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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 (Mollon, 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 reevalate the relationship between shame and depression by recreating group membership according to BDI scores.

Criterion for the deflation defense in the Thurston-Cradock Test of Shame (TCTS; Thurston & Cradock, in press) currently scores for 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) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(A6) fatigue or loss of energy nearly every day

(A8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(A9) Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

Text in blue indicate depressive symptom criteria evaluated in this study

Method

Sample

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 <10 were determined to not be depressed.

		Subgroup			
Group	N	Depressed	Sexual offender	SMI	Nonclinical
Depressed	74				
Not depressed	93				
Total	167	33	50	42	43

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 (deflation, 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.

Procedure

Double-blind

Hypotheses

As compared with non-depressed individuals, depressed individuals were expected to have

1. more suicidal ideation/act (SI/A; MDD criteria A9)
2. more contemplated aggression, but less actual (physical and retaliatory) aggression (MDD criteria A5, A6, A8)

Analyses

Group differences were evaluated using ANOVA. Correlations between tests and subgroup scores were computed.

TCTS cards

Results

Findings were nonsignificant for group differences in TCTS experimental scores of SI/A and aggression scores.

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

TCTS category	BDI
Time to tell stories	.323**
Word count	.259**
Total direct shame	.199*
Total maladaptive resolutions	.215*
Type of story resolution	.195*
Total indirect shame	-.162*
Unresolved/ambivalent resolutions	-.199*

*significant at the .05 level (2-tailed),
**significant at the .01 level (2-tailed)

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 SI/A and less active anger expression. Little SI/A in TCTS stories might reflect the relative rarity of SI/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

American Psychiatric Association (1994). *Diagnostic and statistical manual of mental disorders (4th Ed.)*. Washington DC: Author.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*, 561-571.

Cradock, J. A. (1999). The Thurston-Cradock Test of Shame (TCT): Construct and discriminant validity. *Dissertation Abstracts International, 60*, 04-B, (UMI No. AAG9926568).

Grant, J. J. (1999). Shame, narcissistic injury, and depression: A comparison of clinically depressed and normal participants. *Dissertation Abstracts International, 60*, 04B (UMI No. AAG9926572).

Ivanoff, A. (1989). Identifying psychological correlates of suicidal behavior in jail and detention facilities. *Psychiatric Quarterly, 60*, 73-84

Kessler, R. C., Berglund, P., Borges, G., Nock, M., & Wang, P. S. (2005). Trends in suicide ideation, plans, gestures, and attempts in the United States, 1990-1992 to 2001-2003. *Journal of the American Medical Association, 293*, 2487-2495.

Lewis, M. (1995). *Shame: The exposed self*. New York: Free Press.

Mollon, P. (1984). Shame in relation to narcissistic disturbance. *British Journal of Medical Psychology, 57*, 207-214.

Thurston, N. S., & Cradock O'Leary, J. (in press). *The Thurston Cradock Test of Shame (TCTS)*. Los Angeles, CA: Western Psychological Services.

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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, Fuller Theological Seminary, Pasadena, CA

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