' remained statistically significant and negative (r = -0.508, p = 0.011). Therefore, the original correlation was not highly confounded by frequency of self harm.

From these partial correlation coefficients, we can conclude that there was a significant negative correlation between ISS shame score and recency of self harm that was not significantly affected by the adjustment for frequency of self harm. Participants who self harmed most recently had higher ISS shame scores. However, no significant correlation was found between frequency of self harm and ISS shame scores or YSQ active schema once we adjusted for recency of self harm. Hence, our hypothesis was not upheld.

3.5 Case Examples

Case Example 1

HJ is a 29 year old female with a clinician's diagnosis of Borderline Personality Disorder. She was recruited by her psychiatrist, and suggested as suitable for the self harm group. Her scores on the questionnaires were as follows;

Measure	Score		Interpretation
ISS Shame	54		50+ painful problematic levels of shame
Positive Self Esteem	13		60+ extreme levels of shame associated with severe symptoms 18> positive self esteem <18 low self esteem
YSQ significant shame schema	6	No one I desire would want to stay close to me if he/she knew the real me	Score 5> = significant schema
	6	I am inherently flawed and defective	
	5	No matter how hard I try, I feel that I won't be able to get a significant man/woman to respect me or feel that I am worthwhile	
	6	I have inner secrets that I don't want people close to me to find out	
	6	It is my fault that my parents could not love me enough	
	5	One of my greatest fears is that my defects will be exposed	
	6	I can not understand how anyone would love me	
PDQ4+ positive personality diagnosis	Narcissistic Obsessive Compulsive Paranoid Schizotypal		
Clinician – positive personality diagnosis	Borderline		
HADS Anxiety	18		8+ = clinically significant
Depression	9		
SHI Total Score	12		
Score out of criteria	6		

HJ's first attempt at self harming occurred when she was 12 years old. She recalls cutting herself on the upper arm with a pen knife in the school toilets, and describes this as a desire to "experiment with suicide". She now regularly self

harms using various methods including; cutting her skin with blades, rubbing bleach into her eyes, inserting needles under her skin and cutting her hair off.

HJ feels that she self harms to manage feelings of "abandonment" and insecurity. Prior to self harming she finds herself confused and disorientated. She experiences emotions that are difficult to deal with, and has difficulty expressing them. These emotions are intense negative feelings about herself, others and her surroundings. HJ describes self harming as "crying red". Before the act of self harming HJ can feel nervous, she notes that this happens when she is preparing to self harm e.g. buying blades. She also describes the nervousness as being related to the knowledge that she has reached a point at which she can not go back, and she knows that it will hurt. She explains that she does not enjoy the pain, but that it is a distraction from her emotional feelings. However, she also finds that part of her loves "being sore". Being in pain makes her feel "special, happy and loved". She describes pain as almost having an identity, that being in pain means that someone might fix how you feel, or that the pain itself might be able to do this. By self harming HJ finds that she comes back in touch with a reality that she can cope with. She describes self harming as a "cleansing procedure". After she has self harmed HJ feels better and "normal".

HJ describes shame as feeling guilty inside and out, embarrassed and wanting the ground to swallow her up. She also describes shame as a sense that people can see right through her. She feels that it is related to her self harm, and that she feels shame daily. For HJ shame can lead to self harm by making her feel that she should be punished. During the self harming she places the shame to the back of

her mind. She believes that if she could feel shame during the self harming she would not do it. She makes the point that she does not self harm in front of others as she knows that it is "wrong". For HJ self harming is a private experience.

HJ describes ongoing and intense feelings of shame that occur after episodes of self harm. She explains that she covers her arms and legs to hide scars, as she feels ashamed of her self harm. HJ also has strong views about the treatment that she receives from professionals, when she attends Accident and Emergency departments for help with the injuries that result from her self harming. She explains that professionals can make her feel worse about herself as they accuse her of attention seeking. She also says that when staff are too kind this can make her feel bad too. HJ suggests that the most helpful response is for professionals to be neutral towards her and make her feel safe.

Case Example 2

CH is a 22 year old female who has been cutting since the age of 15. She was referred to the study by her clinical psychologist. CH has a diagnosis of Borderline Personality Disorder. Her scores on the questionnaires are shown below;

Measure	Score		Interpretation
ISS Shame	89		50+ painful problematic levels of shame
			60+ extreme levels of shame
ISS Positive Self Esteem	3		associated with severe symptoms
			18> positive self esteem
			<18 low self esteem
YSQ significant shame schema	6	I am inherently flawed and defective	Score 5> = significant schema
	5	I often find myself drawn to people who are very critical or reject me	
	6	It is my fault that my parents could not love me	
PDQ4+ positive personality diagnosis	Avoidant Dependent		
Clinician – positive personality diagnosis	Borderline		
HADS Anxiety	7		8+ = clinically significant
Depression	6		
SHI Total Score	14		
Score out of criteria	6		

She recalls her first attempt at self harming occurring following an argument with her mother. CH had broken a mirror a few days prior to the episode, and used a piece of the broken mirror to scratch her skin. She found that a small scratch made her feel better. She repeated this four months later, and then continued to use self harm as a means of making herself feel better from this point onwards. CH has a clinician diagnosis of Borderline Personality Disorder, and her scores on the questionnaires are shown above.

CH describes the feelings and emotions that she has prior to self harming as overwhelming. She identifies these feelings as shame and disgust. In addition, she explains that she can experience overwhelming memories of her abuse history. She finds that the emotional level that she experiences becomes so high that she cannot distract herself from it. It is at this point she will cut herself. CH feels a release when she cuts herself, and finds that seeing her blood means that "horrible stuff" is coming out. CH feels that she wants to punish herself by self harming. The more blood and the deeper that she can cut the better she feels. CH finds the relief that she experiences as short term, and that it is shortly followed by a feeling that she hates herself for cutting. As a result this reinforces her negative feelings towards herself. CH does find that she experiences pain when cutting, but that his has no meaning for her. She identifies the purpose of her self harm as a means of damaging herself as she feels that she deserves to be punished.

CH understands shame to be a feeling of disgust, humiliation and embarrassment, and something that causes her to see herself as dirty, a bad person and unworthy. She feels that she experiences this on a daily basis, and that she can go days experiencing this at a low level without self harming. However, she finds that this level of shame builds up and leads her to self harm. She also finds that when she cuts, the shame becomes worse because she sees herself as "bad" for cutting, this consequently makes her want to punish herself more. Immediately after cutting, CH finds that the intensity of her difficult emotions reduces and she experiences a sense of relief.

CH finds that those close to her respond by being angry, or by suggesting that her self harming distresses them, and that this reaction makes her feel worse about herself, as she feels like a bad person for putting them though the experience. With regard to responses by professionals, CH describes feeling ashamed when she attends Accident and Emergency for the treatment of her wounds. She finds that the responses she receives from staff can be upsetting when she is made to feel that she is a "time waster". She suggests that responses that are more caring and empathic would be helpful. CH does not feel shame toward her scars from cutting. She views them as part of her history, her "battlescars".

Chapter 4: Discussion

4. Discussion of Hypotheses and Literature

Hypothesis 1 stated that;

Individuals who meet criteria for a personality disorder, and self harm, will report higher levels of internal shame and shame related schema than individuals who meet criteria for a personality disorder and do not self harm

However, the results of the study did not support this hypothesis, therefore the null hypothesis could not be rejected. This would suggest that individuals, who have a personality disorder and self harm, do not have higher shame schema nor do they report higher levels of internal shame than those who do not self harm. This finding would suggest that shame is not the mediating factor in self harm behaviour within this client group. Therefore, although self harm behaviour, shame schema and internalised shame have been found to have common origins in the form of early trauma and invalidating environments, (Walsh & Rosen, 1988; Hawton et al., 2002; Meltzer et al., 2001; Briere and Gil, 1998; Favazza, 1996, Young, Kelso & Weishaar, 2003), these results do not suggest that there is a simple relationship between the two.

Hypothesis 2 stated that;

In individuals who self harm, levels of shame and shame related schema will be positively related to the frequency of SIB. Therefore, those who report higher levels of shame will also report higher frequencies of SIB

The estimated frequency of self harm behaviour was not found to significantly correlated with the total number of active shame schema items on the YSQ or the total score on the ISS . Therefore, it would seem that the intensity of the shame schema and internalised shame do not appear to have a significant relationship with self harm frequency. Again this suggests that there is not a straightforward co-varying relationship between self harm frequency and shame.

However, the experiences described by HJ and CH within the case examples (discussed below), would not seem to support the above pattern of results for either hypothesis. It is possible therefore, that methodological weaknesses have influenced the significance of the results. This will be discussed later in this chapter.

Further investigation into the relationship between self harm frequency and shame, found that estimated frequencies of self harm behaviour, reported by the participants in the self harm group, were found to correlate negatively with the internal shame score on the ISS. However, it was noted that the correlation was very weak, and that the high correlation between 'recency' and 'frequency' may have been partly responsible for this significant finding. In order to explore this, the correlation was repeated, controlling for recency. The results of this correlation showed that when recency was controlled for, the statistical relationship between frequency and shame changed to a positive but non significant correlation. This would suggest that recency is a mediating factor, and this hypothesis was not upheld.

i) Understanding the relationship between self harm recency and shame

It is likely that those who self harm more frequently, are statistically more likely to be in the category of a more 'recent' self harmer. However, as frequency itself is not significantly correlated with shame, whereas recency is, this suggests that it is not the actual time frequency that is important in the relationship between shame and self harm, but rather the "timing" or stage which an individual is at in terms of their own 'self harm cycle'.

There are various clinical interpretations that we could make from these findings which suggest a relationship between recency of self harm and shame. Firstly, we could suggest that self harm is not an effective method of reducing shame. Therefore, high shame levels

experienced prior to a self harm episodes are not reduced by the act of self harm, and therefore remain high. However, with reference to previous research findings on self harm, it would seem that there is strong support for the function of self harm to cause relief from negative emotions (Brown, 2002). It is possible that self harm achieves this in relation to other emotions but that shame is more resilient. The descriptions of self harm and emotional intensity provided in the case examples of HJ and CH (discussed below), do provide some support for this notion in that they described feelings of release and relief, but shame feelings did not appear to dissipate. Another explanation of these findings could be that individuals feel shamed about the fact that they have self harmed, this results in an increase in shame intensity close to the self harm episode. However, this intense shame at the self harm attempt may be more episodic, and therefore reduces over time, but in the long run reinforces internal negative schema about the self.

The case studies of HJ and CH, also provide an interesting insight into the population which has been investigated, and further our understanding of the discussions so far. Although the statistical results related to the questionnaires from the study do not appear to support the hypotheses, the experiences described during these interviews, would suggest further links between shame and self harm. Obviously we cannot generalise these observations on the basis of two case studies. In addition, this study specifically aimed to explore shame and shame relate schema, therefore it may be the case that other emotional and psychological factors are experienced by these individuals. Despite this, the case examples do provide us with good clinical examples to illustrate potential relationships between shame and self harm.

HJ – This case example describes an interview with a participant who would appear to engage in quite severe self harm behaviours. HJ's shame score would suggest that she experiences 'painful and problematic' levels of internal shame. In addition to this, her active schema items describe her inner feelings of defectiveness, fears about this being

exposed to others and consequent rejection. HJ understands shame as an internal and external feeling of guilt and embarrassment, and offers the analogy of wishing the ground would swallow her up. She recognises that shame is linked to her self harm as she often feels that she should be punished for being such a bad person. This would be in keeping with previously suggested links between negative attitudes towards the self and self injurious behaviour (Friedman et al., 1972; Kaplen & Pokomy, 1976) HJ also identifies a build up of overwhelming negative emotions prior to self harming. She finds that self harming does bring her some relief from this. This would be congruent with the idea of self harm being used as a means of managing or regulating such emotions (Calof, 1995; Linehan, 1993; Haines et al., 1995; Briere and Gil, 1998). In general, such theories suggest that self harm functions as a means of regulating emotion and ending the distress of emotional intensity. To expand upon this, Linehan (1993), in her Biosocial understanding of BPD, suggests that individuals experience heightened sensitivity to emotions and increased emotional intensity. Linehan suggests that SIB is considered to be a modulating behaviour, as a means of coping with the emotional experiences.

Interestingly, HJ describes shame related to self harming itself, and recognises that it is a "socially unacceptable" thing. This is potentially a description of external shame (Gilbert, 1998). She also states that if she could feel shame during self harming episodes she would not do it. It could be suggested that self harming allows her to dissociate from the emotion of shame. HJ's description of being able to cut off from these emotions, would meet our understanding of the experience of dissociation during self harm, which is believed to function as a psychological defence, that has the capacity to keep emotional feelings and distress out of conscious awareness (Lowe et al.,2000).

Although HJ gains some temporary relief from her negative emotions, she also describes an escalation of shame following her self harming behaviour. She feels that this is due to feelings of negativity towards herself because she has "self harmed again". This would

appear to support the findings of an increase in shame following a self harm episode. In addition, HJ also identifies her experiences, and interactions with professionals when she seeks treatment for her wounds, as shame inducing. She finds that this type of negative experiences makes her feel that she is 'attention seeking' and wasting the time of others. It would seem therefore, in keeping with Linehan's (1993) understanding of BPD, that her emotions continue to be invalidated. In addition to this, her sense of herself as unworthy and flawed may also be reinforced by this experience.

Further to this, HJ also describes feeling shame towards her body, and the need to hide her arms and legs to prevent others from seeing scarring. This body shame is potentially another dimension to shame and self harm. Bodily shame is a rapidly growing field in our understanding of shame. Gilbert & Miles (2002) in his book Body Shame, recognises the intensity of this clinical problem. Multiple scarring on the body, as a result of self harm, is likely to lead to noticeable differences in appearance which are not culturally sanctioned (tattoos or piercings are examples of culturally sanctioned differences in appearance). Consequently, individuals may then become vulnerable to discrimination or stigma (Scambler & Hopkins, 1986). It is also recognised however, that there is considerable variation in the experience of bodily shame (Kent & Thomson, 2002), and that some individuals have less difficulty in coping with disfigurement (Kalick, Goldwyn & Noe, 1980). This difference in body shame attitudes within self harm is possibly demonstrated by the two case examples, as unlike HJ, CH does not describe feeling shame towards her scars, but rather sees them as "battlescars". Literature specific to body shame and self harm would not appear to exist at present. Therefore, this is a hugely significant gap in our understanding of shame and self harm

On the whole, it would seem that HJ describes a cycle of SIB. We can understand this better by suggesting the possibility of a shame cycle (see figure 4.1). This cycle of shame and self harm would potentially begin with negative emotions (possibly shame) towards

the self. HJ finds these difficult to manage and overwhelming. She then begins the preparation for self harming e.g. finding blades. She describes the possibility of being 'found out' at this stage shameful in itself. During the act of self harm HJ would seem to gain some relief from her negative emotions. However, negative feelings towards the self are reinforced by her own recognition that she has reengaged in self harm, and also from negative responses toward her self harm behaviours. Further to this, she also has a sense of shame about how others may view her, and shame towards her own body because of her scarring. The concept of a cycle of self harm behaviour is in agreement with the suggestions of the five stages involved in self harm identified by Liebenluft et al.(1987; 1) a precipitating event, 2) escalation of dysphoria, 3) attempts to forestall the self-injury 4) self-injury and 5) the aftermath). A cycle of self harm behaviour is also described by Fossum and Masson (1986). They propose a 'control-release cycle', in which individuals going through a cycle of control over their emotional experience of shame, which is believed to ultimately result in a 'breakout phase' (e.g. self harm) During the breakout phase this control is released as a consequence of the overwhelming pressure of shame and control.

HJ's case therefore provides us with a good demonstration of how shame can not only be an internal emotion during self harm, but also how it can have may layers and functions in an individual's behaviour and psychopathology.

Similar to the case of HJ, CH also contributes to our understanding of shame and self harm. CH scored very highly on the ISS internal shame score, and this would be described as an "extreme level of shame associated with severe symptoms". CH's descriptions of herself and her self harm suggest that she feels the need to "punish" herself and that she sees herself as flawed and unlovable. Again, this would fit with a working understanding of internal shame and shame related schema.

As in the case of HJ, CH identifies overwhelming emotions prior to self harming. She also describes thoughts of early abuse experiences, that cause her distress and specifically shame. CH finds these emotions and thoughts unmanageable. Again, the suggestion of self harm as a means of reducing this level of emotional intensity (Calof, 1995; Linehan, 1993; Haines et al., 1995; Briere and Gil, 1998), but also as a means of creating a psychological defence against distressing memories (Lowe et al., 2000) is also validated by CH's descriptions. When CH self harms, alongside punishing herself she often needs to see the blood which she depicts as "horrible stuff" coming out of her body. This would seem to be related to her sense of internal 'badness', a sense that she is internally flawed, and what could be seen to be internal shame at her 'self'. CH's description of the blood representing a release of what is internally bad, is similar to HJ's description of self harm as a cleansing process. This would seem to present a powerful example of psychoanalytic suggestions of self harm as a means of punishing the bad self (van der Kolk, 1996), but also supports the existence of a core shame schema about the self being defective and unloveable (Young & Brown, 1990).

Although CH describes relief from the negative emotions as a result of self harming, she also describes 'shame' towards herself for self harming "again". This offers further support for the increase in shame post self harm. In addition to this, the shame that exists for CH within her interpersonal relationships, and the shame that is induced from interactions with professionals, also seem to reinforce her negative view of herself. This would also appear to fit with the descriptions that JH also gave, and therefore reinforces the concept of this client group evoking invalidating responses from others (Linehan,1993).

From the two case examples it would seem that both individuals describe similar cycles and experiences of shame and self harm (demonstrated in figure 4.1). However, there are also differences in the experience, function and intensity of shame. During her interview,

CH made the point that self harm is unique to the individual. It would seem important that this is understood when we attempt to apply a psychological understanding to self harm and shame. The interviews with these participants focused on the shame and self harm specifically. However, the early and adult experiences that contribute to schema and internal shame development undoubtedly contribute to the uniqueness of the function of this experience.

The following model could be suggested to demonstrate the cycle of shame and self harm;

Figure 4.1. Summary of shame/ self harm cycle as described by HJ and CH
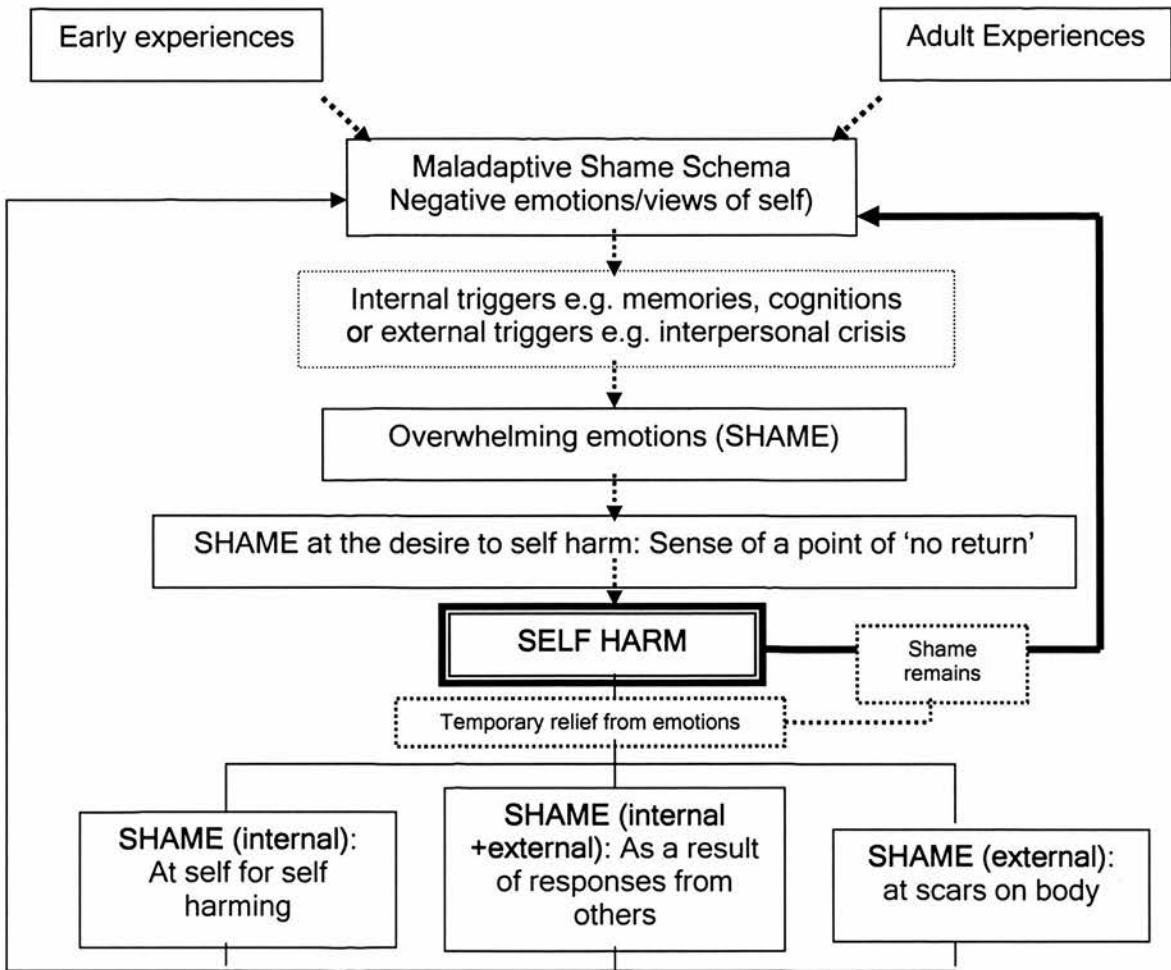
4.2 Discussion of Other findings

During the course of exploring the differences between group, several other interesting findings became apparent. Although these are not specific to the hypothesis, they are of relevance to this client group and also of clinical and theoretical interest. These are discussed briefly below.

i)Age Differences between groups

The age differences between groups were found to differ significantly. Individuals in the non self harm group tended to fall within an older age range (40+) whilst those in the self harm group tended to fall within the 18-35 age group. This would be in keeping with literature about self harm across the age span, as it is suggested that self harm is more frequent in the late adolescent/early adulthood age group. In addition to this, it is possible that with the increased research and awareness of the diagnostic term 'personality disorder', younger patients are now being recognised to fit this criteria. However, the cohort differences in self harm behaviours remain unclear.

ii)Anxiety, Depression and Shame

A significant correlation between the ISS shame score and the HADS anxiety score was found. This would be in keeping with other findings on the relationships between shame and anxiety (Gilbert & Andrews, 1998). However, no significant relationship was shown between the HADS depression score and the shame measures. This would be contrary to previous research findings, which suggest a link between shame and depression (Gilbert, 1992). This may have been due to the measurement used, as there has been previous criticism of the HADS effectiveness in measuring depression in psychiatric populations (Silverstone,1994).

iii)Self Harm Inventory (SHI) Total Score

The total score on the SHI refers to the total amount of behaviours that an individual indicated that they engaged in from the inventory of 22 self harm behaviours. As detailed earlier, from this inventory, 6 of the questions were selected as inclusion criteria (i.e. an answer of 'yes' to any of these 6 questions would have placed an individual in the self harm group).

The difference in the *total* score of the Self Harm Inventory between the two groups was also found to be significant. All participants were asked to complete the inventory, as this was felt to be important for the purposes of exploratory data analysis of the group studied. From the results, we can see that across both groups, all but 1 individual scored at least 1 on the inventory. These findings would suggest that most individuals with a diagnosis of personality disorder would engage in some form of 'self harm', either self directed e.g. *cut self on purpose* or less direct e.g. *abuse of alcohol* or *multiple sexual partners*. However, the self harm group were found to score significantly higher on the total score of the inventory. Therefore we could suggest that those who engage in self directed self harm are more likely to engage in other types of self harm or self destructive behaviours. Therefore it would appear that in this particular PD sample, rather than there being two distinct groups (those who self harm and those who don't) it is more accurate to conceptualise their self harming in a hierarchical way, with all individuals engaging in some or other (lower level) indirect self harm or self destructive behaviours, but with some also engaging in (higher level) self-directed self harm..

iv)Personality Disorder Diagnosis

Individuals included in the study met criteria for a personality disorder according to DSM-IV criteria. Participant's were considered to meet the diagnostic criteria by their active clinician, and the PDQ4+ self report screening assessment for personality disorders was also used. As the clinician's diagnosis and the PDQ4+ diagnosis for each participant

appeared to vary, statistical analysis was used to assess whether the differences in diagnosis of personality disorder were significant. There are many interesting findings and questions that have arisen from the results of personality disorder diagnosis during this study, and this is perhaps not surprising given that the whole area of diagnositc classification and its validity is a much debated area (Livesley, 1998; Klonsky 2000). However, as it is not the main focus of the investigation, these will only be highlighted briefly below.

PDQ4 and Clinician's Diagnosis

In the self harm group, the PDQ4+ and the clinician's diagnosis of Paranoid Personality Disorder, Dependent Personality Disorder and Obsessive Compulsive Personality Disorder, differed significantly. The figures show that the PDQ4+ was more likely to diagnose these personality disorders than the clinician was. However, for the diagnosis of Borderline Personality Disorder and Avoidant Personality Disorder, both the clinician and the PDQ4+ were in relatively high agreement.. In the non-self harm group, there appeared to be no significant differences in diagnosis of participants by the PDQ4+ and the clinician. Interestingly the highest concordance was for the diagnosis of Avoidant Personality Disorder which was positive for all 9 members of the control group (non self harm group) on both the PDQ4+ and by the clinician.

Differences in PD Diagnoses across groups

It would seem that the most common diagnoses within the self harm group are BPD (10 out of 21) and Avoidant Personality Disorder (7 out of 21). This would be in keeping with earlier discussions on the topic of Personality Disorder diagnosis, as self harm has been shown to be associated with the diagnosis of BPD, and is in fact part of the diagnostic criteria for BPD[1]. However, it is interesting that self harm was also found to be associated

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[1] self harm is one of several possible criteria for the diagnosis of BPD, therefore self harm is not determinate of a diagnosis of BPD

with other Personality Disorder diagnoses in this study, and this supports the need to move away from a simplistic link between self harm and BPD (Johnstone, 1997). In the albeit smaller non self harm group, Avoidant Personality Disorder was clearly the most common diagnosis and it is also interesting that the diagnosis of Borderline Personality Disorder though uncommon was still present in this group, with 1 participant meeting positive diagnosis by both clinician and the PDQ4+.

Multiple diagnoses

Participants across both groups tended to be positive for more than one personality disorder and across the 3 clusters. This was found to be more likely when using the PDQ4+ than the clinician's diagnosis. This would also support previous writings on the over-lap commonly found in using the current DSM-IV diagnostic system (ref)

Despite these findings, the diagnostic issues relating to personality disorder diagnosis must be interpreted cautiously for the following reasons;

1. The numbers of subjects in each group were relatively small, particularly the non self harm group. Conclusions on the reliability of diagnosis can not realistically be based on such numbers

2. Not all participants (5 of the 30) returned or completed PDQ4+ clinical significance sheets, therefore the vulnerability of the PDQ4+ to over diagnose was less controlled.

3. It has been suggested in the past that the PDQ4 can be over inclusive. The clinical significance sheets were introduced to reduce this. Self report measures of personality disorder psychopathology are considered to be less reliable than clinician interview based measures (Davidson, 2002).

It is clear therefore, that much more research and understanding is needed on the diagnostic issues presented by this client group. However, the findings do highlight some valid and important points.

4.3 Implications of current study for future research

The findings of the current research raise many possibilities for future research. With specific reference to the topic of shame and self harm, it is clear that there is a limited understanding of the relationship that exists. The complexity of shame and self harm in the personality disorder client group, needs much further research and development. From the case examples discussed, participants were able to offer unique and valuable insights. Qualitative and interview based research may provide us with common themes and links as a starting point to explore this topic from.

It can be seen that shame operates on many different levels in reference to self harm. A fuller understanding of the types, and intensity of shame at various stages of self harming would be a good focus for future research. In addition to this, it may be interesting to look at the severity of self harm and it's relationship to shame. CH for example, described the need to cut herself very deep to gain relief from the intensity of her negative feelings towards herself. However, the difficulty in this lies with defining severity of self harm, when the range of self harm behaviours is so vast.

4.4 Limitations of the study

There are various factors that may have influenced the outcome of these results. Firstly, the number of participants in the non self harm group was low (n=9), and although the self harm group was larger (n=21) it was still lower than the power calculation suggested as necessary for a large effect size (n=26).

Recruitment difficulties - Although recruitment issues are an obstacle for most research studies, informal discussions prior to commencing the study suggested that recruitment would not pose any great difficulty. The issue of personality disorder treatment, and management of the client group, is an ongoing issue within the hospital, and it was felt that awareness of this among therapists would have motivated participation. Unfortunately this was not the case. In order to address recruitment difficulties, the researcher made frequent attempts to contact staff groups within the hospital who would be likely to come into contact with this client group. This involved meeting and discussing the project with individuals, circulating reminders about the project specifying the recruitment difficulties and asking for the project to be mentioned during mental health and departmental team meetings. Further to this, the researcher made links with individuals who had a special interest in clinical work and research with this client group. Despite these efforts, recruitment difficulties remained challenging.

There are several reasons as to why this may have been so. Firstly, due to the changeable and potentially vulnerable nature of this client group, clinicians may have been reluctant to involve clients in research. Another reason may have been that fact that much of the recruitment took place via clinician psychologists, and it became apparent during the course of the research that several members of staff were reluctant or in disagreement with classifying an individual as having a personality disorder. This is a valid and important point, however, for the purposes of research it was necessary to define the client group by DSM-IV diagnostic criteria.

Further to this, 5 participants were excluded from the study as they answered 'no' to the question on the participant sheet that asked whether they self harmed, but later went on to indicate they did engage in certain self harm behaviours. Therefore, it seems that within the client group itself, there appears to be some confusion about what constitutes self harm behaviour. This appeared to be mirrored by clinicians, as it emerged through

informal discussions with clinicians, during the process of referring clients to the study, that a further 5 of the participants who they suggested for the *non self harm* group met the criteria for the *self harm* group, and were therefore included in the *self harm group*. These participants themselves recognised that they did self harm, and indicated this in their answers. This was an interesting situation, as it would seem that clinicians are not always aware that their clients are engaging in self harm. This has important implications for the assessment of risk and also raises issues relating to the factors which prevent patients from disclosing this information, or factors which prevent clinicians from routinely asking this.

Problems with small sample research – In considering the sample size achieved during this study, we must acknowledge difficulties associated with small sample size. More specifically, as the study has low power there is the possibility that the power was insufficient to detect a significant result (Type II error). The findings should therefore be considered with caution, as no firm conclusion can be drawn at this stage.

In addition to the points discussed above, the fact that this study was based on a clinical population, actively involved in some form of ongoing treatment, may have influenced the responses of the client group on the YSQ. Young et al. (2003) would suggest that maladaptive schemas are changeable, and are expected to positively change during the course of therapy. As the participants were recruited via their clinician, it may have been the case that clinicians selected participants who they considered to psychologically well enough to complete the questionnaires. It is also a possibility that patients who were approached regarding participation, had been in contact with their clinicians for longer periods of time, allowing the clinician to feel more able to make a clinical decision about their ability, and likely willingness, to participate. For these reasons, the stage of therapy that the individual was at may have influenced the YSQ findings.

4.5 Ethical issues during the research process

During the course of the research, care was taken to ensure that ethical issues surrounding the involvement of patients and clinicians were of central focus. On one occasion, when the researcher met with a participant to complete questionnaires, the researcher had some concerns about the general psychological state of the participant as indicated by the results of the questionnaires, which indicated that the client was self harming daily and had had several attempted overdoses. In response to this, the researcher felt it was appropriate to contact the clinician to highlight these concerns. This raised awareness of the necessity of good communication and involvement of an active clinician when researching vulnerable client groups, such as a personality disorder client group.

4.6 Conclusion

Although the experimental hypotheses were not upheld by the results of this study, the case examples which are included in this study suggest that the relationship between shame and self may be more relevant than the current study detected. Despite this, the study has offered the opportunity to consider and highlight some of the issues surrounding shame and self harm in an Axis II disorder client group. Self harm presents us with a challenging clinical problem. It is important that we continue to explore and expand our knowledge of these clinical domains, in order to facilitate good and effective clinical practice.

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Appendix 1. Young's Maladaptive Schemas & Developmental Stages

Young (2003)

DOMAIN: DISCONNECTION & REJECTION
(Expectation that one's needs for security, safety, stability, nurturance, empathy, sharing of feelings, acceptance, and respect will not be met in a predictable manner. Typical family origin is detached, cold, rejecting, withholding, lonely, explosive, unpredictable, or abusive.)

SCHEMAS:

1. ABANDONMENT / INSTABILITY (AB)

The perceived instability or unreliability of those available for support and connection. Involves the sense that significant others will not be able to continue providing emotional support, connection, strength, or practical protection because they are emotionally unstable and unpredictable (e.g., angry outbursts), unreliable, or erratically present; because they will die imminently; or because they will abandon the patient in favor of someone better.

2. MISTRUST / ABUSE (MA)

The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence. May include the sense that one always ends up being cheated relative to others or "getting the short end of the stick."

3. EMOTIONAL DEPRIVATION (ED)

Expectation that one's desire for a normal degree of emotional support will not be adequately met by others. The three major forms of deprivation are:
A. Deprivation of Nurturance: Absence of attention, affection, warmth, or companionship.
B. Deprivation of Empathy: Absence of understanding, listening, self-disclosure, or mutual sharing of feelings from others.
C. Deprivation of Protection: Absence of strength, direction, or guidance from others.

4. DEFECTIVENESS / SHAME (DS)

The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed. May involve hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one's perceived flaws. These flaws may be private (e.g., selfishness, angry impulses, unacceptable sexual desires) or public (e.g., undesirable physical appearance, social awkwardness).

5. SOCIAL ISOLATION / ALIENATION (SI)

The feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.

DOMAIN:IMPAIRED AUTONOMY & PERFORMANCE

(Expectations about oneself and the environment that interfere with one's perceived ability to separate, survive, function independently, or perform successfully. Typical family origin is enmeshed, undermining of child's confidence, overprotective, or failing to reinforce child for performing competently outside the family.)

SCHEMAS:

6. DEPENDENCE / INCOMPETENCE (DI)

Belief that one is unable to handle one's everyday responsibilities in a competent manner, without considerable help from others (e.g., take care of oneself, solve daily problems, exercise good judgment, tackle new tasks, make good decisions). Often presents as helplessness.

7. VULNERABILITY TO HARM OR ILLNESS (VH)

Exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it. Fears focus on one or more of the following: (A) Medical Catastrophes: e.g., heart attacks, AIDS; (B) Emotional Catastrophes: e.g., going crazy; (C): External Catastrophes: e.g., elevators collapsing, victimized by criminals, airplane crashes, earthquakes.

8. ENMESHMENT / UNDEVELOPED SELF (EM)

Excessive emotional involvement and closeness with one or more significant others (often parents), at the expense of full individuation or normal social development. Often involves the belief that at least one of the enmeshed individuals cannot survive or be happy without the constant support of the other. May also include feelings of being smothered by, or fused with, others OR insufficient individual identity. Often experienced as a feeling of emptiness and floundering, having no direction, or in extreme cases questioning one's existence.

9. FAILURE (FA)

The belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers, in areas of achievement (school, career, sports, etc.). Often involves beliefs that one is stupid, inept, untalented, ignorant, lower in status, less successful than others, etc.

DOMAIN: IMPAIRED LIMITS

(Deficiency in internal limits, responsibility to others, or long-term goal-orientation. Leads to difficulty respecting the rights of others, cooperating with others, making commitments, or setting and meeting realistic personal goals. Typical family origin is characterized by permissiveness, overindulgence, lack of direction, or a sense of superiority -- rather than appropriate confrontation, discipline, and limits in relation to taking responsibility, cooperating in a reciprocal manner, and setting goals. In some cases, child may not have been pushed to tolerate normal levels of discomfort, or may not have been given adequate supervision, direction, or guidance.)

SCHAMAS:
10. ENTITLEMENT / GRANDIOSITY (ET)

The belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interaction. Often involves insistence that one should be able to do or have whatever one wants, regardless of what is realistic, what others consider reasonable, or the cost to others; OR an exaggerated focus on superiority (e.g., being among the most successful, famous, wealthy) -- in order to achieve power or control (not primarily for attention or approval). Sometimes includes excessive competitiveness toward, or domination of, others: asserting one's power, forcing one's point of view, or controlling the behavior of others in line with one's own desires---without empathy or concern for others' needs or feelings.

11. INSUFFICIENT SELF-CONTROL / SELF-DISCIPLINE (IS)

Pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one's personal goals, or to restrain the excessive expression of one's emotions and impulses. In its milder form, patient presents with an exaggerated emphasis on discomfort-avoidance: avoiding pain, conflict, confrontation, responsibility, or overexertion—at the expense of personal fulfillment, commitment, or integrity.

DOMAIN: OTHER-DIRECTEDNESS

(An excessive focus on the desires, feelings, and responses of others, at the expense of one's own needs -- in order to gain love and approval, maintain one's sense of connection, or avoid retaliation. Usually involves suppression and lack of awareness regarding one's own anger and natural inclinations. Typical family origin is based on conditional acceptance: children must suppress important aspects of themselves in order to gain love, attention, and approval. In many such families, the parents' emotional needs and desires -- or social acceptance and status -- are valued more than the unique needs and feelings of each child.)

SCHEMAS:

12. SUBJUGATION (SB)

Excessive surrendering of control to others because one feels coerced - - usually to avoid anger, retaliation, or abandonment. The two major forms of subjugation are:
   A. Subjugation of Needs: Suppression of one's preferences, decisions, and desires.
   B. Subjugation of Emotions: Suppression of emotional expression, especially anger.
Usually involves the perception that one's own desires, opinions, and feelings are not valid or important to others. Frequently presents as excessive compliance, combined with hypersensitivity to feeling trapped. Generally leads to a build up of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behavior, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, "acting out", substance abuse).

13. SELF-SACRIFICE (SS)

Excessive focus on voluntarily meeting the needs of others in daily situations, at the expense of one's own gratification. The most common reasons are: to prevent causing pain to others; to avoid guilt from feeling selfish; or to maintain the connection with others perceived as needy . Often results from an acute sensitivity to the pain of others. Sometimes leads to a sense that one's own needs are not being adequately met and to resentment of those who are taken care of. (Overlaps with concept of codependency.)

14. APPROVAL-SEEKING / RECOGNITION-SEEKING (AS)

Excessive emphasis on gaining approval, recognition, or attention from other people, or fitting in, at the expense of developing a secure and true sense of self. One's sense of esteem is dependent primarily on the reactions of others rather than on one's own natural inclinations. Sometimes includes an overemphasis on status, appearance, social acceptance, money, or achievement -- as means of gaining approval, admiration, or attention (not primarily for power or control). Frequently results in major life decisions that are inauthentic or unsatisfying; or in hypersensitivity to rejection.

DOMAIN: OVERVIGILANCE & INHIBITION

(Excessive emphasis on suppressing one's spontaneous feelings, impulses, and choices OR on meeting rigid, internalized rules and expectations about performance and ethical behavior -- often at the expense of happiness, self-expression, relaxation, close relationships, or health. Typical family origin is grim, demanding, and sometimes punitive: performance, duty, perfectionism, following rules, hiding emotions,

and avoiding mistakes predominate over pleasure, joy, and relaxation. There is usually an undercurrent of pessimism and worry—that things could fall apart if one fails to be vigilant and careful at all times.)

SCHEMAS:

15. NEGATIVITY / PESSIMISM (NP)

A pervasive, lifelong focus on the negative aspects of life (pain, death, loss, disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes, betrayal, things that could go wrong, etc.) while minimizing or neglecting the positive or optimistic aspects. Usually includes an exaggerated expectation— in a wide range of work, financial, or interpersonal situations – that things will eventually go seriously wrong, or that aspects of one's life that seem to be going well will ultimately fall apart. Usually involves an inordinate fear of making mistakes that might lead to: financial collapse, loss, humiliation, or being trapped in a bad situation. Because potential negative outcomes are exaggerated, these patients are frequently characterized by chronic worry, vigilance, complaining, or indecision.

16. EMOTIONAL INHIBITION (EI)

The excessive inhibition of spontaneous action, feeling, or communication – usually to avoid disapproval by others, feelings of shame, or losing control of one's impulses. The most common areas of inhibition involve: (a) inhibition of anger & aggression; (b) inhibition of positive impulses (e.g., joy, affection, sexual excitement, play); (c) difficulty expressing vulnerability or communicating freely about one's feelings, needs, etc.; or (d) excessive emphasis on rationality while disregarding emotions.

17. UNRELENTING STANDARDS / HYPERCRITICALNESS (US)

The underlying belief that one must strive to meet very high internalized standards of behavior and performance, usually to avoid criticism. Typically results in feelings of pressure or difficulty slowing down; and in hypercriticalness toward oneself and others. Must involve significant impairment in: pleasure, relaxation, health, self-esteem, sense of accomplishment, or satisfying relationships.
Unrelenting standards typically present as: (a) perfectionism, inordinate attention to detail, or an underestimate of how good one's own performance is relative to the norm; (b) rigid rules and "shoulds" in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts; or (c) preoccupation with time and efficiency, so that more can be accomplished.

18. PUNITIVENESS (PU)

The belief that people should be harshly punished for making mistakes. Involves the tendency to be angry, intolerant, punitive, and impatient with those people (including oneself) who do not meet one's expectations or standards. Usually includes difficulty forgiving mistakes in oneself or others, because of a reluctance to consider extenuating circumstances, allow for human imperfection, or empathize with feelings.

Appendix 2. DSM-IV Personality Disorder Diagnostic Criteria

DSM-IV Diagnostic Criteria for Axis II Disorders – Personality Disorder

General diagnostic criteria for a Personality Disorder

A. An enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individuals culture. This pattern is manifested in two (or more) of the following area:
1) cognition (i.e., ways of perceiving and interpreting self, other people, and events)
2) affectivity (i.e., the range, intensity, lability and appropriateness of emotional response)
3) interpersonal functioning
4) impulse control

B. The enduring pattern is flexible and pervasive across a broad range of personal and social situations .
C. The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning
D. The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early childhood
E. The enduring pattern is not better accounted for as a manifestation or consequence of another mental disorder.
F. The enduring pattern is not due to the direct physiological effects of a substance (e.g., drug abuse, medication) or a general medical condition (e.g. head trauma)

301.0 Diagnostic criteria for Paranoid Personality Disorder

A. A pervasive distrust and suspiciousness of others that their motives are interpreted as malevolent, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) or the following:
1) suspects, without sufficient basis, that others are exploiting, harming or deceiving him or her
2) is preoccupied with unjustified doubts about the loyalty or trustworthiness of friends or associates
3) is reluctant to confide in others because of unwarranted fear that the information will be used maliciously against him or her.
4) Reads hidden demeaning or threatening meanings into benign remarks or events
5) Persistently bears grudges, i.e., is unforgiving of insults, injuries or slights
6) Perceives attacks on his or her character or reputation that are not apparent to others and is quick to react angrily or to counterattack
7) Has recurrent suspicions, without justification, regarding fidelity of spouse or sexual partner

B. Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, or another Psychotic Disorder and is not due to the direct physiological effects of a general medical condition.

301.20 Diagnostic criteria for Schizoid Personality Disorder

A. A pervasive pattern of detachment from social relationships and a restricted range of emotions in interpersonal settings, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
1) neither desires nor enjoys close relationships, including being part of a family
2) almost always chooses solitary activities
3) has little, if any, interest in having sexual experiences with another person
4) takes pleasure in a few, if any activities
5) lacks close friends or confidants other than first-degree relatives
6) appears indifferent to the praise or criticism of others
7) shows emotional coldness, detachment, or flattened affectivity

B. Does not occur exclusively during the course of Schizophrenia, a Mood Disorder With Psychotic Features, or another Psychotic Disorder and is not due to the direct physiological effects of a general medical condition.

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301.22 Diagnostic Criteria for Schizotypal Personality Disorder

A. A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive perceptual distortions and eccentricities of behaviour, beginning by early childhood and present in a variety of contexts, as indicated by five (or more) of the following:
1) ideas f reference (excluding delusions of reference)
2) odd beliefs or magical thinking that influences behaviour and is inconsistent with subcultural norms (e.g. superstitiousness, belief in clairvoyance, telepathy or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations)
3) unusual perceptual experiences, including bodily illusions
4) odd thinking and speech (e.g. vague, circumstantial, metaphorical , overelaborate or stereotyped)
5) suspiciousness or paranoid ideation
6) inappropriate or constricted affect
7) behaviour or appearance that is odd, eccentric or peculiar
8) lack of close friends or confidants or other first –degree relatives
9) excessive social anxiety that does not diminish with familiarity and tends to be associated with paranoid fears rather than negative judgements about self

B. Does not occur exclusively during the course of Schizophrenia, a Mood disorder with psychotic Features, another Psychotic Disorder, or a Pervasive Developmental Disorder.

301.7 Diagnostic criteria for Antisocial Personality Disorder

A. There is a pervasive pattern of disregard for and violation of the rights of others occurring since age 15 years, as indicated by three (or more) of the following;
1) failure to conform to social norms with respect to lawful behaviours as indicated by repeatedly performing acts that are grounds for arrest
2) deceitfulness, as indicated by repeated lying, use of aliases, or conning others for personal profit or pleasure
3) impulsivity or failure to plan ahead
4) irritability and aggressiveness, as indicated by repeated physical fights or assaults
5) reckless disregard for safety of self or others
6) consistent irresponsibility, as indicated by repeated failure to sustain consistent work behaviour or honour financial obligations
7) lack of remorse, as indicated by being indifferent to or rationalising having hurt, mistreated, or stolen from another

B. The individual is at least age 18 years
C. There is evidence of Conduct Disorder (see p. 98) with onset before age 15 years
D. The occurrence of antisocial behaviour is not exclusively during the course of Schizophrenia or Manic Episode

301.83 Diagnostic Criteria for Borderline Personality Disorder

A pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity beginning by 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 **Note**: Do not include suicidal or self-mutilating behaviour covered in criterion 5
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
5) recurrent suicidal behaviour, gestures, or threats, or self mutilating behaviour

2

6) affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days
7) chronic feelings of emptiness
8) inappropriate, intense anger or difficulty controlling anger (e.g. frequent displays of temper, constant anger, recurrent physical fights)
9) transient, stress-related paranoid ideation or severe dissociative symptoms·

301.50 Diagnostic criteria for Histrionic Personality Disorder

A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1) is uncomfortable in situations in which he or she is not the centre of attention
2) interaction with others is often characterised by inappropriate sexually seductive or provocative behaviour
3) displays rapidly shifting and shallow expression of emotions
4) consistently uses physical appearance to draw attention to self
5) has a style of speech that is excessively impressionistic and lacking in detail
6) shows self-dramatisation, theatricality and exaggerated expression of emotion
7) is suggestible, i.e. easily influenced by others or circumstances
8) considers relationships to be more intimate than they actually are

301.81 Diagnostic criteria for Narcissistic Personality Disorder

A pervasive pattern of grandiosity (in fantasy or behaviour), need for admiration, and lack of empathy, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1) has a grandiose sense of self-importance (e.g., exaggerates achievements and achievements and talents, expects to be recognised as superior without commensurate achievements)
2) is preoccupied with fantasies of unlimited success, power brilliance, beauty, or ideal love
3) believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
4) requires admiration
5) has a sense of entitlement, i.e. unreasonable expectations of especially favourable treatment or automatic compliance with his or her expectations
6) is interpersonally exploitative, i.e. takes advantage of others to achieve his or her own ends
7) lacks empathy: is unwilling to recognise or identify with the feelings and needs of others
8) is often envious of others or believes that others are envious of him or her
9) shows arrogant, haughty behaviours or attitudes

301.82 Diagnostic criteria for Avoidant Personality Disorder

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1) avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection
2) is unwilling to get involved with people unless certain of being liked
3) shows restraint within intimate relationships because of fear of being shamed or ridiculed
4) is preoccupied with being criticised or rejected in social situations
5) is inhibited in new interpersonal situations because of feelings of inadequacy
6) views self as socially inept, personally unappealing, or inferior to others

7) is usually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

301.6 Diagnostic Criteria for Dependent personality Disorder

A pervasive and excessive need to be taken care of that leads to submissive and clinging behaviour and fears of separation, beginning by early childhood and present in a variety of contexts, as indicate by five (or more) of the following;

1) has difficulty making everyday decisions without an excessive amount if advice and reassurance from others
2) needs others to assume responsibility for most major areas of his or her life
3) has difficulty expressing disagreement with others because of fear of loss of support or approval **Note:** Do not include realistic fears of retribution
4) has difficulty initiating projects or doing things on his or own (because of lack of self confidence in judgement or abilities rather than a lack of motivation or energy)
5) goes to excessive lengths to obtain nurturance and support from others, to th point of volunteering to do things that are unpleasant
6) feels uncomfortable or helpless when alone because of exaggerated fears if being unable to care for himself or herself
7) urgently seeks another relationship as a source of care and support when a close relationship ends
8) is unrealistically preoccupied with fears of being left to take care of himself or herself

301.4 Diagnostic criteria for Obsessive-Compulsive Personality Disorder

A pervasive pattern of preoccupation with orderliness, perfectionism, and mental and interpersonal control, at the expense of flexibility, openness , and efficiency, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

1) is preoccupied with details, rules, lists, order, organisation, or schedules to the extent that the major point of the activity is lost
2) shows perfectionism that intervenes with task completion (e.g. is unable to complete a projects because his or her own overly strict standards are not met)
3) is excessively devote to work and productivity to the exclusion of leisure activities and friendships (not accounted for by obvious economic necessity)
4) is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values (not accounted for by cultural or religious identification)
5) is unable to discard worn out or worthless objects even when they have no sentimental value
6) us reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things
7) adopts a miserly spending style towards both self and others; money is viewed as something to be hoarded for future catastrophes
8) shows rigidity and stubbornness

Appendix 3. Ethics

GRAMPIAN RESEARCH ETHICS COMMITTEE

Chairmen

Committee One
Dr John Dean
Consultant
Department of Medical Genetics
Medical School
Foresterhill
Aberdeen
AB25 2ZD

Committee Two
Professor Nigel Webster
Professor of Anaesthesia & Intensive Care
Institute of Medical Sciences
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23 February 2004

Project No: 04/0008

Miss Christina S. Lamb
Trainee Clinical Psychologist
Clinical & Counselling Psychology
Block A
Clerkseat Building
Royal Cornhill Hospital
Cornhill Road
ABERDEEN

Dear Miss Lamb

REC Ref: 04/0008
Study title: Shame and shame related schemes in individuals who self harm

The Chair/Manager on behalf of the Grampian Research Ethics Committees has considered your response to the issues raised by the Committee at the first review of your application on 15 January 2004 as set out in our letter.

The Chair/Manager, acting under delegated authority, is satisfied that your response has fulfilled the requirements of the Committee. You are therefore given approval for your research on ethical grounds providing you comply with the conditions set out below:

Conditions of approval:

- *(Where approval is given before receipt of CTX)* Please let the LREC have a copy of the CTX when it is available. If changes to the protocol are required by the MHRA (Medicines and Healthcare Products Regulatory Agency), the LREC approval will become void until those changes have been made and the revised protocol will need to be approved.

- You do not undertake this research in any NHS organisation until the relevant NHS management approval has been received.

Your application has been given a unique reference number, please use it on all correspondence with the LREC.

- You do not deviate from, or make changes to, the protocol without the prior written approval of the LREC, except where this is necessary to eliminate immediate hazards to research participants or when the change involves only logistical or administrative aspects of the research. In such cases, the LREC should be informed within seven days of the implementation of the change. Likewise, you should also seek the relevant NHS management approval for the amendment, or inform the NHS organisation of any logistical or administrative changes.

- You complete and return the standard progress report form to the LREC one year from the date of this letter and thereafter on an annual basis. This form should also be used to notify the Committee when your research is completed and should be sent to the REC within three months of completion. For a copy of the progress report please see www.corec.org.uk.

- If you decide to terminate this research prematurely, a progress report form should be sent to the LREC within 15 days, indicating the reason for the early termination. For a copy of the progress report please see www.corec.org.uk.

- You must advise the LREC of all Suspected Serious Adverse Reactions (SSARs) and all Suspected Unexpected Serious Adverse Reactions (SUSARs).

- You advise the LREC of any unusual or unexpected results that raise questions about the safety of the research.

- The project must be started within three years of the date of this letter.

NHS LRECs are compliant with the International Conference on Harmonisation/Good Clinical Practice (ICH GCP) Guidelines for the conduct of trials involving participation of human subjects.

Yours sincerely

Mrs Kellie MacLeod
Manager
Grampian Research Ethics Committees

cc   Research & Development Department. NHS Grampian

Your application has been given a unique reference number, please use it on all correspondence with the LREC.

Appendix 4. Definition of Shame

Some descriptions of Shame

Feeling defective as a person and that there is something wrong with you

Feeling insecure of others opinions of you

Feeling small and insignificant

Wanting to shrink away

Fear of your faults being exposed to others

Thinking that others see your flaws

Feeling exposed

Feeling unlovable

Appendix 5. Clinician Information Sheet

NHS

Grampian

Clinical and Counselling Psychology
Block A.
Clerkseat Building
Royal Cornhill Hospital

Date:
Tel:
Ref:

Dear Colleague,

Re: Research on Shame and Self Harm in Axis-II Disorders

I am currently conducting a research project in order to complete my Clinical Psychology Doctorate dissertation. I am interested in the topic of shame in self harm, particularly in individuals with a working diagnosis of an Axis-II disorder (according to the DSM-IV diagnostic criteria, see attached). I am hoping to recruit participants via clinicians, and would be grateful if you would take the time to read the following description of the study and consider facilitating the participation of your clients.

What is the main aim/question being researched?
The main aim of the study is to look at the relationship between the emotion of shame and self harm. In addition to this, I will also be looking at shame related schemas that experienced by this client group. The main question that I will be looking to answer is; Do individuals who self harm and have an axis-II disorder report higher levels of shame and shame related schemas than those who have an Axis-II disorder and do not self harm.

How will this be done? What would my client have to do?
Two groups of people will be compared in the study
1. Those with a working diagnosis of an Axis-II disorder who self harm
2. Those with a working diagnosis of an Axis-II disorder who **do not** self harm

These individuals will be asked to complete a sheet of information about themselves (looking at information such as demographics and frequency of self harm behaviour) and also the following questionnaires;

Personality Disorder Questionnaire -4	Self report personality diagnostic questionnaire
Self Harm Inventory	Inventory of self harm behaviours
Hospital Anxiety Depression Scale	Measure of clinical levels of anxiety/depression
Internalised Shame Scale	Shame measure
Young's Schema Questionnaire (short form)	Schema based questionnaire

In addition to this, I also hope to collect qualitative information about participants own views on shame and self harm. This will be achieved by giving participants the option to volunteer for a meeting with the researcher. A **maximum of 3** participants will be interviewed.

Questionnaires would take an average of 30 minutes to complete.

Who would be suitable for the study?
- Individuals who have a working diagnosis of an axis-II disorder. This would include those who self harm and those who do not. Participants should be aged 16+, male or female.

What do you mean by self harm?
For the purposes of this study, the definition of self harm would be non suicidal self harm behaviours that involve the individual harming to themselves in order to manage, cope with or vent feelings. This would include self harm behaviours such as cutting, burning and scratching.

Who would not be suitable?
Individuals who will not be included are those who
- Do not have a working diagnosis of an axis-II disorder

Those with an axis II disorder who:
- have ever met the criteria for schizophrenia, schizoaffective disorder or bipolar disorder
- met criteria for a substance use disorder in the past month

What would I have to do?
- In order to ensure that the participant is supported in the event of any risk or distress it was decided that recruitment via an active clinician was the best practice.
- Due to the nature of the research topics, it was felt that clinician involvement and awareness of information provided was essential. In order to address this, clinicians will be asked to read over all information provided by the participants. This is to screen for risk and to ensure that the clinician is aware of any information that may be essential to their intervention. (Participants will be aware of this).
- There are **three possible options** for completing the questionnaires. Clinicians should make the decision as to which option would be most suitable for their client:

  a) Clinicians should complete all questionnaires with their client
  There is also a brief validation questionnaire with the PDQ-4 that needs to be administered by the clinician. All other questionnaires can be completed by the participant under the clinician's supervision/guidance.

  b) The researcher can arrange to meet with the participant and complete all questionnaires with them.

  c) The Participant can complete the questionnaires alone, and return them to their clinician during their next appointment. The brief PDQ-4 validation questionnaire would need to be completed by the clinician and participation return of the questionnaires.

- In all circumstances, the clinician will be asked to provide information on the diagnosis of the participant. The participant will be aware of this.
- In the event of a client agreeing to meet with the researcher for interview, the clinician will be notified and consulted to confirm that the participant will be suitable. Where possible, the researcher shall arrange to meet with a participant prior to a meeting with their clinician.
- For ethical reasons clinicians and participants will be asked to sign a consent form to ensure that they are aware of all aspects of their involvement and of any possible risks.

If you feel that you have any clients that would be suitable for this study, and that you would be willing to participate as their clinician, please contact me as soon as possible. I shall forward you the relevant materials and would also be happy to meet with you.

If you have any questions about the study, please do not hesitate to contact me.

<div style="border:1px solid black;">

Contact Details

Christina Lamb (Principal Researcher)
Trainee Clinical Psychologist
Clinical and Counselling Psychology
Block A,. Clerkseat Building, Royal Cornhill Hospital
Tel: 01224 557219 (ext. 57219)

</div>

Many thanks for your time and consideration.

Yours sincerely,

Christina Lamb   **Adeline Graham**
Trainee Clinical Psychologist   **Chartered Clinical Psychologist**

Appendix 6. Clinician Consent Form

NHS
Grampian

8th December 2003   Clinician Consent Form   Version1

Clinician Consent Form
Study: Shame and Self Harm

Clinician's name: _____

Client's name: _____

Principal Investigator: Christina Lamb, Trainee Clinical Psychologist

Please read the information below and sign if you agree with the statement

I have read the clinician participation information sheet on the above study and have been given a contact number and the opportunity to discuss the details with Christina Lamb and ask questions if I wish.

I have agreed to take part in the study, along with my client, as it has been outlined to me. I understand that I am completely free to withdraw from the study or any part of the study at any time I wish.

I understand that these trials are part of a research project designed to promote healthcare knowledge, which has been approved by the Grampian Research Ethics Committee, and may be of no benefit to me personally.

I hereby fully and freely consent to participate in the study which has been fully explained to me.

Signature _____
Date   _____

The above participant will be able to contact me if they have any queries at any time throughout the research study.

_____
Christina Lamb
Trainee Clinical Psychologist

Appendix 7. Participant Information Sheet

NI S
Grampian

Clinical and Counselling Psychology Services
Clock A, Clerkseat Building, Royal Cornhill Hospital Aberdeen
Tel: 01224 557219

An Invitation to Participate in Research

Study Title: Shame and Self Harm
You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss
It with other if you wish. Please feel free to contact us if there is anything that is not clear or you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of this study?
The purpose of this study is to look at some of the emotions that people experience, and the beliefs that they hold about themselves. More specifically, the study is looking at the emotion of shame in individuals who self injure. The reason for this is to help us to understand the experience of self injury. In gaining a better understanding, we are then able to help individuals in a more effective way should they wish to seek help. Data collection for the study will be taking place over a period of approximately five months.

Why have I been chosen?
Two groups of people have been chosen to take part in the research. Firstly there will be a group of approximately 26 people who self injure and there will also be another other group of approximately 26 people who do not self injure. The two groups will be compared to see if there are any differences in the experiences that they have. The groups of people have been matched by the complexity of psychological problems that they experience.

Do I have to take part?
It is up to you to decide whether or not to take part. If you decide to take part you will be given this information sheet to keep and asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will happen to me if I take part?
Taking part in the research will involve completing some 5 questionnaires and some information about yourself. These will include;

Participant information sheet	3-5 minutes
YSQ (selected questions)	5-10 minutes
Self Harm Inventory	5 minutes
HAD scale	5-10 minutes
PDQ-4 and follow up to this with clinician	20-30 minutes
ISS	10-15 minutes

This will involve one of three possible methods;
-On your own and returning them to your clinician at your next appointment
-With your clinician during a appointments
-With a researcher at an arranged meeting
Your clinician will decide which option is best for you. The reason for this is to ensure that you have a good understanding of questions, to support you through answering them and to ensure that you are not distressed after completing them. When you have completed questionnaires they should be returned to your clinician (or researcher). There will then be a very short follow up questionnaire that will be completed with you.
If you are in the group of people who self injure, you will also be given the option to meet with a researcher to speak about your experiences. Only 3-4 people will be selected for this. You are under no obligation to agree to do this.

What do the questionnaire look at?
The questionnaires look at;
The types of problems that you experiences, and related behaviours and feelings
The levels of the emotion of shame that you experience
Self harm behaviours
The beliefs that you have about yourself
Your current feelings of depression and anxiety

Will my clinician (psychologist/psychiatrist) be taking part in the study?
Yes, in order to make participation in the study safe and to help you feel supported during it, your clinician will be;
- Reading over the questionnaires before you are given them in order to screen them for anything that may cause you distress
- Involved in helping you to decide whether you wish to take part
- Helping you complete you questionnaires (in some cases you may do most of this alone or with a researcher)
- Reading over your completed questionnaires to ensure that they are informed of anything that may suggest that you or anyone else is at risk in any way
In addition to this, your clinician will be asked to complete a short questionnaire to provide us with information about the types of problems that you have been experiencing.

What are the possible disadvantages and risk of taking part?
The questionnaires that we are going to use in the research have been completed by lots of people to make sure that they are suitable to be used by researchers and clinicians. However, due to the nature of the topics that the questionnaires and research is focusing on, e.g. shame, self harm, beliefs about self etc., you may find some of the questions upsetting.or triggering

What are the possible benefits of taking part?
Although there may be no direct benefits to you as a direct result of taking part in the research, the information that we get from this study may help us treat future patients with similar problems better.

Will my taking part in this study be kept confidential?
All information which is collected about you during the course of the research will be kept strictly confidential. The only individuals that will have knowledge of the answers that you have given will be your clinician and the researchers. When your questionnaires are received the consent sheet that you sign will be removed from them, and stored in a locked filing cabinet. You will then be assigned a numerical code, to protect your identity when the questionnaire information is being processed.

What will happen to the results of the research?
The results of the study will be written up as a dissertation project. Information from this dissertation may be used in presentations to health professionals or client groups. They may also be published in psychological journals. However you will not be identified in any presentation or publication.

What do I do now?

Please read the information contained in this form carefully to help you decide if you would like to participate in this study. If you decide that you would like to take part, please notify the clinician that you received this from, and they will arrange for you to complete the questionnaires. Please keep this information sheet for your own use.

You will only have to complete your name on the consent form. You do not need to put your name on any of the questionnaires as they will be numerically coded.

If you have completed the questionnaires on your own, please return them to your clinician at your next appointment. Your clinician then will complete a final short questionnaire with you.

If you have completed the questionnaires with the researcher, the researcher will complete the final short questionnaire with you, and pass your completed questionnaires onto your clinician to read over.

If you wish to ask any questions or require further information, please contact
Christina Lamb
Trainee Clinical Psychologist (Principle researcher)
Clinical and Counselling Psychology Services
Clock A, Clerkseat Building
Royal Cornhill Hospital
Tel: 01224 557219

Thank you for taking your time to read this information and for considering taking part in our study.

Christina Lamb   Adeline Graham
Trainee Clinical Psychologist   Chartered Clinical Psychologist

Appendix 8. Participant Consent Form

Code _____

NHS
Grampian

Clinical and Counselling Psychology
Block A.
Clerkseat Building
Royal Cornhill Hospital

Date:
Tel:
Ref:

Participant Consent Form
Study: Shame and Self Harm

Your name: _____

Principal Investigator: Christina Lamb, Trainee Clinical Psychologist

Please read the information below and sign if you agree with the statement

I have read the patient/participant information sheet on the above study and have been given a contact number and the opportunity to discuss the details with Christina Lamb and ask questions if I wish.

I have agreed to take part in the study as it has been outlined to me, but I understand that I am completely free to withdraw from the study or any part of the study at any time I wish and that this will not affect my continuing psychological treatment in any way.

I understand that these trials are part of a research project designed to promote healthcare knowledge, which has been approved by the Grampian Research Ethics Committee, and may be of no benefit to me personally.

I hereby fully and freely consent to participate in the study which has been fully explained to me.

Signature _____

Date   _____

The above participant will be able to contact me if they have any queries at any time throughout the research study.

_____

Christina Lamb
Trainee Clinical Psychologist

Appendix 9. Personal Information/Self Harm information Sheet

8th December 2003 Version1 Participant Information Sheet

Participant Information Sheet
Please answer the following questions about yourself. If you are unsure of any answers please give your best guess or estimate.

AGE ____	SEX ____

Relationship status (please tick):

Single ____	Separated ____	Widowed ____
Married ____	Live with someone ____	
Divorced ____	Live alone ____	

Current Contact with professionals
(Please tick and give an estimate of how long you have been seeing this professional)

<u>Estimate how long</u>

Clinical Psychologist ____ _____
Psychiatrist ____ _____
CPN ____ _____
Other? (please state) ____ _____
____ _____

Have you been an in-patient recently due to mental health problems?
No ____
Yes ____
If yes, how recently? (Please tick)

In past month ____	In past 3-6 months ____
In past 2-3 months ____	In past 6-12 months ____

Do you self harm?
Yes ____   No ____
If YES, please answer the following questions:
What are your most common methods of self harm? (please state)

Thinking of over the past year, how often would you say you have self harmed? (please give an estimate of you are unsure)

More than weekly ____	Once a fortnight ____	Every 2-3 months ____	Once a year ____
Weekly ____	Once a month ____	Every 3-6 months ____	

When was your most recent attempt at self harming?

In the past week ____	In the past 2-3 months ____
In the past fortnight ____	In the past 6 months ____
In the past month ____	Over 6 months ago ____

Thank you for completing this questionnaire

Appendix 10. Hospital Anxiety Depression Scale

HAD Scale   #3

Name: Date:

Doctors are aware that emotions play an important part in most illnesses. If your doctor knows about these feelings he will be able to help you more.

This questionnaire is designed to help your doctor to know how you feel. Read each item and place a firm tick in the box opposite the reply which comes closest to how you have been feeling in the past week.

Don't take too long over your replies: your immediate reaction to each item will probably be more accurate than a long thought-out response.

Tick only one box in each section

I feel tense or 'wound up':
- Most of the time ....
- A lot of the time ....
- Time to time, Occasionally ....
- Not at all ....

I still enjoy the things I used to enjoy:
- Definitely as much ....
- Not quite so much ....
- Only a little ....
- Hardly at all ....

I get a sort of frightened feeling as if something awful is about to happen:
- Very definitely and quite badly ....
- Yes, but not too badly ....
- A little, but it doesn't worry me ....
- Not at all ....

I can laugh and see the funny side of things:
- As much as I always could ....
- Not quite so much now ....
- Definitely not so much now ....
- Not at all ....

Worrying thoughts go through my mind:
- A great deal of the time ....
- A lot of the time ....
- From time to time but not too often ...
- Only occasionally ....

I feel cheerful:
- Not at all ....
- Not often ....
- Sometimes ....
- Most of the time ....

I can sit at ease and feel relaxed:
- Definitely ....
- Usually ....
- Not often ....
- Not at all ....

I feel as if I am slowed down:
- Nearly all the time ....
- Very often ....
- Sometimes ....
- Not at all ....

I get a sort of frightened feeling like 'butterflies' in the stomach:
- Not at all ....
- Occasionally ....
- Quite often ....
- Very often ....

I have lost interest in my appearance:
- Definitely ....
- I don't take so much care as I should.....
- I may not take quite as much care ....
- I take just as much care as ever ....

I feel restless as if I have to be on the move:
- Very much indeed ....
- Quite a lot ....
- Not very much ....
- Not at all ....

I look forward with enjoyment to things:
- As much as ever I did ....
- Rather less than I used to ....
- Definitely less than I used to ....
- Hardly at all ....

I get sudden feelings of panic:
- Very often indeed ....
- Quite often ....
- Not very often ....
- Not at all ....

I can enjoy a good book or radio or TV programme:
- Often ....
- Sometimes ....
- Not often ....
- Very seldom ....

Do not write below this line

Appendix 11. Internalised Shame Scale

ISS

Name: _____   Date: _____

Below is a list of statements describing feelings or experiences that you may have from time to time or that are familiar to you because you have had these feelings and experiences for a long time. Most of these statements describe feelings and experiences that are generally painful or negative in some way. Some people will seldom or never have had many of these feelings. Everyone has had some of these feelings at some time, but if you find that these statements describe the way you feel a good deal of the time, it can be painful just reading them. Try to be as honest as you can in responding.

Read each statement carefully and circle the number to the right of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement. Use the scale below. DO NOT OMIT ANY ITEM.

		Never	Seldom	Sometimes	Often	Almost always
1.	I feel like I am never quite good enough	0	1	2	3	4
2.	I feel somehow left out	0	1	2	3	4
3.	I think that people look down on me	0	1	2	3	4
4.	All in all, I am inclined to feel that I am a success	0	1	2	3	4
5.	I scold myself and put myself down	0	1	2	3	4
6.	I feel insecure about others' opinions of me	0	1	2	3	4
7.	Compared to other people, I feel like I somehow never measure up	0	1	2	3	4
8.	I see myself as being very small and insignificant	0	1	2	3	4
9.	I feel I have much to be proud of	0	1	2	3	4
10.	I feel intensely inadequate and full of self doubt	0	1	2	3	4
11.	I feel as if I am somehow defective as a person, like there is something basically wrong with me	0	1	2	3	4
12.	When I compare myself to others I am just not as important	0	1	2	3	4
13.	I have an overpowering dread that my faults will be revealed in front of others	0	1	2	3	4
14.	I feel I have a number of good qualities	0	1	2	3	4
15.	I see myself striving for perfection only to continually fall short	0	1	2	3	4

	Never	Seldom	Sometimes	Often	Almost always
6. I think others are able to see my defects	0	1	2	3	4
7. I could beat myself over the head with a club when I make a mistake	0	1	2	3	4
8. On the whole, I am satisfied with myself	0	1	2	3	4
I would like to shrink away when I make a mistake	0	1	2	3	4
I replay painful events over and over in my mind until I am overwhelmed	0	1	2	3	4
I feel I am a person of worth, at least on an equal plane with others	0	1	2	3	4
At times I feel like I will break into a thousand pieces	0	1	2	3	4
I feel as if I have lost control over my body functions and my feelings	0	1	2	3	4
Sometimes I feel no bigger than a pea	0	1	2	3	4
At times I feel so exposed that I wish the earth would open up and swallow me	0	1	2	3	4
have this painful gap within me that I have not been able to fill	0	1	2	3	4
feel empty and unfulfilled	0	1	2	3	4
take a positive attitude toward myself	0	1	2	3	4
y loneliness is more like emptiness	0	1	2	3	4
eel like there is something missing	0	1	2	3	4

Internalised Shame Scale (ISS) 2

Appendix 12. Personality Disorder Questionnaire 4+

PDQ-4+

Personality Questionnaire

Your name _____

Today's date _____

Your age _____

Your sex _____

Your marital status _____

Your race/ethnic group _____

Highest level of education _____

Instructions

The purpose of this questionnaire is for you to describe the kind of person you are. When answering the questions, think about how you have tended to feel, think, and act over the past several years. To remind you of this, on the top of each page you will find the statement: "Over the past several years..."

T (True) means that the statement is generally true for you.

F(False) means that the statement is generally false for you.

Even if you are not entirely sure about the answer, indicate "T" or "F" for every question.

For example, for the question:

    xx. I tend to be stubborn.   T   F

If, in fact you have been stubborn over the past several years, you would answer True by circling T.

If, this was not true at all for you, you would answer False by circling F.

There are no correct answers.

You make take as much time as you wish.

Over the last several years. . .

1. I avoid working with others who may criticize me. T F

2. I can't make decisions without the advice, or reassurance, of others. T F

3. I often get lost in details and lose sight of the "big picture." T F

4. I need to be the center 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 who I love from ever leaving me. T F

1

Over the last several years. . .

7. Others have complained that I do not keep up with my work or commitments. T F

8. I've been in trouble with the law several times (or would have been if I was caught). T F

9. Spending time with family or friends just doesn't interest me. T F

10. I get special messages from things happening around me. T F

11. I know that people will take advantage of me, or try to cheat me, if I let them. T F

12. Sometimes I get upset. T F

2

Over the last several years...

19. I either love someone or hate them, with nothing in between.   T   F

20. I get into a lot of physical fights.   T   F

21. I feel that others don't understand or appreciate me.   T   F

22. I would rather do things by myself than with other people.   T   F

23. I have the ability to know that some things will happen before they actually do.   T   F

24. I often wonder whether the people I know can really be trusted.   T   F

Over the last several years...

13. I make friends with people only when I am sure they like me.   T   F

14. I am usually depressed.   T   F

15. I prefer that other people assume responsibility for me.   T   F

16. I waste time trying to make things too perfect.   T   F

17. I am "sexier" than most people.   T   F

18. I often find myself thinking about how great a person I am, or will be.   T   F

Over the last several years. . .

25. Occasionally I talk about people behind their backs. T F

26. I am inhibited in my intimate relationships because I am afraid of being ridiculed. T F

27. I fear losing the support of others if I disagree with them. T F

28. I suffer from low self-esteem. T F

29. I put my work ahead of being with my family or friends or having fun. T F

30. I show my emotions easily. T F

Over the last several years. . .

31. Only certain special people can really appreciate and understand me. T F

32. I often wonder who I really am. T F

33. I have difficulty paying bills because I don't stay at any one job for very long. T F

34. Sex just doesn't interest me. T F

35. Others consider me moody and "hot tempered." T F

36. I can often sense, or feel things, that others can't. T F

Over the last several years...

37. Others will use what I tell them
    against me.   T   F

38. There are some people I don't like.   T   F

39. I am more sensitive to criticism or
    rejection than most people.   T   F

40. I find it difficult to start something
    if I have to do it by myself.   T   F

41. I have a higher sense of morality
    than others people.   T   F

42. I am my own worst critic.   T   F

Over the last several years...

43. I use my "looks" to get the attention
    that I need.   T   F

44. I need very much for other people
    to take notice of me or compliment me.   T   F

45. I have tried to hurt or kill myself.   T   F

46. I do a lot of things without considering
    the consequences.   T   F

47. There are few activities that I have
    any interest in.   T   F

48. People often have difficulty
    understanding what I say.   T   F

Over the last several years...

49. I object to supervisors telling me how I should do my job. T F

50. I keep alert to figure out the real meaning of what people are saying. T F

51. I have never told a lie. T F

52. I am afraid to meet new people because I feel inadequate. T F

53. I want people to like me so much that I volunteer to do things that I'd rather not do. T F

54. I have accumulated lots of things I don't need that I can't bear to throw out. T F

Over the last several years...

55. Even though I talk a lot, people say that I have trouble getting to the point. T F

56. I worry a lot. T F

57. I expect other people to do favors for me even though I do not usually do favors for them. T F

58. I am a very moody person. T F

59. Lying comes easily to me and I often do it. T F

60. I am not interested in having close friends. T F

Over the last several years. . .

61. I am often on guard against being taken advantage of. T F

62. I never forget, or forgive, those who do me wrong. T F

63. I resent those who have more "luck" than I. T F

64. A nuclear war may not be such a bad idea. T F

65. When alone I feel helpless and unable to care for myself. T F

66. If others can't do things correctly I would prefer to do them myself. T F

Over the last several years. . .

67. I have a flair for the dramatic. T F

68. Some people think that I take advantage of others. T F

69. I feel that my life is dull and meaningless. T F

70. I am critical or others. T F

71. I don't care what others have to say about me. T F

72. I have difficulties relating to others in a one-to-one situation. T F

Over the last several years. . .

73. People have often complained that
    I did not realize that they were upset.   T   F

74. By looking at me, people might think
    that I'm pretty odd, eccentric or weird.   T   F

75. I enjoy doing risky things.   T   F

76. I have lied a lot on this questionnaire.   T   F

77. I complain a lot about my hardships.   T   F

78. I have difficulty controlling my anger,
    or temper.   T   F

Over the last several years. . .

79. Some people are jealous of me.   T   F

80. I am easily influenced by others.   T   F

81. I see myself as thrifty but others
    see me as being cheap.   T   F

82. When a close relationship ends,
    I need to get involved with someone
    else immediately.   T   F

83. I suffer from low self esteem.   T   F

84. I am a pessimist.   T   F

Over the last several years. . .

85. I waste no time in getting back at people who insult me.　　T　F

86. Being around other people makes me nervous.　　T　F

87. In new situations I fear being embarrassed.　　T　F

88. I am terrified of being left to care for myself.　　T　F

89. People complain that I'm "stubborn as a mule."　　T　F

90. I take relationships more seriously than do those who I'm involved with.　　T　F

15

Over the last several years. . .

91. I can be nasty with someone one minute then find myself apologizing to them the next minute.　　T　F

92. Others consider me to be stuck up.　　T　F

93. When stressed, things happen. Like I get paranoid or just "black out."　　T　F

94. I don't care if others get hurt so long as I get what I want.　　T　F

95. I keep my distance from others.　　T　F

96. I often wonder whether my wife (husband, girlfriend, or boyfriend) has been unfaithful to me.　　T　F

16

Over the last several years. . .

                                                    T   F

97. I often feel guilty.   T   F

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

Check all that apply to you:

a. Spending more money than I have. ___

b. Having sex with people I hardly know. ___

c. Drinking too much. ___

d. Taking drugs. ___

e. Eating binges ___

g. Reckless driving. ___

17

Over the last several years. . .

                                                         T   F

99. When I was a kid (before age 15)
    I was somewhat of a juvenile delinquent,
    doing some of the things below.
    Check all that apply to you:

(1) I was considered a bully. . . . . ___

(2) I used to start fights with other kids. . . . . ___

(3) I used a weapon in fights that I had. . . . . ___

(4) I robbed or mugged other people. . . . . . . ___

(5) I was physically cruel to other people. . . . ___

(6) I was physically cruel to animals. . . . . . . ___

(7) I forced someone to have sex with me. . . . ___

(8) I lied a lot. . . . . ___

(9) I stayed out at night without my parents. . . ___
    permission.

(10) I stole things from others. . . . . ___

(11) I set fires. . . . . ___

(12) I broke windows or destroyed property. . . . ___

(13) I ran away from home overnight. . . . . ___
    more than once.

(14) I began skipping school, a lot. . . . . ___
    before age 13.

(15) I broke into someone's house. . . . . ___
    building or car.

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Appendix 13. Young Schema Questionnaire – Shame Section

YSQ – Selected Questions   DATE:

INSTRUCTIONS: Listed below are statements that a person might use to describe himself or herself. Please read each statement and describe how well it describes you. When you are not sure base your answer on what you emotionally feel, not o what you think to be true. Choose the highest rating from 1 to 6 that describes you and write the number in the space before the statement.

RATING SCALE:
1= Completely untrue of me
2= Mostly true of me
3= Slightly more true than untrue
4= Moderately true of me
5= Mostly true of me
6= Describes me perfectly

*si

55. _____ No man/woman I desire could love me once he/she saw my defects.

56. _____ No one I desire would want to stay close to me if he/she knew the real me.

57. _____ I am inherently flawed and defective.

58. _____ No matter how hard I try, I feel that I won't be able to get a significant man/woman to respect me or feel that I am worthwhile.

59. _____ I'm unworthy of the love, attention, and respect of others.

60. _____ I feel that I'm not lovable

61. _____ I am too unacceptable in very basic ways to reveal myself to other people.

62. _____ If others found out about my basic defects, I could not face them.

63. _____ When people like me, I feel I am fooling them.

64. _____ I often find myself drawn to people who are very critical or reject me.

65. _____ I have inner secrets that I don't want people close to me to find out.

66. _____ It is my fault that my parent(s) could not love me enough.

67. _____ I don't let people know the real me.

68. _____ One of my greatest fears is that my defects will be exposed.

69. _____ I cannot understand how anyone could love me.

Appendix 14. Self Harm Inventory

Self-Harm Inventory

Instructions: Please answer the following questions by checking either, "Yes", or "No." Check "yes" *only* to those items that you have done intentionally, or *on purpose*, to hurt yourself.

Yes	No	**Have you ever intentionally, or on purpose, . . .**

____ ____   1. Overdosed? (If yes, number of times____)

____ ____   2. Cut yourself on purpose? (If yes, number of times____)

____ ____   3. Burned yourself on purpose? (If yes, number of times____)

____ ____   4. Hit yourself? (If yes, number of times____)

____ ____   5. Banged your head on purpose? (If yes, number of times____)

____ ____   6. Abused alcohol?

____ ____   7. Driven recklessly on purpose? (If yes, number of times____)

____ ____   8. Scratched yourself on purpose? (If yes, number of times____)

____ ____   9. Prevented wounds from healing?

____ ____   10. Made medical situations worse, on purpose (e.g.,skipped medication)?

____ ____   11. Been promiscuous (i.e., had many sexual partners)? (If yes, how many?____)

____ ____   12. Set yourself up in a relationship to be rejected?

____ ____   13. Abused prescription medication?

____ ____   14. Distanced yourself from God as punishment?

____ ____   15. Engaged in emotionally abusive relationships? (If yes, number of relationships?____)

____ ____   16. Engaged in sexually abusive relationships? (If yes, number of relationships?____)

____ ____   17. Lost a job on purpose? (If yes, number of times____)

____ ____   18. Attempted suicide? (If yes, number of times____)

____ ____   19. Exercised an injury on purpose?

____ ____   20. Tortured yourself with self-defeating thoughts?

____ ____   21. Starved yourself to hurt yourself?

____ ____   22. Abused laxatives to hurt yourself? (If yes, number of times____)

Have you engaged in any other self-destructive behaviors not asked about in this inventory? If so, please describe below.

Appendix 15. Clinical Significance Sheet

PDQ-4 CLINICAL SIGNIFICANCE SCALE

This is a follow up questionnaire to the PDQ-4 that you completed previously. It is designed to strengthen the validity of the questionnaire by checking that the answers you gave are still true for you, and to look at the impact that they have on your life.

Please complete the following:

You have reported that the following related items are true for you:

9 Spending time with my family or friends just does not interest me
22 I would rather do things by myself than with other people
34 Sex just doesn't interest me
47 There are few activities that I have any interest in
60 I am not interested in having close friends
71 I don't care what others have to say about me
95 I keep my distance from others

A. Are any of the items not really true for you?
Indicate which (note number) _____

B. How long have these items been part of your personality?
Less than one year   _____
One to five years   _____
Most of your life, or since before age 18 _____

C. Have these items been part of your personality only when you have been depressed, anxious, using alcohol/drugs or physically ill or have they been there most of the time regardless of your mood, level of anxiety, use of alcohol/drugs or general state of health?
Only when depressed _____
Only when anxious _____
Only when using alcohol/drugs _____
Only when physically ill _____
Not related to any of the above _____

D. In what areas have these items created difficulties for you:
At home   _____
At work   _____
In relationships   _____
Other (specify)   _____

E.

Are you bothered about yourself because of the above?
yes _____
No   _____

Appendix 16. Interview Questions

Shame and Self Harm Research Project
Interview

Self Harm
1) Can you start by telling me a little bit about your own views about self harm?
2) How long have you been self harming?
3) How do you think self harm helps you?
4) Describe the feelings/emotions that you have/or experience when you self harm
5) Before During After
6) How do you feel about yourself in relation to self harm?
7) Before During After

Shame
1) What do you understand the emotion of shame to be?
2) How would you describe the feeling of being shamed?
3) Do you ever experience shame?
4) Do you ever experience this in relation to self harming, before during or afterwards?
5) These are some definitions of my understanding of shame: Sheet
6) Would you ever experience these in relation to self harm?
7) Would you ever use self harm to help you cope with some of these feelings?
8) Can you think of any other ways to describe shame?

9) When you self harm do these feelings reduce/become easier to cope with or go away?

Other
1) Has anything been particularly helpful in assisting you to cope or manage with your self harm?
2) What are helpful responses?

3) Do you have any other points or comments that you think might be relevant to the topic of shame and self harm or negative emotions and self harm