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ATTEMPTED SUICIDE AND SHAME

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Institutet**

Stockholm 2012

To Birgitta Ahlin

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ISBN 978-91-7457-640-5

ABSTRACT

A suicide attempt constitutes not only a risk factor for suicide, but also an expression of human suffering. As therapists, physicians and caring personnel we have an opportunity to reach out to this suffering individual and offer help. However, suicidal individuals often decline psychiatric follow-up or drop out of treatment prematurely. An improved understanding of these patients' needs and problems may enhance our capability to treat them.

This thesis is focusing on attempted suicide patients' experiences. In the first study, eighteen patients were interviewed about their experiences of psychiatric inpatient treatment after a suicide attempt. Mixed feelings of relief and shame were common. Since shame is an emotion that triggers avoidance behaviors, and thus could lead to help negation, non-attendance and treatment drop-out, the following studies focused on shame in attempted suicide patients. The second study explored the shame theme in the interviews from the first study. The finding of shame with qualitative method also raised the question whether suicide attempters were generally shame-prone, that is, if suicide attempters in common were inclined to react with shame. A self-rating scale of shame-proneness, the Test of Self-Conscious Affect (TOSCA), was translated into Swedish and used as measurement of shame in the last two studies. In the third study, the propensity to shame in suicide attempters was compared with shame-proneness in non-suicidal psychiatric patients and healthy controls. In the fourth study, the TOSCA results of a small group of individuals who completed suicide were explored.

The interviews with attempted suicide patients (study I and II) indicated that shame was common after a suicide attempt; thirteen out of eighteen participants described feelings and behaviors that were interpreted as shame reactions. Most women and two thirds of the men described shame reactions in the interviews.

In the investigation of shame-proneness in groups of suicide attempters and non-suicidal controls, a more complex pattern emerged. Large gender differences in shame-proneness were found among the attempted suicide patients (but also among the non-suicidal controls). Female suicide attempters with borderline personality disorder (BPD) had the highest shame scores, while male suicide attempters (without BPD) had the lowest shame scores in the study. Shame-proneness among patients was also investigated with multiple regressions. It was found that shame-proneness in these samples of psychiatric patients was predicted by BPD and depression severity (but not by suicidality) in women, and level of depression and non-suicidality in men.

Our studies indicated that shame reactions after attempted suicide are common, but that shame-proneness in everyday life is not typical for all groups of suicide attempters. A small group of suicide attempters who subsequently committed suicide did not differ in shame-proneness, from suicide attempters who were alive.

LIST OF PUBLICATIONS

- I. Samuelsson M, Wiklander M, Åsberg M, & Saveman, B I (2000).
Psychiatric care as seen by the attempted suicide patient.
Journal of Advanced Nursing, 32(3), 635-643.
- II. Wiklander M, Samuelsson M, & Åsberg M (2003).
Shame reactions after suicide attempt.
Scandinavian Journal of Caring Sciences, 17(3), 293-300.
- III. Wiklander M, Samuelsson M, Jokinen J, Nilsson Å, Wilczek A, Rylander G,
Åsberg M.
Shame-proneness in attempted suicide patients. (*Manuscript submitted for
publication.*)
- IV. Wiklander M, Samuelsson M, Jokinen J, Nilsson Å, Wilczek A, Rylander G,
Åsberg M.
Shame-proneness in patients who subsequently committed suicide.
(*Manuscript.*)

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LIST OF ABBREVIATIONS

BPD	Borderline Personality Disorder
DBT	Dialectical Behavior Therapy
DSM-III-R	Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
ESS	Experience of Shame Scale
SIS	Suicide Intent Scale
SUD	Substance Use Disorder
TFP	Transference Focused Psychotherapy
TOSCA	Test of Self-Conscious Affect

1 INTRODUCTION

*“I felt that, not only had I failed with something I had been sure to succeed with, I was still here, still had the same problems that were there. And in addition, I had done something awful ”
(Woman from study I and II)*

“It’s a feeling of shame over having done what you’ve done. It’s like a stumbling block holding you back. Having done this feels like a failure in itself” (Man from study I and II)

1.1 BACKGROUND

The objective behind this doctoral project is very simple. I worked with suicidal patients and noticed the clinically well-known phenomenon that new patients that were referred to outpatient follow-up after attempted suicide often did not show up for their appointment. We had tried to optimize the referral routines, so that those who had visited the psychiatric emergency room for a psychiatric consultation after a suicide attempt could be offered an appointment at the outpatient clinic within one or two days. Still, many patients did not come! When several patients described shame in the interviews in study I, I started to wonder whether shame could be one of the barriers to treatment after attempted suicide. Therefore, shame in attempted suicide was chosen as the focus of the thesis.

1.2 SUICIDE AND ATTEMPTED SUICIDE

Every year, almost one million people die from suicide (WHO 2012). In Sweden, about 1500 individuals commit suicide every year (Jiang, Floderus et al. 2010) and 70% of these suicide victims are men (Reutfors, Brandt et al. 2010). Many factors are thought to contribute to suicide; psychiatric disorders are almost always present (Bertolote, Fleischmann et al. 2004), but do not fully explain why some individuals commit suicide. The disorders most prevalent among suicide victims are mood disorders, substance use disorders, psychotic disorders, and personality disorders (Bertolote, Fleischmann et al. 2004) and about 10% of all individuals with these conditions commit suicide. A strong predictor for later death from suicide is a previous suicide attempt (Nordström, Samuelsson et al. 1995; Maris 2002; Owens, Horrocks et al. 2002; Oquendo, Currier et al. 2006; Tidemalm, Langstrom et al. 2008; Large, Smith et al. 2011), but also in this group about 90% of the individuals survive. In Sweden and most other countries, more women than men attempt suicide (Wasserman 2012) and it is estimated that there are 10-40 suicide attempts for each suicide (Wasserman, Rihmer et al. 2011). Psychiatric disorders are equally prevalent among individuals who attempt

suicide as among individual who complete suicide (Beautrais, Joyce et al. 1996; Suominen, Henriksson et al. 1996; Haw, Hawton et al. 2001). Thus, psychiatric treatment of individuals who have attempted suicide is important both as suicide prevention and as a goal in itself. Furthermore, a suicide attempt can be understood as a “cry of pain”, and regardless of diagnosis, individuals who attempt suicide do so because they experience their situation as unbearable (Shneidman 1993).

1.2.1 Definitions of suicidal behaviors

Suicidal behavior is conceptualized as a continuum of thoughts and behaviors ranging from suicide ideation or suicide thoughts, to completed suicide. It can be divided into

- Completed suicides
- Suicide attempts
- Preparatory acts toward imminent suicidal behavior
- Suicidal ideation
- Self-injurious behavior without intent to die
- Non-deliberate self-harm
- Self-harm behavior with unknown suicidal intent

The term parasuicide is used in some countries, referring to both attempted suicides and non-suicidal self-harm. Another concept is deliberate self-harm, which means an intentional self-poisoning or self-injury regardless of suicidal intent (Wasserman, Rihmer et al. 2011). In this thesis, attempted suicide refers to an intentional self-destructive act that the suicide attempter himself/herself thought could be possibly lethal. The completed suicides in the thesis were classified as such in an autopsy.

1.2.2 Suicide prevention

The effectiveness of different suicide prevention strategies have been investigated (Mann, Apter et al. 2005). However, it is difficult to prospectively compare the effectiveness of different treatments because suicide is a rare phenomenon. Furthermore, for ethical reasons, all who attempt suicide should be offered treatment. There is consensus that treatment of psychiatric disorders is an effective strategy for suicide prevention (Mann, Apter et al. 2005). The effectiveness of psychiatric follow-up as suicide prevention strategy has been difficult to demonstrate, although some studies give support for this strategy (Greer and Bagley 1971; Mann, Apter et al. 2005). Since psychiatric contact in many cases is a prerequisite for treatment of psychiatric disorders in suicide attempters, lower rates of drop-out and non-attendance to treatments are the remote objectives of this doctoral project.

1.3 PSYCHIATRIC TREATMENT

1.3.1 Non-assessment and patient non-attendance

Patient non-attendance to treatment is a problem within the whole health care sector (e.g. (Hon, Leung et al. 2005; Leong, Chen et al. 2006; Lemly, Mandelbrot et al. 2007; Mitchell, Psych et al. 2007). For suicide attempters, lack of referral to follow-up (Suominen, Isometsa et al. 2004), lack of psychiatric consultation in the emergency room (Suominen, Isometsa et al. 2004), drop-out from follow-up assessments (Maris, Connor et al. 1974), short treatments (Wolk-Wasserman 1987), non-attendance (Wolk-Wasserman 1987; Van Heeringen, Jannes et al. 1995; Jauregui, Martínez et al. 1999), and drop-out of treatment (Rudd, Joiner et al. 1995) have been described. Sometimes patients leave the emergency room before any assessment has been made (Hickey, Hawton et al. 2001). However, a recent systematic meta-analysis of suicide risk within a year of discharge from hospital showed that patients who received less psychiatric follow-up were less likely to commit suicide in the year after discharge (Large, Sharma et al. 2011). On the other hand, Nordström and coworkers (Nordström, Samuelsson et al. 1995) found high rates of suicide among young men who had been referred for psychiatric consultation after a suicide attempt. Although it was not systematically investigated whether these men had any psychiatric follow-up, case notes indicated that these men were rather unknown to psychiatric services (personal communication with coauthor Mats Samuelsson, January 29, 2012).

1.3.2 Patient experiences

An early investigation of patient experiences of care following attempted suicide reported that these patients often were more discontented with their care than psychiatric patients in general (Lebow 1982). A recent systematic review of self-harming patients' perceptions of the care came to similar conclusions; many patients had negative reactions to and perceptions of their management (Taylor, Hawton et al. 2009).

1.3.3 Experiences of psychiatric personnel

Several studies have investigated the attitudes toward suicidal patients, in different categories of health care workers, (Goldney and Bottrill 1980; Wolk-Wasserman 1985; Suokas and Lönnqvist 1989; Anderson 1997; Samuelsson, Sunbring et al. 1997; Samuelsson, Åsberg et al. 1997; Long and Smyth 1998; Suominen, Suokas et al. 2007; Suokas, Suominen et al. 2009). Negative attitudes, especially among non-psychiatric personnel, have been reported in several studies (Goldney and Bottrill 1980). Other studies have reported that caring personnel feel uncertain of how these patients should be treated (Wolk-Wasserman 1985; Samuelsson, Sunbring et al. 1997; Samuelsson, Åsberg et al. 1997). Maltzberger and Buie (Maltzberger and Buie 1974) pointed out the

risk for termination of psychotherapies of suicidal patients, due to psychotherapists' difficulties to handle strong negative emotions ("countertransference hate") towards the suicidal patients. They argued that this resulted in an even greater risk of patient suicide, since the patients were then abandoned.

1.4 SHAME

1.4.1 Shame

Shame can be conceptualized in a number of ways. From an evolutionary perspective, shame behaviors like bending one's head and blushing, can be seen as a human analogue to submissive behaviors in animals (Darwin 1872/2005). The function of submissive behavior in animals is likely to turn off aggression from hierarchically superior conspecifics. In humans, shame functions to regulate social relationships, as a warning signal that makes us aware of our behaviors. However, the relative importance of shame, as well as its expressions and contexts, varies between cultures (Fessler 2004).

According to several psychological respective psychoanalytic theories, shame has a central function for intrapsychic regulation or for our view of ourselves (Piers and Singer 1953/1971; Lewis 1971; Nathanson 1992; Tangney, Stuewig et al. 2007). Freud saw shame as a force against urethral-erotic temptation and a defense against exhibition and voyeurism (Fenichel 1946/1990). Piers (Piers and Singer 1953/1971) later defined shame as a tension between the ego and the ego-ideal. Psychoanalyst Helen Block Lewis made important contributions to the understanding of shame in her recognition of the importance of shame in psychotherapeutic treatment, and her definition of shame as a negative evaluation of the global self, and guilt as a negative evaluation of a specific behavior (Lewis 1971). This distinction between a global negative self-evaluation in shame, and a specific negative self-evaluation in guilt, is the foundation for much of the contemporary research on shame in different kinds of psychological malfunctioning and psychiatric disorders.

According to attribution theory, peoples' interpretations of causes of events can be described in terms of attribution of locus, globality, and stability (Abramson, Seligman et al. 1978). Shame experiences are likely to involve internal, stable, and global attributions. In comparison, guilt experiences typically involve internal, specific and unstable attributions (Tangney and Dearing 2002).

In this thesis, shame is broadly defined as an innate emotion distinct from guilt, which functions to regulate behaviors in social relationships, and that can be expressed and understood in different ways in different group and societies, but which also has basic universal qualities (such as averted gaze etc.) Thus, the definition used is broad and influenced by, among others, theories by Lewis, Tangney, Fessler, Tracy and Robins (Lewis 1971; Tangney and Dearing 2002; Fessler 2004; Tracy and Robins 2004).

Shame-proneness, the stable propensity to react with shame in various situations, has been related to different expressions of psychopathology, such as depression, anxiety, anger, difficulties with interpersonal problem-solving, substance abuse, borderline personality disorder, and suicide ideation (Tangney, Wagner et al. 1992; Tangney, Wagner et al. 1992; Allan, Gilbert et al. 1994; O'Connor, Berry et al. 1994; Meehan, O'Connor et al. 1996; Lester 1998; Andrews, Brewin et al. 2000; Hastings, Northman et al. 2000; Andrews, Qian et al. 2002; Feiring, Taska et al. 2002; Covert, Tangney et al. 2003; Chan, Hess et al. 2005; Rüschi, Lieb et al. 2007; Brown, Linehan et al. 2009; Fergus, Valentiner et al. 2010; Kim, Thibodeau et al. 2011).

1.4.2 Shame connected with being ill and being a patient

Patient experiences of shame in the medical encounter, have been described (Lazare 1987; Harris and Darby 2009). In the study by Harris and Darby, half of the participants, in a web-based survey to 915 individuals in the community, had experienced shame during interaction with a physician. Forty-five percent of those who had experienced shame also reported that they had terminated treatment, avoided, or lied to their physician to avoid experiencing further shame. On the other hand, 33% of the participants experienced the shame-provoking interaction as helpful for behavioral changes.

The role of stigma as a barrier to seeking help for psychiatric problems has been investigated in several studies (e.g. (Barney, Griffiths et al. 2006; Golberstein, Eisenberg et al. 2008; Schomerus, Matschinger et al. 2009), with many studies giving some support for the idea that stigma, expressed as, for example, embarrassment, self-stigmatization or fear of negative reactions from others, decreases peoples' willingness to seek psychiatric help. In a Swedish study of use of mental health services, shame was found to be the most common reason for not seeking help for psychiatric problems (Forsell 2006). In a similar investigation in Australia, however, those who had psychiatric problems but did not seek help reported that they "preferred to manage on their own" (Andrews, Issakidis et al. 2001). In a study of patients' reasons for non-completion of treatment for dangerous and severe personality disorder (Sheldon, Howells et al. 2010), shame was one of several reasons reported (by the personnel) for the drop-out.

Kroll and Egan (Kroll and Egan 2004) have discussed moral emotions from a different perspective, suggesting that we should respect patients' moral perspectives, e.g. feelings of remorse and guilt in PTSD patients, and not just view them as psychiatric symptoms. For example, depressed patients may worry excessively about their private economy during a depressive episode and the relevance of this worry should be examined when the patients have recovered.

1.5 SHAME AND SUICIDE

The relationship between shame and suicide is complex. Throughout history, different societies have viewed suicide as an honorable act, a shameful act, or neither (van Hooff 1990; Anderberg 1992; Whelan 1993; Tzeng and Lipson 2004). Shame has been reported to be the most common reason for suicide in ancient Roman Empire (van Hooff 1990) and classical Greek mythology (Preti and Miotto 2005). Suicide can be a consequence of shame, or function to avoid or attenuate shame.

1.5.1 Shame, suicide and religion

In the three main monotheistic religions, suicide is viewed as a violation of God's will. Although suicide is not condemned in the Tanakh or the Bible, it is basically prohibited in Judaism and Christianity. In Christian society, suicide has historically been interpreted as a violation of the commandment "Thou shalt not kill", since the fifth century (Augustinus 426/1998). However, psychiatric illness and other extreme conditions, such as fear of torture, have for a long time been viewed as mitigating circumstances in both Judaism and Christianity (Legal Code of Sweden, 1736; Farberow 1975; Catechism of the Catholic Church, 2012). In Islam, suicide is strictly forbidden, reflecting the idea that man always must submit to the different expressions of Divine Will (Farberow 1975; Qur'an, 2012). However, also in Islam are suicide victims often seen as mentally ill and therefore not fully responsible for their actions (Simpson and Conklin 1989).

In Muslim, Jewish and Catholic populations, the suicide rates are generally lower than in Protestant populations (Gearing and Lizardi 2009) and the suicide rates are generally highest in non-religious societies (Bertolote and Fleischmann 2002). Since shame is easily elicited when people are breaking social rules, shame may contribute to the lower rates of suicide in countries dominated by a religion that condemns suicide. However, for individuals who have integrated these religious values, and also have a religious life view in general, other emotions and cognitions than shame, like guilt, fear, hope, feelings of security and meaning, might be equally or more important protective factors against suicide and attempted suicide. For example, higher moral or religious objections to suicide have been negatively related to attempted suicide in several studies (Dervic, Oquendo et al. 2006; Lizardi, Dervic et al. 2008; Dervic, Carballo et al. 2011).

Suicide was earlier prohibited in Sweden and many other European countries (see text from the Swedish Code of misdeeds from 1734 on the next page) (Legal Code of Sweden, 1736).

XIII Cap. Om then, som förgiör sig sielf.

13.1. Dräper eller förgiör någon sig sielf; tå må thes kropp af then, som honom finner, oförwit uptagas, och afsides läggas: pröfwar Domaren sedan, at han med wilja sig förgiördt; tå skal en sådan sielfspilling af skarprättaren til skogs föras, och i jord gräfwas. Finnes thet i hufwudswaghet, raseri, eller annor sådan wånda skedt wara; tå må han af annat folk handteras, och begrafwas.

13.2. Kan någon frälsa hans lif, som sig sielf uphängdt hafwer, eller å annat sätt sig förgiöra wil, och frälsar honom ej; plichte efter omständigheterna.

13.3. Finnes någon ligga död, och wet ingen, huru han omkommen är; then må ärliga begrafwas, Hafwer han fördt ett ogudachtigt lefwerne; warde tå i Kyrkiogård afsides lagd.

13.4. Nu kan så hända, at then sig sielf förgiöra wil, ej får död theraf; plichte med fängelse wid watn och bröd, spö eller ris, efter omständigheterna.

13.5. Bekänner någon falskeliga, thet han sådan gierning giordt, som dödsstraff förtienar; ware lag samma.

(Missgärningsbalken, kap. 13 [Code of misdeeds, chapter 13]) (1736)

1.5.2 Shame and suicide in different societies

The suicide rates differ between countries (Wasserman, Rihmer et al. 2011) and several factors are thought to influence these differences. For example, high alcohol consumption contributes to high suicide rates in some countries, such as those in Russia (Wasserman, Värnik et al. 1994; Stickley, Jukkala et al. 2011), or Greenland (Grove and Lynge 1979). Conversely, countries with e.g. high social inclusion of the elderly have lower suicide rates (Yur`yev, Leppik et al. 2010). A high proportion of lethal outcomes of suicide attempts in China, India and Sri Lanka have been attributed to the use of pesticides in self-poisoning (Gunnell and Eddleston 2003). The importance of shame for attempted and completed suicide in different countries and societies may thus vary. In a comparison between sixty-nine non-industrial societies, Smith and Hackathorn (Smith and Hackathorn 1982) found that suicide rates were higher in societies that emphasized shame and pride. In a study of attitudes towards mental illness in a small society of tornedalers (Gerholm 1992), a Swedish national minority, it was suggested that mental illness and suicide might be concealed or attributed to external causes to protect the social cohesiveness and identity among the interdependent villagers. In Taiwan, suicidal patients feel embarrassment and emotional pain because of two Chinese cultural values, *mientze* (saving face) and *hsiao* (filial piety) (Tzeng 2001). Committing suicide is considered shameful, but surviving a suicide attempt is even more shameful, since it means losing face. Suicidal behaviors are seen as a violation of Confucian ethics, in which younger should obey and take care of the elderly. Firstly, the body is seen as a gift from one's parents and violation of the body is thus a violation of *hsiao*. Secondly, children should take care of their parents. Since suicidal behaviors are common among young and middle-aged individuals, the behavior is a violation of *hsiao*. Suicidal behaviors are attributed to "bad luck" or "hot temper", and are often also concealed by relatives and friends (e.g., by giving other explanations; "She had an accident") (Tzeng and Lipson 2004). The concealing of suicidal behaviors in these societies could be seen as an expression of the socially

regulating function of shame. A famous example of a socially accepted form of suicide is *seppuku* in earlier Japanese culture, in which a shamed individual throws back the blame on the accuser, by committing suicide in a ritualized way (Anderberg 1992). However, Fusé (Fusé 1980) argues that *seppuku* best can be conceptualized as a form of altruistic suicide that is not mainly intended to reverse shame, but rather to sacrifice one's life for the good of others.

1.5.3 Shame and suicide in the psychiatric literature

Several authors (Breed 1972; Smith and Hackathorn 1982; Lansky 1991; Mokros 1995; Kaufman 1996; Lester 1997; Lester 1998a; Lester 1998b; Kalafat and Lester 2000; Tangney and Dearing 2002; Foster 2003; Pompili, Mancinelli et al. 2003; Preti and Miotto 2005; Pridmore and McArthur 2008; Kölves, Ide et al. 2011) have argued that shame plays an important role in suicidal behaviors. Breed (1972) described shame as one of five components in a syndrome preceding suicide. His theory was validated by quantitative and qualitative data from interviews with friends and relatives of 137 individuals who committed suicide. In a study of suicide notes, Foster (2003) found "apology/shame" to be the most common theme. Also, shame has been reported as an important feature in case studies of individuals who committed suicide (Mokros 1995; Lester 1997; Kalafat and Lester 2000). Lester (Lester 1998b) has pointed out the risk of suicide in connection with being investigated for crimes and being exposed in the media. Pridmore and McArthur (2008) investigated suicides reported in the media, and found fifteen cases of men without any known psychiatric disorder, who committed suicide after reputation damage.

Birtchnell (Birtchnell 1971) investigated the motivational and emotional states of suicide attempters and found that many patients, both men and women, reported that they had felt "sorry or ashamed of something", had felt that they had failed in life, or had felt lonely or unwanted (the latter also a possible expression of shame) at the time of the suicide attempt. Other common feelings were anger and worry about the future. A relationship between self-harm and shame has been demonstrated in studies of offender women (Milligan and Andrews 2005) and women with BPD (Brown, Linehan et al. 2009). Tangney and Dearing (Tangney and Dearing 2002) found that shame-proneness in fifth grade predicted attempted suicide in adolescence or early adulthood. Lester (Lester 1998a) and Hastings and coworkers (Hastings, Northman et al. 2000) have also found an association between suicide ideation and shame in college students.

Thus, there are several indices from the psychological, psychiatric and sociological literature that the relationship between suicide and shame might be relevant to study further.

2 AIMS

The aim of the current series of studies was to investigate experiences of attempted suicide patients, with a special focus on shame.

In study I, the aim was to elucidate patient experiences of receiving specialized psychiatric in-patient care following a suicide attempt.

In study II, the aim was to investigate patients' experiences of shame during hospitalization after a suicide attempt. The study also aimed at highlighting aspects of care that were reported as associated with the shame reaction.

In study III, the aim was to investigate self-rated shame-proneness, as measured by the Test of Self-Conscious Affect (TOSCA), in attempted suicide patients, non-suicidal psychiatric patients and healthy controls.

In study IV, the aim was to explore self-ratings of proneness to shame, guilt, externalization, detachment, and pride in a small group of psychiatric patients, who subsequently committed suicide. A secondary purpose was to compare TOSCA scores of the deceased patients, with TOSCA scores of suicide attempters who were alive at follow-up five to twelve years after the collection of TOSCA data.

3 METHODS

The thesis consists of two qualitative (study I and II) and two quantitative (study III and IV) studies. In study I, attempted suicide patients were interviewed about their experiences during inpatient care following the suicide attempt. In study II, the subset of interviews from study I that contained shame data, were analyzed with focus on shame. In study III, trait shame in suicide attempters, non-suicidal patients and healthy controls was investigated with the self-rating scale TOSCA. Study IV investigated the self-rated levels of trait shame and other measures of self-conscious affect, in the small group of participants from study III, who subsequently committed suicide. The attempted and completed suicide patients in the thesis are presented in Table 1.

Table 1. Attempted and completed suicide patients in the thesis

	N	Sex	Age	Patients
Study I: Psychiatric care as seen by the attempted suicide patient	N = 18	Women (n = 6) Men (n = 12)	18-53	Attempted suicide inpatients
Study II: Shame after suicide attempt	Subset from study I; N = 13	Women (n = 5) Men (n = 8)	22-53	Attempted suicide inpatients
Study III: Shame-proneness in attempted suicide patients	Suicide attempters N = 175	Women (n = 150) Men (n = 25)	19-62	Attempted suicide outpatients
Study IV: Shame-proneness in patients who subsequently committed suicide	Subset from study III; N = 13	Women (n = 8) Men (n = 5)	25-55* 28-58†	Suicide completers

*Age at TOSCA assessment. † Age at suicide.

3.1 DEFINITIONS OF ATTEMPTED SUICIDE

Attempted suicide was defined as an intentional self-destructive act, that the individual himself/herself thought might be lethal, as assessed by experienced psychiatrists, using structured interviews. In study I and II, the Suicide Intent Scale (SIS) (Beck, Schuyler et al. 1974), and a ten item scale based on criteria by Freeman (Freeman, Wilson et al. 1974), reflecting lethality and reversibility of method, were used. In study III and IV, a structured interview (Karolinska Suicide Case History Interview, unpublished) or the Parasuicide History Interview (Linehan, Wagner et al. 1989), was used. Crucial in the

assessment was whether the participant had believed that he/she would survive the self-destructive act or not. If the patient had believed that he/she would die, or was uncertain of the outcome, the behavior was defined as a suicide attempt.

3.2 DIAGNOSTICAL ASSESSMENTS

The participants in study I and II were diagnosed for clinical disorders (Axis I) and personality disorders (Axis II) according to DSM-III-R (American Psychiatric Association 1987). The assessments on Axis I were made by a trained and experienced psychiatrist and the assessments on Axis II were made by a trained and experienced social worker, as part of the clinical investigation. In study III and IV, all patients were diagnosed by trained and experienced psychiatrists, using the SCID-I (First, Spitzer et al. 1997) for clinical disorders (Axis I) and by trained and experienced psychiatrists or psychologists, using the DIP-I (Ottosson, Bodlund et al. 1995; Bodlund, Grann et al. 1998) for personality disorders (Axis II), according to DSM-IV (American Psychiatric Association 1994). The healthy controls in study III were assessed for mental health by trained and experienced physicians, using the MINI (Sheehan, Lecrubier et al. 1998) for clinical disorders and SCID-II (First, Gibbon et al. 1997) for personality disorders, according to DSM-IV (American Psychiatric Association 1994).

3.3 SHAME REACTIONS (STUDY I AND II)

Study I and II were based on semi-structured interviews with men and women, who were admitted to a psychiatric inpatient ward after a suicide attempt.

3.3.1 Study setting

The participants were recruited to the study from an inpatient ward at the Karolinska Hospital in Stockholm, Sweden, during a period of eight months in 1996. Twenty-one Swedish speaking patients were asked to participate in the study. Three patients declined to participate. The participants in study I represent roughly forty percent of all inpatients, and one third of all patients, who were referred to this psychiatric clinic after a suicide attempt during this period.

3.3.2 Participants

3.3.2.1 Study I

The participants in study I were six women and twelve men, aged 18-53. Seven of the participants were first time suicide attempters, while eleven participants had attempted

suicide previously. The participants had attempted suicide by drug overdose (n = 11), deep cuts along the forearm (n = 3), carbon monoxide (n = 2), jump from a height (n = 1), or a combination of methods (n = 1). The main diagnoses of the participants were major depression (n = 14), adjustment disorder (n = 1), panic disorder (n = 1), respective personality disorder (n = 2). Due to the ward profile, there were no patients with psychosis or narcotic abuse in the study. All participants were Swedish speaking and voluntary admitted. At fifteen year follow-up in 2012, two male participants that had reported shame (thus participants in study I and II), and one female participant that had not reported shame (participant in study I), had died by suicide. Another participant that had not reported shame (participant in study I) had died in an accident, where the cause of death was not possible to determine.

3.3.2.2 *Study II*

The participants in study II were a subset of participants from study I: five women and eight men, ranging in age between 22 and 53. Five of the participants were first time attempters, eight had attempted suicide previously. The attempted suicide methods used were drug overdose (n = 7), deep cuts along the forearm (n = 2), carbon monoxide (n = 2), jump from a height (n = 1), or a combination of methods (n = 1). Twelve of the participants were diagnosed as meeting the criteria for one or more Axis I disorder (major depression n=11, alcohol dependence n=3, anxiety disorders n=4, adjustment disorder n=1). Seven participants also met criteria for one or two personality disorders (personality disorder UNS n=2, borderline n=2, dependent n=2, masochistic n=1, antisocial n=1). One participant met criteria for personality disorder UNS only.

3.3.3 Procedure

The participants received written information about the study and were asked if they would like to participate. In the information leaflet, it was explained that we wanted to make video-taped interviews about their experiences of being treated in a psychiatric ward following a suicide attempt. It was emphasized that participation was voluntary and could be interrupted at any time without any particular reason, and with no consequences regarding further medical care. The interviews took place at the psychiatric ward, between one and eleven weeks after the suicide attempt, as close to discharge as possible. The interviews lasted approximately 60 minutes. All interviews were conducted by me or coauthor Mats Samuelsson. None of us worked in the ward investigated or had met any of the participants previously.

3.3.4 Interviews

A semi-structured interview method was used, in which the participants were asked to narrate their experiences of the sequence of events after the suicide attempt and during

the hospitalization. The participants' narratives were followed up by questions from an interview guide concerning events as well as feelings, thoughts and reactions. The participants were also asked about some specific aspects of the care, which the interviewers considered relevant. Examples of subjects brought up by the interviewers were admission to the hospital, participants having their belongings searched by the personnel and the participants' interaction with other patients. During the entire interview, participants were asked to tell about their experiences of interaction with the personnel. When participants expressed vague statements, they were asked to specify. The participants were not specifically asked about shame reactions, but were asked openly about their feelings, thoughts and reactions.

3.3.5 Data analyses

3.3.5.1 Study I

The interviews were analyzed with a qualitative content analysis, inspired by Burnard (Burnard 1991). All interviews were transcribed verbatim. Coauthors Mats Samuelsson and Britt-Inger Saveman read the whole text as open-mindedly as possible, to gain a sense of the whole and to formulate ideas for further analysis. The central categories seemed to be feelings associated with "being a psychiatric patient", "perceptions of the care received", "perceptions of the caregivers" and "the importance of the psychiatric care". Mats Samuelsson reread the text, and headings/aspects of the text were written down. All aspects of the content (except utterances unrelated to the topic) were taken into account. This analysis resulted in 350 meaning units. These meaning units consisted of statements, phrases and sentences related to any of the categories. The text was then freely generated to codes and sorted according to how it related to the four categories above. As next step, Mats Samuelsson and Britt-Inger Saveman reflected on, interpreted and discussed all codes and their relevance to the four categories. This resulted in a reduction into three categories and ten subcategories. In the final step, all the text was sorted into the subcategories and all four authors compared the categories and subcategories with the meaning units and the interviews. An agreement was reached concerning the categories and their meaning units.

3.3.5.2 Study II

All interviews from study I were reanalyzed with respect to shame. I read the eighteen interview transcripts and made marginal-notes about what themes were brought up. Descriptions of shame feelings appeared in several interviews. One of the interviews where shame feelings were described repeatedly was chosen for a more thorough analysis. The content was scrutinized, i.e., "How is shame expressed exactly?" The contexts in which shame reactions appeared were analyzed, and an appraisal of the relevance of the shame theme was made. The conclusion was that the shame feelings were relevant to study, since they seemed to have importance for the patient's overall

experience of the care. Shame also seemed important for the patient's susceptibility to the care provided. All other interview transcripts were then analyzed with specific focus on shame. Thirteen interviews that contained descriptions of feelings, thoughts, or behaviors that were interpreted as shame reactions, were chosen for a more thorough analysis of the shame theme. These shame descriptions, which functioned as inclusion criteria in study II, were: using the words "shame" or "being ashamed" to describe their experiences (n = 9), feeling "a little bit stupid" (n = 1), experiencing failure and feeling exposed (n = 1), fleeing away, becoming paralyzed and silent, considering to leave the hospital, when feeling punished and treated with disrespect (n = 1), feeling ignored and reacting with cynicism and withdrawal (n = 1). Participants' descriptions of shame that were not directly related to the suicide attempt but occurred during the stay at the psychiatric ward were also included in the study. All units of data describing shame reactions were copied from the interview transcripts. The units of "shame data" were then sorted repeatedly, to find themes, which could explain their significance. Data units from different participants were compared in order to confirm or dispute tentative interpretations arrived at through the analysis process. I also went back to the interviews repeatedly, to understand the contexts in which the shame descriptions appeared. This alternating case-oriented and variable-oriented qualitative analysis was inspired by Miles and Huberman (Miles and Huberman 1994). In order to enhance credibility, coauthor Mats Samuelsson compared the shame themes and their interpretations with the interview transcripts. There was agreement concerning the themes and their meaning units. Also, all participants were contacted for a follow-up after two years (which they had previously given consent to). Six participants agreed to participate in a follow-up interview and all these participants confirmed the interpretations of shame from their first interviews.

3.4 SHAME-PRONENESS (STUDY III AND IV)

Study III and IV were based on self-ratings of shame-proneness with the scenario-based instrument TOSCA.

3.4.1 Study settings

During the years 1998-2005, the TOSCA instrument was administered together with other questionnaires, in three clinical research projects. In 2009-2010, the TOSCA was also administered to healthy controls in a research project collecting reference values for psychiatric measures. The projects are briefly presented below.

3.4.1.1 The SKIP project

The Stockholm county council and Karolinska Institutet's psychotherapy project for suicidal women with BPD (SKIP), was a randomized controlled study of

psychotherapy for chronically suicidal women with BPD. Main inclusion criteria were a BPD diagnosis and two previous suicide attempts, one of which within the previous six months. Participants in the project were randomized to dialectical behavior therapy (DBT), transference-focused psychotherapy (TFP), or treatment as usual. Since both suicide attempts and non-suicidal self-harm are common in individuals with BPD, circumstances around the previous self-destructive acts were thoroughly investigated. Non-suicidal self-harm was not sufficient for inclusion. Women who were included in the project completed the TOSCA questionnaire before randomization to the treatments. In study IV, all participants from this research projects were followed up for mortality and causes of death. Seven of the completed suicides in study IV were from this project.

3.4.1.2 Suicidal patients – a study of risk factors for subsequent suicide in attempted suicide outpatients

The research project investigated biological and psychological aspects of attempted suicide. The participants were consecutive outpatients followed up at a suicide prevention clinic in Stockholm, after a current suicide attempt. The participants in this project were men and women with heterogeneous psychiatric diagnoses. Six women and three men from this project fulfilled criteria for BPD, and were analyzed within the attempted suicide BPD group in the investigation of shame-proneness in study III. In study IV, all participants from this research projects were followed up for mortality and causes of death. Four of the completed suicides in study IV were from this project.

3.4.1.3 Long-term sick leave for depressive disorders and work related stress

This group mainly functioned as a clinical control group in the investigation of shame-proneness. The project was a rehabilitation project for employees in private employment, who had been on sick leave for a mood disorder, an anxiety disorder or a stress-induced psychiatric condition for more than three months. A majority of the participants from this group were non-suicidal (no previous suicide attempts and no current suicide ideation) and functioned as a clinical controls in the investigation of shame-proneness in study III. One woman with BPD and one man without BPD from this group had attempted suicide within six months before inclusion in the project. These two participants were analyzed within the attempted suicide groups in the investigation of shame-proneness. There were no non-suicidal participants with BPD. Twenty-one participants from this project reported that they had attempted suicide previously, but not within the last six months, and ten participants had current suicide ideation, but had never attempted suicide. These thirty-one participants were excluded in study III. In study IV, all participants from this research projects were followed up for mortality and causes of death. It was found that two men from this project had

committed suicide within the years of follow-up. One of these men had had a history of attempted suicide, and had thus been excluded in study III. The other man had not been suicidal at the time of assessment, and had thus belonged to the “non-suicidal” comparison group in study III. These two suicide victims were included in the investigation of shame-proneness in patients who subsequently committed suicide, in study IV.

3.4.1.4 Collection of a healthy control material for reference values of psychiatric variables, and biological markers for inflammation and thrombosis.

Participants from this project functioned as healthy controls in the investigation of shame-proneness in study III. The participants were a randomized sample, drawn by Statistics Sweden, of Swedish speaking adults, who were assessed for mental health in a screening telephone interview by a trained nurse and an ensuing structured interview by a trained physician who excluded anyone with a history of psychiatric illness or previous or current suicide attempts or ideation.

3.4.2 Participants

3.4.2.1 Study III

The patient participants were from the three clinical research projects described above. Patients from the research projects who met our inclusion criteria of *either* a recent suicide attempt (within six months before inclusion in the projects) *or* no previous suicide attempt and no current suicide ideation, were included. Seventy patients were excluded. Thirty-nine patients were excluded because of missing data (missing or incomplete TOSCA data [n = 32], incomplete diagnostic examination [n = 7]). Thirty-one patients did not fit our inclusion criteria (a history of attempted suicide but no recent suicide attempt [n = 21], no previous suicide attempt but current suicide ideation [n = 10]). Due to the high proportion of female attempted suicide BPD patients, we dichotomized the attempted suicide group into BPD and non-BPD patients. Due to exclusion criteria in the research projects, there were no patients with severe forms of psychosis, anorexia nervosa, substance dependence or melancholia in the study. There were no non-suicidal participants with BPD in the study. The healthy controls were from the research project “Collection of a healthy control material for reference values of psychiatric variables, and biological markers for inflammation and thrombosis” described in the previous section.

The attempted suicide methods used by the attempted suicide patients were self-poisoning by drugs (n = 86), wrist cutting (n = 9), other cuts (n = 4), hanging/strangulation (n = 5), jumping from a height (n = 1), combined methods (n = 2), and not specified (n = 1) for BPD suicide attempters, and self-poisoning by drugs

(n = 45), wrist cutting (n = 6), other cuts (n = 2), attempted drowning (n = 1), jumping from a height (n = 2), jumping in front of moving object (n = 2), crashing of motor vehicle (n = 4), combined methods (n = 4), and other method (n = 1) for non-BPD suicide attempters. Due to inclusion criteria in the research projects, most (97%) BPD patients were attempted suicide repeaters, compared to 33% of the non-BPD suicide attempters.

3.4.2.2 *Study IV*

Study IV was based on TOSCA data from thirteen individuals who had eventually committed suicide. In 2010, mortality data and causes of death for participants in the three clinical projects were collected from the National Board of Health and Welfare of Sweden. Thirteen of the study participants had died by suicide. The suicide victims were 8 women and 5 men, aged 28-58 by the time of the suicide. Eleven of the suicide victims were from the attempted suicide groups in study III. Two suicide victims were from the psychiatric comparison group, one who had been excluded from study III due to a history of attempted suicide and one who had been previously classified as non-suicidal (no previous suicide attempt and no suicide ideation during the assessments). The suicide victims had committed suicide by drug overdose (n = 5), hanging/strangulation (n = 5), explosives (n = 1), shooting (n = 1), and jumping in front of a train (n = 1). All suicide victims had been diagnosed with an affective disorder (major depression n = 10, dysthymia n = 2, bipolar disorder n = 1) by the time of the TOSCA completion six months to ten years before the suicide. Eight of the patients had comorbid anxiety disorder, five were diagnosed with substance use disorder, two patients had eating disorder and eight had been diagnosed with a personality disorder (BPD = 7, avoidant personality disorder n = 1).

3.4.3 **The Test of Self-Conscious Affect (TOSCA)**

The Test of Self-Conscious Affect, TOSCA (Tangney, Wagner et al. 1989), is a widely used scenario-based instrument, assessing proneness to shame, guilt, externalization, detachment, and pride. The pride subscale is divided into pride in oneself (Alpha Pride) and pride in one's behavior (Beta Pride). The fifteen scenarios depict common situations from social life (e.g., missing an appointment with a friend) and the response alternatives reflect affective, cognitive and behavioral expressions of the variables investigated. The TOSCA was translated into Swedish, using a bilingual committee and a translation back-translation procedure (Hambleton and Kanjee 1995). The Swedish version was back-translated into English and approved by professor June Price Tangney, who is the constructor of the instrument (personal communication, July 19, 1999). The TOSCA has since been revised (Tangney, Dearing et al. 2000), but only the first version of TOSCA was available when we started our data collection.

3.4.4 Statistical methods

In study III, internal consistencies for the TOSCA subscales were calculated with Chronbach's α . Gender differences in shame-proneness within groups, were computed with two-tailed t -tests. Gender x group interaction was computed with a two-ways ANOVA. Differences between groups were computed with one-way ANOVAs for men and women separately. Post hoc comparisons of group differences were performed with the Tukey-Kramer HSD test. Correlations between predictors of shame-proneness were calculated with Pearson's r . The relationship between shame-proneness and attempted suicide within the patient sample was examined with simultaneous multiple regressions in men and women separately, controlling for age, level of depression, borderline personality disorder, and substance use disorder.

In study IV, differences in shame-proneness between male and female suicide victims, as well as between suicide victims and living suicide attempters, were computed with two-tailed t -tests. Men and women were analyzed separately in the comparison between individuals who committed suicide, and suicide attempters who were alive.

3.5 ETHICAL CONSIDERATIONS

Several ethical issues need to be considered when attempted suicide patients are asked to participate in research. The patients are in a crisis and may have lowered capacity to handle emotionally upsetting experiences and to defend their integrity. As patients, they are dependent on the health care providers. When the question about research participation is posed within such a context, there is a risk that patients agree to participate because of their dependency, e.g. fear of negative consequences if they refuse to participate. Furthermore, discussing the suicide attempt in interviews, or otherwise bringing up possibly sensitive issues in the interviews or questionnaires, may further destabilize the patient.

The following measures were taken to minimize these risks:

- Patients and healthy controls were given oral and written information about the research projects in all studies included in the thesis. It was stated that participation was voluntary and could be withdrawn at any time, without any further explanation.
- In study I and II, it was underlined that the decision to participate in the research projects or not, would not influence their further treatment.
- In study III and IV, participation in the research project entailed randomization to specialized treatments or treatment as usual for BPD in one of the attempted suicide patient groups. In the other attempted suicide patient group, it was stated that participation in the research project did not influence the treatment given. In the clinical control group, some participants had opportunity to participate in group treatment as part of the research project, but participation did not influence their treatment in other ways.

- In study I and II, the patients were interviewed by researchers who had not participated in the treatment.
- In study III and IV, the TOSCA questionnaire was administered by research nurses who did not participate in the treatment of the patients.
- In study I and II, it was explained that if the patients chose to participate in the studies, they could decline to answer questions or discuss issues in the interviews.
- In all studies, there was a possibility to arrange for support by psychiatric personnel after the interviews or research assessments.
- All studies were formally approved by research ethics committees.

4 RESULTS

4.1 MAIN FINDINGS

The major findings from studies I-IV are that shame reactions are common after attempted suicide, but that these reactions cannot be explained by a general tendency for suicide attempters to experience shame. We found a large variation in trait shame among suicide attempters, with higher shame in women than in men. Women with BPD who had attempted suicide were more shame-prone than all other groups (except for the three men with BPD). There were only three male suicide attempters with BPD in our investigation, but these men also had high shame scores. One of the most unexpected findings in these studies was the relatively low level of self-reported trait shame among men (without BPD) who had attempted suicide. We conducted multivariate regression analyses to investigate shame-proneness among suicidal and non-suicidal patients, and found that level of shame-proneness was predicted by BPD and depression severity, but not by attempted suicide, in female patients, and level of depression and non-suicidality in male patients. In the last study (IV), we found that a small group of patients who had committed suicide, had levels of trait shame that were similar to those of suicide attempters who were alive. We do not have enough knowledge to fully understand the role of shame in attempted suicide, but the results from these studies suggest that a suicide attempt, possibly in combination with the exposed role of being a psychiatric patient, is an event that can elicit shame in both shame-prone and less shame-prone individuals.

4.2 STUDY I

In study I, attempted suicide patient experiences of care were explored. Several patients described that they were themselves shocked over the fact that they had actually tried to kill themselves. They often had mixed feeling towards being a psychiatric patient and their experiences of the interaction with the personnel had great importance for their overall impression of the inpatient treatment. Initial feelings of shame and discomfort could be replaced by an experience of relief, when patients felt that they were understood and experienced the personnel as caring and respectful. Almost all participants described the conversations with the personnel as important and helpful. The participants stressed the importance of having received help, which they thought had been necessary and sometimes life-saving. The categories and subcategories from the content analysis are presented in Table 2.

Table 2. Categories and subcategories from study I (N=18)

<ul style="list-style-type: none">- Being a psychiatric patient:<ul style="list-style-type: none">o Mixed feelings – shame and reliefo Insight into the necessity of receiving help- Patients' perceptions of the caregivers and the care provided:<ul style="list-style-type: none">o Care and securityo Commitment and lack of respecto Confirmation and neglecto Sensitivityo Confidence- Important aspects of the psychiatric care received<ul style="list-style-type: none">o To talk and to be understoodo A critical incidence for living
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4.3 STUDY II

Descriptions of shame reactions were found in thirteen of the eighteen interviews. These reactions were expressed as feelings of failure, feelings of being exposed, being ashamed of oneself, impulses to hide or flee, and aversive feelings of having trespassed a boundary. All participants described that they had felt distress after the suicide attempt and that the initial encounter at the hospital was emotionally difficult. Being treated with kindness and respect during these first encounters alleviated the initial shame reaction for several participants and helped them agree to being admitted into the psychiatric clinic. Participants described great sensitivity to the personnel's attitudes towards them and towards the suicide attempt. Many participants described a readiness to leave the hospital if the personnel showed any skepticism or uncertainty regarding their need for help. Furthermore, experiencing the personnel as non-judgmental and experiencing low demands during the stay in the ward seemed to alleviate shame for some participants. Participants described that their feelings of shame exacerbated when they felt that they had exposed themselves too much and when they experienced the personnel as unsympathetic, disrespectful, authoritative and punishing. The themes and subthemes from the qualitative analysis are presented in Table 3.

Table 3. Themes and subthemes from study II (N=13)

- Shame:
 - feelings of failure
 - for having attempted suicide
 - for having survived the suicide attempt
 - for being in need of help
 - for not having recovered successfully
 - feelings of being exposed
 - being ashamed of oneself
 - for their mere existence, for being burdensome
 - for their bodies
 - for their feelings
 - for being a psychiatric patient
 - for having lost control
 - not daring to talk or make requests
 - impulses to hide or flee
 - impulses to flee
 - wanting to hide, or conceal the suicide attempt
 - experiences of trespassing
 - the suicide attempt as a transgression
 - shame for intruding

- Aspects of care that were experienced as alleviating shame:
 - experiencing the personnel as kind
 - experiencing the personnel as respectful
 - experiencing the personnel as non-judgmental
 - low demands on the patients

- Aspects of care that were experienced as exacerbating shame:
 - having exposed themselves too much
 - experiencing the personnel as unsympathetic
 - experiencing the personnel as disrespectful
 - experiencing the personnel as authoritative
 - experiencing the personnel as punishing

4.4 STUDY III

This study investigated trait shame in attempted suicide patients. Major findings were that male and female suicide attempters differed in the disposition to shame, suicide attempters with BPD were highly shame-prone, and male non-BPD suicide attempters reported relatively low shame-proneness. Furthermore, in multivariate regression analyses, we found that BPD and level of depression, but not attempted suicide, predicted shame-proneness in female patients, while level of depression and non-suicidality predicted shame-proneness in male patients.

4.4.1 The TOSCA instrument

To test the internal consistency of our Swedish version of TOSCA, we calculated Cronbach's α for all subscales. The results were similar to those in other studies using TOSCA (Fontaine, Luyten et al. 2001; Tangney and Dearing 2002). We also calculated the internal consistencies for the TOSCA subscales for men and women, as well as for patients and healthy controls. The TOSCA Shame subscale had good internal consistency (Cronbach's $\alpha = 0.80$) when all cases ($N = 498$) were analyzed together, but somewhat lower when analyzed within the subgroups (0.78 for women, 0.75 for men, 0.80 for patients and 0.75 for healthy controls). The internal consistencies were questionable (Cronbach's α between 0.60 and 0.70) for the Guilt, Externalization, and Detachment subscales, and unacceptably low (Cronbach's $\alpha < 0.5$) for the Pride subscales, when all cases were analyzed together. The calculation of Cronbach's α , for these TOSCA subscales in the subgroups, yielded similar results, with the exceptions that the Guilt subscale had poor internal consistency (Cronbach's α between 0.50 and 0.60) in the female subgroup, the Externalization subscale had poor internal consistency in the patient group, and the Alpha Pride subscale had poor (instead of unacceptable) internal consistency in the healthy control group.

4.4.2 Gender and age differences in shame-proneness

Women had higher shame scores than men of the same participant group. The gender differences in shame-proneness within groups were significant in attempted suicide non-BPD patients ($t[65] = 4.860, p < 0.001$), non-suicidal patients ($t[160] = 2.261, p = 0.025$), and healthy controls ($t[159] = 2.806, p = 0.006$). Shame-proneness was influenced by gender ($F[1,490] = 13.217, p < 0.001$), group ($F[3,490] = 5.108, p = 0.002$) and gender x group interaction ($F[3,490] = 3.304, p = 0.020$). There was a negative correlation between shame-proneness and age ($r[496] = -0.225, p < 0.001$).

4.4.3 Differences between participant groups

Among female participants, a significant difference between groups was found ($F[3,365] = 25.409, p < 0.001$). Post hoc analysis with the Tukey-Kramer HSD test showed that attempted suicide BPD women were more shame-prone than each other female subgroup ($p = 0.001$). Attempted suicide non-BPD women were more shame-prone than female healthy controls, but this difference did not reach statistical significance ($p = 0.098$). Among men, a significant group difference was also found ($F[3,125] = 3.739, p = 0.013$). A post hoc analysis with the Tukey-Kramer HSD test showed that the few attempted suicide BPD men were more shame-prone than attempted suicide non-BPD men ($p = 0.023$). Attempted suicide non-BPD men were less shame-prone than male non-suicidal patients, but this difference did not reach statistical significance ($p = 0.076$). The TOSCA Shame scores are presented in Table 1.

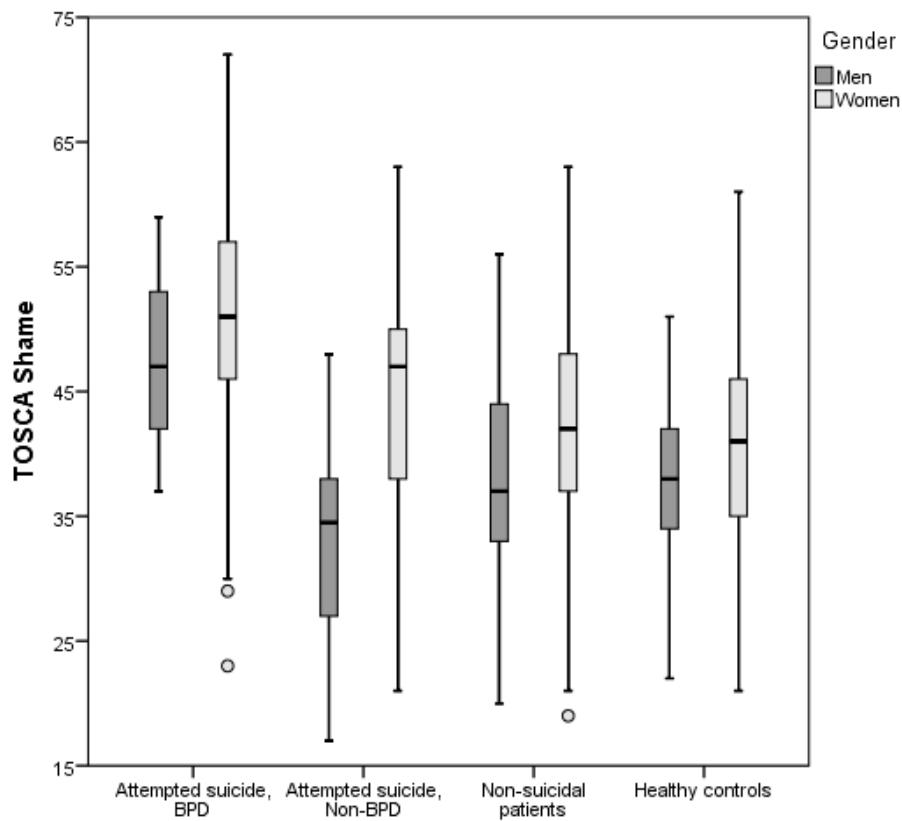


Figure 1. Distribution of TOSCA Shame by group and gender (N=498). Boxes are representing medians and quartiles, whiskers and dots are representing range. N.B. The attempted suicide BPD men were only three individuals.

4.4.4 Predictors of shame-proneness in the psychiatric patients

To analyze the association between attempted suicide and shame among the psychiatric patients, multiple regression analyses were performed separately for men and women, adjusting for age, depression severity (as measured by MADRS-S), borderline personality disorder, and substance use disorder. Shame-proneness was used as dependent variable in the model. There were no indications of collinearity between the predictors (tolerance levels ≥ 0.390).

The regression model for shame-proneness in female patients was significant (Adj $R^2 = 0.183$, $F[5,260] = 12.874$, $p < 0.001$). Borderline personality disorder ($p = 0.001$) and depression severity ($p = 0.003$) were statistically significant predictors for shame-proneness in the regression model, whereas attempted suicide was not a predictor. The regression model for shame-proneness in male patients was also significant (Adj $R^2 = 0.136$, $F[5,63] = 3.142$, $p = 0.014$). Within the model, depression severity ($p = 0.020$) and non-suicidality ($p = 0.022$) were significant predictors of shame-proneness.

4.5 STUDY IV

This study explored shame-proneness and other self-conscious emotions in thirteen patients who subsequently committed suicide. A major finding was that the deceased patients did not differ in shame-proneness, or other measures of self-conscious affect, from attempted suicide patients who were alive.

4.5.1 Shame-proneness in the suicide victims

Among the participants deceased by suicide, the range of TOSCA Shame was 40-62 (mean 51.63, SD 7.63) for women, and 26-48 (mean 35.80, SD 9.65) for men. A significant gender difference in shame-proneness among the suicide victims was found ($t [11] = 3.30$, $p = 0.007$), with women being more shame-prone than men. Those who died by a drug overdose (mean 54.00, SD 8.63) were more shame-prone than those who died by a violent suicide method (mean 40.25, SD 9.79) ($t [11] = 2.57$, $p = 0.026$) (Figure 2). However, all who committed suicide by a drug overdose were women.

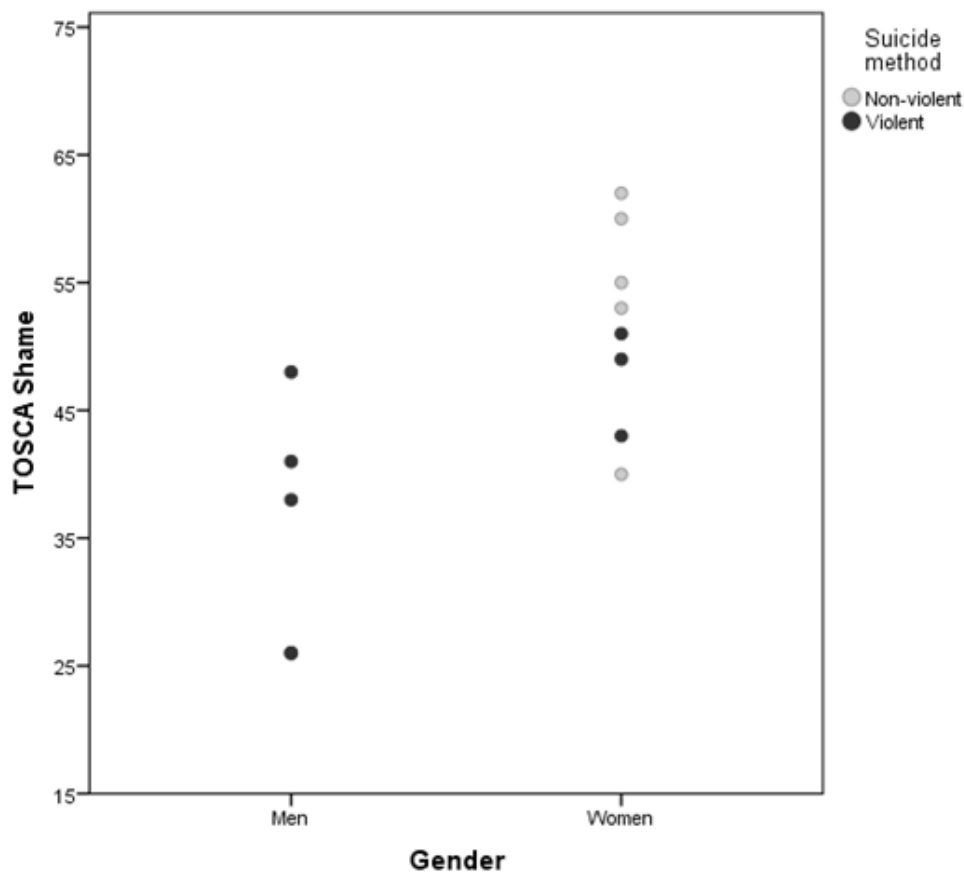


Figure 2. TOSCA Shame scores, by gender and suicide method, in the suicide victims (N = 13).

4.5.2 Comparison between suicide attempters and completers

TOSCA scores of the patients deceased by suicide, were compared with TOSCA scores from suicide attempters, who were recruited to the study after a suicide attempt, and were alive at follow-up after five to twelve years. The comparisons were performed separately for men and women. The comparisons did not yield any significant differences on the TOSCA variables, between individuals who had committed suicide and suicide attempters who were alive.

5 GENERAL DISCUSSION

Shame and relief was one of the themes found in our interviews with men and women who were treated in a psychiatric inpatient ward after a suicide attempt. Our studies indicated that shame reactions after a suicide attempt were common, but that shame-proneness in everyday life, as measured with the self-rating instrument TOSCA, was not typical for all groups of suicide attempters. Proneness to shame differed between men and women, and between patient groups. Women were generally more shame-prone than men. Furthermore, patients with borderline personality disorder (BPD) had higher levels of shame-proneness than other participants. Since there were only three men with BPD in the study, no firm conclusion can be drawn regarding shame in BPD men. Male suicide attempters without BPD had a tendency to low reported shame-proneness. Similar results were found in a small group of completed suicides. With the results from all four studies taken together, our results suggest that the specific situation of having attempted suicide and survived is generally shame-provoking. The clinical implications of this conclusion, as well as other issues concerning the studies, are discussed below.

5.1 FINDINGS

5.1.1 A tentative model for treatment

To conclude, how do the findings in the thesis relate to the original ambition to understand suicide attempters and, if possible, improve our ability to treat these patients? I would like to present a tentative model for treatment of attempted suicide patients, with respect to shame:

The specific situation of having attempted suicide and survived is generally shame-provoking. The suicide attempt indicates different forms of failure. It could be interpreted as a reflection of a “failed life”, the individual who tries to commit suicide rejects his own life as a whole. It could also indicate a specific failure, an event or individual flaw that led up to the suicide attempt. It is also a failed attempt to die. The sense of failure could both reflect contemporary western (individualistic) ideals of being healthy and successful, or more traditional, originally religious, beliefs that suicidal behavior is morally wrong.

Being an attempted suicide *patient* is also generally shame-provoking since it implies being subordinate, being restricted, having to expose oneself and talk about sensitive issues. Being a patient in general, being bodily or otherwise examined, is shame-provoking, and being a psychiatric patient adds the stigma of mental illness.

The suicide attempt constitutes a distancing from the social group. Shame expressions after the suicide attempt appeal to others for forgiveness. The suicide attempters are sensitive to the behaviors, judgments and attitudes of others, because it signals if they are forgiven and socially included, or still “outside” the rest of mankind. It is thus important that the caregivers show that the patients are accepted and included.

Some suicide attempters are poor at showing this socially appropriate behavior, and may therefore not evoke this “forgiving” response of the caregivers. They are thus at risk for a double lack of understanding and validation: they don’t understand themselves and are not understood by the people they meet.

Some other suicide attempters are, on the other hand, highly shame-prone. They feel that attempting suicide, surviving, and ending up in a psychiatric ward is so typical for them. They may receive understanding and kindness from the personnel, but their own negative view of themselves makes it difficult for them to take advantage of this.

The acute psychiatric treatment of both these shame-prone and less shame-prone suicide attempters should ideally be easily accessed and minimally invasive, to increase the chance that the patient accepts treatment. Patients who seldom feel shame or repress shame feeling (and cognitions) may be especially sensitive to the shame-provoking experience of surviving a suicide attempt and being confronted with caring personnel and other patients in a psychiatric ward. If we treat these individuals with respect and acceptance, expressed as respect for their integrity (e.g. respectful searching through their belongings, respectful questioning during psychiatric assessments) and a non-invasive kindness, we might make it easier for them to accept psychiatric treatment and follow-up. In a similar way, minimally shame-provoking treatment of shame-prone suicide attempters may protect them from terminating their treatments because they feel overwhelmed or because the shame elicits avoidance behaviors.

One ultimate goal of this shame-minimizing approach in the acute psychiatric treatment is to enable treatment of psychiatric disorders, thus one of the interventions that, according to available evidence, can reduce suicide rates. This might be the ultimate goal in treatment of patients who are reluctant to talk about themselves or admit failures or shame feelings.

For shame-prone patients, on the other hand, in addition to treatment of psychiatric disorders, a treatment of their shame-proneness might be a good idea.

5.1.2 High and low shame-proneness

The finding of a divergent tendency to high, but also low, shame-proneness among attempted suicide patients was unexpected. Contemporary empirical research on shame has almost exclusively focused on the negative consequences of high shame-proneness. We have only found one study that explicitly describes low shame-proneness, namely among patients with schizophrenia or bipolar disorder (Guimón, Hayas et al. 2007). There might be connections between low shame-proneness and dysfunction, which have not been detected, either because of sample characteristics (non-clinical samples or patients with less severe morbidity) or for other methodological reasons. However, since most shame theories view shame as regulator of behaviors, it is reasonable that both excess and lack of shame would lead to difficulties in interpersonal relationships and adaptation to society in general. More research is needed to investigate if there is a connection between low shame-proneness and certain kinds of dysfunction.

Also, the meaning of low shame-proneness in TOSCA needs to be examined. It could reflect a lower propensity to experience shame, difficulties in identifying shame, a reluctance to report shame or inappropriate TOSCA scenarios for some populations.

5.1.3 Treatment of shame in borderline personality disorder

Women with BPD who engage in suicidal behaviors, are common patients in mental health care. It is debated how BPD patients should be treated when seeking help for suicidal and self-harming behaviors. In recent years, treatments tailored to fit patients with BPD have shown promising results in reducing suicidal and other dysfunctional behaviors (Linehan, Armstrong et al. 1991; Giesen-Bloo, van Dyck et al. 2006; Clarkin, Levy et al. 2007; Bateman and Fonagy 2008). Shame-proneness in BPD is conceptualized and treated differently within the different theoretical frameworks. For example, in dialectical behavior therapy (DBT), specific interventions for shame include training to counteract automatic (unwarranted) shame behaviorally (to look upward instead of averting the gaze etc.) and to replace global judgments (of the entire self) with a non-judgmental, problem-solving focus on behaviors. According to Lewis' distinction between shame and guilt (Lewis 1971), where shame is seen as a negative evaluation of the self, and guilt as a negative evaluation of one's behavior, the DBT approach could be conceptualized as a training to replace shame with guilt. At a general level, DBT aims at increased understanding and tolerance of emotional experiences (Linehan 1993). In transference-focused therapy (TFP), which is a psychoanalytically oriented psychotherapy, the goal is to change characteristics of the patient's internalized object relations that lead to maladaptive behaviors and chronic affective and cognitive disturbances (Clarkin, Yeomans et al. 1999). According to TFP, diffusion of positive and negative representations of self and others results in alternating conceptions of either perfect or worthless images. The exploration of these images in the therapeutic relationship is aimed at leading to knowledge needed for integration into more complex and balanced images. With respect to shame, this

integration is thought to resolve the shame for imperfection, but also to lead to a better tolerance of shame in general. A more balanced view of self and others would also result in increased responsibility in relationships. These aspects of the treatment could also be conceptualized as a change from shame to guilt. Theory and interventions for treatment of shame in psychotherapy with BPD patients have also been described thoroughly by Nathanson (Nathanson 1992). In clinical situations other than psychotherapy, awareness of attempted suicide BPD women's proneness to shame, combined with a non-judgmental stance, might facilitate treatment of these patients.

5.2 METHODOLOGICAL CONSIDERATIONS

5.2.1 To investigate shame

A central question when investigating shame is whether the respondents are willing to admit such feelings. Shame is a painful and not very flattering emotion, reflecting personal failures and flaws. Furthermore, shame makes us want to hide or conceal these deficiencies. Denial of shame has been described by several shame theorists (Lewis 1971; Nathanson 1992). Thus, if people want to admit shame at all, there may at least be individual differences in their willingness to report shame. Also, recognition of emotions requires a certain level of introspection. Not all people notice their emotions and not all people are able to identify which emotion they feel.

5.2.1.1 Differences in methods between the studies

We investigated shame with interviews and questionnaires. In the interviews we had not intended to investigate shame, but found that participants reported shame feelings or described situations that we interpreted as related to shame. These shame data could reflect situationally determined shame, or possibly be expressions of shame-proneness. In the TOSCA questionnaires, on the other hand, we explicitly wanted to investigate shame-proneness. Thus, we investigated different kinds of shame, with different measures. So how do these measures differ in their capacity to capture this sensitive emotion? Andrews and coworker (Andrews, Qian et al. 2002) have used both interviews and questionnaires in their investigations of characterological, behavioral, and bodily shame (interviews and the Experience of Shame Scale, ESS) and come to the conclusion that both methods yield roughly similar results.

5.2.1.2 TOSCA

The TOSCA Shame subscale had good internal consistency in our investigation, but the other subscales had questionable or even unacceptably low Cronbach's α . It could be

discussed if the results from the other subscales should be presented at all. I decided to present these results and also gave some attention to them in study IV, since I considered them to add to the existing knowledge regarding self-conscious emotions in suicide attempters and completers. We seldom have possibility to look into the minds of men and women who later commit suicide. Much of the existing knowledge is based on case records, suicide notes and reports from relatives. As therapists, we can interpret the meaning of our patients' behaviors and utterances within a theoretical framework or try to compile the known facts about a patient. So I think the self-reported measures of e.g. pride from these patients also have their place in the jigsaw puzzle of knowledge about individuals who commit suicide. The items in TOSCA Alpha and Beta Pride (pride in oneself and one's behaviors) do not fit together in such a tight way that they can be shown to reflect a solid concept of pride. On the other hand, they are known and standardized questions, which have also been given to others, and the results of the suicide victims can be reflected upon, in a similar way as we reflect upon other fragments of knowledge concerning the inner world of suicide victims. It has also been argued that each item in a scenario-based instrument reflects a unique aspect of the concept measured, beyond the shared variance of the items (Tangney and Dearing 2002) Therefore, measures of internal consistency might underestimate reliability in scenario-based instruments, while test – retest measures of reliability tend to yield higher results. It can furthermore be discussed whether it, given the low consistency of the subscales, would have been more appropriate to present the results of each TOSCA item instead of the sums on the subscales. Another reflection on the pride items in TOSCA, is that they investigate pride in multifaceted situations, where the subject has also done something “wrong”. Some individuals may feel pride in themselves, but not in such ambivalent situations as those in TOSCA. Bearing the limitations of the scale in mind, the results can still be seen as a contribution to our understanding of suicidal individuals.

Another important question is whether respondents recognize and are willing to report feeling of shame. For example, the respondents are asked to rate the likelihood of feeling stupid, incompetent and small in some of the scenarios. Some respondents may be reluctant to report such feelings. It is thus difficult to interpret the finding of the relatively low shame-proneness in male non-BPD suicide attempters. An alternative interpretation of the results could be that they just do not want to admit weaknesses or repress such feelings. It has also been argued, that the scenarios in the TOSCA present situations that are more shame eliciting for women than for men, which might explain some of the gender differences (Ferguson et al. 2000). Gender differences in TOSCA shame has been reported by Tangney and Dearing (Tangney & Dearing 2000) but have not been found in all studies using TOSCA.

5.2.2 The use of convenience samples

One major limitation in study III was the use of convenience samples. In the attempted suicide group, the large proportion of women with BPD was managed with

dichotomizations of the suicide attempter group into BPD and non-BPD patients, and men and women. However, a limitation is that there were few attempted suicide men in the study, resulting in lack of statistical power. Another limitation is that all non-suicidal patients were from a group of psychiatric patients on long-term sick leave, many of whom had depressive symptoms in combination with work-related stress. This control group was thus not representative for psychiatric outpatients in general. Therefore, future investigations should include larger groups of male suicide attempters and more diverse groups of non-suicidal patient controls. In study IV, the investigation of TOSCA results of thirteen suicide victims was explorative, and the characteristics of each participant were taken in account, thus lessening the risk of faulty generalizations.

5.2.3 Depression – a confounder?

A majority of the participants in the studies were diagnosed with a major depression when they participated in the interviews or completed the TOSCA questionnaires. In studies III and IV, we controlled for depression in the multivariate analyses of shame-proneness in patient participants and found that level of depression significantly predicted shame-proneness among both male and female patients. In study I and II, we could not control for the impact of depression in the descriptions of shame. The aim was to understand the subjective experiences of individuals who were admitted to inpatient care following attempted suicide. It should be pointed out that when the participants in study I/II were interviewed, they had almost completed their stay in the ward and had received treatment for their depressions. In the interviews, most participants vividly described both positive and negative experiences in a way that is uncharacteristic for a severe depressive episode. There were no such ruminative or unrealistic expressions of worthlessness or guilt that characterize depressive symptoms. However, it is plausible that depressed mood and thinking influenced many participants' experiences during the first time after the suicide attempt, e.g. feeling of being burdensome and feelings of being a failure. Thus, many of the initial experiences described, were probably influenced by depression, but the *reporting* of these experiences in the interviews were less influenced by depression.

6 CONCLUSIONS

- Attempted suicide patients often experienced their psychiatric inpatient treatment as important and helpful.
- They were sensitive to the attitudes of the personnel.
- Their experience of the attitudes and behaviors of the personnel had great impact on their wellbeing and their overall experience of the care.
- Having attempted suicide is shame-provoking.
- Being an attempted suicide *patient* is shame-provoking.
- The behaviors of the personnel alleviated or exacerbated the feelings of shame for some patients.
- Experiencing the personnel as kind, respectful, tolerant, and non-judgmental was helpful.
- Experiencing the personnel as unsympathetic, disrespectful, authoritative, and punishing was shame-provoking.
- Care routines sometimes alleviated or exacerbated the feelings of shame.
- Low demands were experienced as decreasing the shame.
- Exposure situations, like talking to several people during the intake, were shame-provoking.
- There were differences in shame-proneness among the suicide attempters..
- Gender differences, with higher levels of shame-proneness in women, were found in both suicidal and non-suicidal participants, but the gender differences in shame were largest between male and female non-BPD suicide attempters.
- The female suicide attempters with BPD had the highest level of shame-proneness, they were significantly more shame-prone than all others groups except for the male suicide attempters with BPD.
- The male suicide attempters without BPD had the lowest levels of shame-proneness. However, they were not significantly less shame-prone than male healthy controls or male non-suicidal patients.
- In multiple regressions, BPD and level of depression predicted shame-proneness in female patients. Suicidality did not.
- In male patients, shame-proneness was predicted by level of depression and non-suicidality.
- Thirteen patients who committed suicide did not differ from living suicide attempters on any subscale of TOSCA.

7 ACKNOWLEDGEMENTS

Först av allt vill jag uttrycka min tacksamhet till alla deltagare i studierna, för att ni delat med er av era upplevelser.

Min tacksamhet går sedan till alla som på olika sätt möjliggjort detta arbete, eller helt enkelt lyst upp tillvaron med sin existens Särskilt tack till:

Min huvudhandledare Marie Åsberg, som vänligt och tålmodigt åtagit sig arbetet att handleda mig. Marie, du är klok och snäll och rolig i en fantastisk kombination! Tack för att du är en nyfiken och inspirerande person.

Min bihandledare och vän Mats Samuelsson, för att du har varit ett viktigt stöd i doktorandarbetet och för att vi gjorde intervjustudien tillsammans. Och tack för lång vänskap!

Alla medförfattare Britt-Inger Saveman, Jussi Jokinen, Åsa Nilsonne, Alexander Wilczek och Gunnar Rylander, som på olika sätt kommit med värdefulla bidrag.

Professor emeritus Åke Nygren, som hjälpt till med praktiska förutsättningar för projektets genomförande och som dessutom är rolig och norrlänning.

Lisbeth Eriksson, tack för omtanke och all sorts praktisk hjälp under många år! Tack särskilt för att du informerade mig om möjligheten att söka doktorandtid 2008.

Elisabet Hollsten, min skugghandledare, som verkligen bidragit till mitt och alla projekt (i hela världens) framskridande. Tack för många dråpliga stunder i Annexet och hus 47!

Peter Nordström, Eva Lundbäck, Björn Mårtensson och Kaj och Anna-Lena Forslund, Anna Kåver och Alan Fruzzetti för gemensam forskning och arbete.

Petter Gustavsson, Kimmo Sorjonen och Tatja Hirvikoski för goda råd angående statistiken.

Alla nuvarande arbetskamrater i hus 47: Ingrid Hedlén, Kristina Wahlberg, Anna Bryngelson, Veronica Murray, Kristian Hagfors, Eva Faxé, Aniella Besér, Anna Nager och Ulla Peterson för trevligt umgänge och stöd i olika sammanhang.

Beatrice Johansson, Nina Ringart och Marianne Youssefi för att ni med vänlighet skött viktiga administrativa sysslor.

Arbetskamrater från Psykiatriska kliniken KS: Lennart Jörnstedt, Siv Kahlau, Ritva Augustinsson, Raivo Vanajan, Eva Rydin, Britt Isaksson och många andra.

Arbetskamrater från Kronan: Raili Rosengren, Ulla-Britt Sundmark, Agneta Apelman, Gunilla Sundqvist och många andra.

Arbetskamrater från Borderlineenheten: Peter Csatlos, Hanna Sahlin-Berg, Lena Lindberg, Per Lundström, Maria Norell, Giulia Arslan och Marianne Ask. Och alla kollegor från vårdgrannen Ångstenheten.

Mina kära bästisar (in order of appearance) med familjer: Johanna König, Li Eneroth Orci, Clara Quarfood Lindberg, Ammis Hansson Brusewitz, Birgitta Charléz och Eva Faxé. Min kära vän Birgitta Ahlin!

Mina kära släktingar mamma Gudrun Wiklander och Bengt Esk, pappa Levi Wiklander och Eva Andersson, mina svärföräldrar Alli och Herman Johansson, min bror Björn Wiklander med familj, min syster Hedvig Wiklander och Adil Sheik, moster Marianne Larsson med familj, moster Kerstin Lindeman Blomqvist med familj, Kicki, Gunilla och alla andra! Mina kära mor- och farföräldrar i mycket ljusst minne bevarade!

Slutligen, min kära familj: min käre make Keijo Johansson som inspirerar och stöttar mig i alla delar av livet, inklusive detta doktorandarbete! Och våra underbara pojkar Robert och Rikard! Tack för att ni finns!

Finansiellt stöd gavs av Vårdalstiftelsen, Söderström Königska sjukhemmet, Vetenskapsrådet och AFA.

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9 APPENDIX: TOSCA

Namn _____

Datum _____

Här nedan följer beskrivningar av sådana situationer som människor kan råka ut för i sitt dagliga liv och sedan ett antal vanliga sätt att reagera på sådana situationer.

När du läser varje beskrivning, försök att föreställa dig själv i situationen i fråga. Gör detta även om det är osannolikt att du skulle hamna i de situationer som beskrivs.

Markera sedan hur sannolikt det är att du skulle reagera på vart och ett av de sätt som beskrivs. Vi vill att du skall sätta en siffra på alla reaktioner, eftersom människor kan känna eller reagera på flera sätt på en och samma situation. Man kan också reagera på olika sätt vid olika tidpunkter.

HÄR FÖRJRER ETT EXEMPEL SOM VISAR HUR DU SKA FYLLA I FORMULÄRET. LÄGG MÄRKE TILL ATT DU SKA FYLLA I EN SIFFRA PÅ VARJE SVARSALTERNATIV!

Du vaknar upp tidigt en lördag morgon. Det är kallt och regnigt ute.

a) Du skulle ringa till en vän för att ta reda på om det hade hänt något nytt.	Inte sannolikt	Mycket sannolikt
	① 2 3 4 5	
b) Du skulle använda den extra tiden till att läsa tidningen.	Inte sannolikt	Mycket sannolikt
	1 2 3 4 ⑤	
c) Du skulle känna dig besviken för att det regnar.	Inte sannolikt	Mycket sannolikt
	1 2 ③ 4 5	
d) Du skulle undra varför du vaknade så tidigt.	Inte sannolikt	Mycket sannolikt
	1 2 3 ④ 5	

I detta exempel har jag markerat *alla* svaren genom att *ringa in en siffra*. Jag ringade in “1” på svar (a) för att jag inte skulle vilja väcka en vän väldigt tidigt en lördag morgon, så det är inte alls sannolikt att jag skulle göra det. Jag ringade in “5” på svar (b) för att jag nästan alltid läser tidningen på morgonen om jag hinner, alltså mycket sannolikt. Jag ringade in “3” för svar (c) eftersom för mig är det hugget som stucket. Ibland skulle jag vara besviken över regnet, och ibland skulle jag inte vara det – det skulle bero på vad jag hade för planer. Och jag har ringat in “4” för svar (d) för att jag förmodligen skulle undra över varför jag hade vaknat så tidigt.

Hoppa inte över några frågor, och gör en markering på alla svaren.

TOSCA är konstruerat av prof June Price Tangney och översatt med vederbörligt tillstånd av Eva Andersson, Maria Wiklander och Marie Åsberg. 1999-09-30

1. Du gör upp en plan att träffa och äta lunch med en vän. När klockan är 5 på eftermiddagen, kommer du på att du har glömt bort honom.

a) Du skulle tänka; "Vad hänsynslös jag är".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
b) Du skulle tänka; "Han kommer säkert att förstå".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
c) Du skulle försöka kompensera honom så fort som möjligt.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
d) Du skulle tänka; "Min chef kom och störde mig alldeles före lunchen".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5

2. Du har sönder något på arbetet, och sedan döljer du det.

a) Du skulle tänka; "Jag blir bekymrad av det här. Jag måste antingen laga det själv, eller också få någon annan att göra det".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
b) Du skulle fundera på att säga upp dig.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
c) Du skulle tänka; "Saker är inte så välgjorda nu för tiden".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
d) Du skulle tänka; "Det vara bara en olyckshändelse".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5

3. Du är ute med vänner en kväll, och du känner dig alldeles speciellt begåvad och attraktiv. Din bästa väns sambo tycks vara speciellt förtjust i ditt sällskap.

a) Du skulle tänka; "Jag borde tänkt på vad min bästa vän känner inför det här".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
b) Du skulle vara glad åt ditt utseende och din personlighet.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
c) Du skulle vara förtjust över att ha gjort ett så gott intryck.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
d) Du skulle tycka att din bästa vän borde uppmärksamma sin sambo mer.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
e) Du skulle förmodligen undvika ögonkontakt med din vän en lång tid framöver.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5

4. På arbetet väntar du till sista minuten med att planera ett projekt och det går illa.

a) Du skulle känna dig inkompetent.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
b) Du skulle tänka; "Tiden räcker aldrig till".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
c) Du skulle känna; "Jag har gjort mig förtjänt av en förebråelse".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
d) Du skulle tänka; "Gjort är gjort".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5

5. Du gör ett misstag på arbetet och upptäcker att en arbetskamrat har fått skulden för det.

a) Du skulle tro att firman inte gillade din arbetskamrat.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
b) Du skulle tänka; "Livet är inte rättvist."	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
c) Du skulle hålla tyst och undvika din arbetskamrat.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
d) Du skulle känna dig olycklig och angelägen om att rätta till situationen.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5

6. I flera dagar skjuter du upp att ringa ett besvärligt telefonsamtal. I sista minuten ringer du samtalet och lyckas manipulera samtalet så att allt går väl.

a) Du skulle tänka; "Jag antar att jag är mer övertygande än jag hade trott".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
b) Du skulle ångra att du hade skjutit upp samtalet.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
c) Du skulle känna dig feg.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
d) Du skulle tänka; "Jag gjorde ett bra jobb".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
e) Du skulle tycka att du inte borde tvingas att ringa samtal som du känner dig pressad att ställa upp på.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5

7. Du har fast beslutat dig för att banta, men när du går förbi bageriet så köper du ett dussin munkar.

a) Vid nästa måltid äter du bara selleri för att kompensera för det.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
b) Du skulle tänka; "De såg alldeles för goda ut för att man skulle kunna gå förbi dem".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
c) Du skulle känna dig äcklad över din brist på viljestyrka och självkontroll.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
d) Du skulle tänka; "En enda gång spelar ingen roll".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5

8. Du spelar boll och råkar kasta en boll så att den träffar en vän till dig mitt i ansiktet.

a) Du känner dig hopplös eftersom du inte ens kan kasta en boll.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
b) Du skulle tänka att din vän kanske behöver öva sig mer i att fånga en boll.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
c) Du skulle tänka; "Det vara bara en olyckshändelse".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
d) Du skulle be om ursäkt och förvissa dig om att din vän kände sig bättre.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5

9. Du har nyligen flyttat hemifrån, och alla har varit väldigt hjälpsamma. Några enstaka gånger har du behövt låna pengar, men du har betalat tillbaka så snart du kunnat.

a) Du skulle känna dig omogen.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
b) Du skulle tänka; "Jag har verkligen haft otur".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
c) Du skulle återgälda tjänsten så fort du nånsin kunde.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
d) Du skulle tänka; "Jag är en person man kan lita på".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
e) Du skulle vara stolt över att du betalade tillbaka dina skulder.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5

10. När du kör på en väg så kör du över ett litet djur.

a) Du skulle tänka att djuret inte borde ha befunnit sig på vägen.	Inte sannolikt	Mycket sannolikt
	1 2 3 4 5	
b) Du skulle tänka; "Jag är förfärlig".	Inte sannolikt	Mycket sannolikt
	1 2 3 4 5	
c) Du skulle känna; "Nåja, det var en olyckshändelse".	Inte sannolikt	Mycket sannolikt
	1 2 3 4 5	
d) Du skulle förmodligen tänka på det ett stort antal gånger och undra över om du kunnat ha undvikit det.	Inte sannolikt	Mycket sannolikt
	1 2 3 4 5	

11. Du har avslutat ett prov eller en examen och tycker att du har klarat dig verkligt bra. Sedan upptäcker du att du klarade dig dåligt.

a) Du skulle tänka; "Nåja, det är ju bara ett prov".	Inte sannolikt	Mycket sannolikt
	1 2 3 4 5	
b) Du skulle tänka; "Examinatorn tycker inte om mig".	Inte sannolikt	Mycket sannolikt
	1 2 3 4 5	
c) Du skulle tänka; "Jag borde ha läst på bättre".	Inte sannolikt	Mycket sannolikt
	1 2 3 4 5	
d) Du skulle känna dig dum.	Inte sannolikt	Mycket sannolikt
	1 2 3 4 5	

12. Du och en grupp arbetskamrater arbetade väldigt hårt med ett projekt. Din chef väljer ut just dig för en belöning eftersom projektet blev en lyckträff.

a) Du skulle tycka att chefen var ganska kortsynt.	Inte sannolikt	Mycket sannolikt
	1 2 3 4 5	
b) Du skulle känna dig ensam och utanför gruppen av dina arbetskamrater.	Inte sannolikt	Mycket sannolikt
	1 2 3 4 5	
c) Du skulle känna att ditt hårda arbete hade lönat sig.	Inte sannolikt	Mycket sannolikt
	1 2 3 4 5	
d) Du skulle känna dig kompetent och stolt över dig själv.	Inte sannolikt	Mycket sannolikt
	1 2 3 4 5	
e) Du skulle känna att du inte borde acceptera belöningen.	Inte sannolikt	Mycket sannolikt
	1 2 3 4 5	

13. Du är tillsammans med en grupp vänner och ni driver med en kamrat som inte är närvarande.

a) Du skulle tänka; "Det var bara på skoj, det gör ingen skada".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
b) Du skulle känna dig ynklig... som ett kräk.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
c) Du skulle tycka att kanske din vän borde ha varit där så att han eller hon kunnat försvara sig.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
d) Du skulle be om ursäkt och tala om den personens goda sidor.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5

14. Du gör ett stort misstag på ett viktigt projekt på ditt arbete. Människor var beroende av dig och din chef kritiserar dig.

a) Du skulle tänka att din chef skulle ha varit tydligare med vad man väntade sig av dig.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
b) Du skulle känna det som om du ville gå och gömma dig.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
c) Du skulle tänka; "Jag borde ha insett problemet och gjort ett bättre jobb".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
d) Du skulle tänka; "Nåja, ingen är felfri".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5

15. Du ställer upp som frivillig för att arbeta med den lokala olympiaden för handikappade barn. Det visar sig vara ett besvärligt och tidskrävande arbete. Du tänker allvarligt på att lägga av, men sedan ser du hur lyckliga ungarna är.

a) Du skulle känna dig självisk och tycka att du i grund och botten är lat.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
b) Du skulle känna dig tvungen att göra någonting som du egentligen inte hade lust med.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
c) Du skulle tänka; "Jag borde bry mig mer om människor som inte är så lyckligt lottade".	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
d) Du skulle må bra för att du har hjälpt andra.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5
e) Du skulle vara mycket nöjd med dig själv.	Inte sannolikt			Mycket sannolikt
	1	2	3	4 5