Are shame and depression related? Understanding their dynamics

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**Recommended Citation**

Cradock O’Leary, Julie; Thurston, Nancy S.; Moore, Kimberley A.; Conlon, Kristin; Jenkins, Danielle D.; and Bufford, Rodger K., "Are shame and depression related? Understanding their dynamics" (2009). *Faculty Publications - Grad School of Clinical Psychology*. Paper 27.  
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Are Shame and Depression Related? Understanding Their Dynamics

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Introduction
Much research connects depression to shame. For example, depressed persons may perseverate on past shameful events (Melion, 1984), and individuals might substitute depressive symptoms rather than experience the disintegrative effects of shame (Lewis, 1995). A common narcissistic injury response to shame (Morrison, 1989) involves withdrawal and deflation. Shame research (Ivanoff, 1989) and theory (Lansky, as cited in Lewis, 1995, Lewis, 1995) is consistent with the extreme narcissistic injury suicidal response when faced with shame.

Grant (1999) evaluated shame among a group of adults diagnosed with depression by a therapist, and compared their scores with a group of nonclinical adults. While findings were nonsignificant, it appears that group composition may have complicated the results. Further exploration of the dataset indicated high Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) scores for participants in various subgroups. The present study sought to reevaluate the relationship between shame and depression by recruiting group membership according to BDI scores.

Criterion for the self-deception defense in the Thurston-Cradock Test of Shame (TCTS; Thurston & Cradock, in press) currently scores suicidal ideation or suicide (Deflation, severe). Test authors sought to further explore the relationship between depression and shame by creating new experimental scores. Such scores are based on DSM-IV criteria for Major Depressive Disorder (MDD) (American Psychiatric Association, 1994).

Diagnostic criteria for MDD includes the following under section A:

(A5) Persistent feelings of hopelessness and guilt or self-reproach (Suicide ideation or suicide attempt)

(A6) Disturbed ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(A7) Recurrent thoughts of death that are not all plans (at least one without a plan, or a suicide attempt or a specific plan for committing suicide)

Test in blue indicate depressive symptom criteria evaluated in this study

Method

TCTS protocols (N=167) from a previous study (Cradock, 1999) were rescored with experimental categories. Subgroups in Cradock’s original study included outpatient adults diagnosed with depression; incarcerated sexual offenders (SO), adults with severe mental illness (SMI), and nonclinical adults.

For the purpose of this study, participant protocols were divided into two groups, according to BDI scores. Those with scores >9 were determined to be depressed, while those with scores <0 were determined to be not depressed.

<table>
<thead>
<tr>
<th>Subgroup</th>
<th>N</th>
<th>Depressed</th>
<th>Sexual offender</th>
<th>SMI</th>
<th>Nonclinical</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>167</td>
<td>35</td>
<td>50</td>
<td>42</td>
<td>45</td>
</tr>
</tbody>
</table>

Measures

TCTS: The TCTS is a card-based projective for which subjects provide stories including a beginning, middle, and end, and characters’ thoughts and feelings. Stories are recorded verbatim, and behavioral observations are noted. Stories are usually rated for shame (direct, indirect), shame defenses utilized (defamation, aggression, inflation/contempt), resolution (highly adaptive, adaptive, unresolved/ambivalent, maladaptive, highly maladaptive), and response style to testing (personalization, laughter, word production).

Criteria for a new experimental scores (such as suicidal ideation/act, contemplated aggression, physical aggression, retaliatory aggression) were determined by TCTS test authors.

BDI: The BDI is a 21 item self-report measure of depression. Each score ranges from 0–3, with a total possible score of 63. Higher scores indicate a more severe level of depression.

Conclusion

Significant correlations were found between the BDI and specific TCTS scoring categories.

TCTS scores

<table>
<thead>
<tr>
<th>BDI &amp; Points</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
</tr>
</thead>
<tbody>
<tr>
<td>BDI</td>
<td>7.8</td>
<td>22.5</td>
<td>29.5</td>
<td>36.5</td>
</tr>
<tr>
<td>Total direct shame</td>
<td>109</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total maladaptive resolutions</td>
<td>125</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type of story resolution</td>
<td>10.5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total indirect shame</td>
<td>24.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unresolved/ambivalent resolutions</td>
<td>39.0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A highly significant group effect was found for BDI scores; depressed participants scored highest, SMI next, and normals and SO were similar and least (Levene = 9.98, p < .001). Group effects: F (1, 163) = 13.73; p < .001.

Conclusions

Experimental TCTS scores did not capture the expected depressive symptomatology of S/A and less active anger expression. Little S/A in TCTS stories might reflect the relative rarity of S/A (Kessler, Berglund, Borges, Nock, & Wang, 2005). Irritable depression, as opposed to symptoms of lethargy or apathy, may have complicated the aggression results. While subgroups varied significantly on BDI scores, depression was found in all groups, suggesting that future studies should evaluate for depression regardless of group membership.

Significant correlations suggest that depressed individuals became more involved in storytelling (more time and more word count), expressed shame more directly, and had more maladaptive and fewer unresolved/ambivalent resolutions. These correlations fit with DSM-IV criteria.

Further exploration of correlational results, via more complex analyses of traditional TCTS scores would be useful.

Literature cited


Acknowledgments

During this study, the TCTS was in development. The final published version may contain revisions.

When protocols used in this study were administered, the authors were affiliated with the Graduate School of Psychology.

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