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# Deliberate self-harm: a search fo self or a cry for help?

Carryn Tertia Padoa  
University of Wollongong

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# **Deliberate Self-Harm: A Search for Self or a Cry for Help?**

A thesis submitted in partial fulfilment of the requirements for the award degree

**Doctor of Psychology (Clinical)**

**From**

**University of Wollongong**

**Carryn Padoa**

BSc. (Behav), Monash University  
PGrad Dip Psych, Macquarie University

**School of Psychology**

**2008**

## **Thesis Certification**

I, Carryn Tertia Padoa, declare that this thesis, submitted in partial fulfilment of the requirements for the award of Doctor of Psychology (Clinical), in the School of Psychology, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged, the document has not been submitted for qualifications at any other academic institute.

Carryn Tertia Padoa

June 2008

## Abstract

**Objective:** The aim of this study was to advance current research on the functions and expressions of self-injury and in particular to examine two motives of self-harm: (a) self-harm in response to threats to self (termed: search for self) and (b) self-harm as an act of communication to others (termed: a cry for help). **Method:** Study 1 investigated 45 participants attending accident and emergency departments following an episode of self-harm. All completed a structured interview and a repertory grid task. Interviews transcripts were classified: ‘cry for help’ (anacletic) or ‘search for self’ (introjective). Self-harm characteristics were obtained using The Parasuicide History Interview which assesses for the number, method, intent, and medical severity of the self-harm event. Study 2 aimed to replicate study 1 using a clinical sample of 42 patients with Borderline Personality Disorder and comorbid Major Depressive Disorder. **Results:** Anacletic typography represented significantly greater risk when compared to introjective psychopathology, despite the latter group exhibiting greater psychological constriction and more frequent episodes of self-harm. In addition, there appeared to be some important differences in the methods of self-harm chosen by the two groups, with anacletic individuals utilising non-violent but potentially lethal methods compared to introjective individuals who utilised more violent and invasive methods of self-harm. **Conclusion:** Suicidal individuals who self-harm may be differentiated in terms of their motive, namely as a cry for help (anacletic) or as a search for self (introjective). In this study, particular precautions and interventions are suggested following suicidal communications or behaviours by those individuals with anacletic vulnerabilities, given their cry for help may be associated with more impulsive gestures that are unplanned and thus higher in medical lethality than introjective self-harmers, who engage in more frequent low-level attempts involving carefully planned actions.

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And finally, whilst putting the finishing touches to this thesis the brother of a good friend of ours completed suicide. It was a devastating blow for all those who knew him. My only hope is that this paper, together with other suicide research like it, can in some way help to identify and treat people like him. I dedicate this to them.

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# Chapter 1

## 1. INTRODUCTION

Deliberate self-harm (to be referred to as self-harm for the remainder of this paper) is a common and serious public health problem that constitutes one of the top five reasons for acute hospital admissions in the United Kingdom (House, Owens, & Patchett, 1998). It also remains the single best predictor of death by suicide with approximately 13% of individuals making a repeat attempt the following year, and about 3% completing suicide over the next 10 years (Hawton, Zahl, & Weatherall, 2003; Zahl & Hawton, 2004). However, these statistics are probably underestimated as many more cases are treated in private and do not reach the attention of services or professionals (Steenkamp & Harrison, 2000). Understandably then, there is a growing need for more comprehensive theories to identify subgroups of self-harmers, and in particular those at greater risk of making more medically lethal attempts (Fazaa & Page, 2003). The aim of this study is to advance current research on the functions and expressions of self-injury and in particular to examine two distinct motives for self-harm: (a) self-harm in response to threats to self (termed: search for self) and (b) self-harm as an act of communication to others (termed: a cry for help).

### 1.1a Defining self-harm

Interest in self-harm has increased in recent years, possibly due to increased media attention on these behaviours (Favazza, 1998). The first formal attempt to describe and understand self-harm was Menninger's (1938) discussion in his book *Man against Himself*, in which he suggested that self-harm is an action to avoid suicide and promote self-healing. Since Menninger's time, empirical research on self-harm has grown considerably and yet the clinical field still lacks a clear understanding of these behaviours.

Part of this difficulty lies with the inability of clinicians and researchers to agree on a single term or definition for self-harm. Another is the disagreement as to whether suicidal behaviour should be included in the definition of self-harm, given that suicidal individuals often exhibit different intentions (i.e. to die) to those who self-harm (not to die). Although there is some validity to this distinction, the division becomes less clear when the persons' intent is ambiguous. Overdose, infection, and other severe injuries for example can lead to death without the explicit intention of dying. Furthermore, up to 40 percent of individuals who engage in self-harm report having had suicidal thoughts at the time of the self-injury (Gardner & Gardner, 1975; Pattison & Kahan, 1983). There is also a strong correlation between past self-harm behaviour and future suicidal events. In fact one of the main variables to distinguish between those who die by suicide from living controls is a significant past history of self-harm (Brown, Comtois, & Linehan, 2002; Cavanagh, Owens, & Johnstone, 1999). At the same time, however, it is important to note that differences have been found between those who self-harm and those who attempt suicide. Beautrais (2001) for instance found that compared to self-harmers, people who die by suicide are more often older males, are unemployed, abuse alcohol, have had previous psychiatric admissions, and have made prior suicide attempts. Based on these findings, it is reasonable to accept that perhaps suicide and self-harm are two distinct, albeit significantly overlapping, constructs. The focus of this research then will be on people that have survived an episode of self-harm and whilst we acknowledge the link between the two groups, the focus will therefore be on this category only. Self-harm will thus be defined as any direct form of 'intentional and non-fatal self-injury irrespective of suicidal intent' (Kreitman, Greer, & Bagley, 1969).

### **1.1b Self-harm as a Search for Self**

One of the commonly cited functions of self-harm is its association with intrapsychic attempts to maintain a sense of self or identity in the face of overwhelming internal

emotions. Although the term “self” is used frequently in the clinical literature, it is rarely defined, leading to some confusion about the term. This study will therefore focus on two problems of the self: 1) difficulties regulating and controlling self-experiences and 2) problems with the structure of the self, for example, an unstable sense of self or low self-cohesiveness (Livesley, Jang, & Vernon, 1998).

*Self-harm as an attempt to regulate and control self-experiences*

It is often reported that individuals who self-harm have difficulties regulating and controlling their emotional state, and as such, they use self-harm to gain control over themselves and their internal world (Haines & Williams, 1997; Linehan, 1993). In fact, a recent review of empirical self-harm research has identified affect-regulation as the predominant function endorsed by the majority of participants in both adult and adolescent studies (Klonsky, 2007). Scratching and burning for instance have important physiological consequences that help to moderate arousal (Linehan, 1993). Similarly, witnessing blood can act as a release, a symbolic eradication of pain according to self-reports of self-harming individuals (Harris, 2000).

Patient self-report studies have correspondingly cited reasons including: to release pent-up emotions, to manage stress and depression, reduce tension, release anger, and enhance self-control (Briere & Gil, 1998; Favazza, 1998; Favazza & Conterio, 1989; Gratz, 2003; Haines, Williams, Brain, & Wilson, 1995). Osuch, Noll, & Putnam (1999) for instance administered the Self-Injury Motivation Scale (SIMS) to 99 inpatients and found that affect modulation and management of overwhelming experiences were two of the most common factors motivating self-harm. Similarly, Briere & Gil (1998) asked 93 subjects to select the functions of their self-harm from a pre-existing list of commonly cited reasons. Participants selected a range of affect-regulation functions including release of painful feelings, management of stress, reduction of tension, release of anger, and enhancement of

feelings of self control. Finally, Gratz (2003) used open-ended questions to assess the reasons for self-harm in a group of 21 college students. Despite the study's small sample size, findings were comparable to earlier research whereby 76% of the participants frequently described wanting to relieve unwanted feelings as the function of their self-harm.

One of the most comprehensive theories to explain this association between affect-regulation and self-harm is Linehan's (1993) biosocial model of borderline personality disorder (BPD), an illness highly correlated with self-harm behaviours. Briefly, Linehan argued that BPD develops from the transaction between invalidating childhood environments and an emotional vulnerability. These two factors interact and prevent the individual from learning (a) how to label and regulate their emotions, (b) how to tolerate feelings of distress, or (c) to trust their own emotions as being valid and accurate responses to events. They subsequently become highly averse to negative internal experiences and may use self-harm as a way to cope with arousal. Linehan's theory has since been supported in a recent study of non-suicidal adolescent self-injurers who, after being exposed to a stressful task, were found to display greater physiological reactivity and a decreased ability to tolerate distress and persist at the task, when compared to adolescent 'non-injurers' (Nock & Mendes, 2008). Self-harm then in this context can be seen as an attempt to re-regulate or re-establish control over overwhelming internal experiences that may threaten to overwhelm the individual.

#### *Self-harm as an attempt to structure the self*

Along with the self-regulation motive of self-harm, theorists have similarly suggested the importance of self-harm behaviour in structuring a person's sense of self. Simpson and Porter (1981) for instance hypothesize that self-mutilation creates or helps to maintain a separate and unique sense of self as "bleeding offers real, tangible evidence that 'I do

exist somewhere in this world” (p. 435). Similarly Socarides and Stolorow (1984) claimed that the experience of physical pain or wounding on the surface of the body can enhance self-cohesion through the establishment of bodily boundaries as well as offering a sense of liveliness through painful experiences. In addition, identity disturbances are often experienced by the patient as a painful sense of “nothingness”, thus the pain of self-harm and / or the shock colour of blood may help to alleviate this feeling, even if for a short time only. This is supported by patient self-reports, with approximately 40% of a community sample rating “to feel [my] body is real”, “to feel inside body”, and “to feel alive” as their reasons for self-harming (Briere & Gil, 1998). Orbach, (2007) in a review of self-destructive processes aptly sums self-theories when he states “to a person with a history of receiving care characterized by pain, trauma and sadomasochism, repeating of such features in one’s own self-care provides a sense of self-consistency. Self-perpetuated self-abuse also allows for a sense of control and omnipotence over a once uncontrollable situation” (p. 267).

Personal construct theorists have also associated self-harm with attempts to structure the self through the process of constriction. Constriction, as defined by Kelly occurs "when a person narrows their perceptual field in order to minimise apparent incompatibilities" (p. 194, Bannister & Fransella, 1971,). This process is thought to occur in a variety of ways such as decreasing social engagements, limiting activities and interests, and excluding emotional stimuli such as anger, pain, and fear so that there is a reduction in the elements of the world that are construed. Constriction has typically been measured using a repertory grid structure where researchers have considered the number of mid-point ratings of grid ‘elements’ (e.g. other people and aspects of the self) on bipolar constructs to reflect an inability to choose between two construct poles, and thus a constricted view of the elements concerned. Landfield (1976) conducted a study with five suicidal patients using a repertory grid structure which looked at the number of ‘not applicable’ ratings that

the sample used in relation to the application of their constructs to the world. Despite the small sample size, he found that serious suicidal attempts were related to disorganisation of the construct system and significantly greater constriction. Similarly, Dzamonja-Ignjatovic (1997) in a study of 50 people with depression and suicide ideation found that suicidal people were particularly constricted in their view of themselves in the future. Further, a recent study by Winter and colleagues (Winter, Sireling, Riley, Metcalfe, Quaite, & Bhandari, 2007) on a group of self-harming patients found that participants with higher levels of hopelessness and suicide ideation showed greater constriction in regard to the future self.

The aforementioned processes of constriction, isolation, and emotional avoidance to protect and structure the self are similarly explored in psychodynamic literature. Blatt and Shichman (1981) for instance hypothesised that during early development, some individuals become preoccupied with independence, self-worth, and self-control in what he termed introjective disorders. Interestingly, individuals with introjective psychopathologies have been found to self-harm in response to disruptions to their sense of identity, self-concept, or sense of achievement and control (Fazaa & Page, 2003). These individuals also reported having a greater intention to die at the time of their injury and they made more medically lethal attempts as compared to individuals who self-harmed for interpersonal reasons (Fazaa & Page, 2003). Although Blatt's introjective and anaclitic typologies derive from a psychodynamic perspective, they are also highly similar to Beck's cognitive distinction between autonomy and sociotropy (Beck, 1983). Thus, self-harm in many ways, regardless of the theoretical orientation, may be seen as an integrating and self-preserving choice for those individuals who lack the necessary skills to cope in more effective ways.

### **1.1c Self-harm as a Cry for Help**

A second commonly cited motive of self-harm is as a primitive yet powerful form of communication, as a way to seek help from or influence others (Arnold & Babiker, 1998; Favazza & Conterio, 1989). Indeed it was Erwin Stengel in 1952 (McAllister, 2003) who first described self-harm as ‘a cry for help’, as an act not just about dying, but also about survival and contact (Dunleavy, 1992). This is congruent with the view that people who self-injure often cannot describe their emotional state before an injury. In fact, individuals who engage in self-harm frequently report an inability to express their feelings (Arnold & Babiker, 1998; Favazza & Conterio, 1989) and studies have found that measures of alexithymia, an inability to identify and describe emotions, significantly correlate with self-harm (Zlotnick, Shea, Pearlstein, Simpson, & Costello, 1996).

The communicative function of self-harm is further corroborated by patient self-reports. A recent study of 75 women with Borderline Personality Disorder found that 61% of participants endorsed reasons related to interpersonal-influence (e.g. “to get others to act differently or change”) to explain why they had self-harmed (Brown et al., 2002). Similarly, Briere & Gil (1998) asked a community sample of 98 subjects to indicate why they engaged in self-injury. Results showed that 41% of the sample selected to “get attention, ask for help” and 15% chose “to get therapist attention” amongst their reasons (Briere & Gil, 1998). In addition, Herpertz (1995) examined self-harm behaviour in a sample of 54 mostly female psychiatric inpatients. Again, reasons such as “longing for attention and care” were selected by at least a quarter of the sample.

Finally, Fazaa & Page (2003) found similar results in a sample of university students preoccupied with issues of interpersonal relatedness (or anaclitic personality configurations). For this group, self-harm functioned as a way to “communicate unhappiness to significant others or as a plea for help or nurturance” (Pg. 181). These



individuals displayed a lower intent to die, made less lethal attempts, took fewer precautions to prevent discovery, and frequently even sabotaged their own attempts. Self-harm then for this group may be conceptualized as an act of communication to elicit help, avoid abandonment, or effect change in others.

## **RESEARCH GOALS**

Based on the above research findings, the overarching goal of this thesis is to examine these two distinct motives for self-harm: (a) self-harm in response to threats to self (termed: search for self) and (b) self-harm as an act of communication to others (termed: a cry for help). It is hoped that demonstrating differences between these two groups would serve a number of important purposes. First, it would add to previous research aimed at understanding and differentiating between subgroups of self-harmers. Second, and perhaps more important, it could result in the identification of specific characteristics and risk factors for prevention and treatment purposes. Virtually all studies examining self-harm acknowledge the current difficulties in finding meaningful ways to discriminate between the seemingly complex and heterogeneous group of individuals who self-harm. Identifying specific vulnerabilities and characteristics is a clinically reliable way, is an especially important goal. For convenience, it is assumed here that the ‘search for self’ and the ‘cry for help’ groups are mutually exclusive. However, it should be acknowledged that both motives might be important to a single individual, and this might be a limitation of the approach here. One way to overcome this is to measure both tendencies in each participant, an approach that will be used in study 2.

### **1.1d Differentiating ‘search for self’ and ‘cry for help’ categories**

In order to examine the ‘search for self’ and ‘cry for help’ categories of self-harm, this study will utilise Blatt and colleagues’ anaclitic and introjective distinctions. Briefly, Blatt

proposed that various forms of psychopathology can occur in response to disruptions to either;

- (a) Interpersonal, or relationship issues, or
- (b) One's self concept or sense of personal identity.

This model has been well supported in the literature on depression, where two distinct categories of depressive experiences have been identified, that is: (a) anaclitic depression which results from disruptions to interpersonal relationships, and (b) introjective depression which is the consequence of an inability to maintain / reach internal standards (Blatt & Blass, 1996; Blatt & Zuroff, 1992). For individuals with anaclitic-type depression, there is an exaggerated preoccupation about the nature and quality of their interpersonal interactions which effects how they feel and behave towards themselves and others. Anaclitic individuals are extremely vulnerable to interpersonal rejection and abandonment and they may express intense needs to be soothed, loved, cared-for, and looked after. According to Blatt and colleagues (1993) anaclitic pathology is associated with internalizing problems such as identity conflicts, suicidality, and somatic complaints. In contrast, individuals with introjective-type depression place a premium on creating a unique and separate self and tend to be ambivalent both in terms of their self-view as well as their interpersonal relationships. Depression in this group is most often precipitated by experiences of loss of control, diminished self-esteem, and an impaired sense of mastery and frequently results in behaviours such as delinquency and aggression. They are also extremely self-critical and are sensitive to criticism and disapproval from others. Not surprisingly, they are mainly influenced by internal rather than by external/ environmental factors (Blatt & Shichman, 1983).

The rationale for utilising this model in our research on self-harm is three-fold. Firstly, there is a strong association between Blatt's anaclitic and introjective depressive

constructs and the two categories of self-harm behaviours described earlier. Second, depression is considered a significant risk factor for self-harm behaviours, with self-harmers scoring higher on measures of depression than non self-harmers (Hawton et al., 2002; Klonsky et al., 2003). And finally, as mentioned above, evidence supports a strong association between disruptions to (a) relationships and (b) self-concept and a vulnerability to depression. It is possible then that the same might be found for self-harm behaviours.

### **1.1e Blatt's anaclitic and introjective types and self-harm**

To date, the research examining the relationship between Blatt's anaclitic and introjective constructs and self-harm behaviours is very limited in scope. Blatt (1974) in his early conceptualization of two depressive subtypes argued that individuals with anaclitic depression would be driven to seek immediate gratification for their "oral cravings and hunger for love" which would manifest as suicide attempts of an oral nature, such as taking overdoses. He later argued that this group would typically make suicidal 'gestures' (Blatt, Quinlan, Chevron, McDonald, & Zuroff, 1982) as opposed to serious suicide attempts. In contrast, he proposed that patients with introjective depression would exhibit strong aggressive tendencies toward the self and others that would be reflected in suicide attempts there were more violent and lethal (Blatt, 1974; Blatt et al, 1982). Yet despite these theories being posited over two decades ago, empirical support for this distinction remains very limited.

Fehon, Grilo, & Martino (2000) utilized an adolescent in-patient sample to explore differences in anaclitic and introjective depression. After controlling for depression, they found a significant association between self-criticism, dependency, and suicide risk. Interestingly, dependency was also significantly associated with impulsivity, whilst the self-criticism factor was not. Similarly, there was a significant inverse correlation between

dependency and the potential for violence and aggression. The authors concluded that “the differences in impulsivity and violence potential suggest that despite a shared risk for suicide, dependent individuals may be more inclined to engage in impulsive gestures and attempts, whereas self-critical individuals may be less impulsive and plan their efforts to harm either themselves or others”(pg. 101). Clearly, this explanation requires further empirical investigation.

In addition, a study of adult psychiatric in-patients and students (Sahin, Ulusoy, & Sahin, 2003) found that three items the BDI came close to differentiating autonomous (introjective) and sociotropic (anaclitic) individuals. Item 9 on suicide (with highly autonomous individuals scoring higher on suicidal ideation), item 18 on sleep problems, and item 20 on physical health (with the highly dependent group scoring higher). Finally, Fazaa and Page (2003) analysed a university sample of 65 self-harmers and found that introjective individuals engaged in self-harm acts that were more lethal in nature. They also took greater precautions against discovery than the anaclitic group. In contrast, anaclitic individuals expressed suicidal behaviour lower in subjective lethality and risk, and higher in the potential for rescue. No comparison was conducted for the method of self-harm between the two groups. One of the limitations of this study, however, was its reliance on a fairly homogeneous university sample. As the researchers acknowledged, the sample contained “few truly and equivocally lethal attempts” (pg. 182). It is possible therefore that this choice of sample limited the generalisability of their results.

### **1.1f The current study**

The aim of the present study is to address some of the aforementioned limitations and examine two distinct motives for self-harm – anaclitic (‘cry for help’) and introjective (‘search for self’) – using two unique samples.

Study 1, to be presented in chapter 2, will draw participants from an adult sample of self-harmers attending accident and emergency departments. The measures that will be used include an anaclitic / introjective prototype classification, a measure of self-harm characteristics (frequency, typology, severity, and subjective intent), constriction, and mastery. The specific research questions, to be addressed in this study are (1) Can individuals who self-harm be reliably classified in terms of their motive, namely as a search for self (introjective), or as a cry for help (anaclitic)? (2) How do self-harm behaviours which are motivated by a search for self (introjective) and a cry for help (anaclitic) differ?

Study 2, presented in chapter 3, will then aim to validate the findings from study 1 using a community sample of patients with Borderline Personality Disorder and comorbid Major Depressive Disorder, a diagnostic profile highly associated with self-injury. In this study, the Depressive Experiences Questionnaire (DEQ) will be used to assess for anaclitic and introjective dysfunction, as this offers an alternative and well validated measure of the two constructs. The use of the DEQ will also allow us to measure both anaclitic and introjective motives in each participant (to help address the assumption that two constructs are mutually exclusive).

Finally, the introjective and anaclitic concepts will be illustrated using case material from two adult clients with self-harm behaviour. It is hoped that these case studies will help to support and extend findings from the quantitative research. In addition, the implications of our findings will be discussed with regards to treatment of self-harming patients.

## Chapter 2

### 2.1 STUDY 1 – RESEARCH QUESTION AND HYPOTHESES

This study has two main research questions and five associated hypotheses. Research at this stage is largely exploratory and the hypotheses are based on the summation of literature from various psychological theories.

**Research Question 1: Can individuals who self-harm be reliably classified in terms of their motive, namely as a search for self (introjective), or as a cry for help (anaclitic)?**

**Research Question 2: How do self-harm behaviours which are motivated by (a) a search for self (introjective) and (b) a cry for help (anaclitic) differ?**

#### 2.1a Hypothesis 1

Based on the literature, it is hypothesized that the anaclitic group who are vulnerable to disruptions in interpersonal relationships will engage in non-violent, low-lethality attempts or gestures using methods such as overdosing (Blatt, 1974; Beck, 1983; Blatt et al, 1982; Fazaa & Page, 2001).

#### 2.1b Hypothesis 2

In contrast, it is hypothesized that individuals in the introjective group will focus on using more aggressive and invasive forms of self-harm (e.g. cutting, stabbing, scratching, burning) to regulate, define, and structure the self through the sight of blood and / or scarring. Given that introjective pathology predicts externalizing behaviours (Blatt, et al,

1993) it is hypothesized that this group may engage in self-harm attempts that rank higher in medical risk than the anaclitic sample.

#### 2.1c Hypothesis 3

Incorporating personal construct theory, we also hypothesize that due to the interpersonal and communicative nature of anaclitic self-harm, repertory grid descriptions will reflect lesser psychological constriction (as indicated by fewer midpoint ratings) than for introjective individuals.

#### 2.1d Hypothesis 4

In contrast, it is expected that introjective individuals will exhibit greater psychological constriction than the anaclitic group.

#### 2.1e Hypothesis 5

Finally, introjective individuals are characterized by an extreme drive for mastery, autonomy and self-worth, to the detriment of relationships which are viewed as secondary or peripheral. Although mastery is a relatively old construct, it has recently been defined as the “acquisition of emotional self-control and intelligence in self-understanding in the context of interpersonal relationships” (Grenyer, 1994). Based on this definition, we would expect introjective patients to score lower on mastery when compared to anaclitic patients, who place a greater emphasis on interpersonal interactions.

### 3. METHOD

#### 3.1 Participants

Participants were 45 men and women who attended Accident and Emergency (A & E) departments serving the North London Borough of Barnet, U.K., after an episode of deliberate self-harm. Aspects of this sample have already been published (Winter et al, 2007). Informed consent was obtained from all respondents. The only exclusion criterion was refusal to participate in the research.

#### 3.2 Measures

##### Structured 17 item questionnaire

Participants were asked to complete a structured 17-question interview to assess the self-harming episode that led to their admission to the A & E department. This occurred soon after the self-harm event, typically within the first 24-48 hours. Participants were asked to detail their perceptions of the event that led to their admission, their reasons for self-harming, their anticipated result, the actual outcome, whether other persons were involved, any attitudinal changes following the self-harm (self and other), their incidence of prior self-harm episodes, the likelihood of future episodes, future precipitants, and perceptions of their treatment. Copies of the interview were transcribed verbatim for later analyses.

##### Anaclitic/Introjective Prototype

To distinguish between ‘cry for help - anaclitic’ and ‘search for self - introjective’ groups, interview transcripts were rated on the prototype classification of anaclitic and introjective psychopathologies using the validated method of Blatt & Ford (1994, p. 277). In the Anaclitic/Introjective prototype method, typical needs, wishes, concerns, preoccupation, relational style, defenses, and coping mechanisms of these personality configurations are



coded to differentiate transcripts. A 1 page coding checklist operationalised the prototype (see Appendix 1). Two judges, one of which was blind to the hypotheses of the study and the other ratings, utilised the coding checklist of the prototype to assist with classifying the interview transcripts, however the final determination was made by reference to the published prototype. Patients whose descriptions were consistent with anaclitic psychodynamics were rated anaclitic, whilst patients whose descriptions were consistent with introjective psychodynamics were classified as introjective. Ratings were not applied where data was incomplete. The validity of this forced-choice method has previously been demonstrated by Blatt and colleagues (1988) and was utilised in a study by Shahar, Blatt, and Ford (2003).

### The Repertory Grid

A repertory grid was used to measure constriction. This tool has been widely used in personal construct psychology (Kelly, 1955; Winter, 2003) and has also been used to examine self-harm from a personal construct theory perspective. The grid takes the form of a structured interview where participants are asked to rate on a seven-point scale various aspects of a) themselves and their partners, b) two significant others, c) and Accident and Emergency and mental health team staff on 10 constructs elicited from them (by asking them to compare and contrast a series of triads of the aspects of self and others included in the grid) together with three supplied constructs relating to the personal construct theory model of self-harm. The grid was completed soon after the self-harm event, typically within the 24-48 hours, so that the memory of the self-harm event was salient yet they had become sufficiently stable in order to attend to the rating task. For our present purposes we examined the total number of midpoint (i.e. 4) ratings in the grid in these analyses. Typically, the excessive use of midpoint ratings has been used to reflect constricted construing, and it has also been associated with high scores on a measure of the ‘meaninglessness’ aspect of alienation (Winter, Patient, & Sundin, 2005). Various

studies attest to the reliability and validity of this repertory grid measure (Bannister & Mair, 1968; Caputi & Keynes, 2001; Winter, 2003).

#### The Parasuicide History Interview (PHI-2)

Characteristics of their self-harm were obtained by the PHI-2 which assesses self-harm behaviours in the past 6-months. The PHI-2 is a comprehensive 47-item semi-structured interview of parasuicidal behaviour (Linehan, Wagner, & Cox, 1983). For the purposes of this study, the PHI-2 was observer-rated and applied to interview data to assess for the method, intent, severity, and medical severity of the self-harm event. Suicide intent was rated on a 2-point scale (1 = not to die, 2 = to die). Severity was rated on a 6-point scale, with 0 being very low and 6 being severe. A moderate 3 rating was applied where insufficient information was obtained. Finally, an overall medical risk score was calculated by summing the intent, severity, and whether the self-harmer was using drugs or alcohol at the time of the episode (where No = 0, and Yes = 1). The PHI-2 has excellent inter-rater reliability (Linehan et al, 1983) and internal consistency, with alpha coefficients ranging from .64 to .86.

#### Method of Self-harm

Self-harm methods were classified into two groups according to whether they (1) involved more violent methods resulting in damage to skin or body parts (such as cutting, burning, scratching, head-banging) or (2) non-violent methods (such as overdose, self-poisoning, and asphyxiation). This distinction has previously been made in the literature examining gender differences and methods of suicidal behaviour (Darke, Degenhardt, Mattick, 2006).

### Frequency of Self-Harm

Participants' responses to question 10 of the structured interview (Have you done anything similar in the past?) were recorded to assess the number of prior self-harm episodes. In addition, intent to self-harm in the future was rated on a 3-point scale (Yes, Unsure, No) based on responses from question 11 (Can you imagine doing something like this again?).

### The Mastery Scale

Finally, The Mastery Scale (Grenyer, 2002) examined mastery scores in the two groups. The Mastery scale is a content analytic scale used to analyse patient narratives, and was applied to the interview transcripts collected here. It is a reliable and valid research instrument that has been validated against a variety of different measures (Grenyer, 2002; Grenyer & Luborsky, 1996). Relationship episodes are divided into grammatical clauses and one of 23 Mastery Scale categories were assigned. A mastery score for each relationship episode was obtained by summing the scores and dividing by the number of scorable clauses. These scores represented average levels of mastery for each participant at the time of the interview. The Mastery Scale has been shown to have excellent inter-rater reliability (range = .75 to .89) and test-retest reliability ( $r = .86$  to  $.97$ ) (Grenyer, 2002). The judge was trained to achieve an inter-rater reliability of  $>.9$  prior to scoring the data.

### 3.4 STATISTICAL ANALYSIS

This study utilised a cross-sectional design therefore most of the analyses examined the relationship between each of the variables. In order to address each of the hypotheses, chi-square comparisons were conducted for group by method, intent (to die or not), and intention to self-harm in the future (yes, no). One-way ANOVAs were also conducted to assess the relationship between group and medical risk scores, group and constriction, and group and frequency of self-harm. In addition, pearsons  $r$  rank order correlation coefficient were used to summarise the strength and direction (negative or positive) of the relationship between mastery and self-harm variables, as well as constriction. Because of the low sample cell size per analysis, we also ran the results using non-parametric statistics and found that it did not change the pattern of results. Finally, a regression analysis was conducted to determine which of the significant variables predicted group membership. Statistical significance was set at .05, using SPSS version 15.

## 4. RESULTS

### 4.1 DEMOGRAPHIC INFORMATION

Table 1 provides the demographic information for the sample. The sample consisted of 24 women, ranging in age from 15 to 48 years ( $M = 33.17$ ,  $SD = 9.5$ ), and 21 men ranging in age from 23 to 57 years ( $M = 35.52$ ,  $SD = 10.3$ ). Sixty-four percent of the sample were rated anaclitic ( $N = 29$ ) and thirty-six percent were rated introjective ( $N = 16$ ). The main method of self-harm involved non-violent forms ( $N = 29$ ).

*TABLE 1: Demographic Characteristics of Total Sample (n=45)*

Variable	N	% (Percentage)
<b>Sex</b>		
Female	24	53
Male	21	47
<b>Employment status</b>		
Employed	23	51
Unemployed	15	33
<b>Grouping</b>		
Anaclitic	29	64
Introjective	16	36
<b>Self-harm method</b>		
Violent methods resulting in damage to skin or body parts (such as cutting, burning, scratching, head-banging)	11	24
Non-violent methods (such as overdose, self- poisoning, asphyxiation)	29	64
Missing	5	11
<b>Intention</b>		
Did not intend to die	13	29
Intended to die	26	58
<b>Drugs / Alcohol Usage at the time?</b>		
No	32	71
Yes	13	29

## 4.2 RESULTS FOR SEARCH QUESTION AND HYPOTHESES

**Research Question 1:** Can individuals who self-harm be reliably classified in terms of their motive, namely as a search for self (introjective), or as a cry for help (anaclitic)?

Using the prototype classification, 29 participants were rated anaclitic and 16 were rated introjective. A second judge, blind to the hypotheses of the study and to other ratings, independently classified 25 percent of the sample. Inter-rater reliability was high, with the median correlation (pearsons  $r$ ) between the two judges being .8. Disagreements between the judges were settled by a discussion between raters. Thus, results suggest that self-harm can reliably be classified into two types.

**Research Question 2:** How do self-harm behaviours which are motivated by (a) a search for self (introjective) and (b) a cry for help (anaclitic) differ?

### 4.2a: Hypotheses for the method of self-harm

We expect that;

- i.) The anaclitic group who are vulnerable to disruptions in interpersonal relationships will engage in non-violent, low-lethality attempts or gestures using methods such as overdosing.
- ii.) In contrast, it is hypothesized that individuals in the introjective group will focus on using more active or violent forms of self-harm (e.g. cutting, stabbing,

scratching, burning) to regulate, define, and structure the self through the sight of blood and / or scarring.

A chi-squared comparison of group (anaclitic, introjective) by method was conducted to explore the relationship between these two variables (see Table 2). Results partly support the hypothesis in that individuals within the anaclitic group used non-violent methods, particularly overdose. In contrast, the introjective group showed no marked preference for the method that was used,  $\chi^2 (1, N = 40) = 5.5$ ;  $p = .026$

*Table 2: Chi-squared comparison of the method of self-harm by group membership*

	Anaclitic	Introjective
Non-violent methods (such as overdose, self- poisoning, and asphyxiation)	22	7
Violent methods resulting in damage to skin or body parts (such as cutting, burning, scratching, head-banging)	4	7

#### 4.2b: Hypotheses for medical severity of self-harm

We expect that;

- i.) The anaclitic group will engage in non-serious, low-lethality attempts or gestures (Fazaa & Page, 2003).
- ii.) In contrast, given introjective pathology predicts externalizing behaviours (Blatt, et al, 1993) and self-harm methods are predicted to be more violent, it is hypothesized that this group may engage in self-harm attempts that rank higher in medical risk than the anaclitic sample.

ANOVA statistics were conducted to examine the medical risk score of the index self-harm event between those individuals rated anaclitic and those rated introjective (see Table 3). Results, also verified by chi-squared tests, did not support the hypotheses in that the anaclitic group exhibited significantly greater medical risk scores than the introjective group,  $F(1, 44) = 4.89$ ;  $p = .036$ .

*Table 3: Comparison of medical risk by group membership*

Group	N	Mean Medical Risk Score	Standard Dev
Anaclitic	29	4.86	1.57
Introjective	16	3.81	1.42

#### 4.2c: Hypotheses for Group and Constriction

We expect that;

- i.) Due to the interpersonal and communicative nature of anaclitic self-harm, repertory grid descriptions will reflect lesser psychological constriction as indicated by fewer midpoint ratings.
- ii.) In contrast, it is expected introjective individuals will exhibit greater psychological constriction than the anaclitic group.

The number of mid-point ratings within the sample ranged from 2 to 102. In order to compare the differences in the mean mid-point ratings between the two groups, a one-way ANOVA was conducted. Results supported the hypotheses in that the introjective group exhibited significantly more total mid-point ratings than the anaclitic group,  $F(1, 43) = 6.67$ ;  $p = .013$ . Thus, the introjective category exhibited significantly greater psychological constriction when compared to the anaclitic sample (see Table 4).



*Table 4: Mean (SD) number of mid-point ratings for each group on the repertory grid*

<b>Group</b>	<b>N</b>	<b>Mean</b>
Anaclitic	28	27.07 (12.29)
Introjective	16	42.13 (26.39)

#### 4.2d: Hypotheses for Group and Mastery

We would expect that;

- i.) Introjective patients will score lower on mastery when compared to anaclitic patients, who place a greater emphasis on interpersonal interactions.

To examine the relationship between mastery and group membership a one-way ANOVA was conducted. Results did not support the hypotheses as no significant difference was found in the mastery ratings between those rated anaclitic and those rated introjective,  $F(1, 43) = 0.67$ ;  $p = .417$ . However, further statistical analyses using Pearsons  $r$  correlations revealed that those individuals who scored higher on mastery displayed a lower number of mid-point grid ratings, indicating lesser psychological constriction ( $r = -.384$ ;  $p = .02$ ). Therefore, as mastery increases, psychological constriction decreases. As discussed above, the introjective group had significantly higher constriction.

#### 4.2e: Intention of self-harm

To explore the relationship between group and intent (to die or not to die) at the time of the self-harm event, a chi-squared analysis was conducted. Results showed that individuals within the anaclitic group demonstrated a trend towards self-harming with the intention to die, whilst introjective individuals did not show the same sort of preference  $\chi^2$

(1,  $N = 39$ ) = 3.69;  $p = .06$ . Further, a chi-squared analysis between group and intent to self-harm in the future (yes, no), indicated a significant difference between the two groups,  $\chi^2$  (1,  $N = 45$ ) = 7.32;  $p = .012$ , where anaclitic individuals were unlikely to self-harm again whilst introjective individuals were more intent on self-harming in the future.

#### 4.2f: Frequency of self-harm

An exploratory analysis was also performed to examine whether the two groups differed in the frequency of prior self-harming episodes they exhibited. The relationship was significant (see Table 5), with introjective individuals having engaged in more previous self-harming episodes than the anaclitic sample,  $F = 4.37$ ;  $p = .044$ .

*Table 5: Mean (SD) scores for the frequency of self-harm attempts for each group*

<b>Group</b>	<b>N</b>	<b>Mean</b>
Anaclitic	24	.75 (1.22)
Introjective	11	5.64 (11.51)

#### **Regression analysis**

Finally, given the pattern of results, we performed a logistic regression equation predicting group membership, entering the significant predictors above. Two predictors survived the analysis and correctly classified 20 of 24 anaclitic patients and 6 of 7 introjective individuals. These were; the number of prior self-harm episodes ( $B = .99$ , Wald = 5.43;  $p = .02$ , odds ratio = 2.7) and constriction ( $B = 0.076$ , Wald = 2.41,  $p = .12$ ; odds ratio = 1.08). Clearly the number of prior self-harming episodes was the strongest predictor of group membership. Thus, it appears that higher self harm episodes and higher constriction equate to a higher likelihood of being introjective.

## 5. DISCUSSION

### 5.1 Overview of findings from Study 1

The purpose of study 1 was to examine two distinct motives of self-harm in a sample of 45 patients attending accident and emergency departments. As hypothesized individuals who were categorized as anaclitic and introjective did in fact exhibit significant differences in their self-harming behaviours on measures relating to the method of self-harm, intent, lethality, prior episodes, future plans, and constriction. Below is a brief outline of the main findings of the study, with a more in-depth discussion of results in relation to the research on self harm occurring in the final chapter (chapter 5).

Firstly, with regards to the demographics of the sample, there was an almost equal distribution of males and females. A quarter of the sample (23%) had ingested drugs or alcohol at the time of their self-harm. In addition the majority of the participants in the study sample had used non-violent methods, in particular the ingestion of substances leading to an overdose or self-poisoning. This is consistent with previous research where drug overdoses remain the most common method of self harm for both men and women who present to an emergency department (Steenkamp & Harrison, 2000). The comparatively large proportion of participants using non-violent methods such as overdose, self-poisoning, and asphyxiation (compared to other methods of self harm) could be attributed to the fact that these methods more often require medical attention; whilst methods (such as cutting, burning, scratching) do not. According to research, people using the latter methods are more likely to seek help via their General Practitioner (Jacob, Clare, Holland, Watson, Maimaris, Gunn, 2005). Finally, the sample consisted of 29 participants who were rated anaclitic and 16 who were rated as introjective.

With regards to our hypotheses, we had predicted that individuals with anaclitic personality configurations would exhibit more frequent use of non-violent, methods such as overdosing whilst the introjective group would focus on using more violent or invasive forms of self-harm such as cutting, stabbing, scratching, and burning. This was partially supported as anaclitic individuals did exhibit significantly more frequent use of non-violent methods (particularly overdosing) compared to other methods. However, there was no marked preference for typography in the introjective group. This is consistent with early research by Blatt, Quinlan, Chevron, McDonalds, and Zuroff (1982) who found similar results when they examined the ‘method’ of suicidal behaviour as one of the criteria for distinguishing between anaclitic and introjective individuals. Like the present data, they found that clinical records of the anaclitic group showed they attempted suicide primarily through overdosing on prescription medication (Fazaa & Page, 2003). Similarly, Beck (1983) theorized that anaclitic or sociotropic individuals would use “passive” suicidal methods, whereas more introjective individuals would use more “active methods” such as firearms, hanging, or jumping. Whilst the present data showed no marked preference for either method in the introjective group, the frequency of overdose, self-poisoning, and asphyxiation in the anaclitic sample certainly warrants further investigation.

A second finding was that the anaclitic sample also subjectively reported a greater wish to die at the time of the self-injury relative to the introjective group, who showed no marked preference whether they intended to die or not. It is possible that this relates to the function of their self-harm (to communicate distress) which requires a larger ‘cry’ or gesture to secure the response or connection that they desire. More significant, however, was the finding that the anaclitic group also engaged in acts that were rated more medically lethal as compared to those persons characterised introjective. This was surprising given previous findings have suggested results in the opposite direction,

specifically that anaclitic individuals engaged in suicidal gestures of lower lethality, whilst introjective individuals performed acts more lethal in nature (Fazaa & Page, 2003). One explanation for this disparity could be related to the different sample characteristics between the two studies. Another possibility is that the theory is wrong and that anaclitic individuals are in fact at greater overall risk for death by suicide. This could have important clinical and theoretical implications and will be discussed in more detail in chapter 5.

In addition, an exploration of the frequency of self-harm and the intention to repeat self-harming in the future indicated that the introjective category was more experienced at self-harming as compared to those in the anaclitic group. That is, the introjective group exhibited a greater incidence of prior self-harm episodes (within six months of the index attempt) as well as a preference to self-harm again. This relationship was found to be strong enough to predict group membership. It is possible then that the increased frequency in the introjective sample relates to both the lower lethality of their self-harming behaviours as well as the original proposition that their self-harming behaviours are related to attempts to structure and regulate the self rather than to alter relationships or terminate life. Besser (2004), for instance, in a study of 187 individuals and their same-sex best friends found that self-criticism or introjective personality configurations were associated with emotion-avoidance defenses, while dependency or anaclitic personality configurations were not. Similarly, in a longitudinal study of pregnant women, self-criticism was found to correlate positively with high emotion-avoidance as well as low approach coping strategies (Besser & Priel, 2003). Thus, self-harm for this category may be a way of defending against overwhelming emotions in order to help maintain or structure a sense of self.

Finally, in line with our hypotheses, the introjective group was found to exhibit significantly more total mid-point grid ratings than the anaclitic group, suggestive of greater psychological constriction (Ross, 1985). In addition, a significant correlation was found between interpersonal mastery and constriction, such that; as mastery increased, constriction was found to decrease. Although mastery is a relatively old construct, as used here it has been defined as the “acquisition of emotional self-control and intelligence in self-understanding in the context of interpersonal relationships” (Grenyer, 1994). Thus, an increase in self-awareness in the context of relationships appears to lead to a widening in one’s construct system and a decreased need for control. It also supports the idea that self-harm (which typically relates to low mastery) appears to be fuelled by relationship conflict and ambivalence.

## Chapter 3

### STUDY 2 – OVERVIEW

Following from study 1, study 2 was subsequently designed to replicate these findings utilizing a new clinical sample of self-harming patients. Population statistics indicate that self-injury is more common than self-poisoning by an estimated ratio of 2:1 (Hawton, Harriss, Hodder, Simkin, & Gunnell, 2001). However, as mentioned previously, in medical settings, it is more common for people who overdose to seek help (Hawton et al, 2001). This phenomenon was observed in our sample in study 1, which was skewed towards individuals who used non-violent methods, in particular overdosing. Furthermore, the sample consisted of a majority of individuals who reported an intention to die at the time of their admission. The next step will therefore be to examine if the results observed in our original pilot study can be replicated in an outpatient, community setting.

In addition, a potential limitation of study 1 was the reliance on the Anaclitic/Introjective Prototype measure, which is less well researched. Whilst inter-rater reliability for this method was high (at 0.8), the self-report Depressive Experience Questionnaire (DEQ: Blatt, D’Afflitti, & Quinlan, 1976) has been more widely used and offers a validated and reliable measure of these two constructs. In addition, the DEQ will allow us to measure both anaclitic and introjective tendencies in each participant, so as to address the assumption that these two constructs are mutually exclusive. Briefly, the DEQ is a self-report measure of the ways in which individuals experience themselves and others. It assesses three main constructs: dependency, self-criticism, and efficacy. Dependency reflects anaclitic typography whilst self-criticism reflects introjective typography. Since the efficacy scale does not measure a theoretical concept of Blatt, it will not be utilized in this study. Recent psychometric investigations have shown the DEQ to be a reliable and valid instrument for assessing both anaclitic and introjective psychopathology.

## 1.1 RESEARCH AIMS AND HYPOTHESES

Building on study 1, we expect anaclitic self-harm to differ from introjective self-harm on multiple domains, with the former group more closely resembling those who self-harm by non-violent methods such as overdosing and asphyxiation. In addition, we expected anaclitic and introjective self-harmers to exhibit differences on measures related to intent, lethality, and the number of previous self-harm events.

### Hypotheses for anaclitic self-harm

Specifically, we expect;

1. High scores on the DEQ (Dependency) factor will be associated with self-harming by non-violent methods.
2. High scores on the DEQ (Dependency) factor will significantly correlate with more medically severe self-harm.
3. Individuals with high scores on the DEQ (Dependency) factor will frequently report an intention to die.

### Hypotheses for introjective self-harm

4. Individuals with high scores on the DEQ (Self-criticism) factor will show no marked preference for the method of self-harm used.
5. High scores on the DEQ (Self-criticism) factor will significantly correlate with more incidences of self-harm.
6. High scores on the DEQ (Self-criticism) factor will significantly correlate with less severe self-harm.
7. Individuals with high scores on the DEQ (Self-criticism) factor will show no preference for whether they want to die or not.



## 2. METHOD

### 2.1 Participants

65 participants seeking treatment at the Affect Regulation Clinic (ARC) for Borderline Personality Disorder were studied. Participants were referred by general practitioners, treating psychologists, community health centers, the accident and emergency department of Wollongong Hospital, or via self-referral. Written informed consent was obtained from the subjects to participate in the research.

Only clients who met criteria for both Borderline Personality Disorder (BPD) and comorbid Major Depressive Disorder (MDD) were included in the study (N = 42). All had a history of self-harm (N = 42). The rationale for adopting selecting clients with BPD and comorbid MDD revolves around the fact that BPD demonstrates highly comorbidity with deliberate self-harming behaviours (between 38% and 73%; Black, Blum, Pfohl, & Hale, 2004; Soloff, Lis, Kelly, Cornelius, & Ulrich, 1994). Similarly, depression is a core issue in most self-harm behaviours in both adults and adolescents (Hawton, Kingsbury, Steinhardt, James, & Fagg, 1999; Lönnqvist, 2000). Finally, research has shown that BPD clients who self-harm exhibit significantly higher depression scores than BPD clients who do not self-harm (Stanley, Gameroff, Michalsen, & Mann, 2001). Thus, by selecting clients with BPD and comorbid MDD, we hoped to increase the likelihood of selecting participants with a history of self-harm behaviours.

#### *The Affect Regulation Clinic*

The Affect Regulation Clinic (ARC) program is collaboration between Specialist Psychological Service (SPS), South-Eastern Sydney Illawarra Area Health, and Northfield's Clinic, University of Wollongong. Clinical treatment is offered to clients meeting criteria for BPD using a model of care based on the principles and techniques of

Dialectical Behaviour Therapy (DBT), Acceptance and Commitment Therapy (ACT), and psychodynamic psychotherapy. Treatment is integrative and is based on evidence-based practice.

The Affect Regulation Clinic operates as a single referral point that coordinates assessment and treatment. Assessments and group treatment are conducted at SPS at no fee. Individual therapy is conducted at Northfields Clinic, University of Wollongong by Doctorate and PhD (Clinical Psychology) clinicians for a nominal fee. Those participants deemed eligible for treatment are placed on a waiting list until a clinician becomes available.

## **2.2 Procedure**

Following the receipt of a referral to the ARC program, participants were contacted by telephone or mail to offer an appointment time to assess for their suitability for the program. Prior to the assessment, each participant was provided with both written and verbal information sheets outlining the study and asked whether they agreed to participate in the research. Clinicians clearly explained to the participant that non-consent would not impact on their involvement in the program in any way.

Once written consent was obtained, participants were administered a standard interview protocol by two doctoral (DPsych) students from the Wollongong University Clinical Psychology program. Both were well trained in the assessment and treatment of BPD and were blind to the study. Two clinicians were present for the assessment to increase inter-judge reliability and higher consensus with regards diagnostic decisions. One clinician took the role of assessor, and the other was observer, although both could ask questions as appropriate. In addition, during the assessment the clinicians consulted two senior clinical psychologists during a scheduled break, and thus had the opportunity to further clarify

diagnostic information with the participant following the break. The assessment comprised of demographic information, the client's perception of their presenting problems, past treatment history, and drug and alcohol history. In addition, the Structured Clinical Interview for DSM-IV (SCID) Axis I and the Borderline Personality Disorder Module of the SCID Axis II (First, Gibbon, Spitzer, Williams, & Benjamin, 1997) were administered. Further Axis II features were also explored with the SCID II questionnaire. Participants meeting criteria for BPD and MDD were then invited to complete a large protocol of self-report questionnaires as well as further interview assessments. Questionnaires included the Parasuicidal History Inventory-2 (PHI-2, Linehan et al, 1983), The Depressive Experiences Questionnaire (DEQ, Blatt et al., 1976), and The Inventory of Interpersonal Problems-64 (IIP-64, Horowitz, Alden, Wiggins, & Pincus, 2000).

### **2.3 Measures**

#### Structured Clinical Interview for DSM-IV (SCID) Axis I and Axis II Disorders

The SCID-I and SCID-II is a structured clinical interview for diagnosing major Axis I and II disorders. It was developed by the DSM-IV taskforce authors to be an operationalised instrument of the DSM-IV for interviewers. The SCID-I is divided into six modules that can be delivered in sequence: mood episodes, psychotic symptoms, psychotic disorders, mood disorders, substance use disorders, anxiety disorders, adjustment disorders, and other disorders. The SCID-II is used to make Axis II personality disorder diagnoses. Previous studies have supported the inter-rater reliability and internal consistency of the SCID-I and II modules (e.g., Maffei, Fossati, Agostoni, Barraco, Bagnato, Deborah, et al. 1997).

### The Depressive Experiences Questionnaire

The Depressive Experiences Questionnaire (DEQ, Blatt et al., 1976) is a 66-item self-report questionnaire inquiring about the nature of an individual's experience of depression, and requires approximately 15 minutes for administration. Participants are asked to identify the extent to which each item was true on a 7-point Likert scale, ranging from 1 (strongly disagree) to 7 (strongly agree). Scores are calculated using a DEQ scoring program for SPSS, (Version 3) that was supplied by Blatt. This program yields scores on three scales: dependency, self-criticism, and efficacy. Since the efficacy scale does not measure a theoretical concept of Blatt, it was not utilized in this study. We chose to use the standard scoring system by Blatt et al (1976) as there were only limited differences in the results of analyses using this system compared to modified scoring systems (such as the McGill revision). The DEQ has been shown to have high internal consistency (Cronbach alphas  $> .75$ ) and test-retest reliability over 12-months in college samples ( $r = .79$ ) (Zuroff, Igeja, & Mongrain, 1990), as well as high convergent, construct, and discriminate validity (Blatt & Zuroff, 1992).

### The Parasuicide History Interview (PHI-2)

Characteristics of their self-harm were obtained by the PHI-2 which assesses self-harm behaviours in the past 6-months. The PHI-2 is a comprehensive 47-item semi-structured interview of parasuicidal behaviour (Linehan, Wagner, & Cox, 1983). For the purposes of this study, the PHI-2 was observer-rated and applied to interview data to assess for the method, intent, severity, and medical severity of the self-harm event. Suicide intent was rated on a 2-point scale (1 = not to die, 2 = to die). Severity was rated on a 6-point scale, with 0 being very low and 6 being severe. A moderate 3 rating was applied where insufficient information was obtained. Finally, an overall medical risk score was calculated by summing the intent, severity, and whether the self-harmer was using drugs or alcohol at the time of the episode (where No = 0, and Yes = 1). The PHI-2 has

excellent inter-rater reliability (Linehan et al, 1983) and internal consistency, with alpha coefficients ranging from .64 to .86.

#### Method of self-harm

As per study 1, self-harm methods were classified into two groups according to whether they (1) involved more violent methods resulting in damage to skin or body parts (such as cutting, burning, scratching, head-banging) or (2) non-violent methods (such as overdosing and asphyxiation). This distinction has previously been made in the literature examining gender differences and methods of suicidal behaviour (Darke, Degenhardt, Mattick, 2006).

#### The Inventory of Interpersonal Problems-64

The Inventory of Interpersonal Problems 64-item circumplex version (IIP-64; Alden, Wiggins, Pincus, 1990; Horowitz, et al, 2000) is a 64-item self-report questionnaire which measures maladaptive relationship behaviour on a 5-point Likert scale from 0 (not at all) to 4 (extremely). This inventory assesses the severity of interpersonal problems in 8 domains: domineering, vindictive, cold, socially avoidant, non-assertive, exploitable, overly nurturing, and intrusive. Some items begin with the phrase “it is hard for me to...” others begin with “These are things I do too much...” The IIP demonstrates high internal consistency (alpha) from .72 to .85, and test-retest reliability from .74 to .89. Convergent validity was established by high correlations with the Revised Interpersonal Adjective Scale (Wiggins, 1982).

## 2.4 STATISTICAL ANALYSIS

This study is a cross-sectional design therefore most of the analyses looked at the relationship between each of the variables. In order to address each of the hypotheses, pearsons  $r$  rank order correlation coefficient were used to summarise the strength and direction (negative or positive) of the relationship between DEQ scores and medical severity ratings and incidences of self-harm (based on PHI-2). ANOVA statistics were performed to determine the relationship between DEQ scores and categorical variables, specifically the method of self harm and their intention (based on the PHI-2). Statistical significance was set at .05, and SPSS version 15 was used.

### 3. RESULTS

#### 3.1 DEMOGRAPHIC INFORMATION

##### **3.1a Personal Characteristics**

Table 1 provides the demographic information for the sample. The sample consisted of 37 women, ranging in age from 18 to 50 years ( $M = 28.1$ ,  $SD = 8.0$ ), and 5 men, ranging in age from 35 to 43 years ( $M = 38.2$ ,  $SD = 3.1$ ). Approximately half of the participants were single ( $N = 23$ ).

*TABLE 1: Demographic Characteristics of Total Sample (n=42)*

<b>Variable</b>	<b>N</b>	<b>% (Percentage)</b>
<b>Sex</b>		
Male	5	12
Female	37	88
<b>Employment status</b>		
Employed	10	24
Unemployed	32	76
<b>Current Relationship Status</b>		
Single	23	55
Married	6	14
Defacto	6	14
Divorced	1	2
Separated	4	10
<b>Dwelling Type</b>		
House (owned)	13	31
House (rented)	13	31
Flat (owned)	1	2
Flat (rented)	9	21
Other	6	14

**3.1b Self-harm Characteristics**

As Table 2 reveals, the majority of participants reported self-harming by cutting, stabbing, burning, scratching, and head banging ( $N = 26$ ). The majority indicated that they did not want to die at the time of their self-harm ( $N = 28$ ) as compared to only a small proportion of people ( $N = 14$ ) who did.

*TABLE 2: Self-harm Characteristics of Total Sample (n=42)*

Variable	N	%
<b>Method (most recent episode)</b>		
Violent methods resulting in damage to skin or body parts (such as cutting, burning, scratching, head-banging)	26	62
Non-violent methods (such as overdose, self- poisoning, and asphyxiation)	14	33
Missing	2	5
<b>Intention</b>		
Did not intend to die	28	67
Intended to die	14	35
<b>Drugs / Alcohol Usage at the time?</b>		
No	34	81
Yes	5	12
Missing	3	7



## VALIDITY CHECK

To assess the validity of the anaclitic and introjective ratings, interpersonal problems experienced by dependent and self-critical women were examined using constructs from the inventory of interpersonal problems (IIP-64). Results indicated that the two typologies related sensibly to the types of interpersonal problems which would be expected in each group (see Table 3).

*Table 3: Correlations between IIP and DEQ scores*

	Dependency	Self-criticism
Vindictive	-.216	.382*
Exploitable	.298**	.077
Avoidant	.265	.280**
Intrusive	.086	.288**
Non-assertive	.237	-.005
Cold	-.377*	.295**
Domineering	-.143	.284
Nurturing	.352*	.224

\*  $p > .05$ , \*\* $p < .1$

Specifically, dependency was negatively related to being cold and positively associated with being overly nurturing. Thus, people high in dependency exhibit problems associated with trying too hard to please others and being too generous, trusting, caring, and permissive in dealing with others. In addition, a significant relationship was found between self-criticism and the vindictive subscale. Therefore, people high in self-criticism experienced difficulties associated with being distrustful and suspicious of others, and being unable to care about others' needs and happiness.

Thus, the DEQ data can meaningfully be described as reflecting both anaclitic and introjective typologies.

### 3.2 RESULTS FOR THE HYPOTHESES

#### 4.2a Hypotheses for the method of self-harm

Based on research findings from study 1, we expect that;

- i) Individuals with high scores on the DEQ (Dependency) factor will exhibit more frequent use of non-violent methods of self-harm.
- ii) Individuals with high scores on the DEQ (Self-criticism) factor will show no marked preference for the method of self-harm used.

To explore the different methods of self-harm between the DEQ Dependency and Self-criticism factors, ANOVA statistics were conducted. It was found that there was no significant difference between the DEQ (Dependency) scores ( $F(1,39) = 2.438$ ,  $p = .13$ ) for those individuals who engaged in violent methods such as cutting, stabbing, burning, scratching, and head banging as compared to non-violent means such as overdosing and asphyxiation (see Table 4). There was however a significant difference between the DEQ (Self-criticism) scores ( $F(1,39) = 4.717$ ,  $p = .04$ ) and method, where higher DEQ (Self-criticism) scores were associated with methods such as cutting, stabbing, burning, scratching, and head banging.

*Table 4: Mean (and Standard Deviation) DEQ scores for method of self-harm*

	<b>Method</b>	<b>N</b>	<b>Mean</b>
Dependency	Violent methods (Cutting, stabbing, burning, scratching, head banging)	26	.50 (.69)
	Non-violent methods (overdose, self-poisoning, and asphyxiation)	14	.11 (.84)
Self-criticism	Violent methods (Cutting, stabbing, burning, scratching, head banging)	26	1.66 (.46)
	Non-violent methods (overdose, self-poisoning, and asphyxiation)	14	1.27 (.67)

3.2b: Hypotheses for the intent of self-harm:

- i) Individuals with high scores on the DEQ (Dependency) factor will report a strong intent to die.
- ii) Individuals with high scores on the DEQ (Self-criticism) factor will show no preference for whether they want to die or not.

ANOVA statistics were conducted to examine the intention of the self-harming behaviour between those individuals rated high on the DEQ Dependency and Self-criticism factors. Results showed a tendency in the opposite direction of the hypotheses for the DEQ (Dependency) scores ( $F(1, 41) = .383, p = .54$ ) (see Table 5). In addition, there was a significant difference between the DEQ (Self-criticism) scores ( $F(1, 41) = 7.509, p = .01$ ) and intent, where higher DEQ (Self-criticism) scores were associated with not wanting to die.

*Table 5: Mean (and Standard Deviation) DEQ scores for intention of self-harm*

	<b>Intent</b>	<b>N</b>	<b>Mean</b>
Dependency	Did not intend to die	28	.42 (.71)
	Intended to die	14	.27 (.86)
Self-criticism	Did not intend to die	28	1.73 (.50)
	Intended to die	14	1.24 (.64)

3.2c: Hypotheses for the frequency of self-harm

- i) High scores on the DEQ (Self-criticism) factor will significantly correlate with greater incidences of self-harm.

To explore the relationship between the frequency of self-harm and DEQ Dependency and Self-criticism ratings, a spearman's correlations was conducted. Results showed no significant correlation for DEQ (Self-criticism) ratings. However, a negative correlation was found for the DEQ (Dependency) factor, whereby as Dependency increased, the frequency of self-harm significantly decreased,  $r = -.402$ ,  $p = .009$  (see Table 6).

*Table 6: Correlations between DEQ factor score and self-harm frequency*

	<b>Times harmed / attempted in past 6mths</b>
Dependency	-.40
Self-criticism	.16

3.2d: Hypotheses for the medical severity of self-harm:

- i) High scores on the DEQ (Dependency) factor will significantly correlate with more medically severe self-harm.
- ii) Individuals with high scores on the DEQ (Self-criticism) factor will significantly correlate with less medically severe self-harm.

To explore the relationship between the medical severity of self-harm and DEQ Dependency and Self-criticism ratings, Pearson's  $r$  correlations were conducted. Results showed a significant correlation between DEQ (Self-criticism) ratings and the medical

severity of the self-harm episode. Specifically, as DEQ (Self-criticism) ratings increased, self-harm severity decreased,  $r = -.363$ ;  $p = .021$  (Table 7).

*Table 7: Correlations between DEQ factor score and medical severity of self-harm*

	Medical Severity
Dependency	-.16
Self-criticism	-.36

## 4. DISCUSSION

### 4.1 Overview of findings from Study 2

The primary purpose of study 2 was to validate and extend the findings from study 1 using a community sample of participants with Borderline Personality Disorder and comorbid Major Depressive Disorder, a diagnostic profile highly associated with self-injury. Overall, the results of the study confirm that there are some significant differences between the self-harm behaviours of those who rated anaclitic and introjective, but in ways that we did not anticipate fully at the outset.

With regards to the demographic characteristics, the majority of the participants in this study were females, who were single and not in the workforce at the time of the attempt. These trends are very similar to findings reported in the literature on self harm (for example Hassan, 1996). In addition, the majority of the participants in the study sample used aggressive / invasive forms of self-injury, which is consistent with community studies that have identified cutting to be the most frequently used method, with most acts taking place within the home (Madge, Hewitt, Hawton, Jan de Wilde, Corcoran, Fekete, van Heeringen, De Leo, & Ystgaard, 2008).

With regards to our hypotheses, we had predicted that individuals with anaclitic personality configurations would exhibit more frequent use of non-violent methods whilst individuals with introjective personality constructs would show no marked preference for the method of self-harm used. However, we found a preference for the introjective style and none for the anaclitic style. Specifically, higher DEQ (Self-criticism) scores were associated with more frequent use of violent methods such as cutting, stabbing, burning, scratching, and head banging as compared to non-violent methods. Whilst this result was

unexpected, it nevertheless corresponds with part of our original hypotheses from study 1, where we predicted that introjective self-harm would involve more active or invasive means in accordance with early theories posited by both Beck and Blatt. Given that empirical support for this distinction of the method of self-harm based on personality is only in the initial stages, further studies examining the interaction between these constructs could help to clarify whether personality could help to predict the type of method used to self-harm (and vice versa). This would have clinical utility in helping to monitor and reduce access to particular means in order to help reduce risk.

Second, it was predicted that introjective individuals would show no preference for whether they want to die or not, whilst anacletic individuals would report a strong intent to die at the time of their self-injury. In fact, results indicated that individuals with high ratings on the DEQ (Self-criticism) factor exhibited a preference for not wanting to die. In addition, a significant negative relationship was found between the introjective scores and the severity of the self-harm episode, so that as introjective ratings increased, self-harm severity decreased. Thus, highly introjective individuals appear to engage in self-harm behaviours that are not intended to be lethal and are low in medical lethality. Whilst this contradicts earlier studies, it supports the theory that self-harm for this group is an action to promote self-regulation and control over one's self, rather than an effort to terminate life or communicate distress to others. The key feature is that they engage in self-injury for reasons that are not suicidal in nature. With self-harm and suicide rates showing a long-term upward trend, this discovery could have important implications in helping to distinguish between those people who are /are not at greatest risk of death by suicide.

Finally, it was expected that introjective self-harmers would engage in significantly greater incidences of self-harm than the anacletic sample (as per study 1). This was partially supported. Although results were not significant for the introjective style, we

found a significant interaction for the anaclitic style. That is, DEQ (Dependency) ratings were negatively correlated with the number of prior incidences of self-harm. Therefore, as anaclitic ratings increased, the frequency of prior episodes of self-harm fell significantly. This is therefore consistent with study 1, whereby anaclitic motives are associated with a lower frequency of self-harm events. One possibility for this outcome is that people who are high on dependency tend to rely heavily on others. As a result, any interpersonal loss or change for these individuals could lead to attempts that are more severe or lethal nature (hence fewer recorded events). However, the lack of significant relationship between the anaclitic style and severity ratings confounds this theory. Further exploration is therefore needed to understand the relationship between the anaclitic and introjective styles and the relative frequency of self-harm behaviours.



## Chapter 5

### 1. GENERAL DISCUSSION

This thesis conducted two studies, both of which explored Blatt's anaclitic and introjective constructs as a way to help understand self-harm behaviours. The first study was a quantitative study designed to compare characteristics in two categories of individuals with recent acts of self-harm, described as 'cry for help' (anaclitic) and 'search for self' (introjective). Findings indicated that the former group exhibited more frequent use of non-violent methods (overdose, self-poisoning, and asphyxiation), higher medical lethality, and a greater wish to die, while the latter manifested greater psychological constriction, and greater incidence of prior self-harm episodes. A validation study was then performed using a community sample of individuals with recent acts of self-harm. Findings indicated that the anaclitic style was associated with fewer previous self-harm episodes. Meanwhile, higher introjective ratings were linked with not wanting to die and using more violent and invasive methods such as cutting, stabbing, burning, scratching, and head-banging to self-injure. In addition, there was an inverse relationship between introjective ratings and the medical lethality of self-harm.

One of the main differences between the two studies was the sample characteristics. Firstly, the sample in study 1 was drawn from accident and emergency departments in the United Kingdom, regardless of diagnoses. The majority of participants had self-harmed by non-violent methods, in particular overdoses of prescription medications. In contrast, study 2 was drawn from a community sample in Australia with Borderline Personality Disorder and comorbid Major Depressive Disorder. In this study, the majority of participants had self-harmed by using aggressive or violent methods associated with tissue damage, in particular cutting, burning, and scratching. In addition, the method of

classifying anaclitic and introjective motives was different between the two studies. Whilst this was intentional (in order to address the limitation of binary classification in study 1 - given that some individuals may exhibit both motives) in hindsight, perhaps it would have been better to have utilised the original prototype classification as well as the DEQ scores in Study 2 to increase the strength of our observations

Nevertheless, there are a number of similarities between the two studies. In fact, it is almost as if the results of the two studies have converged - as if they were mirrors of each other. Namely, the anaclitic type utilised non-violent methods of self-harm (in study 1), whilst the introjective type were found to have utilised more aggressive and invasive means (in study 2). In both studies the anaclitic sample engaged in fewer self-harm episodes, whilst the introjective group engaged in more frequent self-harm (study 1). Attempts by individuals with anaclitic motives were also more lethal in their intent and were rated higher in medical lethality (in study 1) whilst those with introjective motives made attempts without wanting to die and that were rated lower in medical lethality (study 2). Thus, the consistency between the two studies, despite their differences is remarkable and strengthens the overall combined findings.

The suggestion then that anaclitic psychopathology may represent greater risk when compared to introjective psychopathology is an important one. As mentioned previously this contradicts our original hypotheses as well as Blatt and Beck's theories that introjective or autonomous patients (as opposed to anaclitic patients) would be more death-seeking in intent, which would be reflected in suicide attempts of a more lethal nature (Blatt, 1974; Blatt, 2004). To date, Blatt and Beck's theories have not been well validated in the research and given the current findings additional exploration is needed. It is possible perhaps that highly anaclitic individuals are in fact at greater risk for more serious self-harm attempts and death by suicide. Bornstein & O'Neill (2000), for instance,

reported a significant correlation between high dependency scores and high suicidality in both women and men, even when controlling for depression. Furthermore, researchers have found a significant relationship between anaclitic personality configurations and high mean impulsivity scores when compared to introjective individuals (Fehon et al., 2000). In addition, impulsive suicide attempts have often been found to be immediately preceded by interpersonal conflicts (Simon, Swann, Powell, Potter, Kresnow, O'Carroll, 2001). It is possible then – as Fehon et al (2000) suggested – that anaclitic self-harmers are more inclined to engage in impulsive gestures that are unplanned, and thus higher in lethality than introjective self-harmers, who make more careful, planned actions.

In addition, a number of previous studies have shown a positive association between interpersonal conflict or change and increased rates of suicide in many groups, including adult women (Runyan, Moracco, Dulli, & Butts, 2003), adolescents (Brent et al., 1993), patients affected with schizophrenia (Drake, Gates, & Cotton, 1986), Indigenous males (Steering Committee for the Review of Government Service Provision, 2005), and the elderly (Waern, Rubenowitz, & Wilhelmson, 2003). Maris (1981) for instance found that painful, rejecting, or otherwise negative interpersonal interactions were far more common before a suicide attempt than at other times or amongst nonsuicidal people. Similarly, a study by Hawton and Harriss (2007) found that the most common problems faced by patients at the time of their self-harm attempt were family difficulties (50.9 percent) and problems in a relationship with a partner (45.7 percent) (which is consistent with anaclitic vulnerabilities), followed by employment problems or problems with studies (41.9 percent) (which is consistent with introjective vulnerabilities).

Furthermore, there may be important differences in the methods of self-harm chosen by patients with anaclitic or introjective styles, a distinction which has not received empirical research in the past. In study 1, the anaclitic group exhibited significantly more incidences

of self-harming by non-violent methods. In Study 2, the introjective sample exhibited significantly more acts of self-harm by violent methods such as stabbing, burning, scratching, and head banging. Taken together, this supports the original hypotheses, although further exploration is required. It is possible that the observed difference relates both to the sample characteristics (as the samples were drawn from different places and were therefore unbalanced – specifically, the majority of participants in study 1 used non-violent methods, compared to study 2 where the majority engaged in more invasive and violent forms of self-harm) as well as the grouping of the variables, which was influenced by the small sample sizes. Even so, it is interesting to note that there are some important similarities between our findings and results from an earlier study of adolescent self-harmers, which compared the differences between self-poisoners and self-cutters (Rodham, Hawton, & Evans, 2004). Their results showed that people who overdosed most often said that they had wanted to die (66.7%) and had wanted to find out if someone loved them (41.2%) (which is consistent with the anaclitic group in our study). In contrast, self-cutters were more likely to say that they had wanted to get relief from a terrible state of mind (77.2%) (consistent with introjective psychopathology). Thus, it is possible that the choice of method may be influenced by the persons' personality vulnerability, although further exploration is needed.

Finally, the relationship between constriction and introjective self-harm behaviour warrants further comment, as this study is the first time in which these constructs have been applied together. In this study, constricted construing was evident in the introjective group who exhibited a higher number of total midpoint ratings as compared to the anaclitic sample. This difference in construing between the two groups is consistent with findings from past research. Early cognitive studies, for instance, have suggested that individuals with high personal standards and expectations (as per introjective psychopathologies) may respond to aversive self-awareness by trying to escape into a

relatively numb state of cognitive deconstruction, that is constricted temporal focus, concrete thinking, immediate proximal goals, and cognitive rigidity (Baumeister, 1990). In fact, research has shown that highly autonomous, achievement-oriented individuals are very concerned about the possibility of personal failure and often try to maximize their control over the environment in order to reduce the probability of failure and criticism. Thus, self-harm in this group may be associated with the person entering a cognitively rigid state, avoiding new goals, ideas and interpretations in order to exert or maintain control over the internal world and their environment.

### **1.1a Clinical Implications**

Given the aforementioned findings, it is possible that the distinction between introjective and anaclitic self-harm could have significant clinical relevance in both the identification and treatment of those who are most at risk of suicide. Research has suggested that anaclitic patients exhibit a placating and submissive interpersonal style as compared to introjective clients whose interpersonal interactions are characteristically problematic and unpleasant (Blatt, 2004). Therapeutically then, introjective individuals – who engage in more frequent and invasive self-harm, take longer to form a therapeutic alliance, appear hostile, angry, and attacking (Mongrain, 1998; Zuroff, & Duncan, 1999), and frequently cancel sessions or display premature termination (Fazaa & Page, 2005) – may appear to be at greater risk of suicide when compared to their anaclitic counterparts. Yet results of this study suggest that the opposite is true. Instead, the anaclitic client may respond to actual or perceived loss of contact with the therapist or significant others by engaging in impulsive self-harm attempts that are higher in objective lethality in order to quickly secure the closeness and warmth they desire. It is possible their cry for help to others requires a ‘louder shout’ or a bigger gesture, particularly when the response from other is expected to be cold or rejecting. This information could have positive benefits in future assessments of those at greater risk of serious self-harm attempts, particularly given that a

major concern in the treatment of self-harmers is our poor ability to assess for risk reliably and effectively. Whilst we acknowledge that any suicidal ideation or attempt must be addressed with appropriate professional concern, the current findings suggest that precautions and interventions may be particularly warranted following suicidal communications or behaviours by individuals with anaclitic vulnerabilities.

Another important clinical implication of our research is the potential relationship these constructs and therapeutic outcomes. Personal construct theorists for instance predict that individuals with a tight construct system would likely be “threatened by the prospect of reconstruction because this would necessarily involve change in their core constructs” (pg. 33; Winter, 2003). In fact, tight construing has been found to be associated with poor treatment outcomes for group therapy for alcoholics (Orford, 1974), anorexics (Button, 1983), in behaviour therapy for agoraphobics (Winter & Gournay, 1987), and in both group and individual psychotherapy (Carr, 1974; Morris, 1977). Whilst this relationship is not straightforward, the significant interaction between constriction and self-harm in introjective individuals could have important implications for therapeutic outcomes and requires further exploration.

In addition, results of this study could assist with tailoring treatment to match the specific vulnerability of the client’s self-harm event. Blatt, Shahar, and Zuroff (2001) suggest, for example, that the distinction between the anaclitic and introjective configuration of personality and psychopathology has the potential to inform therapeutic practice, as both groups of individuals will experience their worlds very differently. For instance, given that anaclitic patients exhibit an extreme vulnerability to self-harming following disruptions to interpersonal relationships, treatments should focus on fostering insight into the individual’s self as an autonomous being in relation to others. For this group, training in interpersonal problem-solving and assertiveness may be useful to allow the client to

meet their needs through means other than self-harming. In fact studies have found that short-term interpersonal psychotherapy (consisting of 4-sessions) can have significant benefits in reducing self-harm behaviour in a sample of clients who self-poison (Guthrie, Kapur, & Mackway-Jones, 2001). A relevant, indeed greatly abbreviated, clinical example, based on our own clinical observations, will hopefully clarify these ideas. Identifying information has been changed to protect the clients' anonymity.

### *Anaclitic case example*

Jane was a 24-year old female, diagnosed with Borderline Personality Disorder. She was referred for an assessment following frequent self-harm (predominantly via overdosing on prescription medications) and associated hospital admissions.

Her history included child abuse and neglect, incest, rape, and domestic violence. Her parents separated when Jane was 8-years old and she felt abandoned by her mother who she left home with her older sister. Jane's only close relationship during childhood was with her younger brother, who completed suicide when Jane was 16-years old. Her father (with whom Jane and her brother lived) was an alcoholic, with an unpredictable and violent temper. He frequently physically and sexually abused both Jane and her brother. This continued for approximately 5 years. At the time of the assessment, Jane was experiencing intrusive thoughts, flashbacks, and nightmares, in response to triggers associated with her abuse.

Jane's adolescent years and early adulthood were characterised by feelings of being unloved, together with fears of abandonment. These fears were ultimately confirmed when her brother committed suicide and 'left' her alone with her father. Jane defended against these feelings by drinking heavily and engaging in serial sexual contacts with men

and women to provide her with the closeness she desired (but who lacked any genuine interest committed relationship).

At the time of her assessment interview, Jane described having few social supports and she was estranged from her father. She had, however, developed a reputation for repeatedly seeking out contact with treatment providers, in both private and public health settings. Jane had great difficulty tolerating her feelings of loneliness and she frequently responded to small gaps in medical care or attention by threatening (and often engaging) in self-harm attempts, mainly through overdosing. Her typical pattern included becoming angry when others had let her down or otherwise failed to “listen” or “understand” her distress. This would lead to an overdose (most often followed by a call for help to police or a health care provider) to alleviate her distress and obtain the support and care she desired. When describing her self-harm acts, Jane typically stated that she had overdosed;

1. “To be heard”
2. “To show others how bad I feel”
3. “To be admitted to hospital”
4. “To die”

The severity of her self-harm attempts ranged from low lethality attempts to higher lethality acts requiring intensive medical follow-up.

#### Consistency with Research Outcomes:

There is an overwhelming degree of consistency in the findings of the qualitative studies and the above case example. Like with our research data, Jane primarily used medication overdoses to self-harm and her attempts were largely associated with efforts to overcome loneliness and to communicate her distress to others, although she frequently reported a wish to die. Her qualitative responses confirm our conceptualization that self-harm was used as a method for Jane to express her psychological pain when words had failed.



Minimising or dismissing the behaviour is therefore likely to reinforce her negative view of herself and others, and could lead to greater distress and possibly more lethal attempts. Treatment implications are discussed below.

#### Therapeutic Intervention:

The first step in Jane's treatment was to encourage her to develop the capacity to identify and sequentially describe common interpersonal triggers, affective experiences, cognitions, and outcomes of her self-harm behaviour. Research has previously shown that individuals with BPD frequently have difficulties identifying, acknowledging, and describing the precise emotion associated with interpersonal events (Levine, Marziali, & Hood, 1997). For instance, during treatment Jane was able to acknowledge that one serious episode of self-harm enabled her "to be taken seriously... I was angry that I wasn't being heard about not wanting to share a bathroom and it [the self-harm] opened the door for more discussion with my nurse". This is thus nicely consistent with the 'cry for help' motive in the anaclitic style. Treatment then aimed at providing Jane with the interpersonal skills to communicate her distress without having to rely on self-harm. In addition, sessions encouraged Jane to identify and tolerate uncomfortable emotions, whilst addressing her frequent all-or-nothing attributions and misrepresentations of negative reactions from others. The ultimate goal was to encourage the development of an autonomous self-identity as well as decrease her vulnerability to interpersonal rejection and reliance on others so that self-harm was no longer necessary.

#### ***Introjective case example***

Susan was a 21-year old female who was first diagnosed with psychiatric problems in adolescence. She had a history of anorexia nervosa, social anxiety, and major depression. At the time of her assessment, she was diagnosed with Borderline Personality Disorder with chronic and pervasive mood instability, fears of abandonment, emptiness, anger,

dissociation, and suicidal / parasuicidal behaviour. Susan self-harmed daily through cutting and burning of her upper and lower limbs.

Her history included neglect and domestic violence. Shortly after Susan was born, her parents underwent a difficult relationship crisis characterized by many arguments and frequent incidents of leaving home by the father. During this time, Susan's mother fluctuated between over-reliance on Susan, followed by periods of harsh criticism and blame for her problems with her husband. In her early school years, Susan reported externalising her anger by frequently bullying other children. At age 13, however, she changed schools, ceased bullying, and began self-harming by scratching or burning herself with keys, matches, or "anything else I could find". Susan reported frequent periods of significant depression, which ultimately truncated her education. She was a loner and had almost no friends.

At the time of her presentation, Susan was living alone and reported having no positive relationships. Her gothic-like appearance served as a warning for others not to approach and prevented her from forming new relationships. She frequently dissociated, had nightmares, and experienced difficulty sleeping. She described feeling "overwhelmed" by life and was struggling with finances and general activities of daily living. She felt that she had not achieved her potential and saw herself as "worthless" and "a waste of space". She frequently starved herself and would purge after eating in order to meet her own internal standards of thinness. She presented as extremely self-critical and described cutting, burning, and eating as ways to relieve stress and tension. Her typical pattern of self-harm involved berating herself for her failures, and then cutting or burning to relieve anger and distress. Susan described her goals for treatment in the following way;

Susan: I thought well, I'm here to improve my self-esteem and my critical side and um...yeah... um that was pretty much it because once that improves I think everything else will just follow. I'm just... I'm just so critical and pessimistic and that stops me from trying to study or even wanting to try... All I do is sit at home and I don't have any friends and I don't have a job or study or anything, yeah. I just feel worthless and hopeless and just like a waste of space."

#### Consistency with Research Outcomes:

As per our findings, Susan's self-harm behaviours typically involved using violent methods such as cutting, stabbing, and burning. Her self-harm attempts were predominantly related to attempts to regain control over her internal and experiences, such as her food (which felt out of control after bingeing), her feelings, and her overwhelming "critical side". She engaged in self-harm at least daily, often a few times per day. Again, this is consistent with the high frequency of self-harm found for introjective individuals. Finally, Susan had significantly decreased her social contacts, activities, and interests, suggestive of the constricted construing observed in introjective self-harm.

#### Treatment Intervention:

Given Susan's introjective personality type and her associated treatment goals, therapy was aimed at addressing her intense self-criticism and negative self-identity. According to Blatt, introjective clients respond better to therapeutic interactions that are more detached and longer-term, as certain personality traits such as their intense self-criticism and perfectionism, interfere with short-term approaches. Following is an excerpt from a therapy session, which highlights Susan's struggle to integrate positive aspects of her self structure.

Therapist: So when you're sitting here quietly, trying to contain yourself...what's happening for you?

Susan: Um, that's probably, that's when the critical side is like really, yeah, just starts up.

Therapist: Ah, so that when the critical side is really strong, ok.

Susan: And I always, you know, start thinking about everything... like the positive things and hopeful things, and I just always start criticising everything...

Therapist: I can see you're really sad.

Susan: Um, um (grabs a tissue)...um, just cause it, yeah, just whenever I talk about the good side and I always criticise, and it just feels like I'm not letting myself have the hopeful side and the loving side.

Therapist: Hmmm, and that makes you sad.

Susan: It's just not normal, it's not normal to... I don't know, um like to start crying because you're like talking about the good sides and the bad sides and just...

Therapist: It's not normal?

Susan: Yeah, like I just don't think people would like, talk about the good aspects of their personality and the bad sides and then start freaking out because there are good sides or whatever.

In addition, as demonstrated in the above interaction, therapy also aimed to repeatedly verbalize affective experiences (in this case sadness) and draw Susan towards these emotions to counter her emotion-avoidance defenses. Research has suggested that frequent verbalization of affect-laden experiences in the context of the therapeutic relationship can encourage the development of a subjective sense of self or identity (Gregory & Remen, 2008). Furthermore, the attributions of persons with BPD tend to be

distorted and to have a polarized all-or-nothing quality, therefore the identification and integration of Susan's polarized attributions of her self and of others became a core component of treatment:

Therapist: What is it like for you when you think that there may be two parts to you?  
One part that wants things and one that's critical?

Susan: I don't know, I just feel like they're just like, they just feel like they're so different, its like Multiple Personality or something, just, yeah, just, I don't know, I just think whenever I think like I'm going to like kind of change and be happier, I always think I'm going to be hopping around in pink clothes listening to pop music.

Therapist: (Laughs), yeah, so it feels really frightening, it doesn't feel like you can be both at the same time, you're either one or the other?

Susan: Yeah, it's like the black and white thing again, like you're one or the other and you can't really have both

Therapist: Hmmm, so I wonder... if you're imaging that being happy means you're skipping around, listening to pop music, wearing pink, it must be really hard to let go of your critical side?

Susan: Yeah, I kind of know that I won't be doing that but, yeah, that's what it feels like.

As demonstrated above, Susan's concerns about her self-identity (who she was and how to understand herself beyond the clichéd opposites such as gothic versus a pink wearer) formed much of the work.

### **1.1b Strengths, Limitations, and Future Directions**

An important strength of this study was the use of both an inpatient and a community sample to explore self-harm characteristics. Self-injury is highly prominent in emergency departments and in individuals diagnosed with BPD and comorbid Major Depressive Disorder, and was thus very relevant to this area of research. Furthermore, this study offers the only comparison of self-harm behaviour and Blatt's personality constructs in people with a diagnosis of BPD. It is interesting to note that in his early research Blatt (Blatt & Schichman, 1983) proposed that BPD would classify as a form of anaclitic psychopathology only. However, in later years (Blatt & Auerbach, 1988) he revised this and acknowledged two types of BPD, that is, 1) anaclitic borderline, which exhibit primary disturbances with dependency 2) and introjective borderline, which exhibit primary conflicts over issues of autonomy and self-worth. This study would support this latter conceptualization in that high DEQ (self-criticism) ratings were observed in the sample.

We also acknowledge that utilizing two unique samples has its limitations. Whilst validating results across samples could help to increase the generalisability of our results, it is difficult to make any direct comparison between the two studies. We acknowledge, however, that the purpose of study 2 was not to compare, but rather to validate and extend the findings from study 1. However, it is difficult to ascertain whether the observed differences are due to sample characteristics or problems with the model itself. Sample 1 represented undiagnosed self-harm emergency presentations to a North London UK area hospital system. Sample 2 represented self-harming diagnosed borderline clients being seen in a community clinic in Wollongong, Australia. Results would have perhaps been stronger if the two groups were matched for age, gender, diagnoses, socioeconomic, and socio-cultural variables.

In addition, we acknowledge that the cross-sectional design utilised in both of the studies prevents us from commenting on the direction of causality between the observed outcomes. In addition, we appreciate the need to study larger samples of participants. Unfortunately, due to the practicalities of the project and the time constraints, this limitation could not be addressed.

This research also shares a number of common limitations with investigations of this sort in that the data is reliant on patient self-report. The validity of self-reports could thus be influenced by biases such as negative mood states and social desirability. We do note, however, that the use of self-report questionnaires could also enhance self-disclosure of sensitive material (due to the non-direct / face-to-face manner of administration).

A final limitation involved the use of DEQ scores in study 2, which proved somewhat limiting in that the DEQ is not linked to behavioural states and rather derives a statistical estimate based on regression analyses. As a result, it was not possible to categorise participants into introjective or anaclitic groups, but only to show trends of these two subtypes within a person. Nevertheless, it did allow us to explore both motives within a single individual (as opposed to relying on the binary classification in study 1). Furthermore, researchers have concluded that the psychometric properties of the DEQ are more fully developed than the other scales which measure similar constructs of depression (Blaney & Kutcher, 1991). It was therefore deemed the most appropriate measure to use in this study. An important avenue for further research would be to examine the relations between introjective and anaclitic constructs and self-harm using different measures (such as Beck's Dysfunctional Attitudes Scale).

### 10.1c Conclusion

Despite these limitations, we conclude that the findings from this research help us to understand suicidal individuals and their self-harm attempts and support the utility of the cry for help (anaclitic) / search for self (introjective) distinctions in self-harm research. Specifically, suicidal individuals who self-harm may be differentiated in terms of their motive, namely as a cry for help (anaclitic) or as a search for self (introjective). Clinicians will benefit from attending to these dimensions during assessment and treatment of self-harm, particularly given anaclitic vulnerabilities may be associated with more impulsive gestures that are unplanned and thus higher in medical lethality than introjective self-harmers, who engage in more frequent low-level attempts involving carefully planned actions. In addition, the interaction found between constriction and poor therapeutic outcomes reported in other studies highlights the need to tailor treatment to manage self-harm risk for each group. As illustrated in the cases studies presented here, anaclitic and introjective patients may respond to distinct treatment strategies (Blatt & Zuroff, 2005; Blatt, Zuroff, Bondi, Sanislow, & Pilkonis, 1998), although further research is recommended to guide treatment.



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## APPENDIX 1

### Anaclitic versus Introjective Personality Configuration

Instructions: Use the following criteria to help distinguish the critical features of the clients personality configuration. However, only use these as a guide and make reference to the published prototype before assigning the final rating.

#### Anaclitic Configuration

Basic Wish: Wanting to be loved

##### Key Criterion

##### Met / Unmet

- |  |   |
|--|---|
| 1. Movement towards object / other.  | <div style="border: 1px solid black; height: 30px; width: 50px;"></div> |
| 2. Preoccupation with attachment.  | <div style="border: 1px solid black; height: 30px; width: 50px;"></div> |
| 3. Expression of concerns about trust, closeness, affection, and the dependability of another.                                 | <div style="border: 1px solid black; height: 30px; width: 50px;"></div> |
| 4. Primary conflicts include the threat or experience of object loss (including loss of care, affection, love, and sexuality). | <div style="border: 1px solid black; height: 30px; width: 50px;"></div> |
| 5. Expressions of hopelessness and helplessness are likely.  | <div style="border: 1px solid black; height: 30px; width: 50px;"></div> |

#### Introjective Configuration

Basic Wish: To be acknowledged, respected, and admired

##### Key Criterion

##### Met / Unmet

- |   |   |
|---|---|
| 1. Movement away from object / other.   | <div style="border: 1px solid black; height: 30px; width: 50px;"></div> |
| 2. Preoccupation with separation from other, especially those viewed as controlling, intrusive, punitive, critical, and judgmental. | <div style="border: 1px solid black; height: 30px; width: 50px;"></div> |
| 3. Expression of concerns about issues of self-definition, self-control self-worth, and identity.                                   | <div style="border: 1px solid black; height: 30px; width: 50px;"></div> |
| 4. Primary conflicts revolve around the management and containment of affect, especially aggression.                                | <div style="border: 1px solid black; height: 30px; width: 50px;"></div> |
| 5. Feelings of inferiority, worthlessness, and guilt are likely.  | <div style="border: 1px solid black; height: 30px; width: 50px;"></div> |

**Overall Classification: (circle)**

**Anaclitic / Introjective**