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SHAME, SYMPTOM-EXPRESSION, AND DESTRUCTIVE BEHAVIOR IN ADOLESCENT DEPRESSION

By

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ABSTRACT

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Questionnaire data, projective testing, and a semi-structured suicidal interview were utilized in this study of inpatient adolescents (n = 89) examining the relationships of both conscious shame and unconscious shame to depression and ways of coping with emotional turmoil. A new assessment tool--the Shame Rating Scale (SRS; Loraas, 1994)--was developed and used to tap the dimension of unconscious shame. Two independent raters used the SRS to evaluate projective test protocols for shame-themes, and also used a suicide rating scale to assess lethality of adolescent suicide attempts.

Results indicate that depression, conscious shame, and suicidal ideation are highly related psychological constructs which have implications for coping and behavioral patterns among male and female, inpatient teenagers (ages 13 to 15 years). Special emphases are placed upon an expected 2-way interaction between unconscious shame and conscious shame in predicting externalization and an unexpected 2-way interaction between conscious shame and gender in predicting suicidal ideation. No support was found for the hypothesis that risk-taking behaviors

were related to high levels of externalization, high unconscious shame, and low conscious shame. The final hypothesis addressing whether suicide attempts would be most severe among adolescents with high levels of externalization, high unconscious shame, and high conscious shame could not be tested because very few participants actually undertook highly lethal suicide attempts. Overall, the study's findings are deemed valuable because they underscore the importance of assessing both accessible and nonaccessible emotional experiences and provide an empirical way of investigating "masked" or concealed emotional experiences in young adolescents.

In memory of my father and

in honor of my mother.

Both were educators who, by silent example,

instilled in me the value of education.

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with challenging and difficult-to-treat children, adolescents, and families. Dr. Frank and I have always had a strong working relationship, and I am sincerely thankful for the guidance and support she has offered me over the years.

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he had with me in his Baker Hall office in the early 1990s, this discussion was valuable. Dr. Aronoff spoke about the importance of every person having "a passion" in terms of their life's work. This sage advice was quite timely, and helped me to evaluate how I wanted to position myself for the future.

Unfortunately, my working relationship with Dr. Kaufman did not begin until late in my graduate school career (1993-94) when I decided to focus my dissertation on the role of shame in adolescent depression. I had reviewed Dr. Kaufman's excellent books on shame as part of my background readings on the topic. I am grateful that Dr. Kaufman, a recognized authority on shame, agreed to serve on my committee. He made several helpful suggestions during the early stages of the study, and was instrumental in helping me clarify my thinking about the Shame Rating Scale (SRS; Loraas, 1994).

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TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

I. INTRODUCTION

Adolescence is often viewed as a period of emotional instability and behavioral disorganization. This perception, adhered to by many professional and lay persons alike, has its historical roots in the seminal work of G. Stanley Hall (1904), an early pioneer in the field of developmental psychology. Hall believed that the rapid physical, cognitive, and social changes that characterize the teenage years have an adverse effect upon the adolescent's psychosocial functioning. As a result, he postulated a storm-and-stress model in which unpredictable behavior, acute emotional distress, and rebellion against parental and other adult authority were viewed as normative phenomena of adolescence.

Hall's model of adolescent development was widely accepted among developmental and clinical investigators for most of the 20th century (Sisson, Hersen, & Van Hasselt, 1987). However, during the 1960s and early 1970s, the theory of storm-and-stress was challenged by researchers (Douvan & Adelson, 1966; Offer & Offer, 1975; Weiner and Del Gaudio, 1976) who demonstrated empirically that emotional

turmoil was not the sine qua non of the teenage years. It is now generally acknowledged (Ingersoll & Goldstein, 1995; Peterson et al., 1993; Golombek & Marton, 1992) that most adolescents do not develop major psychiatric, behavioral, or emotional disorders, and that they are able to maintain positive relationships both with immediate family members and peers.

Although chronic maladaptive behavior and intense emotional turmoil are no longer viewed as typical adolescent experiences, between 10 and 20 percent of all adolescents will encounter great difficulty coping with the demands of this developmental stage (Rutter, Graham, Chadwick, & Yule, 1976; Kashani et al., 1987). Hence, it remains vital that clinical and developmental investigators continue working collectively toward a greater understanding of the unique stressors, problems, and experiences that confront today's teenagers. Various types of psychopathology, including substance abuse, conduct problems, anxiety disorders, depression, suicide, and eating disorders, are found to occur quite frequently during the adolescent years (Rutter, 1992; Kashani et al., 1987).

Depression appears to play a primary or secondary role in numerous types of disturbances during adolescence, and has received considerable empirical attention since the

mid-1980s (Kovacs, 1996; Peterson et al., 1993). Depressed adolescents, compared to their nondepressed age mates, are found to experience lower self-worth and higher rates of substance abuse, academic difficulty and failure, family and peer difficulty, and suicide (Reinherz et al., 1990). Moreover, depression in adolescence is related to more difficulty in psychosocial functioning during young adulthood (Kandel & Davies, 1982) and with major affective disorders throughout the adult years (Ingersoll & Goldstein, 1995; Langer, Gersten, Wills, & Simcha-Fagan, 1983).

This dissertation is directed at broadening the understanding of adolescent depression by examining the relationships among internalizing and externalizing styles of coping with depressive issues, experiences of shame, and self-destructive behavior. Shame has been described as an acutely painful awareness that one's innermost self has been exposed to others who are likely to respond with ridicule, criticism, denigration, and even rejection (Kaufman, 1984, 1992; Yorke, 1990; Hultberg, 1988; Spero, 1984). Helen Block Lewis (1971), a pioneering figure in shame-theory, maintained that shame results in a passive, self-hatred that immobilizes a person's coping and emotional resources, and leaves the individual feeling "small, helpless, and childish" (p. 430).

The intense emotions generated by shame--helplessness, powerlessness, and acute self-consciousness--are affective experiences that are also frequently seen in the clinical presentation of adolescents with depressive illness (Roberts, Lewinsohn, & Seeley, 1995; Peterson et al., 1993; Reynolds, 1987a) and among those teens who have contemplated or attempted suicide (Curran, 1987). Yet, clinical researchers focusing on adolescent depression have failed to examine ways in which shame can "drive" both self-destructive behaviors and aggressive, acting-out behaviors directed against other persons, objects, or society as a whole.

Given these factors, the purpose of this study is to outline a rationale and empirical design for investigating the extent to which destructive self-directed and other-directed behaviors are outcomes of a complex interaction between more or less accessible shame experiences and externalizing versus internalizing coping styles. A review of the relevant literature will explicate these relationships by examining the features and issues relevant to adolescent depression; by highlighting the characteristics and ramifications of shame during childhood and adolescence; and by suggesting ways in which the

adolescent's primary coping style may affect the expression of depression and shame.

II. ADOLESCENT DEPRESSION

Early Stumbling Blocks. Although abundant research has been conducted on adult depressive illness over the past three decades (Lewinsohn, Hops, Roberts, Seeley, & Andrews, 1993; Achenbach, 1982), clinical concern about and interest in childhood and adolescent depression was nearly nonexistent until the 1970s (Anthony, 1970, 1983; Cytryn & McKnew, 1972; Carlson & Strober, 1978; Kovacs & Beck, 1977). This lack of scientific attention to depression in children and adolescents was largely attributable to the widespread influence of psychoanalytic thought between 1900 and 1960 (Gelfand, Jenson, & Drew, 1988).

Analytic theorists, such as the renowned child analyst, Margaret Mahler (1952), argued that children and most adolescents lacked the mature cognitive skills and ego functions to experience adult-like depression. Although Mahler (1965) believed that children could experience depressed mood, they were incapable of developing true depressive illness because they reacted to loss and

emotional distress by utilizing more primitive defenses such as denial and repression (Mahler, 1952).

Other clinical investigators (see Gelfand, Jenson, & Drew, 1988; see Kazdin, 1989) doubted the clinical significance of most depressive symptoms and behavioral problems in children and adolescents. In general, depressive symptomatology were perceived as natural and commonplace and as a short-lived consequence of growing up. However, some theorists speculated that other childhood problems, ranging from aggressive, disruptive behaviors on the one hand to the anxiety disorders on the other, might conceal or "mask" underlying sadness and depressive feelings, but were not equivalent to adult-like depression (Carlson, 1981).

The construct of masked depression was highly inferential, and, for this reason, it was generally dropped from diagnostic nosology by the early 198Øs (Kashani et al., 1981). However, as Kazdin (1989) pointed out, the idea of depression being masked in children and adolescents was "historically very important" (p.136) for several reasons. First, it postulated that depressive illness could exist in children. Second, it fostered clinical interest and research on depression and overall emotional functioning among children and adolescents. Finally, the notion of

masked depression caused clinical investigators to assess how depressive illness might manifest itself differently in children, adolescents, and adults and in individuals at various sub-stages within each of those major life periods.

Symptoms, Prevalence, and Gender Differences in Depressive Disorders. Currently, it is generally agreed that depression during both childhood and adolescence can be diagnosed using the standard, essential features outlined in the Diagnostic and Statistical Manual for Mental Disorders-Fourth Edition (DSM-IV; American Psychiatric Association, 1994). Adolescents suffering a depressive disorder can be diagnosed with a major depressive disorder (MDD), a dysthymic disorder, or both. With regard to MDD, an adolescent diagnosed with this condition must have experienced five or more of the following symptoms for a two-week period which results in an overall decrease in the quality of their previous level of functioning:

* depressed or irritable mood for most of each day
* a loss of interest from previously enjoyable activities
* significant weight fluctuations (weight-gain, weight-loss)
* sleep disturbances (insomnia, hypersomnia, hyposomnia)
* psychomotor agitation or retardation
* fatigue or loss of energy

* feelings of worthlessness and increased guilt
* poor concentration and difficulty making decisions
* suicidal ideation, suicide attempts, or suicidal plans.

The diagnosis of dysthymic disorder can be made when the adolescent has experienced at least one year of depressed or irritable mood nearly every day without more than two non-symptomatic months. However, for this diagnosis to be made, two or more of the following symptoms must also be present:

* eating problems
* sleeping problems
* reduced energy
* feelings of low self-esteem or self-worth
* reduced concentration and increased indecision
* feelings of hopelessness.

Furthermore, a diagnosis of dysthymia requires that during the first year of the disorder, the adolescent is not affected by a major depressive disorder. When a major depressive disorder follows the onset of a dysthymic disorder, the condition is sometimes called double depression (Peterson et al., 1993).

The incidence and prevalence of depression among adolescents has been assessed infrequently by major epidemiologic investigations (Kandel & Davies, 1982). Moreover, such studies have often focus on features of

depressive disorders such as depressed mood and symptoms rather than directly measuring the prevalence of specific disorders such as MDD or dysthymia.

Epidemiologic investigations of nonclinical (Roberts, Lewinsohn, & Seeley, 1995; Lewinsohn et al., 1993) and clinical populations (Kashani et al., 1981; Kovacs et al., 1984; Reynolds, 1984) report discrepant statistics concerning the rates of depression among adolescent youth. The discrepancies, according to Kazdin (1989), can be attributed to several factors, including the ages of the adolescents studied and inconsistencies in the types of measures used to assess and diagnose depressive disorders.

Although estimates of prevalence rates for adolescent depression among community-based populations have ranged from zero to eighteen percent (Reynolds, 1984), several investigators (McGee et al., 1990; Lewinsohn et al., 1993; Bird et al., 1988) have placed these rates between two and nine percent. A review of fourteen nonclinical studies (see Peterson et al., 1993) found that the average prevalence rate for adolescent depression was seven percent.

Among clinical populations, the prevalence rate for adolescent depression is predictably much higher. Some investigators (Kovacs et al., 1984; Kashani et al., 1981) have assessed prevalence at nearly sixty percent. However,

a review of six clinical studies (see Peterson et al., 1993) places the prevalence rate at 42 percent. Chronic depression, defined as a recurrent major depressive disorder and dysthymia (Shain, King, Naylor, & Alessi, 1991), also has been found to have high prevalence rates (eight percent and 48 percent, respectively) among both community (Kashani et al., 1987) and clinical samples (Ryan et al., 1987, cited in Shain et al., 1991).

Although gender differences are quite small for rates of depression among males and females in childhood (Gelfand & Peterson, 1985), these rates begin to diverge in mid-to-late adolescence (Ingersoll & Goldstein, 1995). From this point onward and throughout adulthood, females are approximately two to three times as likely as males to experience depressive disorders (Peterson et al., 1993; Lewinsohn et al., 1993; Reinherz et al., 1993; Rierdan, Koff, & Stubbs, 1988, 1989; Kandel & Davies, 1982).

Researchers have concluded that these consistent differences in depressive experiences are due, in large part, to socialization factors (Campbell, Byrne, & Baron, 1992). Males in Western cultures are taught to conceal and "bottle up" their painful emotions, while the open expression of depressive symptoms is generally accepted among females. This has implications for how adolescents

cope with emotional turmoil. Whereas males tend to respond to stress by distracting themselves with other concerns or activities, females tend to brood and ruminate about their difficulties which ultimately exacerbates their depressive states (Peterson et al., 1993).

In a study examining patterns of responses to items on a self-report questionnaire assessing depressive symptoms, Baron and Joly (1988) identified two response-styles that differentiated males and females. Adolescent males tended to endorse items indicating that they became socially withdrawn, experienced sleeping difficulties, and had a reduction in their level of work-motivation. In contrast, adolescent females frequently reported body-image concerns, appetite disturbances, and weight loss. In another study, Campbell, Byrne, and Baron (1992) found that among a community sample, adolescent females obtained higher raw-scores than males on the Reynolds Adolescent Depression Scale. In addition, females scored higher than males on items involving crying, stomachaches, fatigue, sad mood, and feeling ill. Taken together, these results supported the notion that adolescent girls are more inclined than their male counterparts to report depressive symptoms, and that their symptomatology are often related to stereotypically feminine characteristics.

Coping Styles, Depression, and Comorbidity. During childhood and adolescence depression in both sexes can be linked to fundamental deficits in managing stress, resolving interpersonal problems, and meeting the challenges and demands of daily life. Whether a child or adolescent copes with emotional distress by withdrawing and experiencing anxiety or by becoming disruptive, aggressive, or overactive is, in part, determined by temperamental factors (Eysenck, 1975). Introverted individuals, who tend to be passive and shy in general, are likely to become less communicative, less sociable, and more anxious as their level of stress increases and control over their environment decreases. In contrast, persons who are more extroverted will likely respond to similar circumstances by taking a more active, impulsive, and aggressive stance toward their environment.

Achenbach (1982) and Achenbach and Edlebrock (1983, 1987) have identified two major broad-band scales--measuring internalizing and externalizing symptoms of disorder--that make it possible to classify types of psychopathology found among children and adolescents in both clinical and nonclinical samples. Internalizing coping styles denote attempts to overcontrol emotional reactions by turning inward the stress generated by such experiences (see Mash & Barkley, 1989; Ingersoll & Goldstein, 1995). This results

in symptoms such as anxiety, somatic complaints, social withdrawal, uncommunicativeness, and depressive functioning. In contrast, externalizing coping styles typically involve undercontrol and poor modulation of affective impulses that are expressed outwardly toward the environment (Hinshaw, 1992). Externalizing behavior problems are characterized by aggressiveness, delinquency, and hyperactivity.

The differentiation between internalizing and externalizing behavioral problems is a highly stable and consistent finding (Verhulst & Van Der Ende, 1992). In comparison to internalizing disorders, externalizing behavioral difficulties are more difficult to treat successfully, are more stable, and carry with them more negative implications for long-term prognosis (see Mash & Barkley, 1989; Verhulst & Van Der Ende, 1992; Feehan, McGee, & Williams, 1993; Fergusson, Horwood, & Lynskey, 1993). Moreover, among children and adolescents, boys tend to manifest more externalizing behavioral problems, whereas girls usually present with symptoms more frequently associated with an internalizing coping style (see Mash & Barkley, 1989; Lewinsohn et al., 1993).

A common finding in the adolescent literature is that depression frequently co-occurs with other internalizing and

externalizing disorders (Kovacs, 1996; Biederman, Faraone, Mick, Moore, & Lelon, 1996; Roberts, Lewinsohn, & Seeley, 1995; Sanford et al., 1995; Harrington, Fudge, Rutter, Pickles, & Hill, 1991; Bernstein, 1991; Strauss, 1988; Clarizio, 1989). Comorbidity in adolescent depression has major implications. Compared to their age mates with only one disorder, youth who suffer multiple disorders are at significant risk for developing more serious, long-term mental health and psychosocial adjustment difficulties (Fleming, Boyle, & Offord, 1993; Feehan, McGee, & Williams, 1993; Offord et al., 1992; Rutter, 1992).

Comorbidity between depression and anxiety disorders has been estimated at 30 to 70 percent (Goldston et al., 1996; Goodyear & Altham, 1991a, 1991b; Connell & Meyer, 1991), and anxiety symptoms frequently occur prior to the onset of a major depressive disorder (Reinherz et al., 1993). Among adolescents with conduct problems, the rate of comorbidity for depressive symptomatology is estimated between 10 and 35 percent (Fleming, Boyle, & Offord, 1993). Adolescents who exhibit both externalizing and internalizing problems in mid-adolescence--conduct problems/oppositional behavior and depression/anxiety--are at heightened risk, in comparison to their counterparts experiencing simply internalizing symptomatology, for continued difficulties in

later adolescence (Feehan, McGee, Williams, 1993) and adulthood (Harrington, Fudge, Rutter, Pickles, & Hill, 1991).

Depressive disorders are also frequently a part of the clinical picture 1) in the occurrence of eating disorders and body-image problems, especially among adolescent females (Rierdan, Koff, & Stubbs, 1989) and 2) in the occurrence of post-traumatic stress disorder (PTSD) and suicidality subsequent to sexual abuse trauma (Brand et al., 1996). Similarly, substance abuse among adolescents is often driven, in large part, by underlying depressive feelings and emotional turmoil (King et al., 1996; Goodwin & Guze, 1989) and by maladaptive patterns in self-regulation (Horowitz, Overton, Rosenstein, & Steidl, 1992).

Coping Failures: Suicidal Ideation and Attempts. Suicidal ideation and suicide attempts are potentially serious consequences of adolescent depression, regardless of whether a depressed adolescent's primary coping style is externalizing or internalizing in nature (Hollis, 1996; Rotherrom-Borus et al., 1996; Fergusson & Lynskey, 1995; Pfeffer, Hurt, Peskin, & Siefker, 1995; Rao, Weissman, Martin, & Hammond, 1993; Hafen, 1986; Diekstra & Moritz, 1987; Curran, 1987). Over the past four decades, the

suicide rate among adolescents has increased by approximately 275 to 290 percent (Ohberg, Lonnqvist, Sarna, & Vuori, 1996; Cimbolic & Jobes, 1990). Among 15 to 19 year olds, this increase in suicide has been even more marked (2 in every 100,000 in 1960 compared to 12 in every 100,000 in the early 1990s (Andrews & Lewinsohn, 1992). The number of attempted suicides is believed to be considerably greater than the number of completed suicides (Ohberg, Lonnqvist, Sarna, & Vuori, 1996; Petti & Larson, 1987; Hafen & Frandsen, 1986). In short, emotionally-troubled teenagers often consider suicide as a viable option for escaping emotional turmoil, depressed mood, and personal problems (Pinto & Whisman, 1996). In particular, depressed adolescents also diagnosed with a personality disorder, experiencing intense anxiety, shame, and guilt, manifesting impulse-control difficulties, or engaging in antisocial or conduct-disordered behavior are especially likely compared to other depressed teenagers without these problems to be bothered by suicidal thoughts and to make suicide attempts (Ohring et al., 1996; Brent et al., 1993; Hafen & Frandsen, 1986; Marttunen, Aro, & Lonnqvist, 1992; Shaffer, 1974; Shaffer & Fisher, 1981).

Sex and racial differences have been found in the rates of adolescent completed versus noncompleted suicide attempts

(Petti & Larson, 1987). In most cases, males tend to use more lethal methods for taking their life (gunshots, hanging, jumping from high places), whereas females tend to utilize less lethal, more reversible methods (overdosing on a few aspirin or medication pills superficial cuts to the wrist) (Ohberg, Lonnqvist, Sarna, & Vuori, 1996; Hafen & Frandsen, 1986). However, there is some evidence (Cimbolic & Jobes, 1990) that this pattern may be slowly changing in that a slight increase has been noted in the number of adolescent females using more lethal methods to commit suicide (Hollis, 1996). In general, however, during the adolescent years, suicide attempters are more likely to be non-Caucasian females who are early adolescents, whereas suicide completers more typically are older, Caucasian males (Deykin, Hsieh, Joshi, and McNamarra, 1986).

A long list of factors have been implicated in adolescent suicide and suicide attempts (Mattunen et al., 1995). These include severe family problems, family history of mental illness, school failure, perceived rejection from peers or romantic partners, and physical, sexual, or emotional maltreatment (Ingersoll & Goldstein, 1995; see Diekstra & Hawton, 1987; Cimbolic & Jobes, 1990; Hafen & Frandsen, 1986; Petti & Larson, 1987). Overall, adolescent suicide appears to be an "endpoint of long-term

[psychosocial] difficulties" (Marttunen, Hillevi, & Lonnqvist, 1992, p. 649). Hence, in addition to family and social factors, severe emotional problems, depression, antisocial behavior, substance abuse, and previous suicide attempts place adolescents at heightened risk for contemplating and committing suicide (Andrews & Lewinsohn, 1992; Hodgman, 1990; Schaffer, 1974; Schaffer & Fisher, 1981).

An adolescent's decision to attempt suicide is, to a large extent, an internally mediated, cognitive process. Although family, peer, and psychosocial stressors can be emotionally disruptive and overwhelming, especially when they are intense, prolonged, or cumulative, it is the adolescent who ultimately decides to harm himself or herself and to end their life. Given this reality, it is important to explore underlying emotional and personality variables that may be driving ineffective coping and self-destructive behaviors. In this regard, there is reason to believe that intense experiences of shame play an important role in the adolescent's "choice" of suicide as a means of coping with external stressors and internal distress.

III. SHAME

The Painful Emotion of Shame and Its Relationship to Depression. Over the past 25 to 30 years, research on shame has become more prominent in the literature, and is now perceived as a viable approach to better understanding maladaptive behaviors and psychological disorders (Kaufman, 1989; 1992; Lewis, 1971, 1987; Fidoli, 1988). Depression and shame have been repeatedly found to co-occur in studies of both community and clinical samples (Lewis, 1971, 1987; Izard & Schwartz, 1986; Hoblitzelle, 1987; Beck & Steer, 1987). Affect theorists (Tomkins, 1963; Kaufman, 1989; Nathanson, 1987, 1992) have maintained that depression is often the result of a dual-process involving cumulative shame experiences and intense, prolonged emotional turmoil.

Shame is generally perceived as an intensely powerful affect that is "central to the human experience" (Kaufman, 1989, p. 7). It is believed to emerge initially during the second and third years of life (Erikson, 1962) as children attempt to assert greater autonomy and independence over their functioning. As the child grows older, matures, and eventually achieves adult-status, the factors that evoke shameful experiences become more complex, and may or may not be related to shame-inducing experiences of childhood

(Spero, 1988). Yet, according to Lewis (1971), shame is a fundamentally primitive reaction to which all persons respond in similar ways. The individual's "body gestures and attitudes include head bowed, eyes closed, body curved in on itself, making the person as small as possible" (p. 427). In addition to these observable phenomena, the individual's autonomic nervous system becomes activated, and the person may blush, sweat, or experience a diffuse rage which Lewis (1971) described as a "flood' of sensations" (p. 427).

Shame can be characterized by four basic features that make it a highly powerful and unpleasant emotion. First, shame is characterized by an immediate reduction or loss of self-worth (Spero, 1988). This emotionally-charged experience has been referred to by Laing (1960) as the "implosion of the self." Second, shame leaves the individual feeling isolated from others and extremely angry at the self (Spero, 1988). Shame-reactions cause the individual to perceive themselves as the "bad thing" and to believe erroneously that this self-perception is, therefore, a reflection of a "bad self" (Tangney, Wagner, Fletcher, & Gramzow, 1992, p. 670). Shame often is experienced in the form of mental imagery in which the individual's thinking is dominated by representations of an "internalized other"

(Lewis, 1971) that the individual experiences as an explicitly or implicitly disapproving or rejecting external figure. This sense that others are acutely aware of the individual's shortcomings and utter worthlessness is a third feature of the shame experience.

Finally, shame results in heightened self-consciousness and a sense that the person's innermost weaknesses and vulnerabilities have been exposed for public viewing and condemnation (Yorke, 1990; Kaufman, 1984, 1992; Spero, 1988). This intense self-awareness leads to withdrawal from the social interaction in which feelings of shame have arisen, and the person is overtaken by a need to hide from others (Yorke, 1990).

Shame versus Guilt. It is important to distinguish shame from guilt which is a related, but separate, negative emotion. Although both shame and guilt are considered to be the result of superego functions and operate in both conscious and unconscious awareness (Lewis, 1971), an important distinction between these two affects is the source from which each emotion arises. In guilt, the negative emotion stems from a perception that one is responsible for injuring or hurting another by acting or failing to act in a certain manner (Hultberg, 1988; Lewis,

1971). The person experiences anxiety that, in turn, stems from "remorse or regret over the 'bad thing' that [he or she has] done and a sense of tension that often serves to motivate reparative action" (Tangney, et al., 1992, p. 669). Hence, guilt arises from the sense of having wronged another, and is characterized by an active stance toward fixing the situation. In contrast, shame is a passive emotion that is directed totally at the self. The person feels that they are the object of other's scorn, contempt, and ridicule, and believes that there is no way to successfully resolve the consequent feelings of unpleasantness and confusion, except to flee from the situation (Lewis, 1971). Whereas guilt creates a need to repair a situation, "shame motivates a desire to hide--to sink into the floor and disappear" (Tangney, et al., 1992, p. 670). In shame, the boundaries that separate self-from-others are highly permeable (Yorke, 1990). Individuals acutely experiencing this emotion are susceptible to periods of overwhelming and immobilizing anxiety during which they may be keenly aware of their most negative qualities and attributes (Spero, 1988).

Sources of Shame in Adolescence. Although shame is an emotion that can manifest at any point during the life-cycle

(Kaufman, 1984, 1992; Erikson, 1963), it is frequently experienced during the childhood and adolescent years. As part of the socialization experience, the child encounters failure and disappointment, is reprimanded by parental and other authority-figures, and begins to understand the nature of their own weaknesses and shortcomings (Sidoli, 1988).

In the very young child, shame-reactions can be evoked by a caretaker's anger, disgust, or refusal to offer positive affirmation or physical contact (Kaufman, 1984, 1992). These emotionally-charged, social interactions create instability for and insecurity within the child. In temporarily fracturing the "interpersonal bridge" (Kaufman, 1992, p. 13) binding the child to its caregiver(s), they intensify abandonment fears and exacerbate feelings of rejection and low self-worth. Kaufman (1992) emphasizes that early shame experiences in and of themselves do not "launch a child on a path toward a shame-based identity" (p. 20). Rather, it is when reactions by significant others are extreme and frequent that shame experiences are likely to become more chronic.

In older children and adolescents whose verbal skills and cognitive abilities are more advanced, shame-experiences can be induced within the family, among peers, at school, or in extracirricular activities. In fact, adolescence has been identified as a period of intense self-consciousness

and significant concerns about the reactions of others (Steinberg, 1985).

Adolescent children are likely to feel shame when they are told that they should be ashamed of their transgressions, that they are a disappointment to their parents or family, or that they have let their parents down by embarrassing them in public (Kaufman, 1992). Similarly, teenage children are likely confronted with feelings of shame when they are repeatedly ridiculed or rejected by peers, or when they perceive themselves as consistently performing poorly on academic tasks which they fear will cause respected others to think less highly of them. Given the rapid physical changes during the teenage years (see Lerner, 1987), coupled with changing family and peer relationships (Steinberg, Lamborn, Dornbusch, & Darling, 1992; Steinberg, Elmen, & Mounts, 1989; Bird & Harris, 1990; Papini & Roggman, 1992; Stivers, 1988; Eccles et al., 1993; Barrera & Garrison-Jones, 1992), achievement-related stressors (Simmons, Carlton-Ford, & Blyth, 1987; Steinberg, 1985), and heightened sexual awareness (Steinberg, 1985; Peterson & Taylor, 1987), it seems readily apparent that adolescents are especially susceptible to feelings of shame.

The Internalization of Shame from an Interpersonal to Intrapersonal Experience. Shame begins as an interpersonal experience, but becomes more chronic and problematic as these painful social interactions are internalized. Shame initially emanates from negative interactions with significant others, usually parents, who are perceived as nurturant figures and important role-models (Kaufman, 1992). The early process of feeling emotionally connected to primary caregivers and other significant adults has major implications for personality development. This process not only plays am integral role in identity formation during adolescence (Erikson, 1968) and in the ability to form and maintain satisfying attachment relationships throughout the life cycle (Bowlby, 1969, 1973), but it also is a necessary condition for developing shameful experiences (Kaufman, 1992).

During childhood and adolescence, the individual searches for adult-figures whose behaviors and actions can be emulated or internalized. Kaufman (1992) noted that this process has three very important characteristics. First, internalizations are built upon the foundation of the individual's own understanding about who they are themselves as individuals and what attitudes and emotions they hold (referred to as "core affect-beliefs"). Second, the manner

in which one is treated by others influences the person's own thoughts and feelings about themselves. Finally, the individual who has identified with others carries around mental images of these significant persons. According to Kaufman (1992), it is through this process of identification and internalization that "the conscious experience of the self . . . is shaped and a relationship with that self develops" (p. 43).

Kaufman (1989, 1992) has identified several avenues that facilitate the internalization of shame from an interpersonal to intrapersonal process for children and adolescents. The first involves the link between affect and shame-inducing experience (Kaufman, 1989, 1992; Tomkins, 1962, 1963). According to Kaufman (1992), affect elicits shame in the following manner:

> Whenever the expression of a particular affect, whether it be anger, fear, even enjoyment, is followed by some parental response which induces shame, an internalized affect-shame bind can result . . . .The development of an affect-shame bind then functions to control the later expression of the particular affect involved (p.45).

The danger associated with affect-shame binds is that the situations, thoughts, or feelings that function to initially

cause shame in children and adolescents "can come to spontaneously activate shame without shame itself being directly induced" (Kaufman, 1992, p. 45).

A second pathway for shame to evolve from an interpersonal to an intrapersonal experience is through the child's or adolescent's expression of basic human drives that are met with parental scorn or communications that such behaviors are shameful. As an example of what Kaufman (1989, 1992) termed a drive-shame bind, he describes the scenario of a child caught by his parents masturbating and told that such behavior is wrong and highly inappropriate. The negative and confusing emotions that accompany such an experience, especially if repeated over time, will, according to Kaufman, cause the child to conceal such activity and to feel shame.

The final pathway for shame to be transformed from an interpersonal to an intrapersonal experience in children and adolescents is through the development of need-shame binds. With regard to these phenomena, Kaufman (1992) identifies several basic interpersonal needs that help not only to foster one's sense of identity, but also play an important role in the development of shame if they go unmet for significant periods of time. These needs include participating in close relationships, engaging in and

receiving physical touch, identifying with significant others, being able to differentiate oneself from others and to show mastery and competence, receiving positive affirmation from external figures, and being able to nurture and show love and affection for others.

In summary, shame arises from an interaction of both interpersonal and intrapersonal factors. When basic human emotions, drives, or needs are experienced as negative and worthy of scorn by others whom the individual admires, the foundation is laid for shame to fester within the individual, and is likely to negatively influence the person's feelings of self-worth. As Kaufman (1992) noted:

> Internalization of shame means that the affect of shame is no longer merely one affect or feeling among many which become activated at various times and then pass on. Rather, internalized shame is now experienced as a deep abiding sense of being defective, never quite good enough as a person. It forms the foundation around which other feelings about the self will be experienced, This affect-belief lies at the core of the self and gradually recedes from consciousness. In this way, shame becomes basic to the sense of identity. While the underlying affect is the same, the conscious experience of internalized shame differs widely. For example, feelings of inadequacy, rejection, or self-doubt, feeling guilt-ridden or unlovable as a person, pervasive loneliness are all conscious or semiconscious expressions of internalized shame (pp. 73-74).

Shame, Coping Styles, and Defensive Maneuvers. Shame is clearly a negative and very powerful emotion that can be evoked in all individuals, including children and adolescents. However, the extent to which an individual responds to and is consciously affected by this affect is somewhat variable. In fact, how a person handles shame feelings and experiences--both intra-psychically and interpersonally--is related, in part, to interpersonal styles and defensive strategies. According to Kaufman (1989, 1992), introverted individuals are more likely than extroverted persons to respond to shame-inducing situations by "withdrawing [themselves] deeper inside, allowing escape from the torment of shame" (p. 102). Conversely, the extrovert, who tends to externalize and openly display thoughts and feelings, is prone in similar situations to exhibit mood lability. Hence, as Kaufman (1989) summarized, "the introvert moves, psychologically speaking, 'in and out' while the extrovert cycles 'up and down'" (p. 98).

The mental operations people use to avoid the painful and immobilizing affective experience of shame are frequently referred to as defense mechanisms in the clinical and personality literatures (Liebert & Speigler, 1982). These mechanisms of defense serve a valuable function. They

can ward off feelings of anxiety, and can decrease an individual's sense of threat from the environment (A. Freud, 1946/1958; 1965).

A very common reaction to shame experiences is intense anger and rage (H. Lewis, 1971; Tangney et al., 1992; Kaufman, 1989, 1992; M. Lewis, 1992; Nathanson, 1992). Anger is considered to occur as a response to a specific shaming incident; rage is believed to occur as a result of prolonged shaming (M. Lewis, 1992). In either instance, anger and rage reactions provide the individual with an opportunity to avoid confronting their shameful feelings, to exert a temporary sense of power and control over their emotional life, and to keep others at a safe, emotional distance. Individuals who primarily rely on anger and rage to defend against shame are perceived as substituting or replacing anger and explosive reactions instead of openly acknowledging their shame (M. Lewis, 1992).

Although anger and rage offer individuals temporary stress-release and protection from consciously confronting shame, these undercontrolled reactions ultimately increase the individual's sense of underlying distress. The

reasoning behind this process is illustrated succinctly in a review by Lewis (1971) who noted the following:

> In shame, hostility against the self is experienced in the passive mode. The self feels not "in control" but overwhelmed and paralyzed by the hostility directed against it. One could "crawl through a hole," or "sink through the floor," or "die" with shame. The self feels small, helpless, and childish. . . . So long as shame is experienced, it is the "other" who is experienced as the source of hostility. Hostility against the rejecting other is almost always simultaneously evoked. But it is humiliated fury, or shame-rage, and the self is still in part experienced as the object of the "other's" scorn. Hostility against the "other" is trapped in this directional bind. To be furious with someone . . . renders one easily and simultaneously guilty of being furious. Evoked hostility is readily redirected back against the vulnerable self (p. 430).

In addition to anger and rage, Kaufman (1992, 1989) has identified five other defensive reactions that people may use to avoid fully confronting shame. These may include 1) showing contempt for others; 2) exhibiting an intense striving for power that serves to erase underlying feelings of defectiveness or low self-worth; 3) striving for perfection in nearly all areas of one's life; 4) projecting or transferring blame onto external figures or factors; or 5) retreating or withdrawing from interpersonal relationships into active fantasy which helps to lessen

one's degree of emotional turmoil. These coping strategies, along with anger and rage, are consistent with Nathanson's (1992) formulation of withdrawal, avoidance, attacking the self, and attacking others as the four main ways that individuals attempt to defend against shame-related affect.

The manner in which adolescents "defend" against distress in general may be vitally important in predicting whether they express resulting feelings of anger and rage in an inner-directed or other-directed fashion. The literature reviewed to this point would suggest that depressed adolescents who internalize their thoughts and feelings will be inclined to withdraw in reaction to shame experiences. In addition, so-called "internalizers" should be more able to acknowledge underlying feelings of shame. Because these internalizing adolescents are more likely to experience intense emotional distress, it is further conceivable that they will not only report more depressive affect, but also will engage in more suicidal thinking and will turn their anger inward in the form of suicide attempts. In contrast, depressed teenagers with externalizing coping styles are more likely to rely heavily upon other-directed, defensive operations such as anger and rage outbursts and probably will deny and, hence, under-report feelings of shame. In one of only a few studies examining shame, anger, and externalizing coping mechanisms in adolescents, Spielberger

(1988, cited in Cook, 1993) found that self-reported shame was highly correlated with the suppression of anger and sensitivity to criticism or negative evaluations by others. However, the relationship ($r = .21$) between shame and anger expressed primarily in aggressive acts toward other persons or objects was relatively low and nonsignificant. One explanation of the failure to find a shame-hostility versus others link is that adolescents with a more externalizing coping style were driven by more "unconscious" or less accessible feelings of shame.

Risk-Taking, Depression, Shame, and Indirect Suicidal Behavior. The notion of **unconscious shame** presumes that shame can go "underground" and can be blocked from conscious awareness. This study will examine the possibility that unconscious shame and externalizing coping styles interact in predicting risk-taking and sensation-seeking behaviors that put the adolescent's life at risk, and, as such, may represent an indirect form of suicidal behavior in adolescents.

Adolescence has been identified as a period when risk-taking and sensation-seeking behaviors increase (Tonkin, 1987). An important question is whether some emotionally-distressed adolescents cope with their personal problems and

feelings of shame by engaging in behaviors that might be considered indirect forms of suicidal behavior and that conceal underlying depressive symptomatology and shame-based affect (Puig-Antich, 1982). These forms would include direct risk-taking and self-injurious (self-destructive) behaviors.

Risk-taking and sensation-seeking actions among older children and adolescents have been identified as serious medical and mental health concerns (Guyer, Lescohier, Gallagher, Hausman, & Azzara, 1989; Russo et al., 1993). Accidents and violent acts, along with suicide, consistently fall at the top of surveys assessing major causes of death among children and adolescents in the United States (Clark, Sommerfeldt, Schwarz, & Hedeker, 1990; Guyer et al., 1989). Moreover, promiscuous sexual behavior, which often arises from underlying unmet dependency needs, can lead to unwanted pregnancies, venereal diseases, and Acquired Immune-deficiency Syndrome (AIDS) (Rosen, Xiangdong, & Blum, 1990; Davis, 1990; Giovacchini, 1986; DiClemente & Ponton, 1993). Similarly, substance abuse places the adolescent at-risk for multiple psychosocial problems, including school and family difficulties, depression, and antisocial behavior (Comerci & Macdonald, 1990). Both promiscuous sexual behavior and substance abuse are addictive disorders that may be "rooted

in internalized scenes of shame" (Kaufman, 1989, p. 126), and mask or conceal underlying emotional turmoil.

Self-destructive behaviors such as burning one's skin, excessive scratching, and eating disorders can also be considered indirect suicidal actions (Delga, Heinssen, Fritsch, Goodrich, & Yates, 1989), and are related to the internalization of shame (Kaufman, 1989; Nathanson, 1992). Furthermore, in comparison to external, risk-taking behaviors, such actions more readily appear to be driven by emotional problems. In his review of several studies on self-destructive behavior in children and adolescents, Green (1978) reported that youth who engage in such behavior have been historically viewed as suffering from major ego-deficits, neurological impairment, and/or mental retardation. However, he maintained that environmental factors, including severe emotional trauma, intense parental rejection, family disorganization, and severe maltreatment, also can lead to the development of self-destructive behavior. Based on the results of his own study, Green (1978) found that among "abused," "neglected," and "normal" children, the physically abused and maltreated children were at greatest risk for self-injurious behavior.

Like rates for depression, suicide, and externalizing and internalizing disorders, there tend to be sex

differences in the rates for risk-taking and self-destructive behaviors among adolescents. In general, whereas male teenagers are more likely to engage in direct risk-taking and sensation-seeking behaviors, female adolescents are more likely to engage in self-injurious behaviors (Guyer et al., 1989). However, it would be misleading to simply breakdown the differences in risk-taking and self-destructive behaviors along gender lines. For example, early-maturing girls and late-maturing boys have been found to manifest more risk-taking behaviors than other adolescents who are of the same age and sex (Irwin, 1990). With respect to early-maturing girls, they manifest developmental needs and interests at an earlier time than their peers. This causes them to feel shame and to be perceived as "different" from their peers. This results in a "proclivity for initiating risk behaviors" (Irwin, 1990, p. 6) within the realm of striving for independence, increasing interest in sexual relationships, and socializing with an older peer group. Like the early-maturing girl, the late-maturing boy is likely to experience shame and to feel "different" from his same-sex peers which alters his self-concept and his sense of masculine identity. In an effort

to counteract these helpless and powerless feelings, the late-maturing boy may be especially prone to risk-taking behaviors.

Regardless of gender, adolescents with externalizing coping styles, as compared to those with internalizing coping styles, are more prone to aggressive, impulsive, and undercontrolled behaviors and emotional reactions when confronted with heightened stress or emotionally-charged thoughts, feelings, and situations. An important clinical as well as empirical issue involves identifying variables that provide insight into why a good number of depressed, externalizing adolescents engage in overt risk-taking behaviors, whereas others, like their depressed, internalizing counterparts, may be more inclined to contemplate suicide and manifest overt suicidal behavior (for example, wrist-cutting; drug overdose; etc.).

One possibility may involve whether shame is experienced in conscious awareness or through "hidden," unconscious processes. This distinction has potentially important implications for how adolescents (both externalizers and internalizers) cope with and react to the feelings of powerlessness and despair that often accompany depressive illness. For example, the levels of conscious and unconscious shame among depressed, externalizing

adolescents may provide valuable information about their susceptibility toward engaging in or acting outwardly through risky and dangerous or direct suicidal behaviors in order to alleviate their experience of negative, painful affect. Hence, the depressed, externalizing adolescent who reports little conscious shame might be more inclined to cope with depressive thoughts and feelings through denial of self-destructive urges and a greater willingness to engage in risk-taking and sensation-seeking behaviors. Such reactions might "mask" or conceal their underlying distress, and represent a counter-attempt at neutralizing their unpleasant feelings of powerlessness, helplessness, and vulnerability. In contrast, the depressed, externalizing adolescent, whose shame-related cognitions and feelings have "broken through" into conscious awareness, will likely admit to greater emotional distress and suicidal ideation, and may be more prone to planning or attempting more serious (lethal) suicides.

IV. SUMMARY OF LITERATURE REVIEW

Depression and shame are related, affect-based phenomena that influence the emotional well-being of children and adolescents. The former is influenced by

situational stress, coping deficits, and poor social problem solving skills. The latter evolves from repeatedly painful and rejecting interactions involving significant others with whom the child or adolescent has identified. In time, these interactions, like the youth's identifications with highly regarded others, are internalized, and become the basis for experiencing shame.

The manner by which adolescents cope with depressive and shameful feelings presumably is related, in part, to interpersonal styles and defensive strategies. Briefly stated, introverted adolescents may be inclined to respond to stress and shame-inducing situations by retreating or withdrawing deeper inside themselves, relying upon inner-directed defenses, and showing greater awareness of their shameful feelings. In contrast, extroverted adolescents may be prone to openly displaying and acting out their thoughts and feelings through other-directed defenses, and may show less conscious awareness of (and a greater reluctance to admit to) their feelings of shame.

Whereas the former group of adolescents--the so-called "internalizers"--are more focused on their innermost thoughts and emotions, the latter group--the so-called "externalizers"--are more likely to deny or minimize their strong emotions. Among internalizing adolescents, it is

conceivable that they are in more conscious distress, and will be more likely to acknowledge their despair whether it takes the form of depressive feelings, shame experiences, and/or suicidal ideation. Conversely, depressed externalizing adolescents will likely be more oriented toward behavioral action rather than thinking about their painful thoughts or feelings. Hence, these teenagers are expected to minimize or under-report their depressive feelings, shame experiences, and suicidal thoughts.

Although internalizing adolescents are expected to report more suicidal ideation and undertake more direct suicide attempts, externalizing adolescents are expected to engage in more sensation-seeking and risk-taking behaviors that not only provide them with a temporary sense of power, control, and invulnerability (Quadrel, Fischoff, & Davis, 1993), but also may represent indirect forms of suicidal behavior. Within this framework, the experience of shame is suppressed and goes "underground" in externalizing adolescents whose feelings of despair get blocked from conscious awareness. In order to assess this notion of "unconscious" shame, projective testing with a storytelling task (such as the Roberts Apperception Test for Children) is required. Partial support for this idea would be obtained if a significant sub-group of externalizing adolescents who

report low conscious shame nevertheless scored high in regard to story-contents that were related to shame-based thoughts, feelings, emotions, and conflicts. However, among all depressed adolescents, the ones believed to be at greatest risk for undertaking the most lethal suicide attempts would be those teenagers who possess an externalizing coping style and whose unconscious shame has "broken through," so to speak, into consciousness (hence, they would report significant levels of conscious shame).

V. HYPOTHESES

Hypothesis 1

A) Adolescent inpatients with highly externalizing coping styles (as assessed by parental report) will report relatively lower levels of conscious shame and depressive symptoms, whereas depressed adolescents with highly internalizing coping styles will report relatively higher levels of conscious shame and depressive symptoms.

B) Conscious shame will moderate the relationship between unconscious shame and externalizing coping styles so that high unconscious shame will be negatively related to externalizing coping styles among adolescents with high

conscious shame, but unconscious shame will be positively related to externalizing coping style among adolescents reporting low levels of conscious shame.

Hypothesis 2

Conscious shame will moderate the relationship between internalizing coping styles and suicidal ideation so that internalizing coping will be positively related to suicidal ideation among adolescent reporting high conscious shame, but will be unrelated to suicidal ideation among adolescents reporting low levels of conscious shame.

Hypothesis 3

Externalizing coping styles and experiences of conscious shame and unconscious shame will interact in predicting risk-taking behavior so that adolescents with high levels of externalization, high unconscious shame, and low levels of conscious shame will report higher levels of risk-taking behaviors than will adolescents with other combinations of externalization, conscious shame, and unconscious shame.

Hypothesis 4

Externalizing coping styles and experiences of conscious shame and unconscious shame will interact in predicting the lethality of suicide attempts so that adolescents with high externalizing coping styles, high unconscious shame, and high conscious shame will undertake more serious suicide attempts than will adolescents with other combinations involving coping styles, conscious shame, and unconscious shame.

VI. METHOD

Participants

The sample for this study (see Table 1) included 50 females and 39 males, all of whom were between the ages of 13 and 15 years. The sample was predominantly Caucasian (i.e., 80 percent). All participants were selected from a pool of psychiatric inpatients. Shortly after their admission, each adolescent was interviewed by a child psychiatrist, and received a DSM-IV, primary diagnosis that fell within the spectrum of depressive disorders. Hence, adolescent participants were selected for this study when they were identified as meeting criteria for Major Depressive Disorder; Major Depression, Recurrent; Dysthymic

Table 1

Characteristics of the Sample

SEX	
Females	n = 50
Males	n = 39
Total Sample	n = 89

AGE	Females	Males
13 years old	n = 10	n = 16
14 years old	n = 18	n = 13
15 years old	n = 22	n = 10

ETHNICITY	Sample Size	Percentage
Caucasian	71	79.9
African-American	5	5.6
Native-American	4	4.5
Hispanic	3	3.4
Other	6	6.7
	n = 89	100.00

Disorder; or Depressive Disorder, Not Otherwise Specified (NOS). No teenager was included in the sample whose psychiatric examination suggested the presence of Mental Retardation, a Pervasive Developmental Disorder such as autism, or Bipolar Disorder.

At the conclusion of data collection and prior to data analysis, 27 of the 89 cases in this study (30.3 percent) were randomly selected for review of intake-admission and final-discharge diagnoses. In 26 of the randomly-selected 27 cases (96.3 percent), intake-admission and final discharge diagnoses remained consistent with depressive-spectrum disorders.

Measures

The Functional Impairment Scale for Children and Adolescents (FISCA) (Frank and Paul, 1995) is a questionnaire that measures functional impairment in children between the ages of 6 and 18 years. It is completed by parents, caregivers, or other adults who possess a good deal of knowledge about the coping and behavioral functioning of a particular child or adolescent. The FISCA assesses emotional and behavioral impairment and functioning within eight major areas of a youth's life. These have been labeled 1) School; 2) Home; 3) Community;

4) Thinking; 5) Aggression; 6) Moods and Emotions; 7) Self-Harm; and 8) Alcohol and Drug Use. In this study, 69 of the 89 participants (77.5 percent) had FISCA data available for inclusion during statistical analyses. Although parents completed the FISCA as part of the inpatient admission process, FISCA data were not available for some participants if, for example, the admission occurred late at night, if the teenager had been hospitalized in the previous three months, or if the parent/caregiver had significant trouble with reading.

The FISCA is based on criteria for impairment as outlined in the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 1990), and utilizes a multiple-choice format. Responses to each item are keyed to specific criteria allowing for automatic and easy scoring. Impairment criteria associated with each of the eight areas define impairment at three levels denoted as mild, moderate, and severe ("mild" receives a score of 10; "moderate" receives a score of 20; and "severe" receives a score of 30). A child receives a score of 0 (no impairment) for a particular area if he or she does not meet any of the criteria associated with mild, moderate, or severe levels of impairment within that area. Impairment levels are usually defined by a number of different criteria (see Appendix A),

but a child only needs to meet one of the listed criteria to be classified at a particular level. The child's score for each impairment area reflects the highest level of impairment for which he or she meets one or more criteria (see Table 2 for an example).

Exploratory factor analysis of the FISCA (Frank, Paul, & Jackson, 1997, in progress) has identified an Externalizing factor (computed by averaging scores for the School, Home, Community, Thinking, and Aggression domains); an Internalizing factor (computed by averaging scores for the Moods/Emotions and Self-Harm domains); and an Alcohol and Drug Use factor. A series of statistical studies involving the FISCA have found it to possess good face, construct, concurrent, predictive, and discriminant validity (see Paul, 1996, for a review). In addition, FISCA scores have been found to predict length-of-stay (LOS) in child and adolescent psychiatric hospitals and recidivism (Frank, Paul, & Jackson, 1997, in progress).

The Reynolds Adolescent Depression Scale (RADS; Reynolds, 1987a) is a quickly administered 30-item self-report questionnaire that assesses clinically relevant levels of depressive symptomatology in adolescents between ages 13 to 18 years and in grades seven and twelve. Item-statements are presented in a 4-point Likert-like format, and require

Table 2

FISCA Level of Impairment: An Example

HOME		
Severe	Moderate	Mild
Ran away from home overnight two times or more and whereabouts unknown to parents or guardians	Ran away from home overnight one time only; whereabouts known by parents	Frequently refuses to do age appropriate chores; intermittent defiance at home
Child highly unmanageable or impaired needing removal from home or in the near future	Persistently refused to comply with requests for age appropriate behavior in home. Chronic failure to meet age appropriate expectations in home	
Child can only be maintained in home with outside assistance	Repeatedly failed to mind rules about safety	

NOTE: A 14 year old child who refuses to do his/her chores, ignores his/her curfew, and who has runaway from home four times in the last month without his/her parents certain of their whereabouts would receive a Home Impairment score of "30" since the running away behavior is one level higher than the chore and curfew concerns.

the adolescent to mark their answers based on how often they feel a certain way (almost never, hardly ever, sometimes, or most of the time). In this study 82 of the 89 participants (92.1 percent) completed this self-report questionnaire. Scoring for the RADS allows for computation of raw scores as well as standardized percentile scores for a teenager's age and sex. Except where otherwise indicated, standardized scores were used in this research.

The RADS demonstrates high internal consistency with reliability coefficients across different grades ranging from .91 to .94 and with a total sample alpha of .92 (Reynolds, 1987a). On the RADS, as is often the case with other depression self-report questionnaires, females tend to obtain higher scores (on average, 5 to 7 points higher) than their male counterparts ($p < .001$) (Reynolds, 1987). Validity studies indicate that the RADS has good concurrent validity (Atlas & DiScipio, 1992; Reynolds, 1987a) and captures many of the domains of depression usually identified in the depression literature (Campbell, Byrne, & Baron, 1994). Similarly, as measures of its convergent validity, the RADS correlates positively with measures of anxiety, hopelessness, loneliness, and suicidal ideation,

and correlates negatively with measures of self-esteem and learned helplessness in academic situations (Reynolds, 1987a).

The Suicidal Ideation Questionnaire (SIQ; Reynolds, 1987b) was developed in order to assess suicidal ideation. The SIQ consists of 30 items, and is typically used with adolescents in grades 10 through 12. A modified version of the SIQ, called the SIQ-JR, is comprised of a 15-item subset of the original 30 SIQ items, and is designed for adolescents in grades 7 through 9. Both versions present suicidal thoughts and cognitions to the adolescent who uses a 7-point scale to report on frequency of ideation over the past month Items are assigned severity scores from 6 (very frequent) to 0 (never). In this study, 19 participants (21.3 percent) completed the SIQ, whereas 60 participants (67.4 percent) completed the SIQ-JR.

According to Reynolds (1987b), the SIQ and SIQ-JR are both characterized by high internal consistency reliability coefficients (alphas greater than .90). The SIQ and SIQ-JR both have reasonable face-validity. Items range from minor and nonspecific thoughts (e.g., "I thought about death." "I wished I were dead.") to more major and specific cognitions ("I thought about how I would kill myself." "I thought about when I would kill myself." "I thought about writing a

will.") (Reynolds, 1987b). Scores on these measures correlate positively with depression, anxiety, hopelessness, and negative life events,and correlate negatively with academic self-esteem and learned helplessness in academic situations (Reynolds, 1987b).

The Internalized Shame Scale (ISS; Cook, 1994) is a self-report questionnaire that assesses feelings and emotions associated with conscious shame. It is is comprised of 30 items, twenty-four of which are considered "shame items" ("I feel like I am never quite good enough" or "I have an overpowering dread that my faults will be revealed in front of others"). The remaining six statements, modified from the Rosenberg Self-Esteem Scale (Rosenberg, 1965), are viewed as measuring self-esteem and are worded in a positive direction ("All in all, I am inclined to feel that I am a success" or "I feel I am a person of worth at least on equal plane with others"). In this study, 82 of the 89 participants (92.1 percent) completed this measure. The six self-esteem items were excluded from all data analyses

The ISS shame scale is highly internally consistent among both clinical and nonclinical populations (alphas greater than .95). The ISS has been shown to differentiate between clinical and nonclinical populations, and reportedly

is not sensitive to gender influences (Cook, 1994). Among a nonclinical subset of individuals, the ISS demonstrated adequate test-retest reliability over a seven-week period ($r = .84$ for shame items; $r = .69$ for self-esteem items). The ISS has good face and construct validity, and has shown strong convergence with assessment measures of global self-esteem (Cook, 1994), depression (Cook, 1994; Berndt, 1986; Rybak, 1991; Lighty, 1990; Waite-O'Brien, 1991), anxiety (Cook, 1993; McFarland, 1992; Rybak, 1991), and anger (Cook, 1994).

The Sensation Seeking Scale for Children (SSSC; Russo, 1991) was completed by 82 of the 89 participants (92.1 percent) in this study, and is 26-item, forced-choice, self-report questionnaire modeled on the Sensation Seeking Scale (SSS) for adults (Zuckerman, 1979, 1983). The SSSC is comprised of three major scales: Thrill and Adventure Seeking [TAS]; Drug & Alcohol Attitudes [DAA]; and Social Disinhibition [SD]. Only the TAS scale score was computed for purposes of data analysis because it best described the construct of risk-taking attitudes utilized in this study. Item examples include:

5. A. "I'd never do anything that's dangerous."
   B. "I sometimes like to do things that are a little scary."

6. A. "I think riding fast on a skateboard is fun."
   B. "Some of the daring acts of skateboarders seem scary to me."

10. A. "I would like to try jumping from a plane with a parachute."
    B. "I would never try jumping from a plane with a parachute."

15. A. "I think skiing fast down a snowy mountain would be dangerous."
    B. "I think skiing fast down a snowy mountain would be exciting and fun."

18. A. "I enjoy the feeling of riding my bike fast down a big hill."
    B. "Riding my bike fast down a big hill is too scary for me."

The psychometric properties of the SSSC have been studied using children and adolescents ages 9 to 15 years. As a child self-report measure, the SSSC has demonstrated adequate internal consistency (alpha for TAS = .81), but findings for test-retest reliability over a three-week interval are inconsistent (Russo et al., 1993). Although one subsample of children and adolescents (from Rhode Island) demonstrated moderate correlation coefficients (around .50), another subsample (from Virginia) obtained much lower correlations (around .15). According to Russo et al. (1993), these latter scores may have been negatively affected by environmental factors such as large testing

groups since the former subsample, in contrast with the latter, were tested in smaller groups with closer supervision.

Scores for the SSSC correlate positively with age and intellectual ability; males typically have higher scores than females; and Caucasian subjects usually score higher than African-American subjects (Russo et al., 1993). Similar results have been found in studies of late adolescents and young adults and also in adult samples using the adult version of the measure (SSS; Zuckerman, 1979, 1983; Zuckerman & Neeb, 1980; Farley, 1977; Kurtz & Zuckerman, 1978).

The Roberts Apperception Test for Children (RATC; McArthur & Roberts, 1982) is a projective storytelling task designed for children and adolescents ages 6 to 15 years. Respondents are shown a series of 16 stimulus cards, each with one to four child or adult figures involved in some activity or interpersonal situation (see Appendix B for a brief summary of what scenes are depicted on each of the individual cards). The respondent is asked to create a story for each card, making sure that they tell a story that describes what is happening in the picture, what led up to the scene, and how the situation ends. They are also

instructed to describe what the characters are talking about, thinking, feeling, and doing in the picture. Respondents stories are assumed to reflect unconscious drives, thoughts, conflicts, fears, and motivations.

Although a respondent's RATC stories are usually rated by McArthur's and Roberts' (1982) standardized scoring system, the stories generated in this study by adolescents were analyzed and scored using the Shame Rating Scale (SRS; Loraas, 1994; see Appendix C) which was developed specifically for this study to assess "unconscious shame." The SRS was created to evaluate how frequently the emotion of shame was used to describe the thoughts, feelings, concerns, or reactions of characters in RATC stories. Content for the criteria used on the SRS was based on modification of the 24-shame items on the ISS (Cook, 1989) as well as references to shame-based thoughts and feelings in the clinical research literature (Kaufman, 1989, 1992; Lewis, 1971, 1987).

The Suicidal Behavior History Form (SBHF; Reynolds & Mazza, 1992) is a brief, semistructured interview that provides a systematic way to gain information and documentation about a person's past history of suicidal behavior. This includes information about the situation and nature of prior suicide attempts. The interview inquires

about method, severity, lethality, intent, and other aspects of the attempt suggesting the seriousness of the behavior. Information garnered from the SBHF interview were rated in this study using the Lethality of Suicide Attempts Ratings Scale (LSARS; Smith, Conroy, & Ehler, 1984). The LSARS is an 11-point linear interval scale ranging from "0," "death is an impossible outcome or result," to "10," "death is an almost certainty." High lethality ratings include hanging oneself from a tree (person survived because tree branch broke) or jumping in front of a car (person survived because the automobile swerved or stopped). Low lethality ratings would include taking 10 aspirin or superficially cutting one's wrists, followed by immediate first-aid or notification to another person. The LSARS is considered a reliable measure, and has demonstrated very strong interrater reliabilities ranging from .94 to .98.

Procedures

Adolescent and parent/caregiver data collection occurred between March 1995 and June 1996 at a child and adolescent psychiatric hospital in the Midwest United States. At the time of admission parents/caregivers signed a consent form (see Appendix D) describing the present study

and outlining how parental and adolescent intake information, questionnaire responses, and other test data would be used in the research. Parents or caregivers completed the Functional Impairment Scale for Children and Adolescents (FISCA; Frank & Paul, 1995) as part of the standardized admission procedures.

A third-year, female graduate student in Clinical Psychology who was blind both to the purpose and hypotheses of the study served as the psychometrician and primary research assistant. Her duties were varied. They included 1) reviewing the adolescent's chart and psychiatric examination report in order to ensure the presence of a depressive-spectrum disorder (e.g., Major Depression, Dysthymic Disorder; Depressive Disorder, NOS); 2) initially meeting with the adolescent on the hospital unit to briefly explain the purpose of the study; and 3) administering the research test protocol.

Adolescent participants completed the various questionnaires and other research assessment measures within 2 to 4 days from their date of admission. After reviewing relevant chart information the psychometrician introduced herself to the adolescent patient, briefly explained the research study, and ascertained whether the teen would be willing to participate. The adolescent was informed that

testing would take between 45 and 50 minutes, that their participation was not mandatory, and that they would not receive any negative consequences if they preferred not to complete the testing battery. Only 8 teenagers (6 males and 2 females) declined to participate.

If the adolescent agreed to participate, he or she was escorted to a private testing office by the psychometrician. Once an adequate working rapport was established the psychometrician presented the teenager with the Adolescent Assent form (see Appendix E). The teenager was encouraged to read the Assent form carefully, to ask questions, and to sign it when they were ready to begin.

During their testing session with the psychometrician, adolescent subjects completed the Internalized Shame Scale (ISS; Cook, 1993) and the Sensation Seeking Scale for Children (SSSC; Russo, 1991). All adolescent subjects were administered the Roberts Apperception Test for Children (RATC; McArthur & Roberts, 1982), and their verbal responses were transcribed by the psychometrician in accordance with the test's standardized administration procedures. Those teens who attempted suicide prior to their hospital admission (n = 40; 44.9 percent of the sample) also completed the Suicidal Behavior History Form (SBHF; Reynolds & Mazza, 1992). All measures were administered in the same

order for the entire adolescent sample so that participants would never have to begin the testing session with the projective storytelling task.

The two remaining questionnaires--Reynolds Adolescent Depression Scale (RADS; Reynolds, 1987) and the Suicidal Ideation Questionnaire (SIQ; Reynolds, 1987)--were administered to adolescent participants within 24 to 36 hours of their admission. These measures routinely were administered to adolescent patients as part of a screening assessment used by the hospital for clinical purposes. During the course of this study, all RADS and SIQ data were collected by closely supervised MSU psychology, undergraduate research assistants completing externships at the hospital.

In the Summer of 1996, two MSU doctoral students in Clinical Psychology (one male and one female), both of whom were blind to this study's purpose and hypotheses, were trained to use the Shame Rating Scale (SRS; Loraas, 1994) as well as the Lethality of Suicide Attempt Rating Scale (LSARS; Smith, Conroy, & Ehler, 1984). The two graduate raters were initially trained to score the RATC protocols on a sample of twenty adolescents (ages 13 to 15 years) who were not a part of the present sample. During the training process, the statistic used to ascertain interrater

reliability was the percentage-agreement statistic. This coefficient is determined by the following formula: Number of times raters agree/Number of times raters disagree and agree. Raters continued to train until reliabilities were between .75 and .80. In addition, interrater reliabilities were obtained on every seventh to ninth protocol using the study sample in order to avoid rater-drift. During the scoring process, interrater reliabilities never fell below .70.

VII. RESULTS

Measurement Issues

Levels of unconscious shame were obtained by using the Shame Rating Scale (Loraas, 1994) to score the adolescents' projective story protocols. Unfortunately, 12 participants (8 females, 4 males) were discharged before projective testing could be undertaken. In addition, 3 male participants refused or declined the projective test, while the data of 3 other male participants and 1 female participant were not used because they were incomplete. In all, a total of 70 protocols were used in the data analyses. Reliability analyses using all 16 cards of the

Roberts Apperception Test for Children (RATC) produced an alpha of .55. Five cards (Cards 1, 3, 4, 6, and 13) were eliminated in order to increase internal consistency; alpha for the remaining eleven cards was .64. The interrater correlations for the two graduate student raters on each of the RATC cards are shown in Table 3, while the overall interrater correlation was .85. Interrater agreement for the Lethality of Suicide Attempt Rating Scale (LSARS) was .88.

Demographic Variables

Table 4 shows the internal reliability coefficients (alphas) indicative of the internal consistency reliabilities for the measures used to assess depressive symptoms, suicidal ideation, conscious shame, and sensation-seeking attitudes, and Table 5 shows the correlations among all of the variables used in the study. None of these variables correlated significantly with father education, father occupation, mother education, mother occupation, or family income.

Males and females differed significantly in their experiences of depression and shame. Raw scores on the RADS for females ($\underline{m}$ = 80.7) were significantly higher than scores for males ($\underline{m}$ = 73.9; $\underline{t}$ (80) = 6.84, $p < .05$). Similarly, on

Table 3

Interrater Agreement for Unconscious Shame Scores for the 11 Roberts Cards

RATC Card Number	Pearson r
2	.63
5	.79
7	.78
8	.62
9	.61
10	.68
11	.83
12	.74
14	.61
15	.84
16	.88

Table 4

Adolescent Measures and Internal Reliability Coefficients for the Questionnaire Measures

Measure	Alpha
1) Reynolds Adolescent Depression Scale (RADS)	.92
2) Suicidal Ideation Questionnaire (SIQ)	.97
Suicidal Ideation Questionnaire-Junior (SIQ-JR)	.93
3) Internalized Shame Scale (ISS) (based upon the 24 shame items only)	.96
4) Sensation-Seeking Scale for Children (SSSC)	
A) Thrill and Adventure Seeking (TAS) scale	.82

Table 5

Correlation Coefficients among the Variables Used to Test the Research Hypotheses

VARIABLE	1	2	3	4	5	6	7	8
1) Unconscious Shame	---							
2) Conscious Shame	.27* (n=70)	---						
3) Depression	.27* (n=66)	.64*** (n=82)	---					
4) Suicidal Ideation	.20 (n=63)	.57*** (n=79)	.56*** (n=79)	---				
5) Suicide Lethality	-.13 (n=29)	.08 (n=40)	-.08 (n=37)	.17 (n=35)	---			
6) Internalization	.08 (n=54)	.19 (n=69)	.25* (n=65)	.42*** (n=62)	.06 (n=29)	---		
7) Externalization	-.03 (n=54)	-.17 (n=69)	-.25* (n=65)	-.09 (n=62)	.10 (n=29)	.08 (n=69)	---	
8) Thrill Seeking (TAS)	-.10 (n=70)	-.09 (n=89)	-.05 (n=82)	.00 (n=79)	.30 (n=40)	-.04 (n=69)	.16 (n=69)	---

* p < .05
** p < .01
*** p < .001

the ISS, the mean raw shame score for females was 46.1 whereas the mean raw shame score for males was 35.2 (t (87) = 10.97, p < .05). Sex was not related to any of the other variables used in the analyses.

Tests of the Major Hypotheses

Regression analyses were used to test the hypotheses. Because gender differences in depression emerge in early-to-middle adolescence (Ingersoll & Goldstein, 1995), I controlled for sex in each of the regression analyses, and also tested all possible sex by predictor variable interactions.

The first set of regression analyses testing Hypothesis 1A assessed whether adolescents with highly externalizing coping styles would report **less** depression and conscious shame, and whether those with highly internalizing coping styles would report **more** depression and conscious shame. The results only partly supported the hypothesis. In particular, there was a two-way interaction between sex and externalization. As expected, highly externalizing females reported less depression ($r = -.38$, $p < .05$) and less conscious shame ($r = -.35$, $p < .05$). However, highly externalizing males reported high levels of conscious shame ($r = .32$, $p < .05$). Male scores for externalizing coping

style were unrelated to reports of depressed mood (r = .Ø6). None of the predicted relationships between internalizing coping style and depression or shame were supported, either for the total sample or for males and females, alone, even though the variables correlated positively which was the predicted direction (see Table 6).

Hypothesis 1B postulated that externalizing behaviors would be highest among adolescents experiencing high levels of unconscious shame and underlying low levels of conscious shame, and would be lowest among adolescents experiencing both high levels of unconscious shame and conscious shame. In examining this hypothesis, I tested the 2-way interaction between conscious shame and unconscious shame (computed as a cross-product). Additional procedures tested the 3-way interaction as well as all possible 2-way interactions with sex (following tests of the main effects, interactions at each level were assessed in a step-wise fashion).

The 3-way interaction was not statistically significant. However, in addition to the significant 2-way interaction between sex and conscious shame already described (i.e., conscious shame correlated negatively with externalization for females and positively for males), there was a significant 2-way interaction between conscious shame and unconscious shame (beta = -.36, $p < .Ø5$). Taken

Table 6

Hypothesis 1A: Correlations between Coping Mechanisms and Depressed Mood and Conscious Shame Scores

Measure	All Subjects		Males		Females	
	EXT	INT	EXT	INT	EXT	INT
Depression	-.24* (n = 65)	.25*	.06 (n = 26)	.15	-.38* (n = 39)	.26
Conscious Shame	-.17 (n = 69)	.19	.32* (n = 28)	.20	-.35* (n = 41)	.10

NOTE: A) * = $p < .05$

B) "EXT" = "Externalizing"

C) "INT" = "Internalizing"

together, the two-way interactions accounted for 20 percent of the variance in parental reports of adolescent externalization. The nature of the interaction between unconscious shame and conscious shame is shown in Figure 1. As expected, adolescents experiencing high unconscious shame and low conscious shame were most externalizing, while those participants with high unconscious shame and high conscious shame were the least externalizing.

Hypothesis 2 postulated that internalizing coping styles would be positively related to suicidal ideation among adolescents with high levels of conscious shame, and unrelated to suicidal ideation among adolescents with low levels of conscious shame. Once again, the 3-way interaction was not statistically significant, nor was the predicted interaction between internalization and conscious shame. However, a 2-way interaction was found between sex and conscious shame (beta = -.26, $p < .05$). This unpredicted interaction is shown in Figure 2. As can be seen, conscious shame is more strongly (and positively) related to suicidal ideation among females than among males.

Hypothesis 3 stated that risk-taking attitudes (as measured by the Thrill and Adventure Seeking scale) would be strongest among adolescents possessing a highly externalizing coping style, experiencing high levels of

Figure 1

Hypothesis 1B: Interaction between Unconscious Shame and Conscious Shame

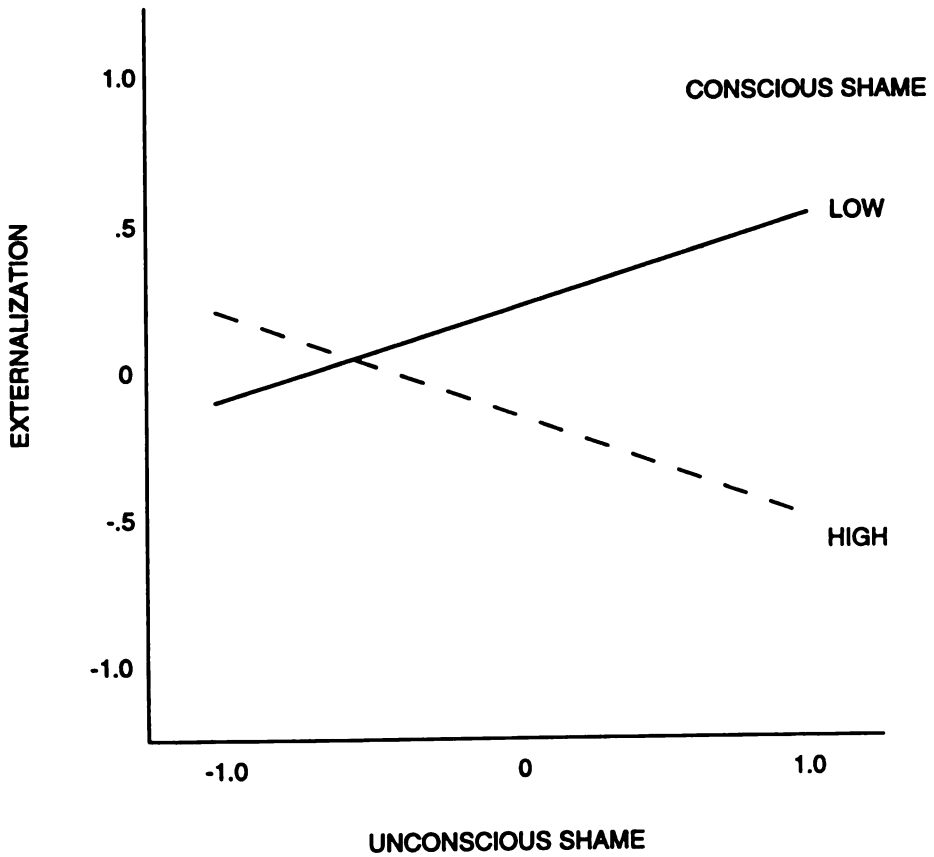
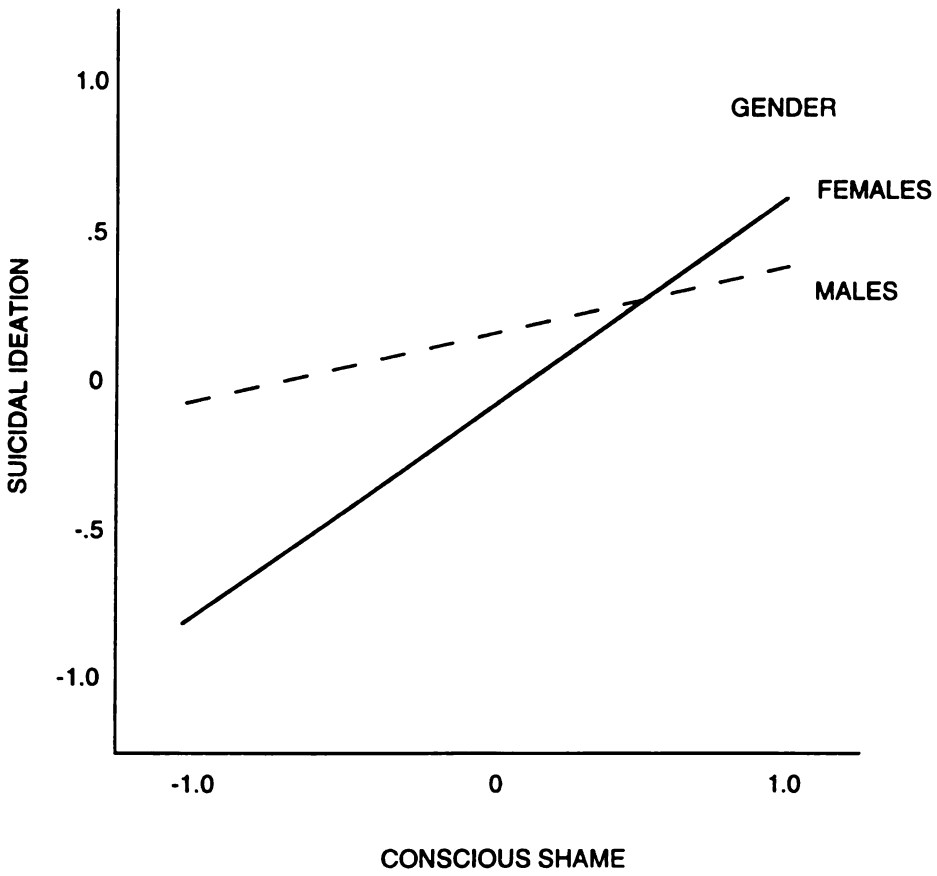


Figure 2

Hypothesis 2: Interaction of Conscious Shame and Sex



unconscious shame, and reporting little conscious shame. This prediction was not supported. In fact, none of the main effects nor any of the interactions were statistically significant.

Finally, Hypothesis 4 postulated that the lethality of a participant's suicide attempt would be greatest among adolescents possessing highly externalizing coping styles and experiencing high levels of unconscious shame combined with high levels of conscious shame. The rationale for this hypothesis was that externalizing adolescents would make more lethal suicide attempts when unconscious shame "broke through" into conscious awareness. Unfortunately, it was not possible to test this hypothesis. Although 40 of the 89 adolescents (45 percent) in the total sample made suicide attempts prior to their hospitalization, these attempts were overwhelmingly low in lethality. First, FISCA data were available on only 21 of the 40 suicide attempters, so it was not possible to consider an interaction with externalization. Secondly, as can be seen in Table 7, only 2 of 40 teens (5 percent) who made an attempt undertook an action that could potentially have resulted in death. Exploratory regression analyses predicting a dichotomous variable (the teen did/did not make a suicide attempt) were

Table 7

Lethality Ratings of Suicide Attempts (n = 40)

Degree of Lethality	Number in Sample	Percentage
Death An Impossible Outcome	17	42.5
Death Very Highly Improbable	9	22.5
Death Improbable	5	12.5
Death Not Likely So Long As First-Aid Is Obtained	6	15.0
Death is a 50/50 Chance Either Directly or Indirectly	1	2.5
Death is Probable Unless There Is Immediate and Vigorous First-Aid	1	2.5
Death Is Likely Since No Attempt Made at Communication or Since Suicidal Act Done in Private	1	2.5
Death Highly Probable, Except for "Chance" Intervention	0	0.0
Death Is Almost Certainity, Regardless of Interventions Or Circumstances	0	0.0

carried out on the data for unconscious shame and for sex; none of the main effects nor any of the interactions were statistically significant as well.

VIII. DISCUSSION

Summary

The results of this study demonstrate moderately strong and positive correlations among depressive symptoms, suicidal ideation, and conscious shame experiences in adolescent inpatients. These associations, which have been reported by other investigators as well (Reynolds, 1987a, 1987b; Cook, 1994), were expected, and suggest that depression, suicidal ideation, and conscious shame, although separate psychological constructs, might be conceptualized as occupying overlapping regions in a larger universe of emotional distress. Given this backdrop, the current study is unique in its effort to assess unconscious shame as a variable that might contribute to an adolescent's experience and/or expression of psychological turmoil. Weaker correlations between unconscious shame on the one hand and conscious shame, depression, and suicidal ideation on the other hand suggest that shame which is relatively

inaccessible to the adolescent but able to be observed and measured via responses to a projective test defines a separate dimension with its own unique properties.

The present study sought to examine the relationships of both conscious shame and unconscious shame to adolescents' experiences of depression and their ways of coping with emotional distress. In order to clarify these processes, each of the major research hypotheses set forth in this study will be reviewed and discussed. Although the data presented only provide partial support for the research hypotheses, they nevertheless suggest that the interface between unconscious shame and conscious shame is important in understanding the links between adolescent depression and externalizing behaviors.

First, Hypothesis 1A maintained that externalizing coping styles (as judged by parental report) would be associated with lower levels of self-reported depression and conscious shame among adolescents, whereas internalizing coping styles (also as judged by parental report) would be associated with higher levels of self-reported depression and conscious shame among the adolescents. Alternatively, when parents indicated that their adolescents were showing overt signs of emotional distress (i.e., they described their teenager as internalizing), the adolescent themselves

should be able to acknowledge these experiences. Partial support for this hypothesis was found. As expected, parent report of internalization for both males and females correlated with adolescents' reports of depressed mood, but the relationship between internalization and conscious shame was not statistically significant. In addition, for females, externalization correlated in the predicted (negative) direction with both depression and conscious shame. However, different relationships were found for males. In particular, males described by parents as externalizing reported more (rather than less) conscious shame and were no more or less likely to describe themselves as depressed. In sum, the relationships between externalizing behaviors and conscious shame are divergent for males and females, and thus may be driven by different underlying mechanisms.

For girls (who psychiatrists had diagnosed as depressed but who did not themselves acknowledge negative emotional experiences), it seems plausible that highly externalizing behaviors "masked" or obscured feelings of conscious shame. Conceivably, these girls may have used acting-out and disruptive behaviors such as anger outbursts, mood lability, school truancy, argumentativeness, running away, and fighting to defensively avoid painful, affective

experiences. Alternatively, it may not be necessary to assume any underlying motivation in that externalizing coping styles (which generally are less typical of girls than boys) simply may have made these "internal" experiences relatively inaccessible to these girls. However, the notion that externalizing styles of coping by definition make negative affect less accessible is inconsistent with the findings for boys in that externalization and conscious shame to some extent went hand-in-hand.

The findings for Hypothesis 1A rule out the usefulness of the concept of masked or concealed shame for males, although the underlying reasons for sex differences in the associations between conscious shame and externalization for males and females cannot be explained by these data. In any event, it is possible that inpatient male adolescents rated by their parents as externalizing have frequently experienced scoldings, deprecation, depreciation, or scorn from adults who found attempts to set limits on these boys to be chronically unsuccessful. Hence, these males may have been all too familiar with shame-inducing experiences, and had an easier time "recognizing" or identifying shame-related feelings in themselves ("I feel as if I am somehow defective as a person, like there is something basically wrong with me"). Nevertheless, this tentative formulation

works only for boys. Why externalizing girls report low conscious shame when the opposite is true for boys remains unanswered.

In contrast to Hypothesis 1A in which externalization was viewed as a predictor variable, tests of Hypothesis 1B conceptualized externalization as an outcome variable. In particular, analyses of Hypothesis 1B showed, as expected, that when adolescents experienced high levels of conscious shame accompanied by high levels of unconscious shame, they were relatively unlikely to exhibit externalizing behaviors. In contrast, when adolescents experienced low levels of conscious shame but high levels of unconscious shame, they were, in fact, likely to exhibit externalizing behaviors.

One explanation for low externalization among adolescents with high unconscious shame and high conscious shame is that the adolescent may be attempting to work through at an intra-psychic level experiences of shame in conscious mentation. This might explain why conscious shame alone for males was positively related to externalization (as shown by the test of Hypothesis 1A), but why conscious shame and unconscious shame were linked to less externalization. Alternatively, a second, more simple explanation in this regard might be that among adolescents

reporting high levels of conscious shame, stories indicating the presence of high unconscious shame on a projective test merely reflect what is on the adolescent's mind.

The finding of high externalization among adolescents with high unconscious shame and low conscious shame is consistent with what was argued in the literature review. Presumably, depressed, externalizing adolescents who report little conscious shame may be more inclined to cope with negative emotional experiences, including shame, through denial and acting-out behaviors aimed at neutralizing untenable feelings of powerlessness and vulnerability. In such cases, it seems plausible that acting-out and disruptive behaviors may have served to ward off the irritating and threatening feelings associated self-deprecating fantasies not available in conscious awareness. Yet, it is impossible to say for certain from this data whether it is more appropriate to make an analytic interpretation suggesting that externalizing behavior is a defense allowing for the repression of shame-based feelings or to give a cognitive explanation that emphasizes that these teens lacked the cognitive skills necessary to articulate their feelings and were left to express them behaviorally through undercontrolled actions.

In the larger picture, these findings may have important implications for therapeutic interventions with adolescent inpatients. They suggest that therapists, after a careful assessment of the presenting problems, might consider trying to "access" and bring into conscious awareness the shame-based thoughts and feelings of their depressed, acting-out adolescents. The treating professional working from such a treatment plan obviously would need to closely monitor the teenager's level of distress and ability to cope with such powerful emotions; in particular, the therapist would need to exercise considerable caution so as to avoid "pushing" the adolescent beyond the point where coping attempts would be unsuccessful.

In this study, high levels of conscious shame were associated with high levels of suicidal ideation. Fortunately, because the hospital environment is structured and staff are prepared to deal with individuals in acute emotional distress, it may provide the externalizing adolescent with highly supportive and safe surroundings in which to address potentially disrupting shame-based thoughts and feelings. Relatedly, Hypothesis 2 was formulated to test whether internalizing coping was positively related to suicidal ideation among adolescents reporting high levels of conscious shame and unrelated to suicidal ideation among

those reporting low levels of conscious shame. Although no evidence was found to support Hypothesis 2 as postulated, there was an unexpected interaction between conscious shame and gender in predicting suicidal ideation. Because very few teens in the sample (40 of 89 adolescents) actually made a suicide attempt prior to admission and because most of these were predominantly very low in lethality, it is interesting to consider what might have been the motivations for such actions. Although it is impossible to know for certain the factors that drive a teenager to consider suicide, one possible explanation for the numerous low lethality attempts in this study could be that such actions served, in large part, an "attention-seeking" function (Curran, 1987). If so, the suicidal actions of the teens in this sample may have been driven to some extent by life, situational, or relationship circumstances with which the teen felt unable to cope, and may have functioned to publicize to significant others the adolescent's experience of despair, hopelessness, depression, or conscious shame.

With regard to Hypothesis 3, there was no evidence to support that risk-taking behaviors were related to high levels of externalization, high unconscious shame, and low conscious shame as well as to the interactions among these variables. In addition, Hypothesis 4 (i.e. that lethality

of suicide attempts would be most severe among teens with high levels of externalization, high unconscious shame, and high conscious shame) could not be tested. However, given the failure to find support for Hypothesis 3, it is likely that the prediction laid out in Hypothesis 4 would not have been supported as well. Nevertheless, it is important to remember that risk-taking is not equivalent to lethal suicide attempts, and that the data to test Hypothesis 4 were inadequate since few teens actually undertook highly lethal suicide attempts. To test this hypothesis in the future, it would be necessary to collect data on a very large sample of adolescent inpatients in order to ensure that there would be an adequate number of teens who had, in fact, made potentially lethal suicide attempts.

Limitations of The Current Study

Obviously it is necessary to take this study's limitations into account in considering the various results. First, there are questions about generalizability. This study only examined depressed adolescents between 13 and 15 years of age. Because adolescence is a developmental period falling between 10 and 13 years at the point of entry and between 19 and 21 years

at the point of exit (Sisson, Hersen, & Van Hasselt, 1987), future investigations might want to consider older samples of teens such as 15 to 17 year olds or 18 to 21 year olds. Conceivably, shame-based thoughts and feelings are relatively mature affective and cognitive experiences. Older teens might be more cognizant of and be better able to report these feelings. Hence, in a young sample such as this, it is possible that the measure of conscious shame was confounded with level of cognitive development.

Secondly, due to sample-size constraints, it was impossible to assess the implications of shame for lethality of suicide attempts. This is an important omission since suicide remains a very serious national health problem among our nation's youth (Hollis, 1996; Ingersoll & Goldstein, 1995). There is clearly much value in examining this question in future clinical studies.

Third, the sample in this study was predominantly Caucasian, and thus it is difficult to confidently generalize the study's research findings to teens of other racial groups (e.g., African-American; Hispanic-Americans). Fourth, this study neither addressed nor controlled for issues linked to differential diagnoses or comorbidity. Future investigations might want to examine the multitude of questions that are related to shame and coping style among

depressed teens who, for example, suffer anxiety disorders as compared to those who show comorbidity with Attention-deficit Hyperactivity Disorder (ADHD) or Oppositional Defiant Disorder.

Fifth, this study did not utilize a nonclinical sample of teenagers whose data then could have been compared to the inpatient depressed adolescents. Such data would have been useful for gaining a better understanding about conscious and unconscious shame in general during the adolescent years. Finally, this study was somewhat limited by the lack of well-standardized and validated measures for tapping into unconscious shame. The Shame Rating Scale (SRS; Loraas, 1994) which was designed specifically for this study was useful, but the level of reliability between the two independent raters, though adequate, was somewhat disappointing. This circumstance may have been partially due to the SRS' 19 separate shame-theme categories which could have made the scale somewhat cumbersome. Future studies with the SRS might want to consider reducing its 19 shame-theme categories to four or five broad-band categories under which similar, individual shame themes could be grouped.

The Importance of The Current Study

Despite its limitations, this study was nonetheless important for several reasons. Adolescence is a very unique developmental stage that is characterized by rapid changes in the physical, social, and cognitive realms (Eccles et al., 1993). Although such changes "have an important impact on adolescents' behavior and also interact with physical development in predicting adjustment" (Alsaker, 1996, p. 249), the rapidity of changes leaves most teenagers quite susceptible to shame-based experiences (Kaufman, 1992). Hence, a valuable feature of this study is that it utilized a relatively large sample of hospitalized teenagers from whom self-report data on shame experiences was gathered. In addition, the painful affective experience of shame has long been considered the neglected emotion of clinical psychology and psychiatry (Nathanson, 1992). Although researchers began studying shame about three decades ago (Lewis, 1971), the general focus has been on the effect of this emotion on psychological and interpersonal functioning (Kaufman, 1992; Sidoli, 1988). The present study is unique because of its focus on individuals at earlier points in the life-cycle: adolescents between the ages of 13 and 15 years.

Finally, what may be this study's most valuable aspect is that it tried to assess and take into consideration the

role of unconscious shame experiences. Because this focus was new, it was necessary to develop a measurement tool to tap this variable. Hence, the uniqueness of the measure and the possibility of using it as a tool for assessing unconscious shame in future studies is an important strength of this research. Moreover, evidence for the predicted interaction between unconscious shame and conscious shame in the present study underscores the importance of assessing both accessible and nonaccessible experiences. Such measures, like the one developed here, provide an empirical way of investigating "masked" emotional experiences which heretofore have been considered not only highly controversial (Kazdin, 1989; Carlson, 1981), but also inaccessible to the empirical investigator.

APPENDIX A

APPENDIX A

FISCA IMPAIRMENT CRITERIA: Some Examples

1) School: (Severe Impairment) Child not attending school because of school refusal, school phobia, or school expulsion. Child seriously harmed a teacher or peer or put others at risk by bringing a weapon to school. Failing all classes.

(Moderate Impairment) Child frequently skipped or refused to go to school. Poor academic performance. Chronic non-compliance at school.

(Mild Impairment) Child occasionally skips or is truant from school. Minor rule violations.

2) Home: (Severe Impairment) Child has runaway two or more times without parental knowledge of their whereabouts. Behavior highly unmanageable.

(Moderate Impairment) Child has runaway only one time and whereabouts of child were known by parents.

(Mild Impairment) Child frequently refuses to do chores; intermittently defiant.

3) Community: (Severe Impairment) Set fires with malicious intent. Severely delinquent or criminal behavior involving confrontation of a victim or serious lawbreaking.

(Moderate Impairment) Serious lawbreaking but no confrontation of a victim. On probation. Play with fire.

(Mild Impairment) Occasional and minor violations of the law.

APPENDIX A

4) Thinking: (Severe Impairment) Child cannot be in a normal classroom AND does not have normal friendships OR cannot interact adequately in the community due to poor reality testing, confusion, or bizarre communications.

(Moderate Impairment) Thinking or behavior more bizarre or impaired than other same age children AND child requires special school program or special supervision because of reality testing impairment, poor control over mentation, or periods of confusion.

(Mild Impairment) Thinking or behavior more bizarre or impaired than other same age children because of intermittent obsessions, occasional lapses in reality testing, or occasional confusion.

5) Aggression: (Severe Impairment) Child has no friends because behavior is chronically hostile. Is cruel to animals. Threatened or used a weapon against others. Sexually abused or molested someone.

(Moderate Impairment) Persistent difficulty in being liked. Sometimes cruel to animals. Markedly poor impulse or anger control.

(Mild Impairment) Trouble interacting with peers. Sometimes harasses others or is mean-spirited.

6) Moods & Emotions: (Severe Impairment) Mood problems accompanied by suicidal intent. Extreme dysregulation. Depression or anxiety associated with academic incapacitation or social isolation or withdrawal.

APPENDIX A

(Moderate Impairment) Severe separation-anxiety. Persistent depression or anxiety with somatic complaints, poor concentration, or sleep difficulties.

(Mild Impairment) Periodic mood fluctuations or anxiety. Periods of intense sadness. Overly self-critical.

7) Self-Harm: (Severe Impairment) Child attempted to hurt or kill self in a way likely to cause serious injury or death.

(Moderate Impairment) Child attempted to kill or hurt self in a way suggesting serious self-harm tendencies. Includes non-life threatening but non--trivial gestures and self-mutilation.

(Mild Impairment) Repeated non-accidental behavior suggesting self-harm tendencies, but unlikely to cause serious injury.

8) Alcohol & Drug Use: (Severe Impairment) Frequently intoxicated or high (at least two times per week). Use of alcohol or drugs has resulted in severe impairment in role functioning (at school, at home, in the community) or injury (e.g., car accident).

(Moderate Impairment) High or intoxicated once a week. Use has led to negative social consequences (e.g., conflicts at home or with friends) or situations where the child or others are put at risk.

(Mild Impairment) Regular use (at least once a week), but without intoxication or getting high. Occasional intoxication without any serious consequences.

APPENDIX B

APPENDIX B

Major Themes of Stimulus Cards from the Roberts Apperception Test for Children

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NOTE: The B/G distinction following certain cards denotes that the child-figures depicted in the picture are either male or female. Male respondents are administered the "B" cards, whereas female respondents are administered the "G" cards.

CARD 1B/G: Family Confrontation: Depicts a father-figure, a mother-figure, and a child all of whom appear to be in a serious discussion.

CARD 2B/G: Maternal Support: Depicts a mother-figure and child on their knees hugging each other.

CARD 3B/G: School Attitude: Depicts a child sitting at a desk with paper and books and staring.

CARD 4: Child Support/Aggression: Depicts two girls. One is standing, the other is laying on the ground with eyes closed.

CARD 5B/G: Parental Affection: Depicts a mother-figure and a father-figure in a loving embrace while the child is standing near them and observing their interaction.

CARD 6B/G: Peer/Racial Interaction: Depicts three children standing and talking. Two of the children are Caucasian, and one child is African-American.

CARD 7B/G: Dependency/Anxiety: Depicts a child sitting up in bed.

APPENDIX B

CARD 8: Family Conference: Depicts a father-figure, a mother-figure, a male child, and a female child standing. They appear to be having a discussion.

CARD 9: Physical Aggression: Depicts two boys. One boy is standing with his fists clenched. The other boy is sitting on the ground and looking up at the other child.

CARD 10B/G: Sibling Rivalry: Depicts a mother-figure holding an infant while an older child is standing near them and observing.

CARD 11: Fear: Depicts a female child with arms raised in front of her, leaning backwards and appearing frightened.

CARD 12B/G: Parental Conflict/Depression: Depicts a child looking over the top of a chair and watching her parents. The mother-figure appears sad and is holding onto the wall from a sitting or kneeling position. The father-figure is standing near the mother-figure and appears concerned.

CARD 13B/G: Aggression Release: Depicts a child holding a chair in the air. The child appears to be getting ready to slam the chair against the floor.

CARD 14B/G: Maternal Limit Setting: Depicts a child making handprints on the wall after getting into a can of paint. The mother-figure appears to be turning the corner and sees what the child has been doing.

CARD 15: Nudity/Sexuality: Depicts a boy looking through a bathroom door and observing an adult female taking a bath.

CARD 16B/G: Parental Support: Depicts a child standing near and looking at a father-figure who is sitting in a chair and reviewing a paper or letter.

APPENDIX C

APPENDIX C

NAME: _____ SUBJECT NUMBER: _____

SHAME RATINGS SCALE (SRS)

DIRECTIONS: The SRS is designed to evaluate how frequently the emotion of shame is used to describe the thoughts, feelings, concerns, or reactions of characters in stories generated to the stimulus cards of Roberts Apperception Test for Children (RATC). Each SRS rater should be familiar with the following story themes or contents in order to determine whether RATC stories are positive for shame-related references. The rater should read each RATC story, examine the SRS list, and place the number(s) of the theme or content statements in the space provided for each of the sixteen cards on the SRS Frequency Sheet.

Shame Themes, Contents, and Conflicts

Characters are described as:

1) Looking or feeling embarrassed or ashamed.

2) Appearing extremely angry or out-of-control.

3) Failing to live up to their own or others' expectations.

4) Being criticized, ridiculed, looked down upon, exposed, or denigrated by others.

5) Being or feeling left-out, rejected, or scorned by others.

6) Being self-critical or self-deprecating (scolding themselves or putting themselves down).

7) Self-conscious and worrying about and concerned with others' reactions or thoughts.

8) Feeling isolated and lonely or believing that they do not fit in with others.

9) Feeling angry or disgusted with themselves, or being the object of others' anger, disgust, or disapproval.

APPENDIX C

10) Possessing low self-worth or feeling "stupid," inadequate, or full of self-doubt.

11) Thinking of themselves (or being perceived by others) as small, unimportant, or insignificant.

12) Defective, worthless, or ineffective.

13) Totally confused or overwhelmed by emotion(s) or a situation that causes them to flee in panic or despair.

14) Striving for perfection, attempting to do more than what is realistically possible.

15) Falling short of their goals, unable to attain what they expected.

16) Helpless, powerless, vulnerable, or weak.

17) Worrying that others' will find out that they did something wrong, immoral, or "bad."

18) Experiencing a sense of emptiness or lack of fulfillment from interpersonal relationships.

19) Having disappointed themselves or others.

APPENDIX D

APPENDIX D

ADOLESCENT DEPRESSION STUDY: Informed Consent Agreement

1) I, _____, parent and/or legal guardian of _____, a minor, am freely consenting to allow my child to take part in a scientific, Ph.D. dissertation research project being conducted at Rivendell by Mr. John Loraas, M.A., and under the supervision of Susan J. Frank, Ph.D., Associate Professor of Psychology, Michigan State University, East Lansing, MI.

2) I understand that this research project involves the study of depression in young adolescents, ages 13 to 15 years, and is examining the relationship between depression, coping styles, and destructive or maladaptive behaviors. In addition to the standard clinical assessment battery that is already given to each adolescent as part of the treatment planning process at Rivendell, I understand that my child also will be asked to complete a questionnaire about feelings of shame, a questionnaire about risk-taking behaviors, a projective storytelling task, and a short, clinical interview. I understand that my child's time commitment for completing these additional assessment measures will be approximately 40 to 50 minutes.

3) I understand that questionnaire data I complete during the standard admission and assessment process regarding my child's overall emotional and behavioral functioning may be used to help identify important and relevant aspects of my child's functioning for purposes of this research project. I also understand that my child's participation as well as my decision to allow my child to participate is voluntary. I understand that either my child or I may choose not to participate in this research project, may choose to participate only in certain procedures or to answer only certain questions, or may discontinue participation at any time without penalty. Moreover, I understand that my decision regarding participation will not affect the quality of care we will receive here at Rivendell.

4) I understand that my child's additional assessment information for this study, like the information collected during the standard clinical assessment process, may be used to assist in the development of my child's individual treatment plan while hospitalized at Rivendell. Moreover, I

APPENDIX D

understand that the results of this project will be treated in strict confidence and that both my child and I will remain anonymous in any scientific reports or discussions of the research findings.

5) I understand that both my child and I can request to discuss this research project with either Mr. John Loraas or Dr. Susan Frank, both of whom can be contacted through Rivendell. In addition, I understand that Ms. Michielle Poorman, M.A., Director of Clinical Services at Rivendell, is familiar with this study, and is also available to answer any questions that I have. I further understand that if either myself or my child would like any publication that might follow from this study, we can contact Mr. Loraas or Dr. Frank as well.

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Witness Date

Medical Records # _____

cc: John Loraas, M.A.

APPENDIX E

APPENDIX E

ADOLESCENT RESEARCH STUDY
Assent Agreement

John A. Loraas, M.A.
Michigan State University
Department of Psychology
East Lansing, MI 48824

Dear Teen:

As you may already know from talking with your doctor, your therapist, or other peers on your unit, all kids who stay at Rivendell fill out worksheets with questions about their thoughts, feelings, and behaviors. This information is very important, because it helps your doctor and therapist develop a treatment plan especially for you.

This short letter was written to let you know about a research project that is being done at Rivendell. Mr. John Loraas, who has worked in our Psychology Department for over four years and who is currently employed part-time, is interested in learning more about teenagers who have been feeling unhappy, sad, or "down-in-the-dumps." For his study, Mr. Loraas is asking teens who are 13, 14, and 15 years old to complete two worksheets, a storytelling task, and a short interview. Mr. Loraas expects that these activities will take about 40 to 50 minutes to complete.

Unlike the other worksheets and questionnaires that you are required to do as a patient at Rivendell, Mr. Loraas wants you to know that participation in his study is voluntary. If you wish, you can choose not to participate. Or you can start, and then decide to stop without a problem.

Again, Mr. Loraas works at Rivendell part-time. Although he may not be immediately available to talk with you, his research assistant, Ms. Sondra Wilen, who will be working with you today, knows a lot about this project and is able to answer any questions that you may have. If you would like to speak with Mr. Loraas, please tell Ms. Wilen who then can relay your message.

APPENDIX E

Mr. Loraas is really excited about this project, and he hopes that you will be willing to help him out.

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I have read the above information and voluntarily agree to participate in this study. I understand that the information I provide will be held in strict confidence. However, I realize: 1) that the information I provide maybe used to assist in the development of my individual treatment plan; and 2) that any scientific report or discussion that may arise from this study will keep my identity unknown.

_____ _____

Adolescent Date

_____ _____

Witness Date

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pg 22+23

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