To the Graduate Council:

I am submitting herewith a dissertation written by Barry Warren Shreve entitled "Constructing a Measure of Shame-Proneness and its Relation to Treatment Outcome for Hospitalized Suicidal Individuals." I have examined the final copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Education.

Michael J. Patton, Professor

We have read this dissertation
and recommend its acceptance:

Accepted for the Council:

Vice Provost
and Dean of The Graduate School

CONSTRUCTING A MEASURE OF SHAME-PRONENESS AND ITS RELATION TO TREATMENT OUTCOME FOR HOSPITALIZED SUICIDAL INDIVIDUALS

A Dissertation

Presented for the

Doctor of Philosophy

Degree

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Barry Warren Shreve

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ABSTRACT

A self-report scale was constructed which attempts to measure the degree to which an individual is succeptible to experiencing debilitating amounts of shame. The concepts of Heinz Kohut's psychoanalytic psychology of the self were employed in the formulation of the definition of and theoretical perspective underlying this study's use of the concept of shame. The Shame-Proneness Scale was found to have sound psychometric properties with high levels of interitem consistency (alpha coefficient of .93) and a high test-retest reliability (r = .81). The Scale had expected relationships with measures of self-esteem, social anxiety, guilt, and private self-consciousness. The Scale was then used to predict the response to treatment of suicidal individuals hospitalized in an acute care mental health facility. Results indicated that a hospitalized, suicidal individual's score on the Shame-Proneness Scale was a significant but limited predictor of a his/her response to treatment, as evidenced by his/her length of stay in the hospital. Additional research and refinement is needed to further establish the reliability and validity of the Scale, to explore the relation of the Shame-Proneness Scale to other self-psychological scales, and to establish the utility of the Scale within clinical populations.

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CHAPTER I

INTRODUCTION

Proneness to experiencing shame has long been identified as a possible contributer to suicial feelings and behaviors. This study was an attempt to construct a scale to measure an individual's degree of shame-proneness and then to discover the relationship between this measure and a suicidal individual's response to inpatient treatment. This chapter presents a review of the literature pertaining to previous attempts to measure shame-proneness and explore its relation to other psychological phenomena, a presentation of the perspective on the problem from classical psychoanalytic and more recent psychoanalytic self-psychological viewpoints, and a statement of the problem.

Literature Review

In the past 30 years, a number of researchers have attempted to design a method/instrument to assess an individual's degree of shame-proneness. Those to be considered here include instruments and/or methods devised by Perlman (1958), Gottschalk and Gleser (1969), Binder (1970), Beall (1972), Smith (1972), and Korpi (1977).

Perlman (1958) initiated the construction of shame-proneness instruments. He developed a test which consisted of 52 descriptions of social situations which respondents rated according to how anxiety provoking they thought each situation would be for most people. The underlying assumption for this approach was that those individuals who reported a greater number of social situations as being anxiety provoking were more shame-prone. Perlman's scale showed a test-retest reliability of .80 but little else to suggest its usefulness. In Perlman's original study his research hypothesis was not supported and subjects reported in posttest interviews that they had been confused about the scale and the meaning of anxiety. In spite of this apparent lack of utility, this scale was used in another study by Negri in 1979. Negri attempted to demonstrate a positive correlation between shame-proneness, field-dependence and sex role adherence. Using 448 undergraduate volunteer subjects, who completed the Perlman instrument (named the Attitude Anxiety Survey) and other instruments measuring field dependence and sex role adherence, Negri was unable to substantiate his research hypothesis.

In 1969, Gottschalk and Gleser proposed a system of content analysis to measure shame and guilt. In their rationally devised system, verbal samples of written transcripts were analyzed to attempt to provide a

quantification of psychological states. They based their system on the theory of shame presented by Piers (Piers & Singer, 1953). To summarize their scoring system, "references to ridicule, inadequacy, shame, embarrassment, humiliation, overexposure of deficiencies or private details, or threats of such" are scored as being indicative of shame anxiety. "References to adverse criticism, abuse, condemnation, moral disapproval, guilt, or threat of such are scored as being indicative guilt anxiety (Gottschalk & Gleser, 1969, p. 31). The system of Gottschalk & Gleser provided clear guidelines for raters and examples for the use of training raters, however no formal attempt was made to establish the independence of the two scales.

Inter-rater reliability using two raters for the Gottschalk and Gleser shame scale ranges from .67 to .90 and for the guilt scale it ranges from .75 to .88 (Gottschalk & Gleser, 1969). The shame and guilt scales have been shown to have an inter-correlation of .43 (Ursu, 1984). These scales have been used to evaluate both verbal and written material with similar results (Gottschalk, Mayerson, & Gottlieb, 1967; Gottschalk, Gleser, Stone, & Kunkel, 1968). It is important to note that Gottschalk and Gleser's content analysis system is designed to measure shame and guilt anxiety, which is a state as compared to shame-proneness, which in the current study is construed as a trait.

One study employing the Gottschalk & Gleser system was conducted by Witkin, Lewis & Weil in 1968. They attempted to demonstrate a relationship between proneness to shame and field dependence. A connection between proneness to shame and field dependence was suggested as a result of the shame-prone individual's alledged sensitivity to his/her social system and, by extrapolation, to his/her sensory surroundings. A total of eight subjects were selected from a pool of 172 individuals who had requested counseling. Half of the subjects were rated as being extremely field-dependent and four were extremely field-independent. A content analysis (Gottschalk & Glesser, 1969) of the individual's counseling transcripts was performed and the researchers suggested that the results indicated that field-dependent individuals are significantly more prone to shame than guilt. This study appears to be flawed for a number of reasons. It used a procedure designed to measure the state of shame rather than the trait of proneness to shame having questionable construct validity (Ursu, 1984). It also failed to consider the inherently shame producing circumstances of the subjects of the study, namely that of being clients seeking counseling. It also failed to take into account the stage of counseling the subjects were in. Lastly, the extremely low number of subjects makes the generalizability of the results questionable. It seems that this study attempted to use the best available measures at

that time, but that its conclusions are of questionable validity owing to the above stated problems.

Another attempt to measure shame-proneness was Binder's (1970) devising of a projective method to measure shame and guilt using a two-page rating system for the Mayman (1968) Early Memories Test. Mayman's test was based on the assumption that reported early memories provide important information about the individual's personality traits. The construction of this method is questionable as there was no attempt made to establish the independence of the two scales outside of their definitional differences. This method is hampered also by the lack of clear, definitive scoring rules and the absence of training examples. Interrater reliability using two raters has ranged from .57 to .88 for the shame scale (Smith, 1972; Bupp, 1983) and from .67 to .81 for the guilt scale (Binder, 1970; Bupp, 1983). When three raters were employed, reliability was reduced, with the shame scale ranging from .34 to .67 and the guilt scale from .48 to .50 (Schubert, 1975).

Crouppen (1977) employed the Binder approach in his study which examined the issues of field-dependence and depression as they relate to shame-proneness. Subjects were individuals receiving treatment at a U. S. Veterans Administration Hospital for depression and a control group of veterans enrolled in a university educational program. Crouppen measured shame-proneness with two measures, the

Binder approach for the Early Memories Test (Mayman, 1968) and the Smith-Beall Shame and Guilt Test (Beall, 1972; Smith, 1972). The results of this study are of little utility, as the two alledged measures of shame-proneness yielded differing results. The Binder approach did not differentiate between the two subject groups, while the Smith-Beall test did.

Another attempt to devise a method to measure shame-proneness was Beall's 1972 construction of a self-report measure of guilt and shame which was later revised by both Smith (1972) and Korpi (1977). The original Beall instrument consisted of 103 items which were brief descriptions of a life situation. The items had been judged by "experts" to stimulate either shame or guilt. Respondents were instructed to respond to each item along a 5-point, unidirectional scale ranging from whether they would be "not at all upset" to "extremely upset" if they found themselves in the described situation. Smith's (1972) revision of the instrument decreased the total number of items to 42. This version of the scale was measured to have a test-retest reliability of .78 and a Kuder-Richardson coefficient of .60. Korpi (1977) suggested that Smith's item reduction process had resulted in the continued inclusion of ambiguous items. Using Beall's original items and a multiple regression procedure, Korpi constructed a 36-item version of the scale. This version of the scale has

a Cronbach's alpha of .76. A correlation between the shame and guilt scales of .41 was found, which is not too surprising given the non-statistical construction method employed in the original Beall version. Bupp (1983) examined the Smith and Korpi instruments and found high correlations between the two instruments scales (r = .80 for shame, r = .84 for guilt) but poor discriminatory power between shame and guilt for each instrument (r = .66 for Smith, r = .65 for Korpi).

Smith (1972) employed his version of this scale in his attempt to assess the relation between shame-proneness and defensive style. Smith proposed that people employ one of two basic "defensive styles" (which were essentially forms of self-regulation). These two styles differred according to whether they involved ego - ego-ideal conflicts resulting in feelings of shame when issues are unresolved, or one involving ego-superego conflicts, which can result in feelings of guilt. In other words, he suggested that people can be classified as being either shame-prone or guilt-prone. Using 70 psychiatric outpatients in varying stages of therapy he performed a multiple correlation on the results from the subjects' completion of the Beall test, the Early Memories Test, the Hinkle Anger Direction Questionnaire (Hinkle, 1970), the Multiple Affect Adjective Check List: Depression (Zuckerman & Lubin, 1965), and the K scale of the Minnesota Multiphasic Personality Inventory

(Hathaway & McKinley, 1967). The results suggested that the more shame-prone the individual, the more she/he would a) direct hostility inward, and b) report feelings of depression, however it did little to support the authors contention about there being people who are shame-prone and people who are guilt-prone. This study does appear to have some serious methodological problems (e.g., the subjects stage of therapy is not considered and the questionable validity of the scale measuring shame-proneness), although some of its results seem supportive of the present study's contention that there is a group of suicidal individuals who are significantly shame-prone.

All the above instruments appear to be of questionable utility, either due to problems with the method of construction or with ambiguous and often conflicting results when the scale/method is employed for research purposes. In a recent study of the above instruments, Ursu (1984) employed a multitrait-multimethod analysis (Campbell & Fiske, 1959) to examine their construct validity. Her results clearly indicated that none of the above measures has sufficient convergent or discriminant validity to warrent its use in further research, let alone in a clinical setting. These results, and those presented above, stand as further evidence for the need to develop a valid, reliable measure of shame-proneness and for the need to conceptualize the construct of shame-proneness more adequately. To this

end, the following section explores the theoretical issue of shame-proneness and outlines the perspective on the problem for the present study.

Perspective on the Problem

Commonsense knowledge, clinical reports and a limited amount of scientific data suggest that a tendency to be unusually vulnerable to the experience of intense shame is characteristic of some suicidal individuals. The general purpose of this study was to acquire understanding of the extent to which the experience of shame is a source of personal difficulty for persons who have been identified by themselves or others as suicidal. More specifically, the purposes of the study were to: 1) construct a self-report measure with which to assess a person's proneness to the experience of intense forms of shame, 2) examine the relation between scores on such a scale and scores on related instruments, and 3) determine the relation between scores on the shame-proneness scale and a measure of treatment outcome among a group of persons who have been hospitalized for suicidal threats or attempts.

Threats to the loss of a person's reputation in his/her own eyes are ubiquitous in ordinary social interaction. Yet, remarkably, most persons seem to adapt to the inevitable insults of everyday life and can restore a feeling of self-esteem following its temporary loss. But, shame,

like any affect, becomes a serious form of personal difficulty when it disrupts normal intellective functions and the person becomes overwhelmed and immobilized by it. In this case such persons may be regarded as shame prone, and are likely to regard their reputation in their own eyes as less than valuable. To mitigate the feeling of degradation that accompanies shame, persons who are shame prone may act impulsively to escape from it, use anger or arrogance to inflate their sense of self worth, try to avoid those situations in which they fear such experiences will occur to them, or all of these and more. In any case, actual suicide, attempted suicide, and the contemplation of it as a method of escaping a profound sense of shame have historical and contemporary precedent.

Shame as one motive for suicide is suggested by Heinz Kohut's (1977, 1978, 1984) psychoanalytic psychology of the self. Briefly, Kohut argues that persons who are unusually prone to shame suffer from a serious defect in the self that prevents them from maintaining a firm sense of cohesiveness and self-esteem. That is, they are more vulnerable than most to experiencing even ordinary criticism as devastating. Thus, when either chronic or traumatic injuries occur to the already fragile self, the person becomes shamed in his/her own eyes and may then use suicide to escape the pain and thereby believe him/herself to be preventing further debilitation of the sense of self. The utility of

constructing and testing a shame-proneness scale is that a) it may help empirically establish the relationship of shame to the phenomenon of suicide, and b) it may then have clinical utility for therapists working with hospitalized suicidal individuals by helping identify a significant area for focus and work within treatment.

The remainder of this chapter presents a review of shame-proneness from classical psychoanalytic and more recent psychoanalytic self-psychological perspectives. A statement of the problem is then given which provides the specific research questions which this study addressed.

From the beginning of psychoanalysis, theorists and clinicians have paid increasing amounts of attention to the issue of shame. Freud (1957) stressed the importance of self-exposure in reactions of shame because he believed that self-reproach for a sexual act in childhood can easily turn into shame if the behavior becomes public knowledge. Later psychoanalytic theorists drew heavily on the works of Erikson (1956) and Piers (1953) for the foundation of their presentations about shame and shame-proneness. Erikson (1956) labeled his second psychosocial phase as "autonomy versus shame and doubt" and identified one of the crucial conflicts as "self certainty versus self-consciousness". He viewed shame as being related to feelings of helplessness and lack of self-control and related it to feeling observed and wishing to hide. Shame, to Erikson, was a natural

by-product of the struggle to achieve a sense of identity. Piers (1953) believed that shame was the product of a tension between the ego and the ego ideal. Furthermore, he defined this tension as being a result of a failure of the individual to reach a specific goal.

Grinker (1955) and later Feldman (1962) reinforced the concepts of both and suggested that shame arises out of a conflict between the ego and the ego-ideal. For Grinker, this conflict is the result of a failure to reach a specific goal and results in fears of abandonment. Feldman saw the conflict arising out of a failure to live up to the expectations of the ego ideal, which could result in feelings of adandonment. From a developmental perspective, Grinker noted that a tendency to experience shame often develops at the time the child is developing a sense of autonomy and control which is visible to others.

Lewis (1963, 1971) suggested that shame functions as a defense against the loss of self-boundaries and helps maintain a sense of identity. Similarly, Levin (1967) pointed out that shame has positive results as well as negative ones. He suggested that shame or the fear of shame protects one from the trauma of overexposure to others and the possibility of rejection or abandonment. He also suggested that shame is the opposite of self-esteem (a position later shared by Kinston, 1983). Levin designated the necessary conditions for the development of shame as

being self-exposure (feared or actual) and an anticipation of rejection by others. Levin (1971) later explored various ways that the ego defends against painful feeligs of shame, including the avoidance of self exposure, repression, the development of the ego ideal, the limiting of commitment to others, and aggressive acting out.

Broucek (1982) suggested that shame weakens and disturbs the automatic, unconscious functioning of the sense of self which is unselfconscious. He proposed that a weakened sense of self and strong shame-proneness may incline the individual to a dominance of objective (i.e., external, "selfconscious") self-awareness over subjective (internal, "unselfconscious) sense of self. This perspective may be the origins of the connection having been made between shame-proneness and field dependence.

Ward (1972) provided a most detailed description of the conditions which may result in the experience of shame, including the revealing of a shortcoming to another person or the self, the failure to reach an ego-ideal goal, a feeling of being seen, a fear of being ridiculed, and a desire to flee. In the course of dealing with the issue of the structural locus of the ego ideal, he appeared to be describing the aspects of the self which later became identified with Kohut's (1977, 1978, 1984) psychoanalytic psychology of the self. Ward indicated that the ego ideal, regardless of its structural locus is comprised of "elements

of narcissistic omnipotence, positive identifications with parental images, and later identifications dependent on the social situation" (p. 234).

To help appreciate the psychoanalytic self psychological perspective on shame, the following is a relatively brief description of the foundations of self psychology. Kohut (1977, 1978, 1984) proposed that the self has three sectors. One pole, or sector, consists of what Kohut refered to as the grandiose self. This is the earliest sector to develop and is considered the most basic part of the self. The second pole or sector of the self Kohut called the idealized parental imago. A third sector identified by Kohut is the intermediate pole of talents and abilities. Each of these sectors of the self is supported and sustained by specific relations among them called self-selfobject relations. It is through these relations that the individual experiences him/her self in relation to the external world. In the simplist of terms, a self-selfobject relation is a mental representation of self and other in which the other is experienced as being essentially a part of the self. Kohut identified three forms of self-selfobject relations: mirroring, idealizing and alter ego. These structures promote and sustain the cohesion of the self.

For the developing child, the primary source of sustanance is parental empathy. The nurturing, empathic

parent responds to the toddler's exhibitionistic displays with support and encouragement, thereby providing the child with mirroring of its grandiosity and support for the phase appropriate fiction of the child's grandiosity and omnipotence. When appropriate, the empathic parent also allows him/herself to be the target of the child's idealization, thereby increasing the child's self esteem and the cohesion of the self structure. The empathic parent also provides an environment replete with the sights and sounds endemic to the human condition. Later important sustenance is received from the increased development of pseudo-work and recreational activities on the part of the child which closely resemble and mimic those of the parents. During the phase of adolescence there is a heightened dependence on the peer group for support of the self. This reliance on peers may even take on special significance and result in the development of secret clubs which embody the groups goals and ideals (Wolf, Gedo & Terman, 1972).

Throughout the development of the child, parental empathy has expected and appropriate lapses. These lapses serve to gradually dissolve the archaic self-selfobject relations and to foster the development of a more realistic perspective in the child of his/her relative significance and power, and a more internal, reality-based sense of respect for the parents and others. If previous phase transitions have been traversed safely, the self arrives at

young adulthood with a balanced, life-long set of self-selfobject needs and mechanisims whereby these needs may be met. The exhibitionism of childhood has been transformed into the ambitions of adulthood, the idealization of youth has been molded into mature goals and ideals, and the peer group dependence of adolescence has been channelled into the adult's sense of belonging to the family of man.

The development of the self, however, does not always flow this smoothly. When lapses in parental empathy are traumatic, or when the parents are chronically unempathic, the individual may experience a severe narcissistic injury to one or more sectors of the self. Kohut (1984) suggested that each successive phase offers a fresh opportunity for consolidation and strengthening of the self. However, a failure to resolve the issues of any one phase places the individual at risk for developing some form of pathology as a result of the defect in the self. The individual so affected may develop any of a number of dysfunctional self-expressions: disturbances of affect (e.g., chronic depression, frequent expressions of rage), behavioral disturbances (repeated acts of violence, sexual acting out), work inhibitions, etc., etc.

Patton and Robbins (1982), using Kohut's (1977) ideas, point out that these dysfunctional self-expressions are attempts of the self to either compensate for or defend

against the experienced defect in the self. As a result of inadequate self development, the individual develops a fixation on more archaic forms of self-selfobject relations. This fixation prets the self from developing new, more mature forms of self-selfobject relations. The earlier the defect in the self occurs, the more infantile and archaic the fixated self-selfobject relations, the more vulnerable the individual is to narcissistic injury, and the potentially more pathological the defensive or compensatory behaviors. Infantile needs for psychological sustenance are difficult for the adult to meet in his/her environment and the result is an individual who is in a chronic state of dis-satisfaction and low self esteem. An individual in such a condition is extremely succeptible to experiencing a debilitating degree of shame.

Kohut suggested (1978) that persons who are unusually prone to shame suffer from a serious defect in the self that prevents them from maintaining a firm sense of cohesiveness and self-esteem. That is, they are more vulnerable than most to experiencing even ordinary criticism as devastating. Thus, when either chronic or traumatic injuries occur to the already fragile self, the person becomes shamed in his/her own eyes and may then use suicide to escape the pain and thereby prevent further deterioration of the sense of self.

Kohut and Wolf (1978) identified four pathological syndromes of self development (i.e., four forms in which a

serious defect may manifest itself), any one of which may entail, for differing reasons, the experience of debilitating amounts of shame. The first of these they labeled the understimulated self. This condition is the result of chronic, inadequate responsiveness from the selfobjects during childhood. These individuals lack an inner sense of energy, purpose and vitality, and they tend to employ external means to enliven their existance in an attempt to ward off their chronic feelings of emptiness. The second form of pathological self development is the fragmenting self. This is a condition which results from the unequal responsiveness of childhood selfobjects and their failure to respond to the developing self as a total individual. As a result, the self never truly develops a cohesive sense of selfhood. This condition becomes manifest when the individual experiences his/her environment as being less than empathic. The result is a marked lowering of self-esteem, possible disruption of cognitive functions, and the loss of the sense of the self as a cohesive whole.

The third form of pathological self is the overstimulated self. This is a condition which arises as a result of phase-inappropriate, excessive responses from the child's selfobjects. This results in an individual who either avoids any possibility of becoming the center of attention, or who avoids contact with potentially admirable selfobjects, or both. The result of the childhood

overstimulation is a tendency to avoid receiving support for either the grandiose or idealized sector of the self. These individuals tend to be reclusive and rarely seek out external means of psychic support. Feelings of a lack of drive, a sense of having nothing or no one to look up to, and a sense of isolation are common experiences for such individuals.

The fourth of the pathological forms of self is the overburdened self. This is a condition which comes as a result of prolonged emotional deprivation during childhood. The developing self is not offered the opportunity to experience the quieting, soothing experience which comes with the subjective merger with the omnipotent selfobject. The result is an individual who is unable to maintain a sense of inner control over his/her emotional state; one who is unable to maintain emotional equilibrium in a threatening and potentially hostile world.

For each of these forms of self pathology, shame is a possible result of the failure of defensive maneuvers. The failure of defensive maneuvers for the vulnerable self may result in the activation of powerful, archaic fears; the understimulated self fears exposure of his/her essential emptiness, the fragmenting self fears the exposure of his/her lack of cohesion, and the overstimulated self fears the exposure of his/her need to be distant from others, the overburdened self fears the exposure of his/her inadequacy

to maintain internal emotional equilibrium. One by-product of these fears is the development of the feeling of shame. Suicidal thinking or behaviors may result as an integral part of the feelings of shame in an effort to ameliorate the feelings of shame, to prevent further deterioration of the sense of self, as a last ditch effort to defend against being overwhelmed by unwanted emotions, or all of these simultaneously.

Statement of the Problem

The first purpose of this research was to construct a self-report scale to assess an individual's proneness to experiencing shame. An initial definition of shame-proneness was written following the formulations of psychoanalytic self psychology (Kohut, 1977, 1978). Items related to the experiencing of primary and secondary shame, and common defenses to these phenomena, were written and responded to by a large group of participants. The participants for this phase of the research consisted of a group of psychiatrically hospitalized suicidal individuals. Final scale items were selected on the basis of a factor analysis and subsequent item analyses. The resulting scale was further examined to assess its degree of stability and its internal and test-retest reliabilities.

The second purpose of this study was to examine the relation between scores on the Shame-Proneness Scale and

scores on selected psychological and demographic variables from the hospitalized suicidal individuals, and from an additional group of hospitalized non-suicidal participants.

The third purpose of this study was to predict the relation between the Shame-Proneness Scale and a selected treatment outcome measure for the group of hospitalized suicidal individuals.

Three research questions were formulated as follows:

Research Question I: To examine the issue of concurrent validity: Are there significant relationships between scores on the Shame-Proneness Scale and measures of self-esteem, private self-consciousness, public self-consciousness, and social anxiety?

Research Question II: To examine the issue of discriminant validity: Does the Shame-Proneness Scale alone, or in conjunction with other measures, reliably discriminate among suicidal and non-suicidal hospitalized participants?

Research Question III: To examine the issue of construct validity: Is there a significant relationship between scores on the Shame-Proneness Scale and a measure of guilt-proneness?

The relation between the Shame-Proneness Scale and a selected treatment outcome measure is to be examined through testing the following regression model:

Research Hypothesis I: The Shame-Proneness Scale in conjunction with the measures of guilt-proneness, suicidal ideation, hopelessness at the time of admission, hopelessness at the time of discharge and age will be significant predictors of hospitalized suicidal individuals' response to treatment as represented by their length of hospitalization.

CHAPTER II

METHOD

The purpose of this chapter is to detail the procedures used to construct the Shame-Proneness Scale and to examine its relationship to a treatment outcome measure for psychiatrically hospitalized suicidal individuals. The research consisted of four phases. The first phase involved the initial scale construction process including scale definition, response format selection, item writing, item selection, and determination of the scale's factorial stability. The second phase consisted of estimating the scale's test-retest reliability and concurrent validity. The third phase entailed the determination of the Shame-Proneness Scale's ability to discriminate between psychiatrically hospitalized suicidal and non-suicidal populations. The fourth and final phase of this research explored the relation between the Shame-Proneness Scale and a measure of the hospitalized suicidal participants' response to treatment.

Research Participants and Their Selection

233 participants from two groups were used throughout the entire research project. The first group (Group I) of

143 participants was recruited from individuals who were currently hospitalized in the acute admissions unit of Lakeshore Mental Health Institute (LMHI), Knoxville, Tennessee as a result of either expressed suicidal threats or some overt suicidal behavior. The second group (Group II) consisted of 90 non-suicidal, non-psychotic individuals currently hospitalized in the acute admissions unit of LMHI. All participants were volunteers and the confidentiality of their responses was maintained. All participants were informed of the voluntary nature of their participation and were allowed to withdraw from participation at any time without consequences. Clearance was obtained from the appropriate human subject review committees (both at LMHI and The University of Tennessee) prior to the collection of data. Tables 1 and 2 summarize the demographic data for each participant group. The average age for Group I was 29.2 and for Group II was 35.5. Both groups consisted of approximately twice as many women as men. The majority of participants had incomes below $10,000 and were unmarried or divorced.

Procedures

Research participants were asked to complete two different sets of research materials. The first set was administered as soon as possible after admission to the hospital, generally within the range of 24 to 48 hours.

Table 1

Demographic Data for Research

Participant Group I

N = 143

		Number	Percent
Age			
Mean	29.2		
SD	6.9		
Median	29.0		
Range	25		
High	40		
Low	18		
Sex			
Male		60	42
Female		83	58
Marital Status			
Single		71	50
Married		12	8
Separated/Divorced		60	42
Years of School Completed			
0 - 9		35	24
10 - 12		71	50
13 +		37	26
Annual Family Income (in thousands of dollars)			
0 - 5		92	64
6 - 10		51	36

Table 2

Demographic Data for Research

Participant Group II

N = 90

		Number	Percent
Age			
Mean	35.5		
SD	7.4		
Median	32.0		
Range	28		
High	53		
Low	25		
Sex			
Male		48	53
Female		42	47
Marital Status			
Single		42	47
Married		6	6
Separated/Divorced		42	47
Years of School Completed			
0 - 9		24	26
10 - 12		48	53
13 +		18	21
Annual Family Income (in thousands of dollars)			
0 - 5		36	40
6 - 10		30	33
10 +		24	27

Materials were coded to facilitate the matching of admission sets with discharge sets. A second set of instruments was completed just prior to discharge from the hospital. The purpose of the study was provided to all participants and written informed consent was obtained prior to the completion of any research materials. Additionally, those participants selected for inclusion in the test-retest phase of the study were asked to complete the items of the Shame-Proneness Scale approximately 2 weeks after their original completion date.

Measures

All research participants were given an initial research packet containing a demographic information sheet and the following: a) the initial pool of items for the Shame-Proneness Scale (see Appendix A), b) the Self-Consciousness Scale (Fenigstein, Scheier, & Buss, 1975), c) the Rosenberg Self-Esteem Scale (Rosenberg, 1979), d) the Hopelessness Scale (Beck, Weissman, Lester, & Trexler, 1974), e) the Apprehensive Scale from the 16 PF (Cattell, 1970) and f) the Scale for Suicide Ideation (Beck, Kovacs, & Weissman, 1979). A separate packet was completed upon discharge, consisting of the Shame-Proneness Scale items and the Hopelessness Scale.

The Self-Consciousness Scale (Fengistein, Scheier, & Buss, 1975) is a 23-item self-report scale consisting of

three sub-scales labeled a) Private Self-Consciousness, b) Public Self-Consciousness, and c) Social Anxiety. A thirty eight item pool was used to select final items using a factor analytic selection process. The Private Self-Consciousness factor concerns the individual's tendency to attend to his/her own thoughts and feelings. The Public Self-Consciousness factor assesses the degree to which the individual is prone to be aware of him/herself as an object of public examination and evaluation (Garfinkel, 1956; Duval & Wicklund, 1972). The Social Anxiety factor assesses the level of discomfort experienced by the individual in the presence of others. Inter-factor correlations have been found to be low, ranging from r = -.06 (private with social anxiety) to r = .26 (public with private). Test-retest reliability was measured for the scales, and was measured to be .84 (public), .79 (private), and .73 (social anxiety). The test-retest correlation for the total score was measured to be .80. A significant positive but moderate correlation was expected between scores on the Public Self-Consciousness, Private Self-Consciousness, and Social Anxiety sub-scales of the Self-Consciousness Scale and scores on the Shame-Proneness Scale.

The Rosenberg Self-Esteem Scale (SES: Rosenberg, 1979) is a 10-item self-report scale which reportedly measures a global sense of self-esteem. Test-retest reliability was measured to be .85 after a two week period using college

student participants (Silber and Tippett, 1965). Low scores on the SES have been found to be correlated with high levels of reported depression (Rosenberg, 1965) and with the reporting of psychosomatic symptoms (Kaplan & Pokorny, 1969). High scores on the SES have been found to correlate with participation in extracurricular activities (Rosenberg, 1965) and participation in Upward Bound programs has been found to produce improved SES scores (Hunt & Hardt, 1969). Scores on the Self-Esteem Scale were expected to correlate negatively with scores on the Shame-Proneness Scale.

The Hopelessness Scale (HS: Beck et al., 1974) is a rationally constructed 20-item, true-false scale designed to measure the degree to which an individual's cognitive schemas are dominated by negative expectations towards the future. One-half of the items are reverse scored, and total scores can range from 0 to 20. Concurrent validity estimates have ranged from .60 to .86, using clinical ratings as the criterion measure. Internal consistency of the scale has been measured and a coefficient alpha (KR-20) of .93 obtained. The HS has been widely used in research dealing with suicide and the issue of hopelessness, as well as having been used as a variable to measure treatment response for depressed psychiatric patients (Beck et al, 1974).

The Scale for Suicide Ideation (SSI; Beck, Kovacs, & Weissman, 1079) is a 19-item clinical rating scale designed

to quantify and assess suicidal intention. The SSI is a rationally derived scale, originally consisting of 30 items. Overlapping and ambiguous items were eliminated through clinical trials and the final 19 item scale emerged. Each item consists of three alternative statements scored from 0 to 2, thus the total possible score ranges from 0 to 38. The scale's items assess a variety of suicidal thoughts and characteristics, including the extent of the individual's wish to die, actual suicide plans, and the presence of internal deterrents. The internal consistency of the scale has been measured and a coefficient alpha (Cronbach, 1951) of .89 was obtained. This item analysis also measured item-total correlation coefficients, with 17 items having correlations ranging from .22 to .72, all significant at the .05 level of significance. Two items (relating to suicide related plans and degree of deception) had non-significant correlations but were retained in the final scale because of their potential clinicaL utility. Interrater relibility has also been measured. Using two independent raters, the interrater reliability coefficient was measured to be .83 ($p < .001$). Concurrent validity has been tested using the self-harm items of the Beck Depression Inventory (Beck, 1972) and a moderate correlation ($r = .41$, $p < .001$) obtained. Discriminant validity has been measured, using suicidal and non-suicidal depressives as the

comparison groups, with the scale demonstrating more than adequate discriminitive capabilities ($t = 4.14$, $p < .001$).

Phase I: Scale Construction Procedures

The following section presents a description of the initial scale construction procedures which were followed, specificially addressing the problems of scale definition, item writing, response format, item selection criteria, and data analysis. For this phase of the study, only the protocol of the hospitalized suicidal individuals were used.

Initial Scale Definition

The personality trait of shame-proneness was selected for operational definition because of the identification of shame as a) a pervasive feature of experience in disturbances of narcissistic equilibrium (Broucek, 1982; Kinston, 1983) and b) an essential element in narcissistically motivated suicidal ideation and behavior (Grinker, 1955; Kohut, 1977). To help the process of item writing, a working definition of shame was written. The initial working definition was as follows:

Shame is an unpleasant affective state which can be either primary or secondary in nature. Primary shame is composed of the following components: a) experiencing or anticipating a painfully heightened awareness of one's self as an object of observation by others, b) this awareness

being related to a self-perceived shortcoming of the self, c) the belief that others are or will have a negative reaction to what is exposed, and d) an attendant wish to withdraw or hide oneself. Primary shame may also be experienced as a result of a similar response involving others with whom the individual identifies (e.g., family members or peer group members). Secondary shame is the same experience but specifically related to the individual's painful awareness of his/her tendency to experience shame. This secondary shame may also be related to shame derivitives such as shyness, grandiosity, etc.

Item Pool and Response Format

Rational procedures were used to guide item writing. Items for the Shame-Proneness Scale were written to assess both primary and secondary shame as well as commonly identified defensive attitudes which may result from a high degree of shame-proneness. Appendix A contains the original list of thirty items which were written according to the scale definition. Because of the self-psychological emphasis on the individual's inner experience versus objective, observable events, an attempt was made to word items in terms of a person's phenomenal perspective, rather than in terms of behavioral or situational perspectives. Items were written to depict moderate to severe experiences of shame or its derivatives in a target population of adult

individuals. Items were written such that endorsement of items represented an affirmation of a tendency to experiencing shame. The decision to write items in a negative direction is made as a result of the nature of the trait under consideration. While shame-proneness may well be a bi-polar trait, the current research is concerned with its manifestation not its absence, which may or may not imply the presence of another trait (for example, self-esteem, as suggested by Levin, 1967). In addition, while shame-proneness is viewed as evidence of a narcissistically vulnerable self, its absence does not necessarily imply cohesiveness of the self (Kinston, 1983).

Items were edited to maintain their clarity and to attempt to maintain a similar level of severity. The items are intended to represent moderate-to-severe forms of the experience of shame. Content for the items was drawn from the clinical literature dealing with shame and suicide, and from conversations with practicing clinicians and hospitalized patients.

A six-point Likert-type response format was selected to provide for a greater range of responses, thereby maximizing the sensitivity of the instrument as compared to using dichotomous items which provide for only one choice: agree or disagree. A six-point scale was selected to allow subjects to respond positively or negatively at three different levels, and to eliminate the possibility of a no

preference response pattern that an odd-numbered scale would allow. Respondents were asked to indicate the degree to which they believe the item is characteristic of themselves. Responses were scaled along a six-point continuum, anchored with Strongly Disagree at 1 and Strongly Agree at 6. The other available choices were Moderately Disagree (2), Slightly Disagree (3), Slightly Agree (4), and Moderately Agree (5). Appendix B contains a copy of the complete Shame-Proneness questionnaire completed by participants. Complete instructions were provided on the first page with each page showing the responses to be used.

Item Selection and Data Analysis

The primary purposes of this step in scale construction were to select the final items for inclusion in the Shame-Proneness Scale and to determine the factor structure of the scale. To accomplish this, four steps were taken. First, the total pool of 30 items had to be reduced in number to maintain a participant-to-item ratio of approximately 10:1. To accomplish this, alpha coefficients were obtained for the total pool of items. A cutoff score of .45 was used to select items for later factor analysis. Next, a factor analysis was conducted using the retained items to identify those items which accounted for the greatest part of the variance present in the responses to all items. A principal components factor analysis was

performed using an orthogonal rotation (SPSS-X, 1986). An orthogonal rotation was chosen because it establishes the independence of factors detected. Items were selected which significantly loaded on one factor but not on any other. Those items with significant factor loadings were retained for further examination. If at least 10 items were not retained as a result of this step (i.e., there are fewer than 10 items with significant factor loadings), additional items were to be selected, if possible, on the basis of their item-factor score correlation and on their contribution to the internal consistency of the scale.

In the third step, those items which contributed most to the internal consistency of the scale obtained via factor analysis were to be examined. Coefficient alpha (Cronbach, 1951) was used to obtain the estimates of internal consistency. A final scale size of approximately 10 items was desired to insure high item and scale reliability. The rating scale's internal consistency was determined by computing the alpha coefficient using the SPSS-X (1986) statistical package. Coefficient alpha is equivalent to the KR-20 reliability estimate for dichotomous data, but has been modified for use with continuous data. Guilford (1954) notes that internal reliability is considered to be the "best" estimate of a scale's reliability.

The fourth and final step consisted of a determination of the factorial stability of the final scale. Factorial

stability was established using the same factor analytic method described above. The responses of the original pool of participants was randomly divided in half and a factor analysis conducted to determine the stability of the derived factor.

Phase II: Estimating Test-Retest Reliability and Concurrent Validity

Once the final items were selected for the Shame-Proneness Scale, the scale's test-retest reliability was evaluated and estimates of concurrent validity were obtained.

Data Analysis

Test-retest reliability was examined by randomly selecting a sample from both participant groups to complete the Shame-Proneness Scale approximately two weeks after initial completion. Correlation coefficients were calculated to determine the temporal stability of the scale. To examine the issue of concurrent validity, correlations were obtained between suicidal participants' scores on the Shame-Proneness Scale and their scores on the Public and Private Self-Consciousness and Social Anxiety sub-scales of the Self-Consciousness Scale and the Self-Esteem Scale.

Phase III: Estimating the Discriminant Validity of the Shame-Proneness Scale

Having selected the items of the scale and estimated its reliability and concurrent validity, further exploration was conducted to estimate the scale's discriminant validity. A preliminary analysis of variance (ANOVA) was performed to determine the presence of any significant differences between the two participant groups along the demographic variables of sex, education level, income level, marital status, and age. If a significant difference existed along any of these variables, the variable(s) would be included in later analyses.

Data Analysis

A discriminant analysis was performed to determine the ability of the Shame-Proneness Scale alone to discriminate between the participant groups of hospitalized suicidal and non-suicidal individuals. In addition, further analyses were performed to explore the scale's ability to discriminate group membership in conjunction with the Self-Consciousness, Self-Esteem, and Hopelessness scales. This latter procedure consisted of a stepwise discriminant analysis utilizing the SPSS-X statistical package (SPSS, 1986).

Phase IV: Shame-Proneness and Treatment Outcome

Shame-proneness has been construed to be a significant predictor of some hospitalized suicidal individuals' response to hospitalization. To examine the relation between scores on the Shame-Proneness Scale and treatment outcome, the following regression model was examined. Treatment outcome was evaluated on the basis of the individual's the length of hospitalization. It was reasoned that shame-proneness would be a significant predictor because of the central aspect of the experience of overwhelming shame to some suicidal thinking and behavior, with the individual's reporting greater shame-proneness showing a less positive treatment response as represented by longer stays in the hospital.

Other variables were included in this analysis as well. The admission level of hopelessness was expected to be a significant predictor of treatment outcome because of its indication of the individual's initial level of distress, with more severely distressed individuals showing less positive response to treatment. The individual's level of reported hopelessness at the time of discharge was expected to be a significant predictor of length of stay because of the importance of the individual's future orientation to those clinicians who make decisions about discharge. As a measure of the individual's degree of suicidal intention, the patients' score on the Scale for Suicidal Ideation was

expected to be a significant predictor of treatment outcome, with the more serious suicidal individual's showing longer lengths of hospitalization. The individual's level of guilt-proneness was expected to be a significant predictor of treatment outcome because of the identification of the guilt-depression cycle as one causitive factor in some serious suicidal behavior, with higher guilt-prone individual's showing less positive response to treatment. The age of the participant was also expected to be a significant predictor of treatment outcome, owing to changes in maturity and readiness to make use of available resources within the hospital. The regression model which was examined is presented in figure 1.

Dependent Variables

One measure was used as the criterion variable for the regression analyses. This variable was the suicidal participant's length of hospitalization in days.

Independent Variables

Six independent variables were used for this analysis: the Shame-Proneness Scale score, the individual's score on the Hopelessness Scale at the time of admission, the individual's score of the Hopelessness Scale at the time of discharge, the individual's score on the Scale for Suicidal Ideation, the individual's score on the Apprehensive

Regression Model

$$\text{Shame} + \underset{\text{Admission}}{\text{Hopelessness}} + \underset{\text{Discharge}}{\text{Hopelessness}} + \text{Guilt} + \underset{\text{Ideation}}{\text{Suicidal}} + \text{Age} = \underset{\text{Stay}}{\text{Length of}}$$

Figure 1. Regression Model for Predicting Treatment Outcome

(guilt-proneness) scale of the 16 PF, and the age of participant.

Data Analysis

The first step of this analysis was the construction of a correlation matrix for the above variables. The relations between the independent variables and the dependent variables were examined. Those independent variables with little or no correlation to the criterion measures and variables showing high intercorrelations were discarded. The resulting variables were employed in a multiple regression analysis to determine the relative contributions of the variables to the treatment outcome measure.

CHAPTER III

RESULTS

This chapter presents the results of the various data analyses and is divided into four sections. The first section presents the results of the scale construction efforts resulting in the selection of final scale items. The second section presents estimates of the scale's reliability and concurrent and construct validity. The third section presents estimates of the scale's ability to discriminate between suicidal and non-suicidal participants, including the results of the ANOVA procedure. The last section presents results from the testing of the regression model to examine the relation between scores on the Shame-Proneness Scale and the suicidal participants' response to treatment.

Initial Scale Construction

Initial scale construction consisted of the factor analysis of the item pool, selecting those items which would produce the most internally reliable scale. Next, a second factor analysis was performed to establish the factorial stability of the derived scale.

Item Analysis

Because the total of suicidal participants numbered 143, the original 30-item pool needed to be reduced in number to approximately 14 to preserve a participant-to-item ratio of roughly 10 to one. Items were selected for retention based on their alpha coefficient, the corrected item-total scale correlation. A cutoff score of .45 was used to select items for final factor analysis. Table 3 presents the alpha coefficients for the total 30-item pool. The 30-item pool had an overall alpha of .91, which indicates that even at this level the items have a high degree of internal consistency.

Use of the above selection criteria resulted in 16 total items being retained for factor analysis, with the resultant participant-to-item ratio being 8.9 to 1. This 16-item pool was then factor analyzed to obtain the final set of items for retention as the Shame-Proneness Scale. A principal components extraction was employed because this form of extraction maximizes the independence between factors. Furthermore, a quartimax rotation was used to arrive at the terminal solution. The quartimax procedure is one of the orthogonal rotations available through the SPSS statistical package. This procedure rotates the initial factors derived from extraction in such a way to maximize the loading of each variable on one and only one factor.

Table 3

Alpha Coefficients for Original Pool of Shame-Proneness Items

Item	Alpha	Item	Alpha	Item	Alpha
1.	.29	11.	.75*	21.	.44
2.	.50*	12.	.24	22.	.06
3.	.43	13.	.68*	23.	.44
4.	.63*	14.	.43	24.	.49*
5.	.39	15.	.47*	25.	.52*
6.	.53*	16.	.49*	26.	.34
7.	.38	17.	.44	27.	.53*
8.	.37	18.	.75*	28.	.73*
9.	.50*	19.	.53*	29.	.85*
10.	.33	20.	.64*	30.	.37

Cronbach's alpha = .91

* - Retained for factor analysis

The principal components extraction derived five significant factors having eigenvalues ranging from 1.03 to 7.46. Table 4 presents a summary of these factors and their relative strength. The factors' eigenvalues, number of associated items, and percent of variance accounted for are noted. Table 5 presents the loadings of each item for the five derived factors based on the quartimax rotation. Items were considered to pertain to a specific scale when they had a significant loading on that scale and no significant loading on any other scale. For N = 143, a loading of .35 was considered significant (Gorsuch, 1974).

Of the five significant factors which were identified, only the first had more than two items associated with it. This factor had ten items which loaded significantly and relatively independently on it (2, 4, 9, 11, 13, 18, 19, 24, 28, and 29). Loadings for these items ranged from .56 to .91. None of these items loaded above .32 on any other factor. Table 6 shows the ten items of this factor and their factor loadings. Because this initial step of scale construction produced a 10-item factor, no additional items were needed to be added to this factor.

Because of the appearance of several secondary factor loadings, exploratory analyses were performed using alternative extraction and rotation procedures, both orthogonal and oblique. None of these combinations produced results as satisfying as the principal components extraction

Table 4

Summary Statistics for Five Significant Factors Derived from Final 16-Item Pool

Factor	Items	Eigenvalue	% Variance
1.	10	7.46	46.7
2.	2	2.37	14.8
3.	1	1.63	10.2
4.	2	1.47	9.2
5.	1	1.03	6.4

Table 5

Factor Loadings for All Derived Factors

Item	Factor 1	Factor 2	Factor 3	Factor 4	Factor 5
2.*	.56	-.09	.27	-.19	.26
4.*	.91	-.25	.07	.20	.09
6.	.34	-.04	.85	.08	.11
9.*	.81	-.09	-.26	.22	.13
11.*	.62	.31	.19	-.25	.04
13.*	.87	-.16	.15	-.14	.25
15.	.11	.29	.90	.02	-.01
16.	.44	.04	.29	.79	-.10
18.*	.83	.23	.02	.23	-.04
19.*	.57	.32	.26	-.14	-.17
20.	.19	.79	.30	-.16	.40
24.*	.84	.17	-.23	.11	-.31
25.	.36	.15	.03	.03	.88
27.	.31	.85	-.02	.17	-.09
28.*	.78	.26	.14	-.09	-.04
29.*	.89	.20	.23	-.19	.18
Eigenvalue	7.46	2.37	1.63	1.47	1.03
% Variance	46.7	14.8	10.2	9.2	6.4

* - retained for final scale

Table 6

Factor loadings for Final Scale Items

	Item	Factor Loading
2.	When I fail at something I feel as if all eyes are on me.	.61
4.	I am afraid that if I fail at something that others will reject me.	.90
9.	I often feel disgraced.	.87
11.	I think my nose (or some other part of my body) just doesn't look right.	.61
13.	I rarely express myself in groups for fear of others laughing at me.	.67
18.	I feel ashamed even when I make a minor mistake.	.83
19.	When I feel ashamed, I want to run and hide.	.65
24.	When I do or say something stupid, I wish the earth would open up and swallow me.	.84
28.	My parents often made me feel ashamed.	.85
29.	I'm always worried that others will think that I'm dumb.	.95

combined with the quartimax rotation. For example, the equamax rotation with a principal components extraction produced a five item scale and the varimax rotation with a principal components extraction produced a 10 item scale but with even greater secondary loadings. The best combination remained the principal components extraction with a quartimax rotation.

From the above analysis, one 10-item scale emerged. This scale has a possible total score ranging from 10 to 60. A score of 60 would indicate strong agreement with the more pathological items. A score of 10 indicates a strong disagreement. Therefore, a low score signifies a lack of agreement with the discohesive items. The mean score for the suicidal participants used in constructing this scale was 47.6 and its standard deviation was measured to be 12.7. These results are as expected, namely that the suicidal individuals tended to agree with the more pathological items contained in the shame scale.

The alpha coefficient for this scale was found to be .93, which suggests that the items are highly inter-correlated and that the scale has more than adequate internal consistency. Individual item alpha coefficients, item means, item standard deviations, and item contributions to internal reliability were also calculated and are presented in Table 7.

Table 7

Individual Item Statistics for Final Scale

Item	Item X	Item SD	Item-Total Correlation	Alpha if Item Deleted
2.	4.85	1.86	.55	.93
4.	4.92	1.45	.80	.92
9.	4.61	1.44	.65	.93
11.	4.66	1.66	.70	.92
13.	4.92	1.63	.84	.92
18.	4.93	1.34	.78	.92
19.	5.17	1.14	.60	.93
24.	4.75	1.52	.71	.92
28.	4.11	2.10	.79	.92
29.	4.66	1.83	.95	.91

Factorial Stability

To test the derived scale's factorial stability, the original pool of participants was randomly divided in half and a factor analysis was performed on the resultant half, again using a principal components extraction and a quartimax rotation. This resulted in a subject to item ratio of approximately 5 to 1, which is still acceptable for statistical purposes. This analysis produced 5 significant factors as indicated in Table 8. The item loadings for the first two significant factors are presented in Table 9.

Using the same selection criteria as in the previous factor anlaysis, the above factor analysis identified one major factor with 10 items significantly and independently loading on it. This factor consisted of the same items as in the original scale: 2, 4, 9, 11, 13, 18, 19, 24, 28, and 29. Factor loadings ranged from .63 to .95. These results suggest that the scale has a reasonable degree of factor stability.

Reliability and Validity Estimates

Reliability of the derived scale was estimated through the examination of the scale's internal consistency as measured by Cronbach's Alpha and by the scale's test-retest correlation coefficient. Concurrent validity was estimated on the basis of the scale's relationship to the Private Self-Consciousness, Public Self-Consciousness and Social

Table 8

Summary Statistics for Five Significant Factors Derived from Randomly Divided Participant Pool

Factor	Items	Eigenvalue	% Variance
1.	11	7.54	47.1
2.	2	2.09	13.1
3.	1	1.56	9.8
4.	1	1.54	9.6
5.	1	1.19	7.5

Table 9

Factor Loadings for Two Major Factors Derived form Randomly Divided Participant Pool

Item	Factor 1	Factor 2
2.	.68	.25
4.	.83	-.36
6.	.49	.46
9.	.63	-.15
13.	.82	-.04
15.	.45	.63
16.	.42	-.27
18.	.82	-.32
19.	.73	.21
20.	.56	.61
24.	.71	-.18
25.	.35	.26
27.	.55	.01
28.	.81	-.03
29.	.95	.06
Eigenvalues	7.54	2.08
Percent Variance	47.1%	13.1%

Anxiety sub-scales of the Self-Consciousness Scale and the Rosenberg Self-Esteem Scale. Construct validity was estimated through examining the relation between scores on the Shame-Proneness Scale and the scores on the guilt-proneness scale of the 16 PF.

Reliability Estimates

The scale's alpha coefficient was calculated to be .93. The test-retest reliability coefficient based on Pearson product-moment correlation for an approximate two-week interval from 61 retest protocols is .81. These results clearly indicate that the scale has a high degree of internal consistency and a more than acceptable test-retest reliability.

Concurrent Validity Estimates

Concurrent validity data are presented in Table 10. The Shame-Proneness Scale was significantly positively correlated with the Private Self-Consciousness and Social Anxiety Scales and significantly negatively correlated with Self-Esteem, as predicted. These correlations suggest that as the individual's succeptibility to shame increases, his/her subjective awareness of self and anxiety in social situations increases and his/her self-esteem decreases. No significant correlation was found to exist between scores on

Table 10

Concurrent Validity Estimates for

Shame-Proneness Scale

Variable	Correlation with Shame-Proneness
Private Self-Consciousness	.23*
Public Self-Consciousness	.09
Social Anxiety	.66**
Self-Esteem	-.55**

* $p < .01$

** $p < .001$

the Shame-Proneness Scale and the Public Self-Consciousness Scale.

Construct Validity Estimates

Because of the lack of distinction between shame and guilt in many clinical articles, an attempt was made to determine the relative independence of these two concepts by examining the relationship between scores of the Shame-Proness Scale and the guilt-proneness scale of the 16 PF. This correlation was found to be .49 and was significant at the $p = .001$ level. This moderately high correlation suggests that shame and guilt, as measured by these two instruments, are related concepts. The guilt-proneness scale employed does have several items which appear to be more shame-related than guilt-related, and its theoretical foundation is not as specific as that of the current scale. The significance of this relationship will be explored further in the next chapter.

Discrimination Between Suicidal and Non-Suicidal Participants

To determine the ability of the Shame-Proneness Scale to differentiate between suicidal and non-suicidal participants, an ANOVA was first performed to determine any differences between the two participant groups based on several demographic and socio-economic variables. Variables

which demonstrated a significant difference between the two groups were then included with the Shame-Proneness Scale and the Self-Consciousness, Self-Esteem, and Hopelessness scales in a stepwise discriminant analysis.

Participant Group Differences

The groups of hospitalized suicidal and non-suicidal participants were compared using an MANOVA procedure to determine the presence of any significant differences along several demographic and socio-economic variables. The variables selected for inclusion were age, sex, income, marital status, and years of school completed. Table 11 presents the results of this MANOVA.

The age of the participant and their amount of yearly income were the only two variables on which the two participant groups differed significantly. The mean age of the suicidal group was 29.5 while the mean age of the non-suicidal group was 35.3. The mean income level of the suicidal group was $3,500 per year while the mean for the non-suicidal group was $9,300 per year. While an observed difference between groups on these variables may indicate selection bias, Neter and Wasserman (1974) strongly indicate that it is inappropriate to attempt to compensate for this by including such variables as co-variates in later analyses. The clinical problems represented by each group may in fact have more to do with the difference than any

Table 11

Participant Group MANOVA Results*

Variable	Sum of Squares	Error Sum of Squares	F	Sig. of F
Income	1725.58	8177.95	48.74	.0001
Sex	.71	57.23	2.89	.09
Years of School	23.50	2117.38	2.56	.11
Marital Status	.33	214.15	.35	.55
Age	2153.61	11,570.92	42.99	.0001

* Univariate F-tests with (1,231) D. F.

selection bias, and to attempt to eliminate or compensate for this difference would possibly filter out important data. Therefore, because of their significance, these two variables were included in the discriminant analysis which is discussed below.

Discriminant Analysis

To determine the ability of the Shame-Proneness Scale to differentiate between suicidal and non-suicidal participants, a discriminant analysis was performed using first the score on the Shame-Proneness Scale as the discriminant. A second analysis was performed which also included the additional variables of age, income level, and scores on the Self-Consciousness Scale, Rosenberg Self-Esteem Scale, and the participant's Hopelessness at the time of admission. The classification results of the discriminant analysis using the scores on the The mean score for suicidal participants on the Shame-Proneness Scale was 47.6 while the mean for non-suicidal participants was 28.5. Shame-Proneness Scale alone are presented in Table 12. Using the variable of Shame-Proneness alone, participants were classified correctly approximately 72% of the time. The discriminant function employing all listed variables was able to correctly classify participants as to group almost 90% of the time (results presented in Table 13). Each variable was also examined for it's ability to correctly

Table 12

Classification Results:

Shame-Proneness

Actual Group	No. of Cases	Predicted Group	
		Suicidal	Non-Suicidal
Suicidal	143	107	36
		(74.8%)	(25.2%)
Non-Suicidal	90	30	60
		(33.3%)	(66.7%)

Percent of cases
correctly classified = 71.67

Table 13

Classification Results:

All Variables

Actual Group	No. of Cases	Predicted Group	
		Suicidal	Non-Suicidal
Suicidal	143	131	12
		(91.6%)	(8.4%)
Non-Suicidal	90	12	78
		(13.3%)	(86.7%)

Percent of cases
correctly classified = 89.70

classify participants alone. Appendix C (Tables 17 through 23) presents the classification results for each individual variable. The variable which could most reliably classify participants was Self-Esteem (79%) and the least reliable was Public Self-Consciousness (51.5%). Table 14 presents a summary of the classification results for each of the variables used.

Shame-Proneness and Treatment Outcome

The ability of scores on the Shame-Proneness Scale to predict treatment outcome for suicidal participants was analyzed using a multiple regression model, with length of stay in the hospital as the outcome measure. A correlation matrix was constructed first to eliminate those variables which had no relation to the outcome measure or which were too highly inter-correlated. The retained variables were employed in a multiple regression procedure to determine the best predictor(s) of treatment outcome.

Correlation Matrix

A correlation matrix of all independent and dependent variables is provided in Table 15. The means and standard deviations for all dependent and independent variables appear in Table 24 (see Appendix C). Significant correlations were found between Shame and all variables with the exception of age. The independent variables of

Table 14

Summary of Classification Results:

Each Variable Alone

Variable	Correct Classification Percentage
Shame	71.67
Age	58.37
Income	68.24
Self-Esteem	79.40
Hopelessness	77.25
Public Self-Consciousness	51.50
Private Self-Consciousness	45.92
Social Anxiety	59.23

Table 15

Correlation Matrix of Independent and Dependent Variables

	Shame	Hope1	Hope2	Suicide	Guilt	Age
Hope1	.58***	1.00				
Hope2	.18*	.02	1.00			
Suicide	-.13*	.08	-.31***	1.00		
Guilt	.49***	.70***	.30***	-.24**	1.00	
Age	-.11	-.09	.44***	.24**	-.17*	1.00
LOS	.21*	-.13*	-.21**	-.05	-.10	-.14*

* p < .05

** p < .01

*** p < .001

shame-proneness (Shame), hopelessness at admission (Hope1), hopelessness at discharge (Hope2), and age were retained for inclusion in the testing of the regression model. The variables of guilt and suicidal level were dropped from further consideration because of the lack of a significant correlation between them and the dependent variable of length of stay in the hospital.

Multiple Regression Model

On the basis of the correlation matrix results, the original regression model was revised, and is presented in Figure 2. A total of 143 participants were used for this part of the study. Table 16 presents a summary of the results of the regression analysis and shows the predictive validity of the independent variables on length of stay in the hospital. The variables of Hope2, Shame, and Hope1 were all found to be significant predictors of the length of stay in the hospital ($p < .01$ for Shame and Hope1 and $< .05$ for Hope2).

Multiple Regression Model

Shame + Hope2 + Hope1 + Age = Length of Stay

Figure 2. Revised Multiple Regression Model

Table 16

Multiple Regression Model: Predicting Length of Hospitalization

Independent Variable	B	Multiple R	R square change	F	Significance of F
Hope2	-.25	.21	.04	6.57	.01
Shame	.06	.27	.03	5.52	.005
Hope1	-.09	.32	.03	5.33	.002

CHAPTER IV

DISCUSSION

Previous chapters have presented a theoretical perspective for this study, a review of related research, the method of the current study, and its results. The purpose of this chapter is to discuss the results of the previously presented data analysis, focusing on their significance to the problem which the study was designed to address and the implications of the results to future research and clinical practice. Five general areas will be covered: the psychometric properties of the constructed scale, the meaning of the scale, the relation of scores on the scale to treatment outcome for hospitalized suicidal individuals, implications from the study for future research and clinical applications, and finally the limitations of the study.

Psychometric Properties of the Scale

The scale construction procedures employed to develop the final scale were a combination of rational and empirical procedures intended to blend the theoretical perspective of psychoanalytic self psychology (Kohut, 1978, 1979, 1984), clinical case material, and state of the art factor analytic

techniques. The formal scale construction efforts began with an initial item reduction step to maintain a subject to item ratio of approximately 10 to 1. The corrected item-to-total correlation (i.e., alpha coefficient) was used to aid in selection of items at this stage. The resultant set of 16 items had alpha coefficients ranging from .47 to .85, which suggests that even at this stage the item pool had moderate internal consistency. These items were then submitted to a factor analytic procedure which resulted in the selection of the ten items of the final scale. The factor loadings for these ten final items ranged from .56 to .91, with seven of the ten loading over .75. Several items did have relatively high loadings on secondary factors, the highest of these being .32. This result suggests that the final scale is not composed of items which correlate only with the primary factor. However, alternative factor analytic approaches failed to produce a simpler result.

The primary, 10-item factor accounted for 46.7% of the total variance produced by the 16 item pool. The six items which comprised the 4 additional significant factors accounted for an additional 40.6% of variance. This suggests that these items dealt with valuable areas of interest related to but separate from those contained in the primary factor. Their differentness from the items of the first factor served to reduce the apparent strength of the

first factor and diminish the amount of varaince for which it accounted.

The final set of items derived from the factor analytic procedure was also examined to determine its internal consistency and reliability. The high internal consistency (alpha coefficient of .93) and the moderately high test-retest coefficient (.81) indicate that the scale is internally cohesive and that it is stable over time. These estimates provide strong support for the stability and soundness of this scale.

The validity of the scale was also examined and predicted relationships were discovered between scores on the constructed scale and measures of Private Self-Consciousness, Social Anxiety, and Self-Esteem. As reported levels of shame-proneness rise, so do levels of subjective self-awareness and anxiety about social situations. Conversely, as reported levels of shame-proneness increase, reported levels of self-esteem decrease. Both these relationships were as predicted by the self-psychological foundations of the scale, and serve as support for the construct validity of the constructed scale.

The Meaning of the Final Scale

The above moderate to strong psychometric support for the final scale supports its existence as a statistical reality which may represent a defined psychological

construct. However, even the most robust psychometric results do not suggest the meaning of the scale constructed. This meaning must be inferred from a) the item content and its relation to the original definition of shame, b) the relation between scores on the scale and scores on measures of related constructs, and c) the scale's ability to discriminate between clinical populations, as suggested by the theoretical foundations of the scale.

The working definition of shame for this study which guided item writing was comprised of three fundamental parts: 1) a painfully heightened awareness that one's shortcomings were the target of observation by others, 2) the belief that others are or will react negatively to what they observe, and 3) a related desire to hide or withdraw. Examining the items of the final scale it is discovered that three of the items describe heightened feelings of being observed by others as a result of some imperfection, three of the items express a feeling or fear of being rejected or criticized by others, two of the items express the desire to hide as a response to feeling ashamed, and the other two items express sensitivity to shame under minor circumstances and a history of being made to feel ashamed by parents. Clearly, the content of these items directly reflects the original definition of shame as outlined above. They include the heightened awareness of being observed, the fear of rejection, the wish to hide, a sensitivity to shame,

and even an historical element related to parents. This set of items clearly represents all the elements of the defined construct of shame-proneness. This close adherance of the final scale items to the original definition of shame provides further support for the notion that the scale being constructed is a measure of shame-proneness, as defined in this study.

The next issue to examine is the relationship of scores on the scale to scores on related measures. These relationships fall into the areas of concurrent and construct validity. Measures used for the concurrent validity testing included the two measures of Self-Consciousness, the measure of Social Anxiety, and the measure of Self-Esteem. The constructed scale had significant positive correlations with Private Self-Consciousness (.23) and Social Anxiety (.66), and a significant negative correlation with Self-Esteem (-.55). The Public Self-Consciousness scale showed no significant correlation with the constructed scale. Although mixed, these results appear to be supportive of the concurrent validity of the shame scale. Clearly, the scale is measuring a construct which incorporates a high degree of discomfort about being around other people, a heightened inner level of attention being paid to one's self, and one which is not found in the presence of high self-esteem, all

of which are supportive of the intent of the scale as a measure of shame-proneness as defined in this study.

To assess the construct validity of the scale under construction, the relationship between the scores on the constructed scale were compared to scores on a measure which assessed some degree of an individual's general apprehensiveness which was used in this study as a measure of guilt-proneness. The intent of this portion was to attempt to distinguish between the related concepts of shame and guilt. The present study, like others before it (e.g., Ursu, 1984) has been unable to do so. Scores on these two measures had a significant positive correlation of .49. This result indicates that the elements of shame-proneness measured by the scale under construction are not independent of those elements of guilt-proneness which are measured by the Apprehensive Scale of the 16 PF. A close examination of the items of the Apprehensive Scale provides a possible explanation for this occurance. Five of the 13 items of the Apprehensive Scale contain ambiguous content dealing with issues such as reactions to feeling criticized, fear of failure, and some degree of social unease. These items'content is such that their content may be related to feelings of guilt or to feelings of shame. Therefore, the moderate correlation between these two measures is viewed as a result of the ambiguity of the items of the Apprehensive

Scale rather than a significant correlation between the constructs of shame-proneness and guilt-proneness.

The final area to consider vis a vis the meaning of the scale is its ability to discriminate between clinical populations. The theoretical underpinnings of the scale suggested that some proportion of suicidal individuals are significantly shame-prone, and the scale was examined for its ability to discriminate between suicidal hospitalized individuals and non-suicidal individuals.

The results of the discriminant analysis indicated that the constructed scale alone was able to correctly calssify a participant's group membership (suicidal or non-suicidal) approximately 72% of the time. When a similar analysis was conducted using eight variables (age, income level, hopelessness at admission, self-esteem, public self-consciousness, private self-consciousness, social anxiety, and the constructed scale) the resultant percentage of correct classification was increased by 25% to approximately 90%. Given that is was hypothesized only that some, not all, suicidal individuals are shame-prone, these results appear to support the position that high degrees of shame are characteristic of a significant percentage of suicidal individuals. Furthermore, these results suggest that scores on a scale constructed to measure shame-proneness do adequately discriminate between suicidal and non-suicidal hospitalized individuals. It is worth

noting that the incorrect classification rate was 32% greater for non-suicidal individuals. While the relatively low number of subjects may account for this to some degree, this result appears to suggest that a fair percentage of non-suicidal hospitalized individuals also score high on the constructed scale. This is not surprising, as shame-proneness has not been construed to be a symptom of suicidal feelings alone and may in fact occur in individuals with a variety of clinical diagnoses.

Reviewing the above, first, strong support is seen for the scale being representative of the original definition from the contents of the items. Next, scores on the scale had expected relationships with two out of three related measures. Third, a moderate correlation was found between scores on the scale and a measure related to guilt-proneness. And lastly, it was discovered that the scale is able to more than adequately discriminate between suicidal and non-suicidal individuals. Although these results are mixed, taken as a whole they appear to be supportive of the relationship between the scale under construction and the original definition of shame, and therefore the scale will be labeled the Shame-Proneness Scale.

Shame-Proneness and Treatment Outcome

To test the potential utility of the Shame-Proneness Scale in a clinical setting, scores on the Scale were included in a multiple regression analysis with the dependent variable being the individual's length of hospitalization in days. It was hypothesized that greater levels of shame-proneness are indicative of greater discohesion in the self structure of the participants, and that individuals with greater self disruption would require longer hospitalization. Hopelessness (upon admission and at discharge) and Shame were found to be significant predictors of participants length of stay, however the model used to predict participant length of hospitalization was not a strong one, accounting for only 10% of the total variance. Hopelessness at admission was the best predictor, accounting for 4% of the variance with a significant F at $p < .01$. Shame was the next best predictor, accounting for 3% of the variance and having an F at $p < .005$. The last significant variable in the equation was Hopelessness at discharge, which accounted for 3% of the variance and which had an F at $p < .002$. The results of this regression model appear supportive of the hypothesis that shame-proneness and hopelessness are significant predictors of psychiatrically hospitalized suicidal individuals treatment outcome. However, the small degree of variance accounted for by the model suggest that either a) the utility of the model

is questionable because it fails to consider other more significant variables or b) the variable selected to represent treatment outcome (length of stay) was not an accurate measure of the participants' response to treatment. To summarize, the regression model appears to support the theoretical or construct validity of the construct of shame-proneness, but at this time the scale constructed does not have much clinical utility. The following section will consider several research design issues which may have resulted in these less than desired results and suggest directions of future research efforts.

Problems

The results of the scale construction efforts reported here are encouraging. Strong, albeit mixed, empirical support was found for the validity and reliability of the scale and the use of the scale to predict treatment outcome resulted in some support for the theoretical basis and potential future utility of the concept of shame-proneness. The two greatest difficulties of the study were in the areas of construct validity and the strength of the prediction model.

The examination of the construct validity issue resulted in a fairly high correlation between scores on the measure used to assess shame-proneness (the Shame-Proneness Scale) and scores on the measure used to assess

guilt-proneness (the Apprehensive Scale of the 16 PF). As noted earlier, the use of the Apprehensive Scale may have been the significant factor behind this result. A high proportion of the items of the Apprehensive Scale have ambiguous content which could be interpreted as relating to shame or guilt. Thus, the high correlation may not in fact represent a correlation between shame and guilt-proneness, but rather the internal confusion of the items of the Apprehensive Scale. In light of the fact that there are few other scales available which adequately measure guilt-proneness, an alternative avenue of research for the future would be to combine the items of the Shame-Proneness Scale with newly written items representing guilt-proneness (after having established a working definition for guilt-proneness, of course), and submitting the entire set to a factor analytic procedure as was done in this study. The independence of the two constructs could then be inferred from the independence of the resultant factors.

The second area of concern about this study was the lack of strength of the prediction model. Having accounted for only 10% of the total variance, the utility of this model is minimal. Examination of the outcome variable, however, may shed some light on this. The use of the participants' length of stay in the hospital was hypothesized to represent the relative ability of participants to benefit from treatment. It was hypothesized

that those with greater levels of shame-proneness had greater fragmentation of their self, and would therefore require greater time to respond to treatment. Length of hospitalization was intended to be a measure of their response time. This model failed to consider that the participant's length of stay in the hospital is a variable which may or may not have a direct correlation with the participant's condition. Factors other than patient response to treatment are considered when a hospital treatment team makes discharge decisions, such as the patient having a place to stay, availability of programming upon discharge, etc. Therefore, the use of length of stay may have been inappropriate because it may or may not reflect the patient's actual readiness to return to the community. Another approach would be the use of a criterion variable which did not entail the subjective decisions of others as the measure of treatment response, such as change in hopelessness within a certain period of time. This would insure that the criterion was related to the state of the participant, rather than to the clinically subjective whims of a treatment team.

Implications for Counseling Research and Practice

This study attempted to construct and test a scale derived from Kohut's (1977, 1978, 1984) psychoanalytic

psychology of the self. It was hypothesized that a trait labeled shame-proneness could be identified empirically and measured. Some empirical data were obtained supporting this contention, although one specific area of concern remained debatable. Regardless of this concern, it was felt that the scale was generally sound psychometrically and an attempt was made to establish the meaning of the scale. Given the concurrent validity estimates and the item content, it was decided that the scale does in fact measure the originally defined construct of Shame-Proneness. This construct incorporates the concepts of vulnerability to shame, feeling observed and negatively evaluated by others, and a concomitant desire to hide from others.

An attempt was made to examine the ability of the Shame-Proneness Scale to predict the response to treatment of hospitalized suicidal individuals. This ability was confirmed, however the strength of the prediction model makes it of little practical utility. Even in combination with other theoretically significant variables, shame-proneness was only able to account for 10% of the total variance. This suggests that more extensive consideration needs to be given to how the concept of shame-proneness fits in with the total set of variables which affect length of hospitalization (e.g., other psychological variables, sociological variables, and systemic/hospital-related variables). Perhaps a variable

which relates more to the individual's specific response to treatment and less to the subjective perceptions of others could be found and its relationship to shame-proneness explored.

In general, the results of this study were encouraging and helpful to increasing the understanding of shame-proneness and how it relates to suicidal feelings. The scale had a moderate ability to discriminate between suicidal and non-suicidal participants. As suggested by the Kohut's self psychology, shame-proneness appears to be a significant feature of many suicidal individuals. Regardless of the predictive validity for the scale itself, this study has offered empirical support for the need to consider shame-proneness when dealing with suicidal individuals.

Future research is needed to establish the validity and reliability of the Shame-Proneness Scale, its clinical utility and its relation to other personality measures. Further examination of the construct validity of the scale is warrented, with a combined study related to guilt and shame being one possible avenue. A replication of the scale construction aspects of this study with another population is also indictaed. It may also be advisable to explore the relation between the Shame-Proneness Scale and other self scales derived from Kohut's theory (Robbins & Patton, 1985; Lapan & Patton, 1986; Shreve, 1986). Once the construct

validity is better established, and the place of the Shame-Proneness Scale among other self scales determined, use of the scale within a clinical setting should be explored.

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APPENDICES

APPENDIX A

INITIAL POOL OF SHAME-PRONENESS SCALE ITEMS

Initial Pool of Shame-Proneness Scale Items

1. When I fail to reach my goals I wish I could crawl into a hole and die.
2. When I fail at something I feel as if all eyes are on me.
3. I frequently blush uncontrollably.
4. I am afraid that if I fail at something that others will reject me.
5. When one of my family or friends says or does something stupid I feel embarrassed.
6. I am embarrassed about feeling self-conscious in front of others.
7. I feel very uncomfortable getting any kind of public recognition.
8. I often feel like people are watching me.
9. I often feel disgraced.
10. I will do almost anything to avoid public criticism.
11. I think my nose (or some other part of my body) just doesn't look right.
12. When I was a teenager I avoided being seen with my parents.
13. I rarely express myself in groups for fear of others laughing at me.
14. I often feel ashamed.
15. Most of the time I am shy around others.
16. I don't feel any pride in myself.
17. I would just die if someone could read my mind.
18. I feel ashamed even when I make a minor mistake.
19. When I feel ashamed, I want to run and hide.

Initial Pool of Shame-Proneness Items

(Continued)

20. I avoid situations where I think I might get embarrassed.

21. I feel that I'm not as good as others expect me to be.

22. I get down on myself for not being able to accomplish things.

23. I avoid situations where I might be observed by others.

24. When I do or say something stupid, I wish the earth would open up and swallow me.

25. I am painfully self-conscious.

26. There is nothing about me that others can respect.

27. When I'm put on the spot, I feel confused.

28. My parents often made me feel ashamed.

29. I'm always worried that others will think that I'm dumb.

30. My feelings get hurt very easily.

APPENDIX B

SHAME-PRONENESS QUESTIONNAIRE

Shame-Proneness Questionnaire

Directions: Following are a number of statements that reflect various ways you may feel about yourself. Read each statement one at a time and circle the number at the right that corresponds to your answer according to the following scale:

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
6	5	4	3	2	1

		Agree					Disagree
1.	When I fail to reach my goals I wish I could crawl into a hole and die. . . .	6	5	4	3	2	1
2.	When I fail at something I feel as if all eyes are on me.	6	5	4	3	2	1
3.	I frequently blush uncontrollably . . .	6	5	4	3	2	1
4.	I am afraid that if I fail at something, others will reject me	6	5	4	3	2	1
5.	When one of my family or friends says or does something stupid I feel embarrassed.	6	5	4	3	2	1
6.	I am embarrassed about feeling self-conscious in front of others. . .	6	5	4	3	2	1
7.	I feel very uncomfortable getting any kind of public recognition.	6	5	4	3	2	1
8.	I often feel like people are watching me.	6	5	4	3	2	1
9.	I often feel disgraced.	6	5	4	3	2	1
10.	I will do almost anything to avoid public criticism.	6	5	4	3	2	1
11.	I think my nose (or some other part of my body) just doesn't look right.	6	5	4	3	2	1
12.	When I was a teenager I avoided being seen with my parents.	6	5	4	3	2	1

		Agree					Disagree

Strongly Agree	Moderately Agree	Slightly Agree	Slightly Disagree	Moderately Disagree	Strongly Disagree
6	5	4	3	2	1

		Agree					Disagree
13.	I rarely express myself in groups for fear of others laughing at me.	6	5	4	3	2	1
14.	I often feel ashamed.	6	5	4	3	2	1
15.	Most of the time I am shy around others.	6	5	4	3	2	1
16.	I don't feel any pride in myself. . . .	6	5	4	3	2	1
17.	I would just die if someone could read my mind.	6	5	4	3	2	1
18.	I feel ashamed even when I make a minor mistake.	6	5	4	3	2	1
19.	When I feel ashamed, I want to run and hide.	6	5	4	3	2	1
20.	I avoid situations where I think I might get embarrassed.	6	5	4	3	2	1
21.	I feel that I'm not as good as others expect me to be.	6	5	4	3	2	1
22.	I get down on myself for not being able to accomplish things.	6	5	4	3	2	1
23.	I avoid situations where I might be observed by others.	6	5	4	3	2	1
24.	When I do or say something stupid, I wish the earth would open up and swallow me. .	6	5	4	3	2	1
25.	I am painfully self-conscious.	6	5	4	3	2	1
26.	There is nothing about me that others can respect.	6	5	4	3	2	1
27.	When I'm put on the spot, I feel confused.	6	5	4	3	2	1
28.	My parents often made me feel ashamed. .	6	5	4	3	2	1
29.	I'm always worried that others will think that I'm dumb.	6	5	4	3	2	1
30.	My feelings get hurt very easily. . . .	6	5	4	3	2	1

		Agree					Disagree

APPENDIX C

STATISTICAL TABLES

Table 17

Classification Results:

Age

Actual Group	No. of Cases	Predicted Group	
		Suicidal	Non-Suicidal
Suicidal	143	95	48
		(66.4%)	(33.6%)
Non-Suicidal	90	49	41
		(54.4%)	(45.6%)

Percent of cases
correctly classified = 58.37

Table 18

Classification Results:

Income

Actual Group	No. of Cases	Predicted Group	
		Suicidal	Non-Suicidal
Suicidal	143	117	26
		(81.8%)	(18.2%)
Non-Suicidal	90	48	42
		(53.3%)	(46.7%)

Percent of cases
correctly classified = 68.24

Table 19

Classification Results:

Hopelessness at Admission

Actual Group	No. of Cases	Predicted Group	
		Suicidal	Non-Suicidal
Suicidal	143	108	35
		(75.5%)	(24.5%)
Non-Suicidal	90	18	72
		(20.0%)	(80.0%)

Percent of cases
correctly classified = 77.25

Table 20

Classification Results:

Self-Esteem

Actual Group	No. of Cases	Predicted Group	
		Suicidal	Non-Suicidal
Suicidal	143	107	36
		(74.8%)	(25.2%)
Non-Suicidal	90	12	78
		(13.3%)	(86.7%)

Percent of cases
correctly classified = 79.49

Table 21

Classification Results:

Public Self-Consciousness

Actual Group	No. of Cases	Predicted Group	
		Suicidal	Non-Suicidal
Suicidal	143	72	71
		(50.3%)	(49.7%)
Non-Suicidal	90	42	48
		(46.7%)	(53.3%)

Percent of cases
correctly classified = 51.59

Table 22

Classification Results:

Private Self-Consciousness

Actual Group	No. of Cases	Predicted Group	
		Suicidal	Non-Suicidal
Suicidal	143	59	84
		(41.3%)	(58.7%)
Non-Suicidal	90	42	48
		(46.7%)	(53.3%)

Percent of cases
correctly classified = 45.92

Table 23

Classification Results:

Social Anxiety

Actual Group	No. of Cases	Predicted Group	
		Suicidal	Non-Suicidal
Suicidal	143	84	59
		(58.7%)	(41.3%)
Non-Suicidal	90	36	54
		(40.0%)	(60.0%)

Percent of cases
correctly classified = 59.23

Table 24

Summary Statistics for Independent and Dependent Variables

	Suicidal		Non-Suicidal	
Variable Name	Mean	SD	Mean	SD
Shame	47.6	12.7	28.5	13.1
Hope1	13.1	5.5	5.7	4.5
Hope2	4.2	2.7	N/A	N/A
Suicide	20.0	5.8	N/A	N/A
Guilt	10.3	1.4	8.4	3.3
Age	29.2	6.9	35.4	7.4
LOS	4.8	2.5	N/A	N/A
SES	17.8	5.5	28.0	4.8
PrivSC	23.4	5.9	23.2	6.5
PubSC	20.7	4.5	19.5	5.5
SocAnx	16.0	4.8	13.4	4.4

VITA

Barry Warren Shreve was born in Philadelphia, Pennsylvania on July 9, 1952. He attended elementary and junior high schools in suburban Philadelphia and was graduated from Upper Dublin High School in June of 1970. In 1975 he received a Bachelor of Arts degree in Psychology from Millersville University in Millersville, Pennsylvania. His first professional position was as a Crisis Intervention Counselor in Lancaster, Pennsylvania, which was followed by a two year term as the Director of Operations Research for the Lancaster County Mental Health/Mental Retardation Program. In the fall of 1981 he accepted a teaching assistantship at Appalachian State University, Boone, North Carolina and began study toward a Master's degree in Community Agency Counseling. This degree was awarded in May of 1983. He entered The University of Tennessee, Knoxville in the fall of 1983 working towards a Doctor of Philosophy in Education degree with an emphasis in Counseling Psychology. This degree was awarded in December of 1987.

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