To the Graduate Council:

I am submitting herewith a dissertation written by Karen Josvanger entitled "The Relationship of Depression to Guilt and Shame in High-Aspiring Women." 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 Psychology.

Alvin G. Burstein, Major Professor

We have read this dissertation
and recommend its acceptance:

Accepted for the Council:

Vice Provost
and Dean of the Graduate School

THE RELATIONSHIP OF DEPRESSION TO GUILT AND SHAME IN HIGH-ASPIRING WOMEN

A Dissertation

Presented for the

Doctor of Philosophy

Degree

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Karen Josvanger

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ABSTRACT

The primary purpose of this study was to investigate the relationship of different "types" of depression to guilt and shame anxiety. Previous research on depression has provided support for the idea that there may be two or more dimensions of depressive experiences. Recent theoretical developments have led to suggestions that the differences between types of depression may be related to differences in proneness to guilt or shame. This proposed relationship is of particular interest vis-a-vis women, who have been shown to exhibit greater incidences and levels of depression than men.

Subjects were 65 female graduate students at the University of Tennessee. Two measures of depression were administered. The Beck Depression Inventory was used as a measure of gross depressive symptomatology. The Depressive Experiences Questionnaire was used to measure experiences of introjective and anaclitic depression. Guilt and shame were assessed through the administration of the Van Lennep's Four Picture Story Test, which was scored by means of the Gottschalk-Gleser Content Analysis Scales.

Hypotheses were tested concerning the relationship between depressive symptomatology, types of depressive experiences, and guilt and shame. No significant differences were found between types of depressive experiences for guilt or shame. Nor were there significant differences for guilt or shame between subjects with depressive symptomatology and those without. Positive significant correlations were shown between the three depression indices.

The lack of significant findings in this study has implications for both theory and future research. Further effort is needed towards the development and construct validation of instruments for the assessment of complex psychological constructs. These results also suggest that caution should be taken in assuming continuity between "normal" and "clinical" depression. Finally, the results of this study demonstrate that further effort is needed to provide empirical support for existing theory.

TABLE OF CONTENTS

LIST OF TABLES

INTRODUCTION

Depression has been called the "common cold of psychopathology" (Coyne, 1986). Although in many ways this analogy is quite apt, it is more aptly applied to women. It is widely acknowledged that depression is more common among women than among men (Amenson & Lewinsohn, 1981; Clayton, 1982; Weissman & Klerman, 1979), both as a clinical syndrome, and as one of the vicissitudes of everyday affective experiences. Kaplan (1986) stated it quite eloquently when she said: "...depression as a mood or a symptom seems to be a specter that haunts women, a mode of experience with which all women seem able to identify" (p. 234). Even more telling is the following anecdote described by Kaplan:

> As I was describing this paper to a woman whom I see in therapy, I explained to her that I would, in part, be contrasting responses of depressed and nondepressed women to an interview protocol. She looked at me with complete sincerity and asked, "So you mean you were really able to find women who were not depressed?" (p. 234).

Numerous studies have investigated possible reasons for the sex differences in incidence of depression (Chino & Funabiki, 1984; Hammen & Padesky, 1977; Lopez, Campbell & Watkins, 1986; Robbins & Tanck, 1984; Small, Gessner & Ferguson, 1984). However, one can argue that understanding the reasons for the the greater frequency of depressive experiences in women first requires a better understanding of those experiences. This is particularly true in light of recent theoretical developments which offer reinterpretions of existing theories intended to more accurately reflect women's experiences (Chodorow, 1978;

Miller, 1984; Surrey, 1985). Based on these alternate theories of development, Kaplan (1986) argued that depression can be viewed as a distortion of "normal" female experience.

Kaplan's position is a variation on theories of depression which aver that "normal" depressive experiences are essentially similar in nature to "pathological" depression. However, Kaplan also implies that something inherent in women's development leaves them more vulnerable than men to both normal and pathological depression. If this is true, a logical area of investigation is the exploration of depressive experiences of "normal" women.

While there is a consensus in the literature that depression is more common among women than among men, this does not mean that all women who experience depression can be viewed as a homogeneous group. The term "depression" encompasses a broad range of experiences, with potentially crucial differences between those experiences. Recognizing and understanding such differences may be of vital importance. The explication of identifiable "types" of depression would have implications for interpretation of research findings; contradictory results of research in depression may often be understood in terms of such differences.

Perhaps even more importantly, the existence of different types of depression impacts on our ability to effectively treat depressive disorders. Depression is undoubtedly one of the major complaints for which people seek psychological treatment. Yet, not all individuals who report problems with depression require the same form of treatment.

Grinker (1955), in fact, pointed out that an intervention which is effective with one depressed patient may have a significantly negative impact on a different patient. Research is needed to clarify the important distinctions between experiences of depression.

In the literature on depression several themes have emerged which may serve to define two types of depression. Thus far, the model which best captures these emergent themes was offered by Blatt (1974), who distinguished between two types of depression: introjective and anaclitic. Blatt described introjective depression as related to feelings of having failed to live up to expectations and standards, while anaclitic depression is defined primarily by fears of abandonment. Both research and literature provide support for Blatt's model. Nonetheless, although Blatt's distinction between introjective and anaclitic depression provides a useful descriptive model from which to explore differences between types of depression, there continues to be a gap in our understanding of dynamic differences between depressive experiences, especially in terms of essential intrapsychic correlates.

One problem apparent in the depression literature is a failure to integrate different bodies of work. For example, there has been a recent influx of writings concerning the importance of shame for development. Much of this work was inspired by Lewis's book Shame and Guilt in Neurosis (1971). Yet, despite the fact that almost two decades have passed since Lewis articulated the role shame may play in the development of depression, little effort has been made to explore how her work might inform existing theories. Only recently has there

been any recognition in the literature that Lewis's explication of differences between guilt and shame might lead to a better understanding of the differences between introjective and anaclitic depression (Hoblitzelle, 1987). This study is designed to investigate this issue by exploring the relationships between these "types" of depression, guilt, and shame.

CHAPTER I

REVIEW OF THE LITERATURE

Depression

"Depression" is a term familiar to almost everyone. Yet its meaning cannot be defined in a simple or definitive manner. Webster's Dictionary (1986) includes among its definitions of depression: 1.) "The state of feeling depressed: dispiritedness, dejection"; 2.) "The lowering of vitality or functional activity: the state of being below normal in physical or mental vitality"; 3.) "A mental disorder of psychoneurotic or psychotic proportions characterized by sadness, retardation of motor and certain vegetative processes, feelings of inadequacy and self-depreciation, and often by suicidal attempts." Thus, according to Webster, depression can be viewed as a feeling state, a physical (behavioral) state, or a mental disorder. The psychological literature is no more precise, offering an even greater variety of partially conflicting and/or ambiguous definitions of depression.

The term "depression" encompasses a number of experiences and phenomena. Attempts have been made both in ordinary discourse and in psychology to semantically differentiate experiences of depression. Individuals talk of feeling sad, "blue," "down," "under the weather," empty, or devastated. In the clinical literature, references are made to melancholia, dysthymia, clinical depression, and depressive characters. Sometimes semantic differences are intended to connote

differences in levels of affective intensity. At other times different words are clearly intended to distinguish between qualitatively different experiences.

Some of the definitional difficulties in using the term depression arise from several unresolved issues as to its nature, classification and etiology. One issue concerns the relationship between depression as a "normal" experience and depression as pathology. Depression was first identified as a clinical syndrome by Hippocrates in the fourth century B.C. (Beck, 1967). Two thousand years later, the question remains: Is "pathological" depression an exaggeration of "normal" depression or is it a qualitatively as well as quantitatively different phenomenon? Some writers reserve the use of the term depression solely for those experiences which can be considered pathological, but this does not resolve the dilemma, as it leaves unanswered the question as to what <u>is</u> the difference between "normal" and "pathological" depression.

A related issue involves the question as to whether depression can be classified as normal or pathological depending on intensity of experience. Certainly there is a continuum of degrees of depression, ranging from mild (e.g. feeling "blue") to severe. Mild depression is often a common and even healthy reaction to the vicissitudes of everyday life. Yet, chronic, albeit mild, depression <u>is</u> typically seen as pathological. Conversely, severe depression almost always warrants the diagnosis of an emotional disorder. Yet, the death of a loved one may lead to acute depression, which is commonly considered a "normal"

reaction. Convention suggests that depression is classified as normal or pathological depending on a number of factors, including: intensity and duration of the affect, presence or absence of vegetative symptoms, effects on functioning, and whether or not a precipitant can be identified. Nonetheless, this is essentially a heuristic process, and does not resolve the conflict as to how to (or even whether it is possible to) differentiate normal and pathological depression.

An additional area of debate involves the "state vs. trait" conflict. Depression can be viewed as either a state or a trait. Depression as a "state" is a more or less transient experience, typically corresponding to identifiable external precipitants. It is generally seen as situational and time-limited. On the other hand, depression as a "trait" generally is seen as an ongoing internal experience characterized by subjective feelings of unhappiness and dejection. Most people at one time or another experience a state of depression. Individuals who are characterologically depressed may be said to have a depressive trait. This distinction, however, is not as straightforward as it may appear. Again, one must look at a continuum of experiences. An individual who is said to have a depressive trait may be better described as being prone to depressive states. The question then becomes at what point on the continuum does one begin talking about traits rather than states?

A related area of contention is whether the diverse experiences labeled depression are simply different manifestations of a single entity, or whether the concept of depression includes more than one

dynamically different phenomenon. This differs from the debate over normal vs. pathological depression in that here the hypothesis is that two (or more) continuums of depressive experiences may exist with distinct etiologies and symptom patterns. Several formulations of these differences have been offered; this study will focus on the theory developed by Blatt (1974), who distinguishes between anaclitic and introjective depression.

Despite the abundance of clinical experience, research and theoretical discourse, the above mentioned issues concerning how best to define depression remain unresolved. The many contrasting claims concerning depression may in fact be due to differences in focus. The only extant solution is to carefully define the focus of study in the hopes that eventually enough "pieces of the puzzle" will be outlined, leading to further clarification of the important issues. This study will explore anaclitic and introjective depression as defined by Blatt. The population of interest will be "normal" women, with the assumption that the findings will reflect a range of experiences of depression, most of which will likely be in the realm of "normal" depression, but some of which will fall in the category of "clinical depression." This is in keeping with Blatt's hypothesis that while depression can be categorized into "types," within each category there is a continuum of related experiences ranging from "normal" to "pathological." Finally, Blatt implies that his theory concerns "traits" of depression (i.e. characteralogical depression). This study refers to degrees of "proneness to depression" because of the difficulty inherent in

defining a "depressive trait." Further clarification and definition of the parameters of this study will follow a review of the relevant literature.

Numerous approaches have been taken in the study of depression. One approach has been to look for biological and/or genetic bases for depression. Most biological theories of depression have centered around proposed disturbances in the functioning of neurotransmitters within the central nervous system, with specific attention given to the role of catecholamines, such as norepinephrine and dopamine (Thase, Frank & Kupfer, 1985). Other studies have focused on possible neuroendocrine abnormalities, especially as a way of explaining the higher incidences of depression in women (Weissman, 1979).

Other studies focus on personality characteristics or intrapsychic factors involved in depression. Broadly, these approaches can be classified as either cognitive or psychodynamic. Beck's cognitive theory of depression will be reviewed, both because his theory has become the prototype of cognitive theories of depression, and because of the influence his work has had on the study of depression via the development of the Beck's Depression Inventory. Arieti and Bemporad (1978) also offer what they label a cognitive approach to depression, but which in fact combines both cognitive and psychodynamic perspectives. Their theory will be reviewed, followed by an overview of psychodynamic theories of depression, with the intention of providing a context for exploring the relationship between depression and the intrapsychic structure of the individual.

Cognitive Theories of Depression

Beck (1967, 1973) developed his theory of depression in response to frustration with the welter of conflicting theories in the literature. He noted that many of the theories speculated about presumed intrapsychic or interpersonal functions of depressive symptoms without first studying the symptoms as they are manifested. As a result, Beck began his studies by focusing exclusively on patterns of depressive symptoms. He found that the symptoms of depression fell into certain clusters, which he classified as follows:

1.) affective symptoms: feelings of sadness, loneliness, emptiness, etc.;

2.) motivational symptoms: intensified wishes for help, yearnings to escape, suicidal impulses, and immobilization;

3.) cognitive symptoms: negative self-concept, pessimism, and negative interpretations of experience;

4.) physical and vegetative symptoms: retardation, low energy, loss of libido, and sleep and appetite disturbances.

In looking for a common thread between these groupings, Beck determined that all of the symptoms can be regarded as derivatives of three basic cognitive patterns, which he labeled the "primary triad in depression." According to Beck, the triad reflects an idiosyncratic view of the world typical of the depressed individual. The first part of the triad involves a negative construction of experiences. For example, the depressed individual tends to interpret experiences with

the environment as representing defeat, deprivation and disparagement. The second component of the triad involves negative evaluations of the self. The depressed individual sees only flaws; unpleasant experiences are attributed to deficiencies or defects in the self. The third aspect of the triad involves a negative view of the future. The depressed individual sees only unremitting hardship, suffering and deprivation ahead. Beck argues that other symptoms of depression result from a progressive domination of these cognitive patterns over competing views in each realm (i.e. environment, self, future). "Depressed thinking" is what leads to feelings of depression; the goal of a therapist would be to help a depressed individual change his or her thinking in order to mitigate feelings of depression. Thus, depression according to Beck's cognitive perspective is essentially seen as resulting from selective and/or inappropriate cognitive representations and interpretations of one's experience.

Beck's Depression Inventory (BDI) preceded the development of his cognitive theory of depression (1961). In fact, Beck developed the BDI following years of psychoanalytic psychotherapy with depressed patients. His intention was to design an objective instrument which would measure behavioral manifestations of depression, in the hopes of improving the reliability of diagnosis for both research and therapy. The success of the BDI is attested to by the wealth of research using this instrument in the more than twenty-five years since its introduction. The BDI has become one of the most widely used instruments for assessing depression in both clinical and non-clinical

populations (Beck, Steer & Garbin, 1988; & Piotrowski, Sherry & Keller, 1985).

The BDI is a useful instrument for assessing depressive symptoms, but it has its limitations. Generally, those individuals who score high on the BDI are depressed, and are correctly identified as such, both by themselves and by others. That is, such individuals usually both feel depressed, and exhibit "objective" symptoms that would lead an outside observer to identify them as depressed. On the other hand, there are individuals who may receive a low score on the BDI who could also be considered depressed. For example, BDI scores are most likely to be elevated if the subject is experiencing vegetative symptoms of depression (e.g. sleep and appetite disturbances). Yet, an individual may have a subjective experience of dysphoria, hopelessness and/or despair, without corresponding vegetative symptoms. These individuals may not appear to others as being depressed, but their internal experience is one of being depressed. Some researchers have suggested that subjective experiences of depression and neurovegetative symptoms of depression are separate and relatively independent phenomena (Akiskal, 1979; Blatt et al., 1982; Depue & Monroe, 1978). To conclude that a person not experiencing vegetative symptoms is not depressed sets up arbitrary parameters around the concept of depression. The BDI is clearly a measure of a depressive state, especially as measured by "objective" symptoms, but it gives little or no information about an individual's proneness to depression.

The BDI is used to operationally define depression in many research projects. Given that there is much confusion stemming from a

failure to clearly define what aspect of depression is being studied, Beck's work is an important effort. Unfortunately, many research projects and theories (including Beck's) have taken an additional and unwarranted step in assuming that depression is only that which is measured by the BDI. Despite Beck's quite valid argument that theorists often generalize too quickly about underlying dynamics, he perhaps moved too far in the opposite direction, dismissing as irrelevant related states.

Arieti and Bemporad (1978) pointed out that Beck's theory is mainly concerned with conscious and simple cognitive formulations, and ignores the significant role of unconscious cognitive structures, as well as the role of conflict in predisposing an individual to depressive states. They suggested that depression can be understood from a cognitive orientation, but only as related to a cognitive history which takes into account longitudinal and psychodynamic elements. According to Arieti and Bemporad, complex emotions, such as anxiety, anger, or depression, develop out of elementary emotions such as tension, rage, or fear through the intervention of complicated cognitive mechanisms. That is, more complicated emotions do not develop independently of thought processes. By adulthood, behavior is to a large extent determined by "cognitive-affective structures which have been built as a result of learning, in the act of facing the early interpersonal situation" (p. 134).

The "early interpersonal situation" is of great importance in Arieti and Bemporad's theory of depression. Infants are inherently

receptive creatures, and are influenced by interactions with the world from the very beginning of life. This interaction is impacted on by the child's natural tendency towards integrative activity. Interactions with the world both inform and transform the child, even as the child transforms the world via these interactive processes. The child's relationship to the world, especially significant others in that world, is a dynamic one, with multiple interpersonal and intrapsychic dimensions.

Arieti and Bemporad suggested that individuals prone to depression typically come from basically cohesive and stable families in which the atmosphere is one of obligation and duty. Initially the child is the recipient of warm and loving acceptance, but this attitude changes as the child grows, and care and affection become contingent on meeting certain expectations. This, of course, is part of normal development; the developing child is expected to master certain tasks. However, in families of depressed individuals there is a general attitude that in order to receive anything in life it must first be deserved. Furthermore, children in such families may be unconsciously resented because of the extra work they represent for parents who already feel that life is too full of responsibilities. A child who grows up in this type of interpersonal situation will develop specific ways of thinking about and operating in the world which may predispose him or her to experiences of depression.

Arieti suggested that individuals usually develop one of three cognitive-affective patterns in response to the type of early

interpersonal atmosphere just described. The patterns develop as a means of maintaining equilibrium, and in fact, many depression prone adults give the appearance of being successful, healthy individuals. However, this apparent success comes at the cost of a difficult and conflictual internal relationship with what Arieti called the "dominant other." In order to maintain some sense of connectedness with an overly demanding parent, the depression prone individual becomes "anchored" to the image of a person whom he or she needs desperately to please. Originally a "significant other" (usually a parent) from the individual's childhood, by adulthood this person has become an internalized dominant other, guiding the individual's actions and self-representations. Three typical patterns are described:

1.) The child who looks for security through acceptance of parental expectations, no matter how aversive. The fantasy is that connectedness can be secured through complete obedience and submission. As an adult, this individual will be compliant, dutiful, and hard working.

2.) The child who believes that love and approval can be acquired through achievement of some fantasied goal. Initially the pursuit of a particular goal is a means of pleasing others. However, as an adult, the goal itself may actually take the place of the dominant other and become the guiding reason for living.

3.) The child who becomes aggressively dependent: He or she forces the parent to re-establish the atmosphere of an earlier developmental period, when there were fewer demands. As an adult, such

an individual is likely to develop a demanding and clinging dependent personality, insisting on indulgence at the expense of individual autonomy.

Although these patterns described by Arieti may allow the person to operate in the world with apparent success, they also leave the person vulnerable to feelings of dissatisfaction and unhappiness. Furthermore, because of the demand for rigid adherence to these internal constructions of reality, external events often lead to disruption and depression. Arieti suggested that the main precipitants to experiences of depression fall into three categories (corresponding to the three cognitive patterns): 1.) a realization that the relationship with the dominant other has failed; 2.) failing in an attempt to reach a dominant goal; 3.) the death or withdrawal of the dominant other. The common theme of the three categories is an experience of a loss of connectedness. Depression may result from the threat of such a loss as well as from an actual loss. The intensity of a depressive reaction relates to the degree to which the dominant other governs the individual's internal world. Individuals who are prone to mild rather than more severe bouts of depression have developed alternate ways of acquiring self-esteem and a sense of approval beyond those prescribed by the "dominant internalized other."

Psychodynamic Theories of Depression

The first significant psychoanalytic understanding of depression was offered by Abraham in 1911. A number of themes in this initial

thesis presaged the development of Freud's ideas in Mourning and Melancholia, published later in that same decade. Abraham commented on several issues which he saw to be related to depression: profound ambivalence regarding interpersonal relationships, diminished capacity for experiencing or expressing love, and the underlying hostility of the depressed individual (Bemporad, 1985). Abraham's observations have been influential in later writings, but it is Freud's interpretation of depression which has been and remains the dominant force in classically psychoanalytic theories of depression.

Freud's treatise, Mourning and Melancholia (1917) is a brief but powerful paper in which he touched on a number of issues related to depression. Freud outlined the distinctive features of melancholia as:

> a profoundly painful dejection, abrogation of interest in the outside world, loss of the capacity to love, inhibition of all activity, and a lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-revilings, and culminates in a delusional expectation of punishment" (p. 153).

According to Freud, the primary difference between this state and the "normal" state of grief, or mourning, is the self-esteem difficulties associated with depression but not with grief. The two states are similar in that they are typically precipitated by a loss of a love object. Mourning follows a very real loss (i.e. through death), whereas melancholia is often precipitated by the loss of the object's love, and/or an unconsious fear of loss of the object.

Freud posited that melancholia is further distinguished from mourning in that melancholia is often accompanied by a regression of

libido into the ego. This reduction in available libidinal energy is the reason for the decline in self-esteem associated with depression, as well as the general impoverishment of the ego manifested in such depressive symptoms as lethargy and anhedonia. Freud was struck by the often extreme level of reproachment and abasement of the melancholic towards the self. He noted that it is as though the melancholic's ego had become two parts, with one part setting itself apart and judging the other part -- in effect, one part of the ego becomes an object for the other part. The explanation for this, according to Freud, is that the reproaches are really intended for a loved other but have been displaced onto the self. He described the process as follows: One individual libidinally attached to another experiences a disruption of some sort to the relationship. The "normal" reaction would be withdrawal of the libido from the first object and transference of it to a new one. However, for the melancholic individual, libido does not readily attach to another object. Instead, libido is withdrawn from the outer world with the ego becoming indentified with the lost object via a cathexis of the ego with itself.

At this point the role of ambivalence (which Freud considers a key precipitant to melancholia) becomes salient. The lost relationship was clearly important to the individual. In fact, it was so important that its loss is defended against through a narcissistic identification with the lost object. However, the loss is also the cause of a great deal of hurt and disappointment. The object is no longer there, and has become identified with a portion of the individual's own ego. The

anger and reproachments which would be directed at the other, who has caused so much pain and torment, instead are directed towards its substitute, the individual's own ego. In this way the individual is able to avoid conscious expression of hostility towards a loved one. However, as a result, he or she suffers from self-accusations and self-hatred, as well as from inhibition of functioning due to the unavailability of libidinal energy. Thus, depression is essentially the result of an individual's anger at another being turned inward.

Freud suggested that certain types of individuals are more prone to melancholia than others. He noted that many individuals suffering from melancholia appeared to have made object choices on a narcissistic basis, leaving them vulnerable to later narcissistic regression. He argued that this tendency is most common among people who are fixated at the oral incorporative stage of development. This position is contradicted somewhat by Freud's later work. At the time that Mourning and Melancholia was written, Freud had not yet defined the intrapsychic structure he later called the superego. Yet it is clear that the critical, accusatory part of the melancholic's ego is equivalent to the superego, which develops during the Oedipal stage of development. Freud's explication of the superego, and the role of guilt in pathology, would suggest that depression may also result from conflicts in the Oedipal period.

The focus on guilt was continued by psychoanalysts writing soon after Freud. Rado (1956), for example, portrayed the depressed individual as needing to undergo a ritualized sequence of anger-guilt-

atonement. He suggested that the depressed individual establishes relationships based on childhood patterns of disturbed relationships with the mother. As a child, the depressed individual learns to fear his or her primitive impulses and need for instinct gratification. Out of this fear the individual develops a pattern of behaving towards the other in such a hostile manner that the other is driven away. The depressive must then attempt to regain the other's love through suffering and self-abnegation. If this does not succeed, the depressive is compelled to seek atonement from the internalized object of childhood, which has become the superego, by withdrawing from the world of real objects until she or he has suffered sufficiently to gain the superego's forgiveness.

Current theories of depression continue to reflect early psychoanalytic thinking, but have also been influenced by the diverse theories offered by the ego-psychology school of thought. Some of these theories are essentially only minor variations on Freud's original outline, while others differ significantly. Many of the later theories reflect a move away from a Freudian "instinct" perspective to a position focused on internalization of self and other representations. Two versions of depression from an ego-psychology point of view will be presented, these versions demonstrating an increased emphasis on the role of the ego.

Bibring (1983) focused on depression as a unitary phenomenon which is manifested differently depending on the mechanisms employed in the struggle for re-adjustment. He described the core of any depression as

similar regardless of whether the depression is "normal", "neurotic" or "psychotic." Depression, according to Bibring, is an ego-psychological phenomenon, i.e. an affective state or "state of the ego." The experience of depression purportedly results from tension within the ego itself; it is a result of "inner-systemic conflict." It is basically a reaction to narcissistic frustration. The lowered self-esteem commonly considered a hallmark of depression results from a rift between certain narcissistic aspirations (to be worthy, loved, appreciated, superior, etc.) and the ego's ability to attain these goals. Depression is the consequence of the subjective sense of helplessness in the face of the needs of the ego. The depressed individual's inhibition in functioning is due to the derivative belief that further striving is meaningless because the ego cannot be gratified. Bibring considered this ego-state (i.e. depression) to be independent of the vicissitudes of libidinal or aggressive drives. Although Bibring acknowledged that in some instances the ego's awareness of its helplessness may lead to turning of aggression inwards, this self-hatred is seen as secondary to the breakdown of self-esteem.

Bibring further noted that early childhood experiences of a traumatic nature may predispose an individual to the later development of depression. In such an event, a fixation of the ego to the state of helplessness is established which is later regressively reactivated when situations arise which resemble the early traumatic experience. He noted that many individuals prone to depression display signs of

oral fixation. This is related the child's utter helplessness at that stage, which leaves him or her more vulnerable to experiences of trauma.

An alternate ego-psychology interpretation of depression is offered by Edith Jacobson. Jacobson's work in many ways represents the formulation most characteristic of the ego psychology school of thought, bringing together the work of many prominent ego-psychologists (Spitz, Mahler and Hartmann).

Jacobson (1971) believed that normal, neurotic, borderline, and psychotic depression are distinct entities, differing in both the content and quality of the depressive states. Nonetheless, she viewed all depressive states as derivatives of a basic underlying conflict, caused by a lack of understanding and acceptance by the mother during the rapprochement phase of development. The child's frustration arouses rage, leading to hostile attempts to obtain the desired gratification. When the ego is unable to achieve this goal (whether for external or internal reasons), aggression is directed toward the self-image. The resulting diminishment in self-esteem reflects the basically narcissistic nature of this conflict, being essentially a conflict between the wishful self-image and the image of the deflated, failing self.

There are similarities between this conceptualization of depression and Bibring's formulation. Jacobson commented on the value she found in Bibring's paper on depression, especially his emphasis on an intrasystemic conflict within the ego resulting from a disturbed

narcissistic equilibrium. Nonetheless, she asserted that Bibring failed to acknowledge the role of underlying sexual and aggressive drives. In positing depression as a "basic ego state," he missed the crucial part played by cathectic and discharge processes and the interplay of self- and object-cathected sexual, aggressive and neutralized drives.

Another perspective on depression is offered by the British object relations theorists. This perspective will be explored from the works of Fairbairn and Guntrip (Guntrip, 1961, 1969). Both men based much of their work on Melanie Klein's theory of development, in which she outlined a stage of development labeled "the depressive position." The depressive position is identified as a normal stage of development in which the infant begins to recognize the wholeness of the maternal object and struggles to integrate the conflicting feelings of love and hate which are directed towards the mother. The beginnings of morality are seen to emerge during this stage, as the child develops feelings of guilt about "taking" from and potentially "destroying" the mother. A process of mourning is also necessary as the child has lost the mother who is "all good," replacing her with a mother who is sometimes good, sometimes bad. Successful passage through this stage of development results in the development of a "whole" person, with an intact ego and the capacity to integrate feelings of love and hate.

Fairbairn posited that the depressive position occurs during the late oral phase of development, in which the crucial struggle (and the basis for all later psychopathology) revolves around infantile

dependence on the mother. Trauma during this period provokes fear that the infant will not be loved (and therefore not cared for) because the infant is bad and destructive (these feelings emanating from the ambivalence towards the maternal object). The individual becomes afraid to love for fear of hating, which leads to the depressive state. Unsatisfactory object relationships at this time leave the individual vulnerable to later regressive reactivation of this early infantile situation.

Guntrip described the internal world of the individual prone to depression. Conflict and guilt surrounding the unresolved ambivalence lead to the "taking in" of the ambivalent object, which is as yet unintegrated and thus consists of both a good and a bad object. Once internalized, a struggle ensues between the sadistic, persecutory bad object (the "antilibidinal ego"), and the individual's libidinal ego, which continues to want to cathect with the good object. However, because of the fear of relationships (which can be destroyed by hate) the persecutory internalized object becomes dominant. Fairbairn asserted that all later neurotic problems are actually a defense against the experience of either the situation just described, or the even earlier schizoid position.

Guntrip expanded this view of depression by suggesting that depression itself is a defense against even further regression into total schizoid withdrawal. The ultimate threat to development is that relationships will become so threatening that the ego withdraws completely from the outer world. Although in many ways such a

withdrawal is enticing because it represents a return to the safety of the womb, it also is the ultimate danger to the ego, because it is only through relationships that the ego maintains a sense of its own existence. Complete regression of the ego would result in loss of the self. Thus the struggle of the depressive is a means of defending against further regression; the depressed individual, unable to tolerate feelings of both love and hate towards an important other, perceives the self as bad and deserving of attack, and maintains relationships that are accusatory in nature. Yet accusatory, bad object relationships are still relationships. Thus the internal world is constructed so as to leave the individual vulnerable to depression, but also serves as a defense against total dissolution of the self.

A review of the depression literature would be incomplete without mention of the works of Bowlby and Spitz, who have formulated theories of anaclitic depression based primarily on observations of infants from a psychoanalytic frame of reference. Anaclitic depression as described by Bowlby (1969) occurs primarily in children between the ages of six months and six years of age as a consequence of prolonged separation from the mother. The primary features are initial "protest" (crying, screaming, and random activity) followed by eventual "despair" (dejection, stupor, retardation of development, retardation of reaction to stimuli).

This syndrome was first delineated by Spitz (1946, 1983), who based his work on observations of children who had been placed in foundling homes. He noted the following symptom categories: 1.)

apprehension, sadness, weepiness; 2.) lack of contact, rejection of the environment; 3.) retardation of reactivity and movement, stupor; 4.) loss of appetite, refusal to eat, weight loss 5.) insomnia. For all infants who developed this syndrome, which Spitz labeled anaclitic depression, there was one etiologically significant factor: the child had been removed from the mother between the ages of six and eight months for three months or longer, during which time the child saw the mother no more than once a week. In each case, the child developed the syndrome within four to six weeks following the separation.

Spitz remarked that a similar cluster of symptoms observed in an adult would be diagnosed as depression. However, he also argued that despite the similarities, one can not conclude that this syndrome in infancy is identical to adult depression, because of the differences in psychic structure between adult and infant. In an adult, a severe trauma (such as loss of love object) impinges on a well-established ego organization, leading to regression to an earlier fixation point. In the infant, such a trauma impinges on a developing ego, and will be manifested in disturbances such as retardation, deviation, or even paralysis of development. Because the infant does not have an already established intrapsychic organization, trauma may result in irreversible progressive personality disturbances. On the other hand, because the ego is in the process of organizing and developing, recovery from damage may actually be swifter and more dramatic than in the case of the adult. From his observations, Spitz concluded that the syndrome described is progressive in nature, if there is no

intervention. He speculated that once a critical point of development is reached the syndrome becomes irreversible, and is likely to result in an array of pathology, including severe and chronic depression. Nonetheless, his research also demonstrated that successful intervention is possible, typically through the introduction of a mother substitute.

Both Spitz and Bowlby focused primarily on depressive syndromes observed in infants and children, and were cautious about generalizing to adult disturbances. Nonetheless, the impact of their work has been enormous: it has contributed to understanding healthy and disturbed development in children, and generated new ideas about the etiology and dynamics of depression in adults.

A number of related ideas emerge from the abundance of apparently contradictory theories regarding the internal world of the depressed individual. It is interesting to note that for the most part, the significant issues were first mentioned by Freud, although this is not at first apparent because of differences in metapsychology and of focus. Underlying almost every theory of depression is the focus on loss. Spitz and Bowlby demonstrated a direct relationship between loss of attachment and depression in infants. Similarly, depression in adults is often precipitated by the loss of a relationship. Often, especially in individuals prone to depression, a fantasied loss, or the threat of a loss, can just as easily result in depressive experiences. Furthermore, as noted by Bemporad and Arieti, loss may be experienced in ways that seem unrelated to a specific relationship. For example,

they talk about the "dominant goal" superceding the "dominant other" in the depressed person's psyche. For an individual with this character structure, the loss of a goal would be equivalent to the loss of a relationship.

Although most theories identify loss as an important factor in depression, other facets identified by key writers do not fit as neatly together into a cohesive framework. However, if one begins with the assumption that two or more "types" of depression exist, then it becomes possible to view the different theories as reflecting different themes. From this vantage point, two distinctive themes begin to emerge.

The first theme concerns the idea that an individual is prone to depression because of an internalized punitive agent, which results in proneness to guilt, internally directed aggression, and intense ambivalence about relationships. Freud introduced the idea that depression is related to internally directed aggression resulting from unresolved ambivalence about a lost relationship in his paper Mourning and Melancholia. Rado placed even greater emphasis on guilt, and the development of a punitive superego. Similarly, the British Object Relations theorists also emphasized guilt, and ambivalence in the context of the early mother-infant dyad. The theme is less apparent, but certainly implied, in Arieti and Bemporad's notion of an internalized dominant other driving the individual to be responsible, dutiful and hardworking.

The second theme which emerges across theories addresses the narcissistic components of depression. Freud hypothesized that vulnerability to depression is related to a tendency to form narcissistic identifications. Both Bibring and Jacobson associated depression with conflicts within the ego, caused by a rift between narcissistic aspirations and the ego's ability to meet those aspirations. One might hypothesize that the issue of loss is more directly relevant to these theories of depression, as the narcissistically vulnerable individual typically requires the presence of an other in order to maintain a sense of identity and self-worth.

The idea that these two dimensions of depression exist was first articulated by Fenichel (1945), although he did not specifically define two types of depression. Rather, he conceptualized depression as resulting primarily from lowered self-esteem, and outlined two ways in which self-esteem may be significantly diminished. The first of these stems from unavailability of narcissistic supplies; this is essentially an oral issue, with self-esteem depending on the direct availability of the object. The second way in which self-esteem is negatively impacted results from problems in resolving the Oedipal crisis; failure to experience appropriate approval and recognition of achievement will result in guilt and loss of self-esteem. Both of these issues emerged in a factor analysis of depressive experiences (Grinker et al, 1961), which revealed several differentiating factors. Included were depression characterized by guilt and desire for restitution, and depression characterized by feelings of deprivation

and neediness. A framework for exploring these issues further can be found in Blatt's theory of depression. Blatt, working essentially from an ego psychology orientation, distinguished between anaclitic and introjective depression.

Anaclitic and Introjective Depression

According to Blatt (1974), there are essentially two types of depression: anaclitic and introjective. Both result from an impairment in the development of object representation, which then interferes with the individual's ability to deal with object loss. Based on the work of developmental psychology, especially the work done by Piaget, Mahler and Spitz, Blatt argued that as the child develops from the undifferentiated world of amorphous, global representations, in which self and other are fused, through stages of increasing differentiation, stability and continuity, the growing ability to evoke meaningful representations of an object enables the individual to face loss or the threat of loss without threat to the self. When the development of good object representation is impeded, the person becomes prone to depression because a threat to the object is also perceived as a threat to the self. The level of representation (both object and self) attained corresponds to the specific type of depression that is experienced.

Anaclitic Depression

Anaclitic depression as defined by Blatt is related to descriptions in the literature of depression dominated by fears of

abandonment. This type of depression is typically precipitated by experiences of deprivation, narcissistic injury, or loss of relationships. The primary feelings experienced are those of helplessness, weakness, and depletion. Accompanying intense fears of abandonment are feelings of being unable to obtain gratification. Individuals prone to these experiences often have a great deal of difficulty expressing anger and/or rage for fear of destroying the relationship. Psychiatric patients in this subgroup are described as relatively free of guilt, but characterized by feelings of dejection, apathy, emptiness, and worthlessness. They tend to have numerous physical and psychosomatic complaints, as well as the vegetative and behavioral symptoms often associated with depression, such as motor retardation, lethargy, and sleep and appetite disturbances.

Introjective Depression

According to Blatt, introjective depression develops not out of a fear of abandonment and neglect, but from internalization of an ambivalent, demanding, critical parent-child relationship. The themes related to this type of depression are of guilt, atonement and forgiveness. Introjectively depressed individuals are characterized by strivings for perfection, high standards of morality, and constant self-scrutiny. Guilt is the salient affective experience: any temptation or thought of transgression is accompanied by guilt and concern about potential disapproval, criticism, or punishment. People who experience introjective depression have a propensity for accepting

blame and responsibility; they tend towards overachievement in an attempt to win approval and recognition. Rarely, however, do they derive any lasting satisfaction from their accomplishments. Instead, feelings of being utterly unable to acquire approval, acceptance, or recognition are common. Their high standards and rigid demands are typically attributed to external figures, towards whom the hostility cannot be displayed for fear of losing the other's love. Relationships are characterized by ambivalence.

The Depressive Experiences Questionnaire (DEQ)

Blatt suggested that both anaclitic and introjective depression involve a struggle to maintain contact with objects (either real relationships or internal object representations) and that both can be precipitated by the loss of an object, either real, apparent or fantasied. Theoretically, an individual's proneness to either anaclitic or introjective depression is determined by the level of his or her self-object differentiation. Of the two, anaclictic depression is presumed to reflect the greater degree of impairment in differentiation of boundaries between self and other, although with either experience, some degree of impairment is presumed.

One might assume that differences would exist in terms of symptomatology between introjectively and anaclitically depressed individuals. However, past attempts to differentiate types of depression by different symptom patterns have been consistently unsuccessful. In fact, subgroups based on similar symptomatology have tended to be quite heterogeneous (Blatt, Quinlan, Chevron, McDonald &

Zuroff, 1982). Blatt et al. argued that insofar as depression is characterized by affective states, subtypes of depression may be identified by differences in subjective experiences. To this end, Blatt, D'Afflitti, and Quinlan (1979) developed the Depressive Experiences Questionnaire (DEQ). The DEQ does not ask about specific symptoms of depression, but rather assesses a wide range of everyday life experiences which have been found to be characteristic of the subjective experiences of depressed individuals. This strategy is consistent with an argument which Blatt makes throughout his writing: that depression as a normal affect state falls on a continuum with various types of clinical depression.

Three factors have been identified from the DEQ which have shown consistent, significant differential correlations with independent measures of depression (Blatt et al., 1976, 1979, 1982; Welkowitz, Lish & Bond, 1985). Factor one includes items which are externally directed and related to interpersonal relationships, with themes of abandonment, feeling lonely and helpless, and wanting to be close to and/or dependent on others. This factor also reflects concerns with rejection, and avoidance of anger or aggression for fear of hurting others. This factor was labeled "Dependency," and identified with proneness to anaclitic depression.

Factor two consists of items which are more internally directed, with concerns about guilt, responsibility, meeting expectations and standards, and ambivalence about self and others. Other themes include feelings of emptiness and hopelessness, a tendency to assume blame, and

to be highly self-critical. This factor was labeled "Self-criticism," and identified with a proneness to introjective depression.

A third factor includes items which reflect a sense of confidence about one's resources and capacities, with themes of independence, satisfaction and pride in one's accomplishments. This factor was labeled "Efficacy," and was identified with feelings of potency and activity, and negatively correlated with depression.

To determine whether the DEQ effectively differentiates between different types of personality structure, Blatt et al. (1982) had subjects rated independently for the three factors by clinical judges who were blind to DEQ scores. They found that the judges' predictions were significantly accurate for all but a group which included subjects high on both dependency and self-criticism. The judges then defined the criteria they had used in making their predictions. For the dependency (anaclitic depression) group the judges looked for evidence of marked concern with abandonment and loneliness, a history of early loss and/or deprivation, impulsive behavior, excesses in oral behavior (e.g. alcohol and/or drug abuse, eating disturbances), and suicide "gestures." Predictions of high self-criticism (introjective depression) were made from evidence of intense and self-critical involvement with work, professional strivings, social isolation, a history of parental criticism, obsessive and paranoid features, anxiety and agitation, and "acting out" behavior (promiscuity, alcoholism, violence).

Another study (Blatt, Wein, Chevron, & Quinlan, 1979) supporting Blatt's theory explored the relationship between DEQ scores and conceptual level of mental representations (as measured by content analysis of parental descriptions based on Piagetian levels of capacity for abstract thinking). According to Blatt's theory, an individual obtaining a high score on the Dependency factor (indicative of anaclitic depression) should also display a less developed (more diffuse, undifferentiated) internal structure than an individual obtaining a high score on the Self-criticism factor (indicative of introjective depression). This study found a correlation between DEQ factors and conceptual level of mental representation, supporting Blatt's conclusion that types of depression are related to different levels of development.

As noted earlier, both the Dependency factor and the Self-criticism factor have been found to significantly correlate with other measures of depression. However, they do not do so in an equivalent fashion. The self-criticism factor correlates more highly with the Zung Depression Scale, a traditional measure of depressive symptoms (Blatt et al., 1976, 1982). Blatt offered several hypotheses to explain this finding. First, he suggested that the Dependency factor assesses a dimension of depression not traditionally emphasized. Another possible explanation is that the Dependency factor is less well differentiated than the Self-criticism factor (much as anaclitic depression theoretically reflects a less well differentiated stage of

development) and so does not fit as neatly into specific descriptive models of depression.

Blatt's third hypothesis was derived from an item analysis of the Zung Depression Scale, which showed that the two factors (Dependency and Self-criticism) correlated with different items. Blatt noted that Zung's theory of depression focused on lowered self-esteem as a factor in depression. The Zung scale reflects that focus, with the items being weighted towards psychological rather then behavioral or vegetative symptoms of depression. The Dependency factor correlated with fatigue, psychomotor retardation, irritability, and indecisiveness, while the Self-criticism factor was associated with the psychological items of the Zung; thus, the Zung scale is more likely to identify the signs of introjective, rather than anaclitic depression. Blatt hypothesized that anaclitic depression may more likely be manifested in somatic-vegetative symptoms, while introjective depression is more likely to be experienced in terms of cognitive-affective symptoms. This hypothesis is supported by other studies which have found similar patterns of correlations using other measures of depression (Blatt et al., 1982).

Evidence is accumulating to support Blatt's formulation of anaclitic and introjective depression as two distinct dimensions of depression. Although Blatt hypothesized about the etiological differences between the two types of depression, this author suggests that further clarification of the character structures of individuals prone to either anaclitic or introjective depression is needed before

further theorizing about etiology. This is particularly true in light of recent work in the area of shame's relationship to depression (Hoblitzelle, 1987; Lewis, 1971, 1976, 1987a, 1987b). Prior to this body of work, shame was rarely implicated in explanations of depression. Guilt, however, has been identified as an important factor from the very beginning of psychoanalytic theorizing about depression. This may be partly due to a more obvious relationship between guilt and depression, but this does not adequately explain the lack of attention to shame. Of interest is that Blatt distinguishes between anaclitic and introjective forms of depression in part by identifying one with intense guilt and the other with the absence of guilt. Lewis (cited in Hoblitzelle, 1987) suggested that the distinction may be more accurately made by distinguishing between guilt and shame experiences. An examination of the literature on guilt and shame may clarify her position.

Guilt and Shame

From the earliest days of psychoanalytic thinking, guilt has been recognized for the role it plays in human development. Freud not only saw it as central in the psyche of the individual, but also considered it to be at the crux of developing civilization, calling it "the most important problem in the evolution of culture" (1951). Shame, on the other hand, has been largely ignored until recent years. In A Critical Dictionary of Psychoanalysis Rycroft (1968) called shame the "Cinderella of the unpleasant emotions." Of the early thinkers only

Alexander (1938) and Erikson (1950) considered shame as important to development as guilt .

There are several reasons cited for the lack of attention to shame. First, there has been a widespread tendency to view shame and guilt as essentially the same thing. Fenichel (1945) reflected the prevailing opinion of his day when he stated that "shame of oneself" was very much related to guilt, Alexander (1938) concurred, even as he attempted to emphasize the importance of shame feelings, or what he called feelings of inferiority. He considered both guilt feelings and feelings of inferiority to be closely related manifestations of the same tension, essentially identical in structural terms. Ward (1972) noted that in the literature which existed at that time, even those writers who recognized shame as a separate and significant affect showed a remarkable lack of interest in its particular role and characteristics.

Related to this is a problem in differentiating and then correctly labeling one's experiences. In a phenomenological study of shame, Miller (1985) found that subjects often related stories that sounded much more like experiences of guilt, even though asked to describe a shame experience. Lewis (1976) described similar phenomena in which shame and guilt are both evoked by some moral transgression, and then labeled guilt. She suggests that shame often is "bypassed"; for instance when one feels both guilty and ashamed, the shame may be hidden in the form of guilty self-reproach.

Another reason suggested for the neglect of shame is that shame is an experience which induces a great deal of discomfort; shame is an experience familiar to almost everyone, but one on which most people would prefer not to dwell. Kaufman (1985) called shame a "taboo" emotion. People are much more willing to admit to feeling guilty or afraid than to acknowledge feeling ashamed. Talking about and remembering shameful experiences makes one vulnerable to reexperiencing the affect, often with an unusual intensity. Miller suggested that psychologists are not immune to this vulnerability and so have colluded in not exploring the experience of shame to its fullest.

The first comprehensive treatise on shame and guilt was offered by Gerhart Piers, a psychoanalyst, and Milton Singer, an anthropologist, in 1953. Their work has been followed by a relatively recent upsurge of interest in the experience of shame as an affect distinct from guilt. More and more, writers are suggesting that shame plays a central role in development, and is crucial to our understanding of both normal behavior and pathology. Not unexpectedly, one focus of study has been the relationship of shame to guilt, with increased understanding of the interplay between the two experiences.

The following sections will outline the history of thinking concerning guilt and shame. Each will be considered separately prior to exploring the relationship between the two.

Guilt

Since Freud, guilt has been seen as playing a central role, not only in pathological development, but also, more generally, in ego development, character formation, and socialization. In his seminal work, Piers (Piers & Singer, 1953/1971) outlines what was, and continues to be, the generally accepted definition of guilt. Guilt is "the painful internal tension generated whenever the emotionally highly charged barrier erected by the superego is being touched or transgressed" (p.16). These barriers are built to defend against id impulses, generally assumed to include both aggressive and sexual impulses, that are unacceptable to the individual. Guilt feelings are generally considered to be a form of anxiety; Alexander (1938) called this anxiety a fear of conscience, or the principle of Talion. Essentially, the fear is of retaliation, provoked by one's aggressive (or sexual) impulses. It is an unconscious fear, emanating from the Oedipal period, when the punitive aspects of the parental images are internalized. The irrational punishment that is most intensely feared is one of annihilation or mutilation; this is known as castration anxiety.

Although this view of how guilt develops is generally accepted in the field, there is some debate about specifics. For example, Piers suggested that the superego actually begins development prior to the Oedipal period. He argued that the role of oral aggressiveness and the mother as a punitive agent are important to the development of an internalized conscience. One also finds definitions of guilt which

include threat of loss of love among the punishments feared (Stein, 1968). These issues will be addressed in the later discussion of the relationship between guilt and shame, since it seems likely that some points of dissension have to do with a confusion of the two experiences. This is especially likely in the case of understanding the role played by the threat of loss of love.

As to the essential nature of guilt experiences, there is little disagreement. Guilt is experienced when there has been a transgression, a violation of a specific taboo or law, or when one has behaved in a way that would be subject to punishment. Alexander (1938) discussed the inhibitory effect of guilt. Lynd (1958) described the forbidding, or sanctioning, quality of the experience. Both described the way in which guilt serves as a signal to the individual that he or she has behaved in a fashion which is not acceptable, because it has violated some standard.

Shame

The literature on the nature of shame does not reflect the same level of agreement as one finds for guilt. A review of this literature will examine both the historical evolution of the concept and emergent themes in the study of shame.

Miller (1985) divided early theories of shame into two categories, the first group including Sigmund Freud, Anna Freud, Nunberg and Jacobson, who saw shame as being primarily a reaction formation against exhibitionistic impulses. From this perspective shame serves as a sort

of super ego deputy. The second viewpoint has been espoused by such theorists as Kohut, Knapp and Lewis, who hypothesized that shame serves an arousal-blocking function, protecting the ego from any arousal which might be disruptive. More specifically, according to this group of theorists, shame serves as a brake against overstimulation from exhibitionism. The first line of thinking sees shame as being similar to guilt in its function as a servant of morality, while the second line of thinking sees shame as helping to maintain a consolidated sense of self.

Theories about shame can also be divided between those which link shame to a specific developmental conflict, and those which suggest that shame develops independent of any specific developmental period (Miller, 1985). Those theorists who place shame in the context of specific developmental conflicts differ in their thinking as to when exactly shame begins to develop.

Freud mentioned shame only briefly in his writings, but implied that it developed during latency, with origins in the Oedipal period. Anna Freud suggested that shame has its origins in the anal period, when concerns about messiness are most focal. This is consistent with Engels' argument that shame usually reflects anal concerns with loss of control. Erikson (1963) also viewed shame as a result of anal conflicts. During this period muscular maturation allows the child to gain some sense of mastery, yet also sets the stage for expectations which the child may not be able to meet, thus creating a vulnerability to experiences of shame and doubt. Still others, most notably Nunberg

and Maymen, placed the origins of shame in the phallic period of development, related to feelings of castration and of genital inferiority.

Those theorists who do not link shame to specific body conflicts also differ in their views. This category includes Alexander and Piers, mentioned previously for their pioneering work in the area of shame. Also included are writers who see shame as primarily a narcissistic issue. Each of these perspectives offers a unique contribution to the field, thus warranting a somewhat lengthier review.

Alexander (1937) suggested that shame results from a failure to move forward developmentally. Similarly, Grinker (1955) posits that shame is a reaction to failure to master a developmental task at the normally expected time. Clearly this line of thinking has been influential, as a sense of failure, or inadequacy, has come to be regarded as one of the hallmark signs of shame.

Piers (1971) was the first writer to emphasize structural differences between shame and guilt. He saw shame as the result of a discrepancy between the ego and the ego ideal. He defines the ego ideal as the structure which contains a core of narcissistic omnipotence, positive identifications with parental images, later identifications with one's peers, and awareness of the ego's potentialities. Shame, according to Piers, is a form of anxiety that is aroused whenever there is a failure to reach a goal or image presented by the ego ideal. The anxiety has to do with fears that one is inadequate, and, by implication unlovable, and thus vulnerable to

abandonment. These ideas have influenced numerous other writers, and will be returned to later.

The specific relationship of shame to narcissistic development has been explored by various writers, expanding on Pier's hypothesis that shame is predominantly an ego ideal issue. Kohut (1972) posited a fairly direct relationship between shame and narcissistic vulnerabilities. According to Kohut, a mother's confirming and approving "mirroring" responses to her child's natural exhibitionism allows for a narcissistic cathexis of the child's "body-self." However, failure to provide this appropriate mirroring leads to a splitting off of the primitive grandiosity, leaving it isolated, and immune to later influences of the adult ego. When this split-off archaic, grandiose self later asserts itself, the "reality" ego will become flooded with unneutralized exhibitionistic impulses, resulting in psychological paralysis and intense feelings of shame and rage. Kohut suggested that an individual's proneness to experiences of intense shame is evidence of severe disturbances in appropriate libidinal cathexis of the self. An individual with such deficits has failed to develop an internalized ideal other, which in normal development would take over the approving functions of the parental figures. Without the presence of a mirroring other, any flow of exhibitionistic libido is disruptive. The ego is paralyzed as it attempts to both respond to the pressure of the exhibitionistic urge, and attempt to stop its flow. "It is this disorganized mixture of

massive discharge ... and blockage ... in the area of exhibitionistic libido which is experienced as shame" (p. 395).

Broucek (1982) also emphasized the role of shame in narcissistic development, stating that "shame is to self psychology what anxiety is to ego psychology - the keystone affect" (p. 369). Broucek distinguished between an "ideal self," which is a part of normal development, and a "grandiose self," which is indicative of narcissistic pathology. It is the grandiose self which leaves one particularly susceptible to shame. Briefly, his position is as follows:

Shame is a derivative of experiences that occur in the first one and a half years of life. When an infant's feelings of interest, joy, or excitement are suddenly halted, either due to the infant's inefficacy or to unexpected external events, the infant experiences a sort of cognitive shock, a discrepancy between expectations and actuality. This type of experience is a precursor to shame. As objective self-awareness (self-consciousness) develops, the child will have occasion to experience a similar "cognitive shock" related to the dawning awareness of his or her relative smallness, weakness, and inadequacy in comparison to others in his or her world. If a child acquires an appropriate number of efficacy experiences, an "ideal self" will develop which is not too dissonant with the actual self. However, when a child experiences too many injuries to the developing sense of self (e.g. because of experiences of failure, inadequacy, or humiliation) the "ideal self" will undergo compensatory elaboration,

taking on fantastical and omnipotent characteristics. It is the development of this "grandiose self" which leaves one especially prone to experiences of shame, since the likelihood is much greater that a discrepancy will exist between the fantasied self-image and actuality.

Wurmser (1987) called shame the "veiled companion of narcissism" and delineated three forms of shame: shame anxiety, shame as a complex reaction pattern, and shame as a preventative attitude. He focused on both the content and function of shame. For Wurmser, shame is inherently a narcissistic issue, as he defines it as "a fairly defined affect ... caused by a discrepancy between expectancy and realization" (p. 76). It is manifested as a tension between the superego and the ego function of self-perception. The greater one's self expectations, the greater likelihood of a discrepancy, and the harsher the resulting self-abasement or chastisement. This definition is very much in keeping with previously discussed definitions of shame and so will not be discussed further. Wurmser, however, saw this as only one aspect of shame, as it is this discrepancy which leaves one vulnerable to "shame anxiety." Both shame anxiety and shame as a complex reaction pattern have to do with shame <u>content</u>. However, Wurmser also focused on the <u>function</u> of shame, specifically as a preventative attitude. He noted that shame also has to do with <u>movements</u> of self-exposure and <u>acts</u> of perception, and in fact serves to inhibit these two behaviors (i.e. shame prevents one from exposing "too much").

Wurmser believed that by inhibiting perception and movement towards self-exposure, shame protects the individual against painful

intrusions by others. This is an especially important function for those individuals who have a fragile sense of self. For example, if as a child, one's drive for self-assertion is thwarted, the development of a sense of self as real and important is impeded. Without healthy perceptual-expressive interactions, the self is left vulnerable to feelings of exposure and inadequacy. Wurmser suggested that shame can serve as a guardian of that fragile self by protecting against overstimulation in the areas of both perception and expression.

Like Wurmser, Lewis (1971, 1987c) saw shame as primarily a narcissistic reaction, because by her definition, shame is about the self. More specifically, she saw shame as a failure to live up to the ego ideal. However, she also focused on the interpersonal aspects of shame, recognizing that shame stirs up feelings of "self-in-the-eyes-of-others" (1987c, p. 181). Shame brings the self into focus, accompanied by an abrupt, often painful, reminder that self and other are separate. Lewis suggested that individuals who are shame prone "lose" themselves more easily in identification with others and that shame experiences serve to re-establish the lost boundaries. She also hypothesized that shame may be a universal reaction to unrequited or thwarted love.

Both Wurmser and Lewis introduced the idea that shame involves both self and interpersonal issues. A number of writers have focused primarily on the interpersonal aspects of shame; Kaufman (1985) and Nathanson (1987) have offered recent contributions in this area.

Kaufman (1985) emphasized the feeling of being "seen in a painfully diminished sense" (p. 8). He argued that although it is an intense self-consciousness which leaves us feeling transparent, (i.e. the sense of being seen does not require the presence of another), it always feels that the "watching eyes" belong to others. This is because of what Kaufman called the "interpersonal bridge" that is built between people during the formation of a relationship. Through reciprocal communication of interest, individuals come to establish emotional ties. In order to do this, the individuals must trust each other enough to become vulnerable, as one does when one needs something from another person. When an expectation that a mutuality of response exists, that is, when one comes to know another well enough to depend on certain responses, an interpersonal bridge has been built. Kaufman hypothesized that shame is most likely to occur whenever the basic expectations that one has of a significant other are suddenly exposed as wrong. This unexpected betrayal of trust (a break in the interpersonal bridge) leaves one feeling exposed and ashamed.

Nathanson (1987) took a slightly different approach, basing his theory of shame on Sylvan Tomkins' Affect Theory. Nathanson saw shame as a primary modulator of interpersonal relatedness. He suggested that shame is essentially an innate affect, manifested first in what has been typically called "stranger anxiety." Nathanson argued that this stereotypic infant behavior is less anxiety about encountering a stranger, and more a "shock" reaction: the infant expected to find mother, and instead found "not-mother." These reactions are suggestive

of what Nathanson called "proto-shame"; shame proper does not develop until an interaction carries meaning in terms of the self.

However, these early experiences of stranger-anxiety, or "proto-shame," do quickly take on meaning, both in terms of the self, and in terms of relationships to others. After all, as Nathanson pointed out, the infant will occasionally experience this confusion in relation to the mother. The mother will occasionally appear as a "stranger" to her child, i.e. she will respond differently than the child has come to expect her to respond. At these times, the "proto-shame" reaction will begin to have implications in terms of the child's sense of itself. If the mother appears as "bad" in some way, she will become a stranger to the child. However, it is dangerous for an infant to perceive its mother as bad, and the feelings of badness will be split off and internalized. Thus, the sudden unrelatedness the child experiences in the context of the mother-infant dyad will impact on the child's sense of security, and ultimately, competency. Such experiences coalesce into a general affect system which comes to be known as shame, which can operate with or without the presence of another person. However, the end result typically is a sense of disruption and isolation.

Although these many writers offer seemingly disparate theories about shame, most of the work can be viewed as essentially variations on a theme, or rather on two themes. First, shame clearly involves self issues. Typically, shame is thought to result from a failure to live up to the ego ideal. This formulation incorporates positions taken by a number of writers, including many who do not use the term "ego

ideal." For example, feelings of inferiority, mastery failures, and discrepancies between the actual self and the grandiose self can all be understood in terms of conflict between the ego and the ego ideal. The second theme has to do with shame as an interpersonal issue. Disruptions in relationships, fears of abandonment, and feelings of isolation have all been cited as correlates of shame. Shame is typically accompanied by feelings of both inadequacy and exposure, reflecting that shame invariably brings both the self and some sense of an "other" into sharp focus. How this differs from the experience of self and other when guilt is the salient affect will be addressed in the next section.

The Relationship between Guilt and Shame

The relationship between guilt and shame is a complicated one. As noted earlier, the two experiences are often confused, not only by the experiencing person, but also by the many individuals who have chosen to write about one or the other through the years. Recent contributions have led to an increasing differentiation between guilt and shame in the literature. Table 1 presents an outline contrasting the key features of guilt and shame. The ideas included represent a distillation of the points of agreement among the major writers in the area (cf. Lewis, 1971, 1976, 1987a, Lynd, 1958, Miller, 1985, Piers, 1971, Wurmser, 1987).

Although most writers concur with the ideas presented in Table 1, dissension exists concerning other facets of guilt and shame. Perhaps

TABLE 1

Summary of Distinctions Between Guilt and Shame

Guilt	Shame
Arises out of conflict between superego and ego	Arises out of tension between ego ideal and ego
Internalization (of super ego) occurs via introjection of punitive parental figure	Internalization (of ego ideal) occurs via introjection of loved parental figure
Implied (unconscious) threat is of mutilation (castration).	Implied (unconscious) threat is of loss of love (abandonment).
Implies transgression	Implies failure
Accompanied by feelings of wrongdoing	Accompanied by feelings of inadequacy
"Self" is active; guilt evokes feelings of responsibility	"Self" is passive; shame evokes image of self as flawed, helpless
Functions to inhibit activity, keep self from overstepping boundaries, protect integrity of the other	Functions to guard boundaries of the self, keep others from intruding, protect the image of the self

the most significant point of contention concerns the question as to when the capacities for guilt and shame develop. Many early writers, most notably Piers (1953) and Erikson (1956), assumed that the development of shame preceded the development of guilt. They also assumed that because of its earlier development, shame was, by definition less developmentally advanced. However, this is not a universally held assumption, and, in fact, Lynd (1958) argued that shame often reflects a higher level of moral development than does guilt.

Current writings tend to reflect thinking more in line with the views first outlined by Hartmann and Loewenstein (1962), who suggested that guilt reactions to transgressions of moral prohibitions and shame reactions to failures to reach certain ideals are equally sophisticated levels of moral development. This is the position taken by Lewis, (1971, 1976, 1987a) who argued that shame and guilt proneness represent different ways of operating in the world rather than different levels of development.

The basic premise of Lewis's theory is that a propensity to either shame or guilt is related to perceptual style. Lewis distinguished between two perceptual styles, field independence and field dependence. A person who is field independent has the capacity to perceive an object as separate from the context in which it is embedded. Someone who is field dependent has difficulty separating an object from its context. For example, if a geometric figure is hidden within a series of lines, the individual who has a field independent perceptual style will be much more able to perceive the figure than will a field

dependent individual. A difference also exists in the perception of one's own body position in space. In experiments involving a tilted room, field independent subjects were more able to correctly assess the position of their bodies than were field dependent subjects. Lewis found other differences between field dependent and field independent individuals, including differences in social interactions and defensive operations. Her work also led her to posit a difference in superego functioning: shame being the superego mode of functioning typical for field dependent individuals, and guilt being the typical superego reaction of field independent individuals.

Lewis offered empirical support for her theory, and cited recent research in the area of brain structure which suggests that perceptual differences may be inherent. The implication is that differences in shame and guilt proneness are also inherent. If this is true, the question as to when each develops becomes less important, the focus shifting to understanding how and why an individual's style creates a propensity to shame or guilt feelings. This perspective parallels work being done in other areas, especially in theories specific to women's development. For example, similar theories have been outlined recently in the areas of moral development (Gilligan, 1982) and the nature of object relationships (Chodorow, 1978).

The study of shame and guilt is complicated by the way in which the two experiences interrelate. Two phenomena in particular contribute to the confusion. The first involves complex affective cycles, of which both shame and guilt tend to be a part. The second

involves defensive operations in which either guilt or shame serves as a defense against the other affect.

Many authors have commented on a unique cycle of affect to which guilt and shame contribute (Kaufman, 1985; Lewis, 1987c; Miller, 1985; Piers, 1971; Scheff, 1987). Either guilt or shame can precipitate this cycle, in which there is a sequence of emotions surfacing and then receding in rapid succession. A typical cycle operates as follows: A young man has aggressive fantasies about his boss. These fantasies cause him to feel guilty. The guilt is inhibitory, such that it not only prohibits him from acting on his fantasies, but also leads to an overcompensatory passivity. The passivity is conflictive for the young man (who has an image of himself as competent and assertive) and leads to feelings of shame. In reaction to the shame, the man has an upsurge of aggressive fantasies, with the corresponding guilt reactions. And the cycle continues.

This cycle is even more likely to be sparked by shame experiences, because a typical concomitant of shame is anger, often in the form of rage. Scheff (1987) describes this as a "feeling trap," in which one feels angry (often directed at both self and other) that one is ashamed, and then feels ashamed about the anger. Once in this state, it is quite difficult to discharge the rage because it is bound by the shame. This state is quite similar to what Kohut calls "narcissistic rage". Kaufman (1985) suggested that rage is a spontaneous reaction to shame because it functions to actively keep others away, thus lessening the vulnerability to exposure. The fact that rage so often accompanies

shame increases the likelihood that shame will set off a cycle of affect in which shame is accompanied by rage, which results in guilt, followed by inhibition, which then touches off the shame again.

Affect cycles such as those described above reflect a situation in flux; individuals experiencing these cycles are "floundering between two horns of two powerful anxieties and wavering in their choice of defenses and behavior" (Piers, 1971, p.34). It is just as common, however, for an individual to be prone to either guilt or shame as a defense against the other. This is especially apparent in certain character styles. Piers cited the example of the "moral masochist": an individual who seems to be pained by a surplus of shameful and humiliating experiences, accompanied by intense self-abnegation and feelings of inferiority. Piers suggested that often this is a defense against a more pervasive, but hidden, sense of guilt, and that the shame functions as an attempt to "buy off" the sadistic superego.

More commonly, guilt serves as a defense against shame. Guilt is associated with actions, whereas shame reflects feelings about the whole self. One feels guilty about something one has done. Shame tends to feel more global and diffuse. When one feels guilty, a typical reaction is to try to undo, or repair, what has been done. Lewis (1971, 1987c) suggested that guilt can be modulated through the use of ideational defenses such as rationalization and obsessional thinking, whereas shame is less amenable to such defenses. Therefore, an individual may avoid shame affect following a stimulus which could

provoke shame by obsessing over what he or she "did wrong." In this way shame affect is "bypassed" and replaced by guilty ideation.

Distinguishing between shame and guilt is made difficult by the phenomena described above. This difficulty is exacerbated by the fact that one stimulus may evoke both shame and guilt affect; both shame and guilt can result from a moral transgression. For example, if a college student cheats on an exam, she may feel guilty for the act, while at the same time feel ashamed that she is the kind of person who would do such a thing.

Despite these problems, there is increasing evidence that shame and guilt can be effectively differentiated. Hoblitzelle (1987) described two essential criteria for distinguishing between shame and guilt states: the role of the self and the contents of consciousness. When the salient affect is shame, the <u>self</u> is the center of awareness, with the self being experienced as passive and helpless. Thought content focuses on ways in which the self is deficient or flawed. When guilt is the experienced affect, awareness centers around the <u>act</u> for which the self is responsible. Attention is focused on how or why something was done or not done, how it might have been avoided, and ways in which the situation can be repaired. In the example of the student cheating on an exam, when the student's experience is one of being a "bad person," or of being stupid for not having been able to do well on the exam without cheating, her experience is best described as shame. When she is most conscious of the behavior itself, perhaps

concerned about getting caught, or wanting to "confess" to the instructor, the focal affect is one of guilt.

Recognition of the need to differentiate guilt and shame is a relatively new development in the history of psychoanalytic thinking. Increasing clarity in this area is important, as it will contribute to better understanding about human nature. Already it is possible to see an impact in the area of intervention, as several authors (Kaufman, 1985; Lewis, 1971; Nathanson, 1987) credit their growing interest in shame and guilt to perceived gaps in their ability to effectively treat psychotherapy patients. Similarly, work has begun on exploring how guilt and shame differentially contribute to psychopathology (cf. Lewis, 1971, 1987a, 1987b, 1987c; Lynd 1958). The following section will discuss how the work on shame and guilt contributes to an understanding of depression.

The Roles of Guilt and Shame in Depression

Despite a growing recognition of the importance of shame, work in this area has yet to be integrated into other areas of psychological understanding. Recent anthologies of theory and research concerning depression list numerous references to guilt in their indexes, but no references to shame (Beckham & Leber, 1985; Gaylin, 1983b; Volkan, 1985). The importance of guilt in the genesis of depression has been noted by most prominent writers since first emphasized by Rado (Gaylin, 1983a). Not only has guilt generally been seen as one facet of depressive experiences, it has often been identified as the most

crucial component. For example, Guntrip (1962) argued that the term depression be reserved for those experiences in which guilt is a predominant affect. The psychoanalytic literature has historically viewed guilt as integral to the formation of depression; the earlier review of psychodynamic theories of depression included discussion of the relationship between guilt and depression from various perspectives. Therefore, further review is deemed unnecessary at this point.

Lewis (1971, 1976) has offered a model of depression that is in direct contrast to most of the traditional theories, positing that shame experiences result in a vulnerability to depression, whereas guilt leads to other forms of pathology. She derived her theory from work on gender differences in pathology, and, in fact, her work is more a study of gender differences in superego functioning than it is a theory of depression. Nonetheless, Lewis introduced new ideas which have resulted in increasing awareness about the previously ignored area of shame's role in depression.

Lewis (1971, 1976, 1985) suggested a number of reasons for the relationship between shame and depression. First, shame affect is characterized by feelings of smallness and inadequacy. The phenomenology of intense shame, suggested Lewis, is an experience of "collapse of the self." Clearly such subjective experiences result in at least a temporary lowering of self-esteem. And low self-esteem often leads to (or at least is accompanied by) depression. Furthermore, the sense of oneself as inadequate, weak, or "bad" that an

individual feels with shame experiences is not easily corrected. Similar feelings may accompany guilt affect; the guilty individual may feel badly about a particular thought, act, or impulse. The self is "bad" because of some behavior. However, this can be dealt with by focusing on how to repair or "undo" the deed for which one feels guilty. With shame, the feeling of badness is more pervasive and less easily defended against. Thus, Lewis argued, chronic problems with shame will leave an individual quite vulnerable to depression, whereas chronic problems with guilt lead to other forms of pathology, particular obsessive-compulsive disorders and paranoia.

Lewis suggested another, perhaps more important, reason for shame's correlation with depression: the effect it has on relationships. While both guilt and shame often signify a disturbance in relationships, guilt facilitates reparation (Lewis, 1985; Levin, 1971; Lindsay-Hartz, 1984), whereas shame makes reparation more difficult. Guilt feelings are often accompanied by a desire to confess and/or atone. When two people have an argument, mutual expressions of guilt will often lead to reconciliation. Conversely, shame is typically accompanied by a desire to escape -- to hide from the sight of others. Shame signifies that there has been a lapse in self-other boundaries; one has been exposed or intruded upon in some unexpected way. The desire to withdraw serves a defensive, and perhaps adaptive, purpose in that it helps to re-establish lost boundaries, but it also highlights the fact of one's separateness from others. The experience of being unconnected from others becomes salient. The fact that shame

is often accompanied by rage makes reconciliation with the other even more difficult. Shame leaves one feeling alone and prone to fears of loss and/or abandonment, and thus vulnerable to experiences of depression.

Grinker (1955) supported the theory of a relationship between shame and depression by citing clinical evidence. He discussed examples of depressed patients who attempted suicide following poorly timed interventions by the therapist (e.g. poorly timed offers of support or premature suggestions for activity), suggesting that such incidents are related to severe shame reactions. He posited a connection between depression and shame reactions to an inability to grow and mature.

Other evidence of the role played by shame in depression is implicit in recent formulations of depression in women. Kaplan (1986) argued that women are more prone to depression because they develop a sense of identity based on "self-in-relation." She suggested that the developmental model in which individuals become increasingly autonomous and differentiated as they develop is a male paradigm, with female development reflecting a more other-centered way of being throughout development. According to Kaplan, women develop and maintain their sense of identity through relationships. Thus, loss of a relationship will impact differently on women than on men; for women the loss is often experienced as a failure of the self, which then leads to depression. Although Kaplan does not label this experience shame, her description of feelings of inadequacy and helplessness which accompany

disruptions in relationships correspond to many writers' definitions of shame.

The literature on depression is varied and often contradictory, especially concerning the roles played by shame and guilt. Some writers have suggested that guilt is the criterial factor associated with depression; others have posited a stronger relationship between shame and depression than between guilt and depression. Studies can be cited to support either position (Hoblitzelle, 1987). This fact alone supports a third position taken by some writers, who have suggested that there are two types, or dimensions, of depression. Several writers have suggested that the difference between types of depression may correspond to a difference between guilt and shame (Hoblitzelle, 1987; Izard, 1972; Kaplan, 1986; Lewis, 1987b). Thus far, however, there has been little effort to demonstrate this relationship empirically. Hoblitzelle (1987) cited several studies which have included an analysis of the relationship between depression, shame, and guilt, with inconclusive results. However, none of the studies cited were designed for the purpose of determining whether types of depression could be differentiated according to differences in guilt and shame proneness.

The results of a study by Golding and Singer (1983) support the idea that the dimensions of depression outlined by Blatt correspond to differences in superego functioning as suggested by Lewis. Their study looked at the relationship between daydreaming styles and depressive moods. They defined several types of daydreaming, including "guilty

daydreaming," characterized by themes of hostility and/or failure, and "distractible daydreaming," which included themes of dependency, excessive concern with others, and trouble attending to one's own work. They found that "guilty daydreaming" correlated with the Self-criticism factor on the DEQ, while "distractible daydreaming" corresponded to the Dependency factor. Based on their results, they concluded that two types of depression (anaclitic and introjective) are each associated with a unique pattern of inner experience, and that the differences between those experiences may be similar to differences between shame and guilt.

Summary and Statement of Problem

The literature on depression includes a myriad of factors presumed to be associated with depression. Historically, guilt has been included as a relevant intrapsychic factor, with psychoanalytic theory suggesting that an individual prone to guilt will also be prone to depression. More recently, writers have recognized a connection between shame and depression. Initially it seemed that this addition to the literature should contribute to increasing clarity regarding the nature of depression, especially regarding the question as to whether there exists more than one continuum of depressive experience. However, while much has been added to our knowledge of shame phenomena, and the relationship between shame and depression, there has been little effort to explore the interaction of both shame and guilt with depression. It appears that many of the people exploring the

relationship between shame and depression have simply dismissed the previous theories which have included guilt as a predominant factor in depressive experiences. Such a failure to account for contradictory theories contributes to the confusing and incoherent nature of the depression literature. Yet the dilemma of accounting for incompatible theories has a rather obvious solution: there is more than one type of depression.

There have been some attempts to integrate the diverse bodies of work on shame, guilt and depression theoretically. Several authors have suggested that the primary difference between anaclitic and introjective depression may be a difference between proneness to shame and guilt (Hoblitzelle, 1987; Izard, 1972; Kaplan, 1986; Lewis, 1987b). However, there has been a tendency in the research literature to focus on either guilt or shame as each relates to depression, with little attempt to explore how the three phenomena interrelate.

The purpose of the present study is to explore the differences between anaclitic and introjective depression, as each type of depressive experience relates to shame and/or guilt. The literature would suggest that anaclitic depression is associated with shame-proneness, while introjective depression is related to guilt-proneness. In addition, this study will explore the relationship between depressive symptomatology, types of depression, and guilt- or shame-proneness. The operational definitions for the hypotheses under investigation are enumerated in the Methods section (Chapter II).

CHAPTER II

METHODS

Subjects

Subjects were recruited from the population of women enrolled in professional degree programs at the University of Tennessee, Knoxville. This population was chosen for the purpose of focusing solely on "high-aspiring" women. High-aspiring women were chosen as subjects for the following reasons. First, epidemiological studies of depression have consistently found depression to be more common in women than in men (Amenson & Lewinsohn, 1981; Fremming, 1951; Helgason, 1964; Weissman & Klerman, 1977). Therefore, it was presumed that a higher incidence of depressive experiences would be found by focusing exclusively on women rather than including both men and women in the sample. Women classifiable as "high-aspiring" were chosen in order to increase the likelihood of finding subjects prone to both anaclitic and introjective depression among the sample. The work of Kaplan, Lewis and others writing on the development of women suggest that women are more prone to an anaclitic form of depression because of their need for relationships as a way of maintaining a cohesive sense of self and for a sense of self-worth. This is not likely to be any less true of "high-aspiring" women than of women in general. Introjective depression, on the other hand, seems to be related to issues of performance and achievement. One becomes depressed when one fails to live up to standards and expectations. These standards and

expectations can be seen in terms of mastering some sort of objective, "instrumental" task. Women who can be classed as "high-aspiring" are more likely to experience these issues as salient than are women who live a more "traditional" lifestyle, centered on the home and family.

Subjects were recruited from a list of women enrolled in graduate programs at the University of Tennessee, Knoxville, during the Fall quarter of 1987. Letters were sent randomly to 175 women from a list of 1547 female graduate students, explaining the study and asking them to return an enclosed postcard if they were interested in participating. Seventy-six postcards (43%) were returned. From this pool, 67 subjects met with the researcher, with 65 subjects successfully completing all of the instruments.

Instruments

Beck Depression Inventory (BDI).

The BDI is a 21-item test in multiple choice format, intended to measure the behavioral manifestations of depression. The test is self-administered and usually requires no more than ten minutes for completion.

The BDI is one of the most widely used instruments for assessment of depression, in both clinical and normal populations. A recent review of the literature (Beck, Steer & Garbin, 1988) reported .87 to be the mean internal consistency coefficient and test-retest reliability of greater than .60. This same review reports high concurrent validity of the BDI with other measures of depression, and strong construct

validity, especially for physiological and behavioral indices of depression.

Depressive Experiences Questionnaire (DEQ)

The DEQ consists of 66 Likert-type items designed to tap attitudes toward the self and interpersonal relations as a way of differentiating between subjective experiences of depression. A factor analysis of the items results in an emergence of three factors: 1.) dependency, 2.) self-criticism and 3.) efficacy. A high score on the dependency factor is considered a reflection of an anaclitic form of depressive experience while a high score on the self-criticism factor suggests an introjective mode of depression.

Significant reliability coefficients have been reported (Zuroff, Moskowitz, Wielgus & Powers, 1981) for the three factors. Test-retest correlations ranged from .81 to .89 for dependency, .75 to .83 for self-criticism, and .72 to .75 for efficacy. Other work (Welkowitz, Lish & Bond, 1985) found internal consistency correlations of .81 (dependency), .86 (self-criticism) and .72 (efficacy).

Van Lennep's Four-Picture Story Test (VLFPST)

The Van Lennep's Four-Picture Story Test (VLFPST) is a story telling projective test similar in nature to the Thematic Apperception Test (TAT). It involves four cards placed together in a specific order. The subject is instructed to write a story in which all four scenes appear. The scene presented on Card I shows two people

together, one person standing and pointing, the other sitting. Card II is a picture of a bedroom, with the bed having been painted ambiguously such that it is possible to see one or more or no people lying on it. Card III is a scene of someone standing by a lamp post, alone in the rain. Card IV is a scene involving a group of people watching a tennis match.

The test is administered individually to each subject, with the subject being given the following instructions:

> In a moment I am going to show you four pictures laid out like this. (Subjects are then shown a diagram of a rectangle divided into four numbered parts). I'll give you a minute to look at them, then I'll take them away and ask you to write a story in which each of the pictures appears as a scene or an event. You can start with any picture and end with any picture but be sure to include them all. Make it a real story with a hero and a plot, a story with a beginning, middle and end. Any questions?

The pictures are laid out and the subject is given 60 seconds to look at them. They are then taken away and the subject is provided a private place in which to write the story.

Gottschalk-Gleser Content Analysis Scales (GGCAS)

In this study the Van Lennep's Four Picture Story Tests were scored using the Gottschalk-Gleser Content Analysis Scales (GGCAS) for guilt-anxiety and shame-anxiety (Gottschalk, L.A., Winget, C.N., & Gleser, G.C., 1969). These content analysis scales were developed using a variety of language samples in both verbal and written form. Although the scales have not previously been applied to the Van

Lennep's test, satisfactory results have been found using this method with TAT cards (Gottschalk, L.A., & Gleser, G.C., 1969). Furthermore, the authors have found the application of their content analysis scales to a variety of written material to be feasible, with the main criterion being that the sample be 70 words or greater in length.

For scoring purposes the sample is broken into units to be coded, with the units being defined as independent or dependent clauses. The GGCAS includes scales for "Anxiety," "Hostility Directed Outward," "Hostility Directed Inward," "Ambivalent Hostility," and "Social Alienation-Personal Disorganization." The Anxiety Scale encompasses six types of anxiety: death anxiety, mutilation anxiety, separation anxiety, guilt anxiety, shame anxiety, and diffuse or nonspecific anxiety. In this study only guilt anxiety and shame anxiety were scored.

The guilt anxiety and shame anxiety scales were developed based on the work of Piers and Singer (1953). Guilt anxiety is scored for references to adverse criticism, abuse, condemnation, moral disapproval, guilt, or threat of such experience. Shame anxiety is scored for references to ridicule, inadequacy, shame, embarrassment, humiliation, overexposure of deficiencies or private details, or threat of such experience. Scores are weighted depending on whether the reference directly involves the speaker, or involves animate others, or is denied. Statements of greater intensity are also weighted. The final score for each sample is adjusted through use of a correction factor related to number of words in the sample.

The authors recommend controlling for error variance due to scoring by using the average of two independent scorings of each verbal sample. In previous studies, interrater reliability coefficients for guilt have been found ranging from .75 to .88 and for shame ranging from .67 to .90 (Gottschalk et al., 1969).

Numerous construct validation studies have been conducted, and reviewed by Gottschalk et al. (1969). Data has been collected from a variety of sources including physiological, biochemical and pharmacological studies. Many of the studies looked at the anxiety scales as a whole, rather than each specific scale, with the goal being to determine whether "anxiety" in general was being tapped before specifying the nature of that anxiety. The evidence does suggest that the scales do a good job of measuring anxiety. As for the type of anxiety, specifically shame and guilt, there are several studies which contribute to an understanding of what exactly is being measured.

Clinical ratings of anxiety have been found to significantly correlate with GGCAS "total anxiety" scores. Clinical ratings of specifically shame and guilt anxiety have not resulted in significant correlations; however, both have contributed to the correlations with total anxiety. Studies using various MMPI scales have found that shame anxiety contributed to correlations between total anxiety and Pt (psychasthenia) scores. In other studies, high anxiety scores for juvenile delinquent boys were primarily attributable to high scores on guilt anxiety.

A series of studies done by Witkin, Lewis, and Weil (cited in Gottschalk et al, 1969), looked at the relationship of shame and guilt anxiety to cognitive and perceptual variables. They found that shame and guilt scores correlated with psychological differentiation as measured by degree of field dependence or field independence. Correlations were found between shame reactions and field dependence (undifferentiation) and between guilt and field independence (differentiation). These findings suggest that the GGCAS measures shame and guilt as the constructs are defined in the work of Helen Block Lewis (1971, 1976).

Two raters were trained to score the Van Lennep's stories using the GGCAS; final scores for each protocol were determined by averaging the two independent scores. Practice scoring was done using a set of 48 Van Lennep's stories from a research study involving bright undergraduate college students at the University of Tennessee. Interrater reliability coefficients for the first practice set (24 stories) was .95 for shame anxiety and .88 for guilt anxiety. Overall interrater reliability was .74 for shame anxiety and .92 for guilt anxiety.

The decrease in interrater reliability for shame anxiety from the training period to the actual scoring of data is likely due partly to "observer drift" (Cone, J.D., & Hawkins, R.D., 1977, p. 261), that is, variations in scoring over time due to such things as fatigue and learning. The risk of this occurring is greatest following the conclusion of rater training and the beginning of data collection.

Thus, to control for deterioration in interrater agreement, the raters continued to meet to discuss disagreements during the collection and scoring of all the data. These meetings, while ensuring greater validity, may actually have had a somewhat adverse effect on overall reliability for shame content. Both raters were well read in the literature for guilt and shame, and engaged in an ongoing discussion around areas of scoring ambiguity. For guilt, a construct which is well defined in the literature, this process proved to be clarifying. However, for shame, which is not as well defined, and where the literature is occasionally contradictory, further discussion led to recognition of subtle scoring distinctions, which were often difficult to integrate into the scoring process in a reliable manner.

Procedures

Those subjects who returned the postcard indicating a willingness to participate in the study were contacted by phone to arrange a time to meet with the researcher. All meetings took place at the researcher's office. Subjects were given instructions for the Van Lennep's Four Picture Story Test. After completion of this instrument, subjects were given three forms to fill out: a sheet asking for demographic information, the BDI, and the DEQ, in that order. All but two of the subjects were able to complete all of the instruments; two subjects felt unable to complete the VLFPST.

Hypotheses

There are two primary questions under investigation in this study, from which a number of hypotheses have been generated. The questions are: What is the nature of the relationship between different types of depression and shame and/or guilt? And, what is the relationship between depressive symptomatology and internal experiences related to depression?

The first question will be addressed by focusing on the relationship between types of depression (anaclitic and introjective), as measured by the DEQ, and content analysis scores from the VLFPST. Specific hypotheses are: 1.) Subjects with high scores on the dependency factor of the DEQ (suggesting anaclitic depression) will have higher scores for shame anxiety on the VLFPST than other subjects. 2.) Subjects with high scores on the self-criticism factor of the DEQ (suggesting introjective depression) will have higher scores for guilt anxiety on the VLFPST than other subjects.

Two additional hypotheses address the relationship between depressive symptomatology as measured by the BDI and intra-psychic factors related to depression, measured by the DEQ, and implied by high scores for shame and guilt anxiety on the VLFPST. It is hypothesized that: 3.) Higher scores on the BDI will correlate with high scores on the dependency factor of the DEQ. 4.) Higher scores on the BDI will correlate with high scores for shame anxiety on the VLFPST.

CHAPTER III

RESULTS

Description of Subjects

Sixty-five women, presently enrolled either full or part time in graduate degree programs at the University of Tennessee, Knoxville, participated in this study. The women ranged in age from 22 to 50 years, with a mean age of 31.8 years, and a median age of 31. Years of education ranged from one year to nine years beyond the bachelor's degree. Some women already had a master's degree, and were working toward's a doctoral degree in their field; however, the majority of the subjects were enrolled in their first or second year of graduate school.

The subjects represented diverse fields of study, including Business, Math, Computer Science, English, Music/Dance, Atomic Physics, Anthropology/History, and Political Science. The largest percentage (29%) of subjects was from Psychology (including Clinical, Industrial/Organizational, and Experimental Psychology), with the second highest percentage (15%) from Education.

Descriptive and Inferential Statistics

Six variable scores were obtained for each of 65 subjects. The six scores were labeled and defined as follows: 1.) Guilt: the subject's guilt anxiety score derived from content analysis of the Van Lenneps Four Picture Story Test (VLFPST); 2.) Shame: the subject's

shame anxiety score derived from content analysis of the VLFPST; 3.) DEQ-E: the subject's score on the efficacy factor of the Depressive Experience Questionnaire (DEQ); 4.) DEQ-I: the subject's score on the self-criticism (introjective depression) factor of the DEQ; 5.) DEQ-A: the subject's score on the dependency (anaclitic depression) factor of the DEQ; 6.) BDI: the subject's score on the Beck Depression Inventory (BDI). Descriptive statistics for these variables are reported in Table 2.

Table 3 presents the intercorrelations between the six variables. Three correlations were found to be significant at the .01 level. As predicted, BDI scores correlated significantly with DEQ-A scores. BDI scores were also found to be significantly correlated with DEQ-I scores. An additional significant correlation was found between DEQ-I and DEQ-A scores.

The hypotheses predicting a relationship between type of depression, as measured by the DEQ, and guilt and shame, as measured by the VLFPST, were analyzed via two 3 X 3 analysis-of-variance factorial designs. For both designs, the two experimental variables were DEQ-I and DEQ-A scores. Three levels -- low, medium, and high -- were defined for each variable. Levels were determined using a trichotomous split, with the high group including subjects with scores in the upper third of the sample, the medium group including subjects with scores in the middle third, and the low group including subjects with scores in the low third. "Guilt" was the dependent variable for the first analysis-of-variance factorial design (Table 4); for the second

TABLE 2

Ranges, Means, and Standard Deviations for All Subjects on Guilt, Shame, Efficacy (DEQ-E), Introjective Depression (DEQ-I), Anaclitic Depression (DEQ-A), and Beck Depression Inventory (BDI)

Variable Name	Range	Mean	Standard Deviation
Guilt	.30 - 3.15	1.20	.59
Shame	.24 - 2.77	1.15	.61
DEQ-E	33 - 54	43.15	4.69
DEQ-I	22 - 87	56.77	15.21
DEQ-A	49 - 118	84.34	16.20
BDI	0 - 18	7.08	5.41

TABLE 3

Intercorrelations between Guilt, Shame, Efficacy (DEQ-E), Introjective Depression (DEQ-I), Anaclitic Depression (DEQ-A), and Beck Depression Inventory (BDI)

Variables	1	2	3	4	5	6
1. Guilt	---	.19	.00	-.06	-.03	-.06
2. Shame		---	.08	.05	.08	.03
3. DEQ-E			---	-.15	-.09	-.04
4. DEQ-I				---	.59*	.53*
5. DEQ-A					---	.38*
6. Beck						---

* $p < .01$

TABLE 4

Analysis of Variance of Introjective Depression (DEQ-I) and Anaclitic Depression (DEQ-A) for Guilt

Source	SS	df	MS	F
DEQ-I	.098	2	.049	.143
DEQ-A	1.446	2	.723	2.110
DEQ-I X DEQ-A	1.748	4	.437	1.275

design, "shame" was the dependent variable (Table 5). Neither analysis was significant at the .05 level for either main effects or interactions.

Tables 6 and 7 reveal the mean scores for guilt and shame respectively across DEQ-I and DEQ-A levels. Examination of these tables reveals no significant pattern of guilt and shame scores across subjects. Of note is the small number of subjects in the High DEQ-I/Low DEQ-A and Low DEQ-I/High DEQ-A groups, an unexpected finding given previous research utilizing the DEQ.

A one-way analysis of variance was used to test the hypothesis concerning the relationship between BDI scores and shame anxiety. Subjects were classified into one of five levels of depression based on number of items endorsed, following guidelines suggested by Beck (1973). The categories are as follows: Normal, Mild Depression, Mild-Moderate Depression, Moderate-Severe Depression, Severe Depression. None of the subjects scored in the range of Moderate-Severe or Severe Depression, so the analysis of variance included only three levels of the independent variable. A summary of the results can be found in Table 8. Because of the unequal number of scores per group, homogeneity of variance was tested for, with the degree of heterogeneity found to be not significant (Cochran's C = .3819, p = .819). The analysis of variance for shame was not significant.

An additional analysis of variance was done to examine the relationship between BDI scores and guilt anxiety (Table 9). Again, the groups were found to be not significantly heterogeneous (Cochran's

TABLE 5

Analysis of Variance of Introjective Depression (DEQ-I) and Anaclitic Depression (DEQ-A) for Shame

Source	SS	df	MS	F
DEQ-I	.844	2	.422	1.112
DEQ-A	.426	2	.213	.561
DEQ-I X DEQ-A	1.418	4	.355	.935

TABLE 6

Mean Guilt Scores for Introjective Depression (DEQ-I) and Anaclitic Depression (DEQ-A)

		DEQ-I			
		Low	Medium	High	Total
DEQ-A	Low	1.12 (12)	1.30 (7)	1.14 (2)	1.18 (21)
	Medium	1.45 (6)	1.13 (8)	1.82 (5)	1.41 (19)
	High	1.29 (3)	1.13 (5)	.99 (17)	1.06 (25)
	Total	1.24 (21)	1.19 (20)	1.18 (24)	

* Number in parentheses indicates number of subjects per cell

TABLE 7

Mean Shame Scores for Introjective Depression (DEQ-I) and Anaclitic Depression (DEQ-A)

		DEQ-I			
		Low	Medium	High	Total
DEQ-A	Low	.87 (12)	1.25 (7)	1.38 (2)	1.04 (21)
	Medium	1.40 (6)	1.25 (8)	1.22 (5)	1.29 (19)
	High	.84 (3)	1.56 (5)	1.06 (17)	1.13 (25)
	Total	1.02 (21)	1.33 (20)	1.12 (24)	

* Number in parentheses indicates number of subjects per cell

TABLE 8

Analysis of Variance of Shame Anxiety for Normal, Mild Depression, and Mild-Moderate Depression Groups

Source	df	Squares	Square	F
Between Groups	2	1.1318	.5659	1.6471
Within Groups	62	21.3006	.3436	
Total	64	22.4323		

TABLE 9

Analysis of Variance of Guilt Anxiety for Normal, Mild Depression, and Mild-Moderate Depression Groups

Source	df	Squares	Square	F
Between Groups	2	.1041	.0521	.1344
Within Groups	62	24.0219	.3874	
Total	64	24.1260		

C = .4664, p = .183). The analysis of variance was not significant at the .05 level.

Additional statistical analyses were performed to determine whether age and educational level had any impact on the predictive powers of the DEQ-I, DEQ-A, and BDI, for Guilt and Shame. Two sets of multiple correlations were computed, using guilt as the criterion variable for the first set, and shame as the criterion variable for the second set. Partial correlations between the criterion and predictor variables are listed in Table 10 for Guilt and Table 11 for Shame. The results indicated that accounting for partial correlations between age, education, and the criterion variables did not significantly affect the correlation between the criterion variables (Guilt, Shame) and the predictor variables (DEQ-I, DEQ-A, BDI).

TABLE 10

Correlations between Guilt and Introjective Depression (DEQ-I), Anaclitic Depression (DEQ-A) and Beck Depression Inventory (BDI) when Controlling for Age and Education

	Partial Correlations for Age	for Education	for Age and Education
DEQ-I	-.114	-.062	-.097
DEQ-A	-.076	-.055	-.063
BDI	-.106	-.036	-.053

TABLE 11

Correlations between Shame and Introjective Depression (DEQ-I), Anaclitic Depression (DEQ-A) and Beck Depression Inventory (BDI) when Controlling for Age and Education

	Partial Correlations for Age	for Education	for Age and Education
DEQ-I	.028	.040	.025
DEQ-A	.062	.062	.060
BDI	-.024	-.026	-.033

CHAPTER IV

DISCUSSION

The subjects in this study were all women presently enrolled in graduate degree programs. Although no effort was made to assess level of academic success, on the basis of their academic status it was assumed that for the most part the subjects were high-functioning and high-aspiring. Subjects' scores on the Efficacy factor of the DEQ support this assumption, as all of the women indicated that in general they perceive themselves as competent. Even the lowest score attained fell in the upper half of the possible range of scores.

For the purpose of studying depressed populations, a cut-off score of 21 on the BDI is recommended as being indicative of clinically significant depression (Beck & Beamesderfer, 1974). None of the subjects received BDI scores in this range. Approximately 20% of the subjects reported symptoms of mild depression and 14% reported mild to moderate depression. The rest (66%) fell in the "normal" (not depressed) range. Thus, consistent with our intent of studying a non-pathological sample, it can be assumed that none of the subjects were clinically depressed.

However, the DEQ scores indicated that a fair number of the subjects are prone to what might be labeled "depressive experiences." DEQ scores on the self-criticism (DEQ-I) and dependency (DEQ-A) factors were normally distributed across the possible range of scores, high scores on the DEQ-I factor considered indicative of introjective depression and

high scores on the DEQ-A factor considered indicative of anaclitic depression. Blatt does not offer cut-off scores for differentiating normal from pathological depression, because the DEQ is not designed to be an instrument for assessing clinical depression. Nonetheless, previous research has supported the conclusion that high scores on the DEQ are related to depression. This is further supported in this study, as both the DEQ-I and DEQ-A correlated significantly with the BDI. Subjects' scores for guilt and shame based on the thematic material also approximated a normal distribution, across a range similar to that reported by Gottschalk and Gleser (1969) for "normal" subjects.

The subject sample was found to be relatively homogeneous vis-a-vis feelings of competency and absence of "objective" depressive symptomatology. However, in terms of internal experiences of depressive phenomena and guilt and shame experiences, the subjects were quite heterogeneous. Descriptively then, this is a group of women who are, as a whole, likely to be considered "normal" and quite competent by those who know them. It may be inferred, though, that some of these women have subjective experiences that leave them feeling dysphoric; some are conflicted about dependency issues, some about self-esteem issues, and some about both. In addition, the daa suggest that a substantial number of the subjects are conflicted about guilt and/or shame issues.

The Relationship Between DEQ Factors

A significantly positive correlation was found between DEQ factors for anaclitic and introjective depression (.59, $p < .01$). Furthermore,

the number of subjects who scored in the upper ranges on both DEQ-I and DEQ-A factors was unexpectedly large. When divided according to DEQ scores, the largest group of subjects consisted of women who scored in the upper third ranges for both the DEQ-I and DEQ-A (26%). The next largest group of subjects scored low on both factors (18%). The smallest groups were those subjects who scored high on one factor but low on the other (5% for each group).

This finding is in sharp contrast with both theory and previous research concerning the DEQ which suggest that an individual may be prone to either introjective depression or anaclitic depression, but is unlikely to have both experiences. The presence of a significant correlation between scores for anaclitic and introjective depression in this study raises questions both about the utility of the DEQ for differentiating types of depressive experiences, and about Blatt's theory of depression.

The results of this study indicate that there may be less factor independence between introjective and anaclitic experiences of depression than has been proposed. The presence of such a relatively large number of subjects who obtained high scores on both the DEQ-I and DEQ-A factors raises questions about what actually is being measured by the DEQ. If as Blatt (1974) argued, introjective and anaclitic depression represent two different levels of development, it should be quite unusual for individuals to report both experiences. Blatt argued that the form of depression a person experiences is contingent upon the level of object representation he or she has attained; therefore an

individual should experience primarily one type of depression. Furthermore, his theory suggests that few of the subjects in this study would report problems with anaclitic depression, since the more primitive level of object representation indicated by such experiences would be inconsistent with the level of achievement that these women have attained. Yet, as noted, the subjects' scores on the DEQ-A are normally distributed across most of the possible range, including scores which are suggestive of anaclitic depression.

An analysis of the items identified as assessing introjective and anaclitic depression on the DEQ reveals one potential problem; many of the items designed to distinguish between introjective and anaclitic depression show some overlap when viewed from a purely theoretical perspective. For example, the item "If I fail to live up to expectations, I feel unworthy" is scored for anaclitic depression. Yet, it could be argued that an individual who endorses that item is primarily concerned with internalized rules and expectations regarding standards of conduct performance- typically considered dynamics associated with introjective depression. Another item - "There are times when I feel 'empty' inside" - is scored for introjective depression, when theory would suggest that feelings of emptiness are more often associated with experiences of anaclitic depression. Blatt designed his test using the statistical procedure of factor analysis to determine which items belonged to which "cluster"; it may be that the apparent item overlap is evidence of subtle distinctions between items that are not revealed when the subject population is quite

heterogeneous, or free of gross clinical symptomatology. However, the relatively high correlation between DEQ-I and DEQ-A factors suggests that, for this sample of bright, high-functioning women, the DEQ failed to distinguish between the two depressive dimensions as expected. This study's finding concerning the DEQ demonstrates a need for caution in assuming validity of an instrument designed to assess complex psychological constructs, especially where the theory concerning those constructs may not be well understood.

Other Findings

This study's hypotheses concerning the relationship between subjective experiences of depression, guilt and shame were not supported. In fact, no statistically significant relationship was found between subjects' scores for guilt and shame and any of the depression indices. These findings will be discussed below.

Methodological Issues

The fact that no relationship was found between any of the measures of depression and guilt and shame, is contrary to both theory and previous research findings. The reasons for this unexpected outcome are not readily apparent. This study attempted to clarify the relationship between several psychological constructs which are themselves neither easily understood nor well defined. A common problem in psychological research, especially that which uses projective tests

(such as the VLFPST) is that a failure to obtain significant results may indicate either a deficit in the measuring device or a need for redefining and clarification of the construct(s) (Anastasi, 1986). The instruments in this study have, for the most part, been found to be reliable and valid in previous research. Nonetheless, given the nature of the constructs being explored, it may be that the research instruments presented special problems for this study that have not been of particular relevance in other studies. This is true even for the BDI - an instrument which has been used consistently and effectively in research on depression for over two decades.

Most research on depression has studied individuals who are considered to be "clinically" depressed. When the BDI is used to indicate the presence of depression, subjects considered clinically depressed have typically been those who have received scores in the Moderate to Severe or Severe ranges. None of the subjects in this study fell into either of those categories. There is empirical evidence to support the validity of the DEQ as a measure of depressive experiences (Blatt, D'Afflitti, & Quinlan, 1976; Blatt, Wein, Chevron & Quinlan, 1979; Pidano & Tennen, 1985); consequently, the presence of depressive experiences in this subject pool was presumed based on DEQ scores. However, there are a number of reservations associated with its use, as noted above. Furthermore, it may be that the hypothesized relationship between depression, guilt and shame is not relevant or detectable among individuals who do not experience the more objectively observed symptoms typically associated with depression.

There is also some question as to whether experiences of guilt and shame were effectively measured. The GGCAS is based on the work of Piers and Singer, pioneers in the study of guilt and shame, whose work continues to be influential in current writings in the area. The GGCAS was judged to have good face validity; both raters were well versed in theories of guilt and shame, and were of the opinion that the GGCAS was theoretically sound. However, the GGCAS was not designed to focus exclusively on guilt and shame. Generally, the GGCAS is used to assess guilt and shame in the context of assessing many different types of anxiety. Attempts to determine the validity of the instrument have focused on whether it accurately measures anxiety, but typically have not focused specifically on guilt or shame anxiety (Gottschalk & Gleser, 1969). Furthermore, there are currently no well researched, objective measures of shame reported in the literature, thus making it difficult to determine the construct validity of the GGCAS for shame anxiety. However, those studies which have explored the relationship between guilt, shame, and related constructs, have supported the construct validity of the scales (Gottschalk & Gleser, 1969; Witkin, Lewis & Weil, 1966).

It is likely that GGCAS scores do reflect psychological experiences related to guilt and shame; yet it is difficult to know exactly what aspects of guilt and/or shame are being assessed, or how specifically. For example, it is possible that the GGCAS measures guilt and shame, but only as they are being experienced at the time of assessment. It has been argued that because the GGCAS is scored for

guilt and shame anxiety, it is essentially tapping a state (Shreve, 1987), that is, subjects will only receive high scores if they are experiencing anxiety about guilt or shame related issues at that time. This position would suggest that the instrument provides no information about a subject's proneness to experiences of guilt or shame. On the other hand, the DEQ was designed to assess proneness to depressive experiences. It is best understood as tapping characterological features (traits) related to depression. For most of the subjects in this study, the experience of depression was not particularly focal at the time of testing - that is, they were not experiencing "objective" symptoms of depression, although they may at times have "subjective" experiences related to depression. Again, it may be that the hypothesized relationship between depression, guilt and shame only applies to those subjects for whom depression is a currently salient experience. Conversely, if the GGCAS only measures the state of guilt or shame anxiety, a relationship between proneness to depression and proneness to guilt and/or shame experiences may exist but limitations of the measuring instruments prevented it from emerging.

The use of projective techniques in research presents a number of unique problems. Certainly the state of the art for projective tests suggests that issues of reliability and validity must always be considered (Anastasi, 1982; Piotrowski, 1984; Weiner, 1983). In this study, adequate interrater reliability was demonstrated (.92 and .74 for guilt and shame respectively). However, two potential limitations associated with the projective test (VLFPST) and scoring procedure

(GGCAS) used in this study should be mentioned. The first issue concerns the use of the VLFPST itself. In a study comparing and analyzing three different types of "fantasy production," Jones (1986) found that themes which emerged from subjects' early memories and dreams were quite similar to each other, but differed significantly from the themes which emerged in subjects' Van Lenneps' stories. He concluded that the demand characteristics of the VLFPST led subjects to "construe the derivatives of unconscious conflicts differently" (p. 105) than when producing other forms of projective material. Thus, it may be that had subjects in this study been presented with a different projective task (i.e. report of early memories or TAT stories), different scores for guilt and shame might have been obtained.

The second limitation associated with this study's use of the VLFPST and GGCAS is that the GGCAS takes essentially a "sign approach" to scoring material. That is, the presence of certain criterial indices was assumed to correlate with the constructs of interest. Criticisms of the sign approach are most often directed toward research utilizing the Rorschach, where single, specific scores are used as research variables. This is particularly problematic with projective tests such as the Rorschach, where many of the scores violate some of the basic standards needed for parametric data analysis, and where the population base rate is too low for there to be any meaningful comparisons between groups.

Many of these concerns are not relevant with respect to the GGCAS, as scores are based on a formula which results in a normal distribution,

and all subjects are assumed to exhibit some level of the construct being measured. Nevertheless, other reservations must be considered when using a sign approach in measuring psychological constructs. The primary concern is that final scores (for guilt or shame) are based on a summary score - essentially adding up all the "signs" to arrive at a final score. No attempt is made to determine whether different signs have different meanings, nor is it possible to account for contextual differences. For example, the statements "I was deeply ashamed" and "I was very worried about failing" would receive equivalent scores for shame content, and yet very likely have different connotations. Similarly, two stories may reveal vastly different ways of dealing with shame related issues: one story may reveal a capacity for tolerating, integrating, and resolving the conflicts, while another may reflect a tendency to withdraw and/or decompensate in the face of shame evoking stimuli. Yet, both stories could easily receive identical scores for shame content. The GGCAS does assign weights to scores based on level of affective intensity and degree of distanciation from subject's experience. This procedure is a step in the right direction vis-a-vis recognizing and accounting for the complexity of individuals' experiences. Nevertheless, there are .cp 3 limitations to any instrument which attempts to assess specific psychological constructs in isolation.

Theoretical Issues

Despite the potential methodological problems previously discussed, the results of this study raise important questions about

clinical theory. Even when problems with instruments are taken into account, theory suggests that some relationship should have emerged between depression, guilt and shame. There are two ways of viewing these results theoretically. One is that theories about the relationship between guilt, shame and depression are incorrect; that is, guilt and shame have nothing to do with depression. It would be inadvisable to form such a conclusion from this study, especially as there is a spate of published studies which demonstrate a relationship between guilt depression (Golding & Singer, 1983; Leber, Beckham & Danker-Brown, 1985; Pidano & Tennen, 1985) and between shame and depression (Izard, 1972; Izard & Schwartz, 1986; Lamont, 1973; Prosen, Clark, Harrow, & Fawcett, 1983). Furthermore, this study hypothesized only that subjective experiences of depression would predict anxiety about guilt and shame related issues.

An alternate way of exploring the relationship between depression, guilt and shame would be to assess whether high guilt and/or shame predict depression. For example, it may be that individuals who receive high scores for guilt or shame also receive high scores for depression, but not the reverse - that is, a number of individuals may receive high scores for depression but not for guilt or shame. This would imply that conflicts about guilt and shame related issues result in depression, but that depression may also be precipitated by other conflicts. The results of this study indicate only that subjective experiences of depression do not predict problems with guilt and/or shame for this sample of women.

The nature of this study and particularly the characteristics of the subject sample necessitate limiting discussion of theoretical issues to specific circumstances. This study explored depressive experiences among "normal," high-aspiring women, none of whom would likely appear depressed to others. Relatively high scores on the DEQ factors for introjective and anaclitic depression indicate a proneness to depression. Perhaps, on a day to day basis, the subjects receiving high scores on the DEQ-I and DEQ-A are not currently struggling with guilt or shame related conflicts. Should, however, a third, mediating factor be introduced, these same subjects might then display the expected relationship between depression, guilt and shame. For example, a recent loss in a subject's life might serve as such a mediating factor, as the review of the literature indicated that most theories identify loss as a typical precipitant of depression.

The following exemplifies how such a process might work: an individual may be characterized as being prone to anaclitic depression (High DEQ-A). As long as all is going well this individual does not experience conflict about shame. If this individual then experienced some sort of loss (e.g. the end of a relationship), her experience of shame anxiety might escalate. This hypothesized sequence unfolds as follows: Subject with high DEQ-A, low shame --> intervening variable such as loss --> high DEQ-A and high shame. If such a sequence were to take place, it would be interesting to note whether the subject's BDI score became elevated as well. It seems quite likely that it would, the implication being that the relationship between depression, and

guilt and shame, only exists when depression is manifested in more objective symptomatology such as that measured by the BDI.

Another way of understanding the results of this study is to consider whether another factor, or other factors, may have played a role. That is, perhaps some characteristic of this group of subjects leads to a different interaction between depression, guilt, and shame than the pattern which was predicted. For example, theories of depression from behavioral and/or social learning models have argued that depression is related to lack of control, or perceived lack of control, in one's life. Numerous studies, based on Seligman's theory of learned helplessness, have examined the effects of uncontrollable events on motivational, cognitive, and affective symptoms associated with depression (Glass & Singer, 1972; Hiroto, 1974; Miller, Rosellini, & Seligman, 1977; Seligman, & Maier, 1967). Miller et al. (1977) suggested that "both depression and learned helplessness have at their core the belief in the futility of responding" (p. 130). A recent reformulation of the theory of learned helplessness in humans (Abramson, Seligman & Teasdale, 1985) explicated several likely precipitants to depression, the primary one being a belief that highly desired outcomes are improbable and that no response will change that.

In this study there was no attempt to assess subjects' beliefs about their ability to succeed at important tasks; however, the fact that all of the subjects are currently enrolled in graduate school, and received consistently high efficacy scores, suggests that the subjects in this study felt in control of important goals for themselves -- at

least in terms of academic or professional achievement. It may be that a sense of competency and control helps to minimize depressive experiences, such that although some of the subjects experienced depressive affect, there were no corresponding motivational or cognitive deficits. Similarly, such a sense of competency and control may help to mitigate any guilt or shame experiences which would typically be associated with depression.

Another possible mitigating factor may be that the subjects of this study are currently engaged in activities which can presumed to have some important meaning for them. Szasz (1961) has argued that the traditional view of depression as related to object-loss is incomplete. He asserted that the loss of "game" is as likely to precipitate a depressive reaction as is the loss of an "object." By "game" he means a series of norms or rules that provide meaning and allow for significant action in an individual's life. Szasz observed:

> ... persons need not only human objects but also norms or rules -- or, more generally -- games that are worth playing!....It is a matter of everyday observation that men suffer grievously when they can find no games worth playing, even though their object world might remain more or less intact (p. 282).

Becker (1986) suggested that not only do people create meanings for themselves by creating games, but that through the rules of the games, they create themselves as well.

> Social rules and objects provide man with a staged drama of significance which is the theatre of his action. Man discovers himself by making appeal for his identity to the society in which he performs (p. 369).

Becker argued that depression results when there is a radical change in the "script" or "role" on which one's identity has been

predicated. When this happens, the individual must attempt to rework his or her fantasy so that "self-esteem, symbolic integrity of the identity and the life-plot, and the possibilities for continued action" (p. 374) are provided for. One means of doing this is by organizing one's selfhood and action possibilities for meaning through guilty self-accusations. Thus, the language of the depressed person is viewed by Becker as an attempt at maintaining meaning following some disruption in that person's "game."

From this perspective it can be inferred that the subjects in this study experienced meaning in their lives. By virtue of being in graduate school, embarked on a course of professional study, the women in this study are all involved in a "game" that provides rules and customs. Perhaps those women who received high scores on the DEQ depression factors are in the process of questioning the meaning of the game they have chosen to play, but as they have not given up that game, they have no need to adopt what Becker calls "guilt-language" (or "shame-language"). In other words, it may be that the subjects in this study are not prone to guilt or shame feelings because they are participants in a system that provides meaning for them.

Implications

This study was designed to test the hypothesis that subjective experiences of depression can be differentiated based on differences in guilt and shame related experiences. The results of this study failed to support the hypothesized relationships. The lack of statistically

significant results is significant from a theoretical standpoint. There exists a growing body of theoretical work attempting to explicate the presumed relationship between depression, guilt and shame (Hoblitzelle, 1987; Kaplan, 1986; Lewis, 1987b; Tompkins, 1987). Much of this work has developed out of a recent upsurge of interest in shame experiences. At the same time, in the depression literature there has been an ongoing effort to distinguish between types of depression (Blatt, 1974; Fenichel, 1945; Grinker et al, 1961), which has increasingly examined affective experiences of depressed individuals as a means for differentiating types of depression. Numerous writers, from diverse backgrounds and areas of interest, have commented on the possibility of distinguishing between types of depression based on differences between guilt and shame (Crouppen 1976; Grinker, 1955; Levin, 1967; Lewis, 1987b; Smith, 1972). Thus far, empirical support for this line of thinking has been lacking.

It is not unusual for research to lag behind theory, especially research concerning complex psychological constructs. However, without objective support, abstract theory is in danger of becoming meaningless. This study's lack of statistically significant findings does not dispute the theory that guilt and shame are related to different types of depression, but it does suggest that the relationship is not as straightforward as has been implied in extant psychological theory. The results have implications for a number of areas of psychological research and theory.

This study was limited somewhat by the paucity of instruments designed to assess guilt and shame. The GGCAS is a well-designed, well-researched instrument overall, and its assessment of guilt and shame anxiety was presumed to be adequate for the purposes of this study. Nonetheless, as previously discussed, there are several reservations associated with its use. As theoretical understanding of shame develops, there needs to be an accompanying development of tools for assessing its presence and meaning.

Most of the recent theorizing about shame has emerged from clinical work. While there is a solid tradition in psychology of building theory from idiographic data, it is essential that such work be followed by the development of what Cronbach and Meehl (1955) called the "nomological net." That is, in order for a theoretical construct to be "scientifically admissable," it must be possible to understand and study that construct from a set of laws involving observable properties or quantities. This is an extremely difficult process, especially "since for many of the constructs dealt with it is not a question of finding an imperfect criterion but of finding any criterion at all" (Cronbach & Meehl, 1955, p. 285).

Furthermore, this study highlights the problems of attempting to study complex psychological constructs as isolated variables. When constructs such as shame or guilt are not studied in a context, the results may be difficult to interpret. Unfortunately, as pointed out above, nomothetical research of psychological constructs is already a difficult process without requiring the use of contextual analysis as

well. There do exist some research instruments designed to provide a broader context for understanding any given variable score. The Rorschach is one such example. Another example is the Structural Analysis of Social Behavior (SASB), developed by Benjamin (1984), based on a multi-level, multi-dimensional model of behavior. Yet neither of these instruments has been particularly useful in nomothetic research. Rorschach research continues to present problems with reliability and validity, and the SASB is rather cumbersome and so has primarily been used for case studies. Furthermore, of the more comprehensive systems currently available, none include methods for evaluating subjects' experiences of shame. Still, given the complexity of the constructs shame and guilt, and the limitations of the assessment instruments currently in existence, it may be best to work towards assessing guilt and shame in a contextual model of behavior, rather than developing tools which isolate and potentially misconstrue the results.

This study's results also suggest a need to re-evaluate the DEQ as a means of differentiating types of depression. The large proportion of women who received high scores for both DEQ-A and DEQ-I factors indicates either that the instrument does not adequately differentiate types of experiences or that introjective and anaclitic depression are not mutually exclusive experiences (as implied in Blatt's theory of depression). The latter explanation seems the more valid -- it seems quite plausible that individuals may be conflicted about both dependency issues and self-esteem issues, leaving them vulnerable to both anaclitic and introjective forms of depression.

This formulation would be in keeping with recent work in the area of women's psychology.

Several writers (Chodorow, 1978; Gilligan 1982; Kaplan, 1986; Miller, 1984) have argued that existing developmental theories are based on a male paradigm in which experiences that are not typically male are perceived as "less advanced." One could argue that anaclitic depression has been perceived as representing a less developed state because conflicts about dependency (traditionally seen as being a "female" issue) are viewed as being less mature than conflicts about self-esteem/mastery issues (traditionally seen as a "male" concern).

That the subjects of this study displayed conflicts in both areas (e.g. deprendency and self-esteem/mastery) supports further reconsideration of Blatt's theory. First, it raises questions about whether introjective and anaclitic depression are mutually exclusive experiences. Further, given that these subjects are all high-functioning and high-aspiring, one would presume that their typical level of development is relatively advanced. If so, the fact that a number of subjects indicated conflicts related to anaclitic depression casts doubt on the invariant sequence of development implied by Blatt's model.

In general, many possible explanations for this study's results have centered around the fact that the subjects were "normal" and competent women, who may at times feel dysphoric, but did not exhibit objective symptoms of depression. It cannot be assumed that the study's hypotheses would not hold for other populations. That is, no

information is gleaned from this study about the relationship between depression, guilt and shame for "clinically depressed" individuals.

In fact, a question that has been raised is whether the hypotheses were not supported because of characteristics of the sample, e.g. because the subjects were "normal", competent women. This question has implications for one of the primary areas of ambiguity in depression research: are "normal" experiences of depression qualitatively different from "pathological" depression? While it was not the intention of this research to address that question, the study's design was based on the assumption that normal and pathological depression are essentially similar experiences existing on a continuum -- or rather, two continuums. That is, in accordance with Blatt's theory of depression, the model of depression adopted presupposed that depression can be categorized into "types," each category representing a continuum of essentially similar experiences ranging from "normal" to "pathological." The results of this study suggest that there may be some crucial differences between individuals who have depressive experiences, but do not exhibit observable symptoms, and individuals whose functioning is impeded by depressive symptomatology. The implications of this finding for future research on depression are clear: not only must great care be taken in operationally defining depression, but it is also important that results be interpreted with clear and specific reference to the subject sample. Caution must be used in generalizing beyond a study's subject population until further

information has be obtained concerning the relationship between normal and pathological depression.

In summary, this study's failure to provide support for its research hypotheses could have significant bearing on future research in the area of depression. The questions raised here about the nature of depressive experiences have implications for the generalizability of the results of other studies. These questions are particularly relevant concerning the viability of generalizing about studies of "normal" depression to clinical depression and vice versa. That is, one must be cautious about assuming continuousness between experiences of depression.

Methodological concerns of this study point to the need for further work towards development of valid instruments for assessment of complex psychological constructs such as depression, guilt, and shame. Furthermore, given the nature of the constructs under study, it may be beneficial for future research to be designed such that idiographic analysis of the data is possible; for example, a longitudinal study in which within-subject statistical analysis can be carried out may be more fruitful than continued between-subject research designs. In sum, the results of this study highlight the need for increased effort towards strengthening an empirical base from which theoretical work concerning depression, guilt, and shame can proceed.

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