Volume 1:

Thesis

Shame and Psychopathology in Adolescence

Robin Bennett

2004

UCL

Doctorate in Clinical Psychology

ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106-1346

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Abstract

Shame has been theorised to contribute to several areas of psychopathology that are particularly prominent in adolescence. However, it is an area that has received little attention in empirical research to date.

In order to explore the role of shame in the development of adolescent psychological problems, a cross-sectional study was conducted which involved one hundred and sixty teenagers from an Inner London school. Data regarding psychological problems, current shame-proneness, and perception of parenting were collected via questionnaires.

Adolescent psychological problems were shown to be associated with shame and no effect was found for age or gender. It was also found that shame, parental styles of overprotection and emotional unavailability, and psychological problems were all related in adolescence, similar to previous findings with adults, and that shame partially mediated the relationships of parenting styles and emotional problems. Furthermore, the independent effect of shame seemed to have a greater effect on psychological problems than did peer group difficulties, which may suggest that even through the 'rebellious' phase of adolescence, parenting style holds more importance psychologically, to the teenager, than peer relationships. The findings imply that feelings of shame may be a useful focus in therapy with teenagers and that preventative interventions aimed at altering parenting style could be implemented before the child reaches adolescence for a better effect.

Acknowledgements

I would firstly like to thank the staff and pupils that participated in this study, particularly Kathy Morgan for organising my visits to the school at such short notice.

I am extremely grateful to my research supervisor, Jane Gilmour, whose support, enthusiasm and expertise made a great difference to the progress of this thesis. Thank you for putting in so much time and effort at such a crucial stage. I would also like to acknowledge Cathy Cresswell for her advice during the initial design of the study, Pasco Fearon for his vast statistical ability, and Chris Barker for overseeing the course of this research.

I would like to thank my friends at UCL for all the advice, support, and discussions regarding research, particularly Judith Friedman for her invaluable help with the data collection. I would also like to thank Katherine Danton for the design of the database.

Finally, I would like to express my gratitude to Anna Caffrey for all her patience, suggestions, distractions, and meals, and to my parents for their continual support and assistance.

Chapter 1

Introduction

This thesis aims to explore the relationship between perception of parenting, particularly those of feeling shamed, and current psychological problems faced by adolescents. It also examines whether current shame proneness relates to recall of parental shaming and whether there are changes in shame proneness across the developmental period of adolescence. Several theories of shame and its development across the lifespan will be presented with attention given to the relevance of studying the emotion as it occurs during adolescence. Research concerning the role of shame as a factor in vulnerability to psychopathology will also be discussed.

1.1 What is Shame?

Shame is a powerful emotion that invokes the feeling that one's self is flawed. It is a painful, negative state that represents a global attack on the self – the statement "I am no good".

> Others can see the awful, ugly, or bad person that we are; and we wish not to be this person. If only we could sink through a hole in the floor and disappear, even from ourselves, then we would not have to face what seems to be the fact of who we are.
>
> from (Lindsay-Hartz, de Rivera, & Mascolo, 1995), p.295

The results of shame are confusion, lapse in ability to talk, and a disruption of the current activity (Lewis, 1971). This overwhelming feeling that is felt both physically and psychologically is coupled with a desire to conceal its existence, which can lead to the risk of further shame being experienced as a response to others noticing the presence of the initial emotion. It would be noticed through observation of physiological signs such as lowering the eyes or head; decreasing facial muscle tone; tilting the head; and losing strength or energy (e.g. Lindsay-Hartz et al., 1995; Nathanson, 1992).

Shame occurs from the interpretation of an event (as exposing the global failure of the self) rather than the event itself (Lewis, 1995). Even though individuals attempt to remove the intense effects of shame, it is difficult to achieve due to the nature of the emotion which implicates the whole self.

1.2 Theories of Shame

1.2.i *Differential Emotions theory*

Differential emotions theorists suggest that emotions are innate and universal, resulting from evolution (Izard & Malatesta, 1987). Their function includes providing motivation for behaviours and visual cues to aid communication, for example of the organism's intent.

Darwin (1872) considered that the physical display of emotions, primarily through facial expressions and physiological phenomena, is in response to the felt emotion.

For example, one of the physiological manifestations of shame that Darwin described was blushing, which he suggested is secondary to the subjective experience of shame. More recently, however, differential emotions theorists believe that the reverse is true. It is not the case that the felt emotion is present from birth, but rather that the innate ability is to produce the physical and physiological expressions of the emotion, which can then lead to the experience of the felt emotion. In other words, new-borns have the neural processes in place that produce the specific facial expressions needed to communicate effectively which then correspond to the relevant feelings later in life (Izard et al., 1987).

An influential theorist in the field of emotions was Tomkins who considered shame to be innate and have its own facial expression (Tomkins, 1963). Its purpose, along with the other affects (joy, fear, anger, distress, interest, contempt, disgust, and surprise) is to facilitate the survival of the organism or species. In this case, shame, described as an "auxiliary affect", occurs as a response to an interruption of pleasure or interest, and its purpose is to inhibit any further interest or enjoyment in the individual (Tomkins, 1987). By lowering the eyes, eyelids, or head, hunching the shoulders and seeming to 'collapse' the upper body, the individual disrupts the communication of visual information as eye contact is broken.

Continuing the work of Tomkins, Nathanson also regards shame as a modulator of positive affect (Nathanson, 1992). It is necessary to be experiencing another emotion on which shame can act so as to interfere with the emotion thus leading to the organism withdrawing from the desired activity. In this way shame disrupts the relationship between the organism and the external world. Nathanson argues that the sole original function of shame was to inhibit positive affects in an organism,

however, due to the evolution of 'higher centres of cognition', shame now influences other functions. Similarly, it is possible to see the presence of the physical signs of shame in infants despite the absence of a subjective experience of the emotion, which develops alongside the infant's cognitive ability.

Although it is accepted that shame does indeed inhibit the continuation of positive affect, the assertion that its role is purely to alert an individual to the disruption of positive affect and then to further disrupt this affect has been questioned. It has been explained that other emotions could lead to the disruption of positive affects, indeed most negative affects should inhibit positive affects to some degree, presuming that their role is to alert organisms to danger and to initiate defensive behaviours (Gilbert, 1989). An example of how an affect other than shame can inhibit positive emotional experiences could be the sudden, unexpected, and acute illness of a close friend who has joined you at an otherwise pleasurable party. In this scenario, the negative emotion inhibiting the positive affect is more likely to be sadness or fear than shame. Therefore, shame is more closely linked with a disruption of positive affect specifically associated with a negative evaluation of the self (Gilbert, 1998). For example, positive affect being inhibited at the party due to feeling that the 'ill' friend was persuaded to come to the party against their wishes. If the individual believed that they contributed to the friend's illness by demanding that they attend the party, and that this persuasiveness related to their character rather than specific behaviour, then it could be the individual's shame that is disrupting their positive affect.

The personal evaluation of the self in a social context, with which shame may be associated, could result from a rupture in an interpersonal bond that was based on trust and shared interest (Kaufman, 1989). The disruption of the bond and associated

positive affect leads to shame, which is described as the feeling of being exposed to oneself and others in accordance with the painful belief that the self is seen as demeaned. The resulting barriers to communication lead to a state of alienation that may increase the intense, negative evaluation of oneself which produce a paralysing state leading to distress and anger.

Other theorists have also suggested that an important component of shame is that, as well as occurring when pleasure is disrupted, an amplified amount of "self-conscious self-awareness" exists in which the individual perceives themselves as inadequate (Izard, 1984). However, this is within the definition of shame as being a purely innate phenomenon that emerges due to biological maturational shifts. Reimer (1996) argues that the subjective experience of shame develops as the cognitive abilities of the individual develop. She suggests that shame should be considered as a "complex cognitive-affective structure" rather than purely as an innate "fundamental emotion".

1.2.ii *Psychoanalytic theories*

The psychoanalytic theories of shame are more concerned with the unconscious causes of the emotion rather than the physical signs. Although it has been suggested that shame is present in every therapeutic encounter (Wurmser, 1981), little attention has been given to the matter until recently. This may have been due to Freud's structural model, which did not place shame as centrally as it did guilt. The model which proposes three components – the id, ego, and superego (see Bateman & Holmes, 1995), views guilt as the result of conflict between conscience (superego) and impulse (id) when the impulse becomes apparent to the ego (Barrett, 1995). Guilt

was linked most closely with aggressive impulses, whereas shame was seen as more connected to sexual impulses. However, it has been argued that some of the feelings of inferiority that Freud described as guilt, may more accurately be described as shame (Morrison, 1989).

Another concept introduced by Freud that has contributed greatly to later studies of shame is that of the "ego-ideal". This ideal involves values, representations of the internalised parent, and, crucially, the 'ideal self-representations'. In other words, the ego-ideal provides us with an image of ourselves as if we have met our high standards. It is this ego-ideal that is considered to be involved in shame (Piers & Singer, 1971), more specifically failures to live up to the expectations of the ideal. This idea was expanded by Higgins (1987) who explained that shame was in response to perceived discrepancies between the ideal and actual self. However, this explanation does not entirely account for why the feeling is so powerful and pervasive. A more complete picture was proposed by Lindsay-Hartz et al. (1995) who found that instead of shame occurring due to a failure to meet an ideal, it occurs due to the individual meeting an "anti-ideal".

It is suggested that shame occurs as one becomes aware of how they may exist for another. It is the belief that one is perceived negatively in the minds of others that leads to the experience of shame (Mollon, 1984).

1.2.iii *Cognitive theories*

The anxiety resulting from an individual believing that they have created a negative image of themselves in the eyes of another has also been considered in cognitive theories (Beck, Emery, & Greenberg, 1985). It is suggested that shame is related to a fear of negative evaluation and that, opposed to anxiety, shame may increase after leaving a feared social encounter due to rumination about how the self was perceived.

In contrast to guilt, where the action of the individual is seen as undesirable, shame occurs when the self as a whole is experienced as intolerable (Lewis, 1971). This emotion is so difficult to experience that it is often replaced with less potent emotions such as anger or sadness. Whereas guilt leads to the motivation and subsequent behaviours to make amends, shame, due to the implication of the whole self, leads to withdrawal, helplessness, and the will to disappear. It leaves the individual feeling unable to rectify the situation, as the sense of failure is so all encompassing, that it seems impossible to begin to make amends (Reimer, 1996).

The sense of failure in a situation, however, may be interpreted in various ways, depending on the causal attributions made of the event and the self. An attributional model of shame (Lewis, 1992) suggests that in order for shame to be experienced, the individual must first have created for themselves a set of rules, goals and standards. When an event occurs, the individual evaluates their success or failure according to their rules, goals, and standards. Whether they will feel hubris, pride, guilt or shame depends on the attributional processes of the self. If the individual perceives that they have failed to meet their standards, and that the cause of this failure is internal and global, shame would ensue. Lewis (1992) also suggested that the standards that are

most likely to lead to shame, if they are not achieved, are those that are more central to the individual's self-definition.

Expanding on the ideas by Lewis (1992), Tangney and Dearing (2002) describe how attributions concern the intrapersonal relations with oneself as perceived via an evaluation following an event. They describe how guilt and shame can be explained using three attributional domains, namely, internal vs. external (locus of control); global vs. specific (specificity); and stable vs. unstable (stability). Both guilt and shame may be focussed internally, however, guilt will involve specific, unstable attributions, whereas shame involves global, stable attributions. In other words, someone may feel guilt following a situation if they believe that their undesirable action was a discreet part of themselves that is changeable, however they would experience shame if they perceived that the action was a display of their irreversibly flawed whole being.

1.2.iv *Evolutionary theories*

An interesting alternative theory regarding the role of shame was put forward by Gilbert who considered the emotion to be related to social rank and status judgements (Gilbert, 1989; 1992). He hypothesised that the behaviours associated with shame are akin to the behaviours exhibited by animals that are taking a submissive position in the face of a challenge or attack (Gilbert, 1997). In this 'ranking theory of shame', the emotion serves the purpose of protecting the animal from further aggression as the shame response of avoiding gaze, lowering head, reducing body size, and inhibiting ongoing activity (Gilbert, Pehl, & Allan, 1994), signals subordination to the attacker.

This signal inhibits further aggression by the attacker and the animal has therefore avoided injury or death, however it has also accepted a lower rank in the hierarchy.

In humans, however, higher social status can be gained (or maintained) not only by aggression, but also by attractiveness. This method of achieving high social rank relies on others bestowing the position on the individual rather than the individual fighting for the rank. Rather than to stimulate fear and inhibit others, the individual inspires and attracts others, and stimulates positive affect in them (Gilbert & McGuire, 1998). In this case, shame acts as a signal (or potential threat) that a particular behaviour may impinge on the individual's 'social attention holding power (SAHP; Gilbert, 1997)', which will relate to losing status.

Someone who loses SAHP will lose social support and will experience a reduction in their value to others. It has been suggested that social support contributes to the physiological well-being of an individual (Uchino, Cacioppo, & Kiecolt-Glaser, 1996), therefore loss of social support (an effect of shame) can have a devastating impact. Shame, then, is focussed on the potential of damage to the SAHP. It is a signal that the individual is unattractive or undesirable and should withdraw from the situation in order to limit further damage (Gilbert et al., 1998).

This theory draws together evolutionary motivations with more complex cognitive abilities such as the capacity to understand others' intentions and emotions (theory of mind) and the ability to give meaning to our own thoughts, feelings and behaviours (metacognitions) (Gilbert, 2003). Gilbert also distinguishes between two types of shame, internal and external. External shame arises through theory of mind as it involves the individual being aware of what others would disapprove of even though

the individual themselves do not see fault in the action. This experience of 'being shamed' may not provoke any negative emotion in the individual unless they are "caught" by the disapproving society, in which case, the aversive state experienced may not be due to shame of the action, rather shame of being discovered. Internal shame, however, is the subjective feeling that one is flawed and undesirable to others. An example of this 'feeling ashamed' is someone who is depressed and feels unlovable and unattractive even those others dispute this. What the two types of shame have in common is that they are an involuntary response to a perception that one has lost value and social rank (Gilbert, 1998).

1.2.v *Summary of the theories of shame*

There are more theories of shame than those that have been identified above, however, the examples that have been elaborated begin to give an idea of the development and current thinking in the field.

Shame has long been considered to be an inhibitor of positive affect and that the ability to exhibit the physical signs of shame are innate. However, this is not the sole function of shame. The inclusion of a negative self-appraisal and the breaking of a bond with others, that share interest and trust, put shame into a more social role.

Psychoanalytical and cognitive theories consider the perception of the self in the experience of shame. Cognitive theorists have suggested that shame occurs when a failure is perceived as being caused by factors that are global, internal, and stable. In other words, that the individual feels that their whole self is flawed and that it is

irreparable. This is heightened if the failure is in a domain that is seen as central to the individual's self-identity.

A more evolutionary approach proposed by Gilbert explains that shame is related to submissive behaviours, and that shame is a signal that injury to the 'social attention holding power' has occurred. Injury to SAHP is associated with the physiologically damaging effects of losing social support and feeling devalued and, therefore, the effect of shame to distance the individual from the group, or situation, may limit the damage.

Two forms of shame were identified - internal and external. Internal shame is the subjective view that one's whole self is deemed unattractive by others even in the presence of evidence to the contrary, whereas external shame is the perception that others find one flawed even though one might not feel personally ashamed by their self.

1.3 The Development of Shame

1.3.i *Infancy*

In early infancy, emotional development is considered to occur through interactions with the primary caregiver. As explained by Attachment Theory (Bowlby, 1969), the infant and mother are in tune in terms of their affect and behaviour. Primarily through vision, the mother helps the infant regulate the powerful arousal of joy by averting and re-establishing gaze in accordance with the child's emotional response.

At around fourteen to sixteen months of age, when the child is able to wander away from the primary caregiver, shame is suggested to first appear (Schore, 1991). This is due to the child returning to the caregiver to display that which they have explored and expecting to be met with pleasure. If the child is met with an unexpected expression (usually disgust), they experience shame, which is the result of the rapid change from a positive to negative state (Schore, 1998). If the caregiver detects this change of state in the infant and becomes 'in tune' with their negative affect, they can then re-establish the 'dyadic visuoaffective transactions' that manifest a positive state in the infant. This teaches the infant to regulate negative affects and to cope with not always being 'in tune' with the caregiver and amounts of this interaction is necessary for a secure attachment.

However, if the primary caregiver often rejects the infant (for example, through humiliation) when they are already experiencing a distressing state, the infant may internalise a sense of their caregiver as rejecting and themselves as unworthy of support. These early failures in attachment have been seen as sources of shame (Kaufman, 1989). Schore (1998) suggests that rather than shame itself, it is the reduced ability to regulate this emotion that can be a vulnerability factor to psychological problems later in life.

1.3.ii *Early childhood*

Experiments designed to explore shame in childhood have mainly involved the observation of behavioural and physical reactions to situations hypothesised to

engender shame. An example of this is an experiment where children aged twenty five to thirty six months were given a doll that was designed to break during play (Barrett, Zahn-Waxler, & Cole, 1993). They found that the toddlers either displayed shame states (those that avoided the examiner initially and exhibited expected behaviours such as averting gaze) or guilt states (those that approached the experimenter and showed no distress). This may be demonstrating that infants as young as two years old may already have the a bias towards attributing a failing to themselves (shame) or to an object (guilt). It also shows that those infants identified in the shame category were more likely to feel helpless in the situation rather than to attempt to repair the situation as did the infants displaying guilt.

Observing slightly older children (three year olds), Lewis, Alessandri, and Sullivan (1992) presented easy and difficult tasks. They found that no child displayed shame when they succeeded in the task or displayed pride when they failed. It was also observed that pride was shown significantly more often following success at a difficult task and significantly more shame was displayed after failing at an easy task. These results indicate that the children were evaluating their performance against their own standards and therefore felt more shame when they failed at a task that they perceived to be within their capability.

1.3.iii *Middle childhood*

When children reach middle childhood, they are considered to have two styles of responses to negative outcomes (Reimer, 1996). They may either persevere with the failing task and show positive affect (mastery-oriented pattern), or may give up and

display negative affect and negative self-cognitions (helpless pattern). It seems that it is the child's evaluation of the cause of the failure that will determine their response pattern. A child that displays motivational helplessness in the face of criticism of their ability is more likely to have attributed their 'failure' to internal, global, and negative factors (Heyman, Dweck, & Cain, 1992).

Even though young children act differently in response to shame- versus guilt-eliciting situations, they do not yet have the ability to verbalise the differences between the situations. This skill becomes apparent as they develop through middle childhood (Ferguson & Stegge, 1995). Stipek and De Cotis (1988) found that twelve to thirteen year olds were able to associate shame with effort and ability and not luck, and that nine to ten year olds were approaching this ability.

Ferguson, Stegge, and Damhuis (1991) were also interested in how children conceptualise guilt and shame. The children (aged ten to twelve) were asked questions regarding stories designed to present situations of shame or guilt. They were able to differentiate between the two emotions and attributed guilt to stories of moral norms violations, and shame to scenarios that exposed moral transgressions and social blunders. They also found that shame was seen to be related to how others may evaluate the deed in the story as negative. Children aged seven to nine were asked to sort features according to whether they felt that shame or guilt was being represented. It was found that the younger children associated shame with embarrassment, blushing, ridicule, and escape, whereas the older children additionally attributed more personal features. These were: feeling stupid; being unable to do things right; and being unable to meet the gaze of others. However, it is

not possible to conclude that this demonstrates a shift in the subjective feeling of shame in middle childhood.

1.3.iv *Adolescence*

The development through childhood demonstrates an increasing ability to understand the emotion of shame and how it differs from other aversive emotions. When adolescence is reached, the individual is able to distinguish the causality of failures in terms of whether they are due to themselves or external factors, and whether internal factors are controllable or not. Stipek and DeCotis (1988) found that it was not until adolescence that one can understand that effort is more internal and controllable than ability. It may be that as the adolescent becomes more capable at discerning the true causes of failures, occurrences of shame become more closely linked with their self-concept (Reimer, 1996).

There is currently not much known about the course of shame through adolescence, nor the main contexts associated with shame, nor whether a vulnerability to shame predicts future experiences of shame as new domains become intertwined with the self-concept (Reimer, 1996). For example, it is not known whether a general proneness to shame brought about by early life experiences may increase the potential of shame as the developing adolescent ascribes an increasing number of roles to their self. However, there has been research in the field of adolescent development that may inform theorising as to the normative experience of shame during adolescence. Some of the features of adolescent development are described below, followed by Reimer's ideas of how they relate to shame.

Identity formation

One of the main tasks of adolescence is that of identity development. Erikson (1968) described how personality develops through eight life-span stages, each concerning the negotiation of a normative conflict. Each stage builds on the last and the task of achieving ego identity during adolescence has been described as the "theoretical linchpin; it is the basis for integrating previous developments and it serves as the foundation upon which subsequent progress will be based" (Berzonsky, 2000). The stage of *identity and diffusion* is when an adolescent must integrate their experiences in order to form a stable sense of personal identity. They must distinguish their sense of self from their caregivers.

Psychoanalytic theories suggest that to complete the task one must detach from relationships with caregivers. Successful adolescent development, however, has been found to still be within the context of attachment with the caregivers (Steinberg, 1990). The adolescent challenges and de-idealises the caregivers whilst concurrently also continues to desire their love and approval. Similarly to the developing infant that needs a secure attachment as a basis to explore and learn to tolerate caregiver unavailability, adolescents also require a secure attachment so that they may explore their new cognitive abilities with the associated challenges for emotion regulation.

This stage of development coupled with the adolescent's emerging abilities in social cognition, lead them to a difficult position. They risk experiencing intense emotions from both parts of the task they undergo. The adolescent may experience shame due to the reactions of the caregivers to the threat to attachment necessary for the

formation of an individual identity. Shame may also be experienced, however, if the adolescent shies away from the task and retreats from identity development.

In younger children, love-withdrawal (the absence of affection from the parent) has been associated with shame (Lewis, 1992). In identity development, the inevitable experiences of love-withdrawal may also be associated with shame. In addition, there is an increasing risk of shame as the individual makes decisions regarding what they view as central to their new concept of self. This risk arises due to evaluations of the self's achievement of identity. The theoretical links between the adolescent stage of identity formation and shame could have an impact on vulnerability to shame throughout late adolescence and adulthood (Reimer, 1996).

Puberty

The pubertal process can be considered as a bio-psycho-social event. The physical changes at this time may be linked with increases in the abilities to understand the self and be aware of others' expectations of the self (Reimer, 1996). Puberty often marks a transition and is a time associated with many different ceremonies around the world. In more affluent societies it marks the beginning of adolescence, however, in less industrialised societies, it may indicate the start of adulthood and associated events such as marriage.

There appears to be gender differences in the levels of self-esteem associated with pubertal changes. It has been found that males' self-esteem raises in response to physical changes, whereas females' self-esteem is more likely to decrease following the change in body shape (Brooks-Gunn & Reiter, 1990).

There is another reason why puberty may be particularly stressful for the female (and possibly male) adolescent, and contribute to a vulnerability to shame. The changes in body shape and sex characteristics are not within the control of the adolescent and yet will be included in their formation of self. How others respond to the physical changes will also be beyond the control of the adolescent and yet may engender shame through the perception of negative appraisals.

Attraction and sexuality

With puberty, a desire to form loving and sexual relationships with others occurs. Adolescents must risk rejection in order to explore the new form of relationship open to them. If they are rejected, it can often occur in humiliating ways and be perceived as relating globally to their selves (Reimer, 1996). It could be relevant that the 'crushes' and brief relationships typical of early adolescence would involve love-withdrawal and the associated experience of shame.

Emerging sexuality could also lead to shame due to the individual evaluating their sexual desires or physiological experiences as not socially acceptable (Katchadourian, 1990). For example, sexual orientation or fantasies, involuntary erections, nocturnal emissions, and masturbation may all be perceived by the individual as unacceptable (and somewhat inevitable), and this may be exacerbated by societal sexual taboos making it more difficult for an adolescent to discover whether their experiences are 'normal'.

Developing cognitive abilities

Adolescents gain new abilities in reasoning and in metacognition. The combined effect of these newly developing skills is that adolescents may get stronger

associations between shame and negative self-appraisals on which they may ruminate perseveratively. This could cause experiences of shame to become more intense and harder to remove (Keating, 1990).

The adolescent's recently developed skills in social perspective taking, which allows them to better view themselves from others' perceptions, have long been considered to also promote self-conscious self-monitoring. This leads to an adolescent egocentrism that manifests itself in part as 'the imaginary audience' (Elkind & Bowen, 1979) which is described as the adolescent's fantasy and fear that every success and failure is important and is being watched closely by others. Reimer suggests that shame would be expected to accompany the effects of the imaginary audience as it is the result of perceiving that one has been found inferior in the eyes of others.

Recently, the idea of the imagined audience has been questioned (Vartanian, 2001). Bell and Bromnick (2003) found that contrary to Elkind's theory, the reason that adolescents have heightened awareness to the perceptions of others is that there are very real personal and social consequences. In other words, the concerns of the adolescent are based in social reality. Reimer's comments, however, still hold value, as the heightened awareness to social appraisal will be associated with shame regardless of whether the consequences are real or imaginary.

Evaluation of successes and failures

Adolescence may be a time when the perception of successes and failures become increasingly important. Competitive situations could seem to have (and actually have) increasing relevance to the academic and occupational future of the individual as well

as current implications (such as the relationships with peers, family, and schools). In addition, the increased cognitive abilities discussed earlier may further increase the potency of subjective evaluations of the adolescent's own success and failures.

Underachievement seems to be more common during adolescence (Riggs, 1992) and has been conceptualised as the avoiding of challenges. It has been suggested that maladaptive learning patterns are associated with internal, global, and uncontrollable attributions, whereas mastery is associated with internal, specific, and controllable attributions (Henderson & Dweck, 1990). In other words, failures in learning may induce shame in some adolescents but guilt in others. This affects their learning patterns and is dependent on their attributions of the cause of the failure. It may be that adolescents that relate the failures to themselves and, in accordance, feel helpless to amend the failure, do so due to initially responding with shame. The 'underachievers' may be attempting to avoid the emotionally aversive state of shame by avoiding the challenges that may result in failure (Reimer, 1996).

1.3.v *Summary of shame development in adolescence*

Reimer (1996) noted that there is not much currently known about how shame develops or changes during adolescence. It has been suggested that adolescence is a crucial time for the emotion of shame as it could be strongly linked to the development of identity and emerging cognitive abilities. Changing roles, for example, due to puberty and the development of sexuality, may also have an impact on levels and experiences of shame through adolescence.

Reimer (1996) suggests that increased vulnerability to shame during adolescence is not due to either external factors (such as attempting to form sexual relationships) or internal factors (such as identity formation), but rather is due to the convergence of both factors. She explains that there are an increased number of situational contexts for self-evaluation as well as increased cognitive capabilities for self-reflection. The combination of these two factors leads to an increased vulnerability to negative attributions of the self and therefore, shame.

1.4 Shame and Psychopathology

Reimer (1996) noted that many of the psychological problems that have been found to change in form and frequency during adolescence have also been found to be associated with shame. It may be that common adolescent emotional disturbances, such as depression, conduct problems, eating disorders, and suicide, develop alongside (or in part, due to) increasing proneness to shame resulting from emerging cognitive skills and higher frequency of potentially shame-evoking situations. The role of shame in depression and anger is discussed below, followed by theories regarding the contribution of parenting style and interpersonal relationships with peers to the development of psychopathology.

1.4.i *Depression*

Historically, research has often cited a relationship between depression and guilt rather than shame. This appears to be due to issues of classification and methodology

(Tangney, Burggraf, & Wagner, 1995) whereby psychologists have termed negative self-conscious affects as guilt rather than differentiating shame as a separate construct. An early example of this is Freud's description of the role of guilt in melancholia. Recent theorists have examined the description given by Freud of guilt and suggested that he was referring to what has now been recognised and termed as shame.

Considering cognitive-attributional models of depression (Beck, 1967; 1976; Beck, Epstein, & Harrison, 1983), the impact of shame and not guilt appears relevant. There have been many studies linking depression to a tendency to make stable, global, internal attributions for failings and negative events (Robins, 1988). These attributions have also been associated with shame by Lewis (1992) and other researchers, whereas guilt has been associated with an internal, unstable, specific attributional style. Theoretically, there is a clear link between Lewis's description of the cognitive biases associated with shame and the attributional style of cognitive models of depression. Empirically, the presence of a link between depression and shame (but not with guilt) has been shown repeatedly (e.g. Tangney, Wagner, & Gramzow, 1992).

Interestingly, Gilbert et al. (1994) found that shame did not correlate with depression in their study involving one hundred and twenty five psychology undergraduates. They suggested that the shame measure utilised *(The Adapted Dimensions of Conscience Questionnaire*: ADCQ: Johnson et al., 1987) may not have been sensitive to measures of psychopathology. The ADCQ asks questions regarding the participant's expected response to hypothesised situations. It may be that a questionnaire that measures the global feeling of shame rather than how it occurs in

specific situations may demonstrate the expected relationship between shame and depression. Gilbert et al. did find, however, that submissive behaviour was related to depression in this study. Previously, Gilbert (1989, 1992) suggested that submissive behaviour is related to shame. Therefore it could be that the ADCQ did not measure the construct of shame as it is currently understood, whereas the measure of submissive behaviour more closely matched the construct of shame as an innate inhibitor of behaviour and pleasure.

Andrews and Hunter (1997) used an interview to measure feelings of shame. Participants were asked about personal experiences of shame rather than responding to a list of items hypothesised to relate to shame as often occurs in questionnaires. They took in to account Janoff-Bulman's distinction between behavioural and characterological shame (Janoff-Bulman, 1979), which is shame regarding one's actions versus shame directed at one's being, and also assessed bodily shame (shame about one's physical form). They did find that there was a relationship between the three types of shame and depression.

Andrews and Hunter also found that there were differences in the strengths of the relationships between the types of shame and childhood experiences of abuse. This may demonstrate that childhood experiences that have been hypothesised to lead to shame-proneness in adolescents and adults may lead to different types of shame depending on the experience. However, the result of each type of shame involves concealment which will affect the individual's ability to seek help and form close bonds, the impact on social relationships being a factor that contributes to depression (Keitner et al., 1995).

Developing a questionnaire based on the principles of the shame interview, Andrews and colleagues also found evidence for the association of depression and shame (Andrews, Qian, & Valentine, 2002). Furthermore, the study found that the levels of shame were more stable over time than levels of depressive symptoms. This is interesting as it suggests that an overall shame-proneness is likely to be a risk factor to developing depression, more so than depression causing shame-proneness, a common theory that had not previously been investigated.

Another finding using this newly developed Experience of Shame Scale (ESS) was that characterological and bodily shame were more related to current depressive symptoms, however, behavioural shame best predicted further depressive symptoms, as did bodily and then characterological shame to a lesser degree. This implies that characterological shame may be the global, internal, stable shame that leads to vulnerability to depression, and the other two types of shame relate to more specific parts of the self. In times of stress, these types of shame generalise to the more global shame which suggests that rather than dormant dysfunctional thoughts becoming activated during stress, shame is always present and becomes generalised. This is akin to research that has suggested that depression is associated with the generalising of specific failures to more global feelings of worthlessness (Carver & Ganellen, 1983).

Depression is more prevalent in adult females than males, and this only occurs in mid adolescence (Kandel & Davies, 1982). Before this, male children exhibit higher levels of depression than females (Rutter, 1986). Some of the factors associated with this increase in depression, including shifts in gender roles, low self esteem, negative body image, and early puberty, have also been linked closely to shame. It has been

found that female adolescents' higher incidence of shame is due to experiencing greater levels of challenges (Wichstrøm, 1999), particularly relating to the timing of puberty (Petersen, Sarigiani, & Kennedy, 1991). Adolescence has been suggested to be the best age group in which to explore the processes and factors involved in increasing depression in girls. It may, therefore, also be a useful time to explore changes in levels of shame between genders, and whether the challenges faced by each gender are currently changing due to shifting gender stereotypes that adolescents may relate to. Examples of potential changing stereotypes could be higher numbers of 'independent' females, or more 'image-conscious' males, in advertising and the media.

A further explanation of the differences in depression and shame between the sexes relates to the coping style of rumination, which has been found to occur more commonly in females (Nolen-Hoeksema, Grayson, & Larson, 1999). Cheung, Gilbert, and Irons (2004) found a relationship between shame, rumination, and depression, and that females scored significantly higher in measures of these variables. They also found that rumination might mediate the impact of shame on depression, although only to an extent.

1.4.ii *Anger and aggression*

An interesting distinction between shame and guilt is that guilt provokes the individual to make amends whereas shame is not associated with this behaviour. Shame is related to lower empathy and also to less constructive forms of anger (Tangney, 1995). The individual experiencing shame may be too involved with their

own painful state to consider the experience of others, and therefore, reacts in a manner that attempts to alleviate their negative emotion but does not help to remedy the situation. It has been suggested that there are cycles of 'shame' and 'humiliated fury' that the shamed individual moves through (Lewis, 1971) and that the fury can be directed internally or externally.

This externalisation of blame seems to be contradictory to the withdrawal behaviour associated with shame described earlier. It may be that the individual feels intensively negative towards themselves due to their perception of their own inadequacy, but also to others in whose eyes the individual believes their shame is reflecting. It has also been suggested by Lewis that the individual may realise the inappropriateness of their anger towards those perceived as disapproving and thus give themselves increased opportunity to feel further shame (Lewis, 1987).

Although there has not been much research exploring the specific relation of shame to anger and aggression, Tangney, Wagner, Fletcher, and Gramzow (1992) performed two studies using undergraduates as participants. They found that shame-proneness was correlated with anger arousal, suspiciousness, resentment, irritability, a tendency to blame others for negative events, and indirect (but not direct) expressions of hostility. It was suggested that initial shame (and associated drop in self-esteem) leads to unfocussed anger which can easily be directed to disapproving others. These 'others' may be real or the imaginary others that the shamed individual believes are judging them. Tangney et al. (1992) also suggested that hostility results in the shamed individual feeling that the negativity that they are experiencing is disproportionate to the event and therefore attribute the "unfair" extra emotional reaction to the action of others rather than their own internal processes. A further explanation of their findings

was that shame-prone individuals use anger as a defence against the painful experience of shame, and therefore gain some temporary relief from the emotion. The study did not look at the relationship between shame and anger in adolescents, however, it may be speculated that shame-proneness could be a contributing factor to both internalised and externalised anger displayed during adolescence, for example, self-harm and conduct disorder.

Evidence for the association of inward directed anger with shame-proneness was also found by Lutwak, Panish, Ferrari, and Razzino (2001) in a study which included responses from adolescents aged sixteen and over. The mean age of participants was 20.1 years however, so the bulk of the respondents would be considered as young adults rather than adolescents. Although inward anger was associated with shame for both genders, a decline in anger control was also found to be associated with shame in males. Lutwark et al. (2001) theorised that adolescent males "lose control of their anger and 'bottle up' these unmanageable feelings by directing them inward".

Tangney et al. (1996a) developed measures to assess how anger is experienced and managed and used these measures to investigate the course of these responses across the lifespan. They assessed responses from children, adolescents, college students, and adults and found general increases in constructive responses to anger and decrease in destructive responses as age increased. When comparing shame and anger across the lifespan, Tangney, Wagner, Hill-Barlow, Marschall, and Gramzow (1996b) found that in all age groups, shame-prone individuals experienced more anger than less shame-prone individuals. They also found that the angered shame-prone individual was more likely to engage in aggression – direct, indirect, and displaced – with malevolent and fractious intentions. This study suggested that shame-prone

individuals have two strategies to manage anger; either withdrawing from the situation, ruminating, and engaging in self-directed aggression (internalising the anger); or active, externalised aggression which may be displaced from the person that was initially involved in the anger-eliciting situation. The common component of both of these strategies is that they are unlikely to solve the situation that provoked anger or strengthen relationships with peers.

Considering Paul Gilbert's evolutionary theory of shame and it's relationship to submissive behaviour, it may be possible that the angered shame-prone individual submits during the event, but then attempts to compensate for the negative feeling of losing social rank by employing aggressive behaviours in a different situation. This may be in order to try to regain social status through aggressive means in a social situation which is removed from the individual that the angered shame-prone individual originally conceded social rank.

1.4.iii *Parenting style, shame and psychopathology*

The role of early life experiences in the development of psychological problems has been explored theoretically and empirically for many years (e.g. Bowlby, 1969; 1980; Goodyer, 1990; Lutwak & Ferrari, 1997; Shah & Waller, 2000). Attachment Theory suggests that children who do not receive continual warmth and love from their parents during their early years do not internalise a sense of self-worth that is positive, and expect others to be harmful, or rejecting. The view of an internalised self as worthless stemming from early experiences has also been proposed in cognitive theories. For example, the cognitive model of depression (Beck, 1967)

posits that critical or disapproving parents will lead the individual to develop negative schemata. These schemata become activated by life events and affect the individual's thoughts and perception of themselves, others, and the world negatively, which is associated with depression. A similar cognitive style to the style that has been associated with depression has been linked to shame, therefore, it may be possible that negative parental styles lead to shame-proneness which then increases vulnerability to depression. The parental styles that have been most closely linked to depression involve low parental care and high overprotection (Parker, 1979; 1981) and it has been found that these two parenting styles have independent, additive effects on depression (Rodgers, 1996).

Shame in adults has been theorised to form from the adult's perceptions of their parents' responsiveness as inadequate (Kohut, 1978; Lewinsohn & Rosenbaum, 1987). Lutwak and Ferrari (1997) investigated this relationship empirically and found that shame in adults was associated with recall of demanding, nonnurturing, and overcontrolling parenting. As is common with studies investigating the role of parental style in the later development of cognitive styles or psychopathology, recall of parenting was measured. This may mean that it is difficult to conclude causality in the relationship between parenting style and shame or psychological problems. It may be that studies have been exploring how adults' perception of their parenting is affected by their current shame or emotional state. Although, this is a flaw in research investigating recall of parenting, it has been suggested that recall is not biased greatly by current mood, and may be an adequate method until more improved methodologies are devised (Brewin, Andrews, & Gotlib, 1993).

Several pathways between parental style and psychopathology in adults have been proposed. For example, Brown and Harris (1978) suggested that self-esteem could be the mediating factor between loss in childhood and depression in adults. This theory has also been extended to suggest that self-esteem could be the mediating factor between parenting styles and later depression (Oakley-Browne, Joyce, Wells, Bushnell, & Hornblow, 1995) and has been empirically shown by Lloyd and Miller (1997). It has been suggested that self-esteem is the mediator between parental emotional warmth and psychological problems, but that the relationship with parental overprotection is mediated by difficulties socially (Parker, Barrett, & Hickie, 1992).

Shame has also been proposed as a mediating factor between parental styles and adult psychological problems. Gilbert, Allan and Goss (1996) found that parental care, overprotection, put-down (shaming), and favouritism were related to depression, and also shame. They also reported that parental shaming and being a nonfavoured sibling were particularly associated to interpersonal problems and psychopathology-proneness. However, the associations were only explored using correlations and therefore do not infer direction, nor assess the independent effect of variables beyond the effect of the other variables. Even though the mediating effect of shame was inferred, it was not directly assessed. As noted by Gilbert et al. (1996), the Parental Bonding Instrument (Parker, Tupling, & Brown, 1979) that they used to assess recalled parental style did not specifically measure shaming experiences and that, even though they added items to assess parental shaming, a more useful measure may have been the Egna Minnen Beträffande Uppfostan (EMBU: Perris, Jacobsson, Lindström, von Knorring, & Perris, 1980).

A study which used the EMBU to measure recall of parental rearing styles found that above the effect of parental overprotection and lack of emotional warmth, parental shaming and feeling less favoured than a sibling were particularly pathogenic (Gilbert & Gerlsma, 1999). They suggested that an individual that experienced parental criticism, shaming experiences, and felt unfavoured compared to siblings may not internalise a sense of self-worth and attractiveness (Gilbert, 1997). The individual then reacts in an over-timid or over-aggressive manner within their peer group which could lead to poor peer relationships – a vulnerability factor to experiencing psychopathology. However, this suggested route between parental style and adult psychopathology via peer problems during childhood was not explicitly tested in the study, and as Gilbert and Gerlsma noted, "Retrospective studies such as the present one give no indications as to the causal direction of that link".

Further research exploring the pathway between parental style and psychopathology showed support for the mediating role of shame (Gilbert, Cheung, Grandfield, Campney, & Irons, 2003). It was found that early life experiences correlated with shame, depression, and social comparison, but that the only predictor of depression was submissive behaviour in childhood. This is in keeping with 'social rank theory' (Gilbert, 1992; Gilbert, Allan, Brough, Melley, & Miles, 2002) that describes shame as relating to an unwanted loss of social rank. Gilbert considers that the relationship between parent and child is also a power relationship. The child may have to involuntarily accept a demoted social rank through certain parental styles, which may lead the child to have under-developed social skills when attempting to relate to peers. The result of which could be an increased vulnerability to depression.

1.4.iv *Summary of adolescent shame and psychopathology*

Adolescence has been theorised to be an important life stage in terms of the development of shame as well as psychological problems such as depression. Despite this, there has been very few studies explicitly exploring the role of shame in the development of such problems. Three types of shame have been identified, and characterological shame appears to be the type most predictive of depression.

Shame relates to anger and aggression in an apparently paradoxical manner. It has been suggested to lead to increased anger (due to externalisation of blame), but also to withdrawal behaviours. The common theme being inefficient strategies to manage conflict and feelings of anger. These reactions to conflict can be understood when considered in terms of feeling demoted in social rank. The shamed individual may withdraw in the conflict situation and then attempt to regain social rank by being aggressive in a different situation. These behaviours could then be labelled as conduct problems.

Parental styles that are recalled as shaming and unfavouring of the child compared to siblings increase the individual's vulnerability to psychopathology beyond the effect of emotionally unavailable or overcontrolling styles. Shame has been suggested to be the mediator of the relationship between parenting and psychological problems, and that difficulties within the peer group is the factor that relates shame to vulnerability to psychopathology. The perceived challenges to social rank within the power relationship between parent and adolescent may explain why shame and subsequent psychopathology could increase at a time where a child is attempting to gain independence as an adult.

1.5 Hypotheses regarding shame and psychopathology in adolescence

The main hypotheses that this study attempts to address are:

1) Levels of shame (as indicated by the Experience of Shame Scale) will increase over the course of adolescence, particularly for females.
2) Levels of shame (see above) will correlate positively with levels of psychological problems (as indicated by the Children's Depression Inventory and Strengths and Difficulties Questionnaire).
3) Increased perceived experiences of parental shaming will relate to adolescents' increased psychological problems and current shame level (see above).
4) 'Interpersonal difficulties' (as indicated by the Strengths and Difficulties Questionnaire) is the factor by which perceived parental style and current shame relate to adolescent psychological problems (see above).

Chapter 2

Method

2.1 Participants

2.1.i *Recruitment*

The study was given ethical approval by the UCL Graduate School Committee for the Ethics of Non-NHS Human Research (*see Appendix A*) and was registered under the UCL Data Protection Registration- Section 19, Research: Social. A Principal Educational Psychologist of a London Local Education Authority was consulted regarding the suitability of the study for secondary school pupils and also to suggest schools that may be suitable for the research.

Large secondary schools in London, Essex, and Hertfordshire were targeted according to the following criteria:

- They contained pupils of both genders.
- They contained pupils from a variety of ethnic backgrounds and socio-economic status (SES).
- They were approximately average in terms of academic achievement compared to other schools in their Education Authority.

Twenty-five schools were identified that met the criteria. Letters and information sheets were sent to the Head Teachers of the schools (*see Appendix B*) together with information sheets and consent forms for parents and participants (*see Appendices C and D*), as well as a sample of the questionnaires. The investigator met, or participated in a lengthy telephone conversation, with Head-Teachers that expressed an interest in the study, to answer questions and provide any further information that was required.

Sixteen of the schools did not respond to the letter or subsequent telephone call. Two schools immediately stated that they do not allow any research to be conducted with their pupils. One school refused due to time constraints already in place because of an Ofsted inspection. One school (with genders taught separately in adjoining buildings) would agree only to the male pupils participating (due to other demands on time for the girls). Two schools that expressed concerns about the content of the questionnaires (mainly the 'Child's Depression Inventory' and the 'Memories of Upbringing'), suggested items they wished to remove. However, removal of these items would have had significant implications regarding the validity of the measures and their ability to answer the research questions.

2.1.ii *School characteristics*

The school that participated in the study was a voluntary-aided, comprehensive school in London. The pupils were in separate, adjacent buildings according to gender, however, staff such as the Head Teacher and Special Educational Needs Coordinator (SENCO) were equally involved in both sites.

The participating school achieved GCSE or GNVQ grades that are similar to the grades achieved by all secondary schools in the LEA, though slightly lower than the national average. The GSCE or GNVQ grades data was only available for the girls as there were not yet male pupils in Year 10 or 11 (the academic years in which GCSE results are predicted and then obtained) as the boys' site has only existed for three years. Levels of absence, levels of achievement academically, and percentage of pupils with Special Educational Needs (SEN) for both boys and girls were similar to the national average. These factors show that the school that participated is representative, in terms of academic achievements and performance, of schools within the London LEA and also nationally.

Eligibility for free school meals is an indication of the SES of the participant's family. To be eligible, the family's annual income must be less than £13,230, and they should receive child tax credit, income support / income based jobseekers allowance, but not working tax credit. The percentage of pupils that meet this criteria at the school is lower than the LEA average, but much higher than the national average. However, SES is not implied in the hypotheses, and other comparisons of the school to the national average indicate that the sample is representative.

See table 2.1 for a comparison of the performance characteristics of the school compared to the LEA and nationally. The percentage of pupils from different ethnic backgrounds within the participating school compared to the national averages can be found in table 2.2.

Table 2.1: *Performance characteristics of the participating school (2003)*

	School %	*LEA %*	National %
GCSE/GNVQ results between grades A*-C	46	43	53
GCSE/GNVQ results between grades A*-G	87	94	89
No passes at GCSE/GNVQ level	0	4	5
Authorised absence	6.8	6.3	7.1
Unauthorised absence	0.8	2.0	1.1
SEN with statements	2.1	4.1	2.4
SEN without statements	13.5	15.1	13.0
Pupils eligible for free school meals	39	62	15
Average class size (not %)	26	22	22

2.1.iii *Sample characteristics*

The SENCO was asked to randomly select four classes from each academic year-seven, eight, and nine. All pupils from the selected classes were invited to participate in the study. Of the 311 pupils selected for the study, two were excluded as their parents refused permission to participate. Of the 309 remaining pupils, 34 were absent on the day of testing or did not return their questionnaires and seven pupils did not wish to take part. The final number of pupils that completed questionnaires (268) represented 86% of the participants originally approached.

There were one hundred and thirty-five boys (50.4%) and hundred and thirty-three girls (49.6%) in the final sample of two hundred and sixty-eight adolescents. One hundred and two (38.1%) participants were from Year Seven, eighty-two (30.6%) from Year Eight, and eighty-four (31.3%) from Year Nine.

Of the 268 participants that returned questionnaire booklets, 72 did not respond to one or more entire questionnaires. Their responses were therefore unusable and were not included in the analyses. The remaining 196 participants consisted of 104 (53.1%) girls, and 92 (46.9%) boys, with 80 (40.8%) from Year Seven, 68 (34.7%) from Year Eight, and 48 (24.5%) from Year Nine, formed 63% of the number of pupils that were originally asked to participate in the study.

Table 2.2: Ethnic background of sample of participants, LEA, London, and national figures.

	National %	London %	LEA %	Participants %
White	**83.7**	**52.6**	**25.5**	**45.4**
British	81.3	44.4	21.9	40.3
Irish	0.4	1.3	0.3	4.1
Other	2.0	6.8	3.3	1.0
Mixed	**2.2**	**4.7**	**2.0**	**16.4**
White and Black Caribbean	0.8	1.6	0.9	7.7
White and Black African	0.2	0.5	0.5	4.1
White and Asian	0.4	0.8	0.1	1.5
Other	0.8	1.9	0.5	3.1
Asian	**6.3**	**17.2**	**56.9**	**6.1**
Indian	2.4	7.6	0.9	2.6
Pakistani	2.4	3.4	0.8	0.5
Bangladeshi	0.9	4.0	54.5	2.6
Other	0.7	2.4	0.7	0.5
Black	**3.3**	**17.4**	**12.7**	**27.0**
Caribbean	1.4	7.0	4.7	11.2
African	1.5	8.6	5.9	15.8
Chinese	**0.4**	**0.9**	**1.1**	**0.5**
Other	**0.8**	**3.7**	**1.3**	**4.6**

Note: National, London, and LEA figures are only reported for ethnic groups that were present in the participating sample.

The final sample consisted of 167 (85.2%) adolescents who were in contact with both parents, 28 (14.3%) who were only in contact with their mother, and 1 (0.5%) pupil whose mother had died and therefore only had contact with his father. In terms of siblings, 16 (8.2%) pupils did not have any siblings, 79 (40.3%) were the oldest sibling in the family, 45 (22.9%) were the youngest, and 56 (28.6%) had both younger and older siblings.

2.2 Procedure

The participating school requested that all communication and organisation be via the SENCO rather than the Head Teacher. After consent was obtained from the Head Teacher, information sheets and consent forms were sent to the parents of all pupils in the twelve classes selected by the SENCO (2 boys' classes, 2 girls' classes, for each year; 7, 8, and 9). Parents were given information regarding the nature of the study and an explanation of why their child was being asked to participate. If parents preferred that their children did not participate in the study, they were asked to sign and return a slip at the bottom of the information sheet (*Appendix C*).

All participants were administered the questionnaires on a group basis during a Physical, Health & Social Education (PHSE) lesson. On the day of testing, each class teacher read an information sheet to the pupils (*Appendix E*). The participants were

informed about the nature of the study and that there would not be any negative consequences if they decided not to participate or decided to cease completing the questionnaires after they had started. They were also informed of the confidentiality and use of their responses. The participants were told that the investigator would be circulating between classrooms throughout and after testing and would welcome questions or comments regarding the questionnaire as well as worries or concerns that may have been raised by the questionnaires.

After the instructions were read and the pupils consented to the study, the consent forms were collected by the investigator so that their names were stored separately to their responses. An identity code was placed on the consent forms that matched the code placed on each questionnaire booklet so that the investigator could identify which participants had consented to the study. Each participant was given an envelope in which to seal their completed questionnaires so that staff or other pupils could not view their responses. One participant reported that he expected the questionnaire would make him distressed. The investigator requested that this pupil complete the questionnaire separately from his classmates, and remained available during and after testing. At the end of the lesson, the investigator collected all the sealed envelopes that were returned to the front of the class. The procedure was repeated a week later when the booklets were redistributed to the relevant participants in order to complete the questionnaires that they did not have time to complete on the first day that the booklets were administered.

2.3 Measures

Appendix F contains the questionnaire booklets used in the study. Personal information was gained, followed by the Children's Depression Inventory (Kovacs, 1985; 1992), Experience of Shame Scale (Andrews, Qian & Valentine, 2002), Strengths and Difficulties Questionnaire (Goodman, 1997), and factors from the Egna Minnen Beträffande Uppfostran ("*My Memories of Upbringing*": Perris, Jacobsson, Lindström, von Knorring, & Perris, 1980).

2.3.i *The Children's Depression Inventory (CDI; Kovacs, 1985)*

The CDI is a twenty-seven item self-report measure designed for children and adolescents aged from seven to seventeen years and includes items that specifically focus on the potential impact of depression on school performance and enjoyment. It was designed to assess a range of depressive symptoms: Negative Mood, Negative Self-Esteem, Anhedonia, Interpersonal Problems, and Ineffectiveness. It also provides a quantified level of overall depression severity.

Each item contains three statements from which the child selects the one that they feel most applies to them over the previous fortnight. The statements in each item are rated from zero to two, where 0 = Absence of Symptom, 1 = Mild Symptom, and 2 = Definite Symptom. This gives and overall score between zero and fifty-four. Scores of nineteen or more are considered to be clinically significant (Hodges, 1990). In the current study, one item of the original CDI was removed, as requested by the SENCO and Head Teacher. This item assesses suicidal ideation, the removal of which left

potential scores in the range of zero to fifty-two. The removal of item nine is in line with several previous studies (e.g. Hewitt et al., 2002; Irons & Gilbert, in press).

The CDI contains thirteen items that are reverse-scored (e.g. "*I sleep pretty well*" scores 2) and requires a low reading level compared to other children's depression measures (Berndt, Schwartz, & Kaiser, 1983). It has been widely used clinically and experimentally and has much evidence of good validity. Test-retest reliability is at an acceptable level, for example, $r = .54$ over six months (Weiss & Weisz, 1988), and $r = .67$ over six weeks (Finch, Saylor, Edwards, & McIntosh, 1987). Alpha reliability coefficients for the CDI are between .71 and .89, which indicates good internal consistency of the measure (Kovacs, 1992; Smucker, Craighead, Craighead, & Green, 1986; Weiss et al., 1988).

2.3.ii *The Experience of Shame Scale (ESS; Andrews, Qian, & Valentine, 2002)*

The ESS was recently developed as a self-report questionnaire to measure feelings of shame over the last year. It was based on an interview measure (Andrews & Hunter, 1997) and assesses overall shame as well three subtypes of shame: Characterological, Behavioural, and Bodily. Its predictive validity for depression was found to be superior to the Test of Self-Conscious Affect (TOSCA: Tangney, Wagner, & Gramzow, 1989).

The 'characterological shame' factor is concerned with personal habits, manner with others, the sort of person you are, and personal ability (e.g. "*Have you felt ashamed of*

any of your personal habits?", "*Have you worried about what other people think of your ability to do things?*"). The 'behavioural shame' factor looks at shame regarding doing something wrong, saying something stupid, and failure in different situations (e.g. "*Have you felt ashamed when you said something stupid?*", "*Have you tried to cover up or hide things you felt ashamed of having done?*"). 'Bodily shame' relate to feelings regarding your body or parts of it (e.g. "*Have you avoided looking at yourself in the mirror?*", "*Have you felt ashamed of your body or any part of it?*").

The ESS is a twenty-five item questionnaire which is rated on a four-point likert scale between one and four, where 1 = not at all, 2 = a little, 3 = moderately, and 4 = very much. It gives potential scores for overall shame in the range of 25 to 100, with scores in the range of 12 to 48 for the 'characterological' subscale, 9 to 36 for 'behavioural', and 4 to 16 for 'bodily'. The internal consistency for the subscales was found to be .90, .87, and .86 (Cronbach's alpha), and a Cronbach's alpha of .92 for the overall scale, indicating a high internal consistency. Test-retest reliability (over 11 weeks) was found to be r (88) = .83. The reliabilities for the subscales were r (90-93) = .78, .74, and .82 (Andrews et al., 2002).

In order to make the measure suitable for adolescents in the current study, explanations of some of the questions were placed in brackets after the item wording. For example: "...your manner with others" was explained as "the way you are with other people"; "...your inability to do things" was explained as "not being able to do things". The response using the word "Moderately" was also explained as "Some".

2.3.iii *The Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997)*

The SDQ is a twenty-five item measure, and the self-report version is considered appropriate for respondents aged eleven to sixteen years. It consists of five subscales, each containing five items. Summed scores from the 'Hyperactivity', 'Peer Problems', 'Conduct Problems', and 'Emotional Symptoms' subscales form a 'Total Difficulties' score. The 'Pro-Social Behaviour' subscale is not included in the overall total. The items are rated on a three-point Likert scale from zero to two, where 0 = not true, 1 = a bit true, and 2 = very true, and the questionnaire contains five reverse-scored items (e.g. "*I think before I do things*").

Each subscale have scores in the range of zero to ten, and the total difficulties score is in the range of zero to forty. For the self-rated version, scores of sixteen to nineteen are considered borderline, and scores of twenty to forty are abnormal (Goodman, Meltzer, & Bailey, 2003).

Good internal reliability of the self-rated SDQ has been reported by Goodman et al. (1997). The internal reliability of the subscales is (Cronbach's alpha coefficients): .69 for Hyperactivity; .61 for Peer Problems; .72 for Conduct Problems; .75 for Emotional Symptoms; and .65 for Pro-Social Behaviour. The Cronbach's alpha coefficient for Total Difficulties was .82, indicating that internal reliability is good. The SDQ correlated highly with the Rutter questionnaires (Elander & Rutter, 1996), providing evidence for good concurrent validity (Goodman, 1997) and was found to be at least as good as the Child Behaviour Checklist (CBCL: Achenbach, 1991) at detecting psychological problems (Goodman & Scott, 1999).

2.3.iv *The Egna Minnen Beträffande Uppfostan (EMBU; Perris, Jacobsson, Lindström, von Knorring, & Perris, 1980)*

The EMBU translates from Swedish as "My Memories of Upbringing" and is a self-report measure of recalled parental rearing styles. It contains eighty-one items which are statements responding to each parent. The scoring is a four-point Likert scale ranging from one to four.

The original EMBU was separated in to fifteen *a priori* subscales: Abusive, Depriving, Punitive, Shaming, Rejecting, Overprotective, Overinvolved, Tolerant, Affectionate, Performance Orientated, Guilt Engendering, Stimulating, Favouring Siblings, Favouring Subjects, and Unspecified. However, it is currently usually divided into four factorially derived scales: Rejection, Emotional Warmth, Overprotection, and Favouring Subject (Arrindell, Emmelkamp, Brilman, & Monsma, 1983). These first-order factors were revealed using data from a large sample (N = 841).

Cronbach's alpha coefficients for the four scales were reported to be "well within acceptable limits and generally attain considerably high values" (see Arrindell et al., 1983 for cohesion values for six subject samples). Examples of Cronbach's alpha coefficients for the 'Normal' subject sample were: .89 for Emotional Warmth, and .76 for Overprotection.

The EMBU has been translated into English by Ross, Campbell, and Clayer (1982), and an adolescent version has been designed (Gerlsma, Arrindell, van der Veen, & Emmelkamp, 1991). A study comparing the EMBU with an established measure of parental styles - the Parental Bonding Instrument (PBI: Parker, Tupling, and Brown, 1979) concluded that the EMBU is superior (Arrindell, Gerlsma, Vandereycken, Hageman & Daeseleire, 1998). This recommendation was, in part, made due to Arrindell et al.'s (1994) findings regarding the strong factorial stability of the EMBU within and between fourteen nations.

In a study exploring the recall of shame and favouritism in relation to psychopathology, Gilbert and Gerlsma (1999) used the 'Emotional Warmth' and 'Overprotection' factors. They also used the 'Favouring Subject (the participant)' factor and 'Favouring Sibling' *a priori* scale to represent favourable and unfavourable comparisons with siblings. Four items from the original EMBU that met criteria for 'public humiliation by parents' and 'parental treatment that affects the whole self' (Dutton, van Ginkel, & Starzomski, 1995) were used to measure Recalled Parental Shaming. In terms of internal reliability, Gilbert and Gerlsma found Cronbach's alpha coefficients greater than .83 for Emotional Warmth and Overprotection, and alpha coefficients of .76 to .83 for the remaining subscales.

The current study used the same items as Gilbert and Gerlsma (1999). There were forty-eight items in total: eighteen items for Emotional Warmth, sixteen for Overprotection, five for Favouring Subject, five for Favouring Sibling, and four for Shaming. The items were posed as questions regarding the current situation, rather than statements regarding the past, and the wording of the items was altered to a level that would be comprehensible by adolescents. This was in keeping with the wording

and structure of the items in the Adolescent Version of the EMBU (Gerlsma et al., 1991). The scale is rated as follows: 1 = No, never, 2 = Yes, sometimes, 3 = Yes, often, and 4 = Yes, usually. This gave scores that were in the range of eighteen to seventy-two for Emotional Warmth, sixteen to sixty-four for Overprotection, five to twenty for the each of the two Favouring subscales, and four to sixteen for the Shaming subscale (Gilbert & Gerlsma, 1999).

Chapter 3

Results

3.1 Preliminary analyses

Of the 268 questionnaire booklets returned to the investigator, 72 (26.9%) were not included as data were missing. The data from the remaining 196 questionnaire booklets were entered in to SPSS v11.5. Total scores for the Children's Depression Inventory (CDI), the Experience of Shame Scale (ESS), and the Strengths and Difficulties Questionnaire (SDQ) factors were calculated using the mean value of the individual items to account for missing variables. This method was chosen as there was only a small amount of missing variables in each of these questionnaires.

The SDQ 'Total Difficulties' score was calculated by summing 'Peer Problems', 'Emotional Symptoms', 'Conduct Problems', and 'Hyperactivity' scores. The ESS total score was calculated by summing the scores for the factors that made up the scale – 'Characterological Shame', 'Behavioural Shame', and 'Bodily Shame'.

Missing data from the EMBU factors were distributed across several items, so Missing Value Analyses (MVA) were used, negating the need to remove single item scores. The MVA function in SPSS uses regression techniques, which rely on a good correlation between variables. The five dependent variables of 'Parental Shaming', 'Favouring Sibling', 'Favouring Participant', 'Overprotection', and 'Emotional

Warmth' were compared with each other separately for 'Mother ratings' and 'Father ratings'. They correlated well with each other, (with Pearson correlation coefficients ranging from r = -.53 to .67) indicating that this method for predicting missing variables provided reliable estimations.

An Expectation Maximization Missing Value Analysis (EM MVA) was performed separately for the EMBU factor ratings for 'Mother' and 'Father' so that any potential differences between the ratings for both parents would be preserved. There were eighty cases with incomplete scores for some factors of the EMBU that were therefore estimated in the MVA. Data were predicted for cases that had at least three complete scored factors from the five dependent variables. In other words, three to four factors were used to predict one to two missing factors. This conservative cut-off level meant that thirty-six cases were removed as they had less than three out of five complete scored factors before the analysis. Of the one hundred and sixty remaining cases, one hundred and sixteen had complete scores before the MVA and therefore remained unchanged after the estimation, and forty-four cases had predicted scores for one or two factors.

Table 3.1 presents the means, standard deviations and skewness for each of the main variables. The variables marked by an asterix were significantly positively skewed, apart from the SDQ subscale of pro-social behaviours, and EMBU factors of emotional warmth, which was significantly negatively skewed.

Table 3.1: Number, Mean, Standard Deviation, and Skewness for Key Variables

	N	Mean (SD)	Skewness	SE of Skewness
CDI	159	1.84 (1.49)	1.22	.192*
SDQ Total Difficulties	160	2.58 (1.12)	.35	.192
SDQ Pro-Social Behaviours	160	1.52 (.37)	-.78	.192*
ESS	157	5.67 (2.15)	.78	.194*
EMBU				
Shaming	160	2.85 (2.55)	1.30	.192*
Favouring Participant	149	3.14 (2.70)	1.10	.199*
Favouring Sibling	149	2.61 (3.10)	1.56	.199*
Overprotection	160	20.61 (6.55)	.38	.192
Emotional Warmth	160	40.59 (8.18)	-.68	.192*

* indicates significantly skewed distribution

Normal distribution curves for each variable were examined for significant levels of skewness. The following variables were found to be skewed significantly: the CDI total; the ESS total; the SDQ subscales of Emotional Symptoms, Peer Problems, Pro-Social Behaviours, and Conduct Problems; all the EMBU factors aside from Overprotection ratings. Square root transformations achieved normal distributions for the CDI score, the SDQ Emotional Symptoms, Peer Problems, and Conduct Problems scores, and the EMBU subscales of Favouring Participant, Favouring Sibling, Emotional Warmth, and Shaming for both parents, and the EMBU subscale of Overprotection ratings for Father. The remaining significantly skewed variables were transformed using logarithms.

3.1.i *Demographic analyses*

The demographic characteristics of the sample were reported in the previous chapter. As previously outlined, there were some missing data. Table 3.2 presents the characteristics, in terms of age, gender, and ethnic background, of the participants in the final sample and the 196 participants who returned questionnaires. Analyses showed that the final sample was representative of the initial 'whole school' population.

The final sample of one hundred and sixty adolescents contained an approximately equal proportion of males and females. There were 51.9% girls and 48.1% boys which was similar to the proportion found in the questionnaires collected originally. The proportion of adolescents in each school year were close to those obtained in the original sample.

Table 3.2: Comparison of demographic data from returned questionnaires and the final sample

	Returned Questionnaires %	Final Sample %
Gender		
Female	53.1	51.9
Male	46.9	48.1
School Year		
Seven	40.8	40.0
Eight	34.7	36.3
Nine	24.5	23.7
Ethnic Group		
White	45.4	46.3
Mixed	16.4	16.8
Asian	6.1	5.0
Black	27.0	26.9
Chinese	0.5	0.6
Other	4.6	4.4

The final sample contained 40.0% from Year Seven, 36.3% from Year Eight, and 23.7% from year Nine, with ages ranging from eleven years and nine months to fourteen years and eight months. The sample were from a variety of ethnic backgrounds, the proportions of which did not change greatly when the incomplete cases were removed.

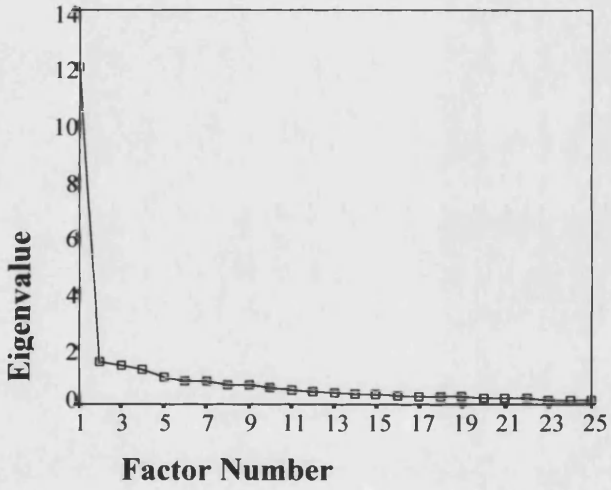
3.1.ii *Analysis of the Experience of Shame Scale*

Since the ESS is a relatively new measure, has not been used with adolescents previously, and included new wording to explain some items, the reliability coefficients of the scale and its subscales were tested. The total score which is the mean of the item scores was tested for skewness. It was found to be positively skewed (.78), showing that there was a significantly larger proportion of adolescents with a lower rating of shame, which could be expected from a non-clinical population. The distribution was normalised using a logarithm which resulted in a skewness of .27. The ESS Total scale had a Cronbach's α of .954, the Characterological scale α = .92, the Behavioural scale α = .89, and Bodily scale α = .85. This is similar to the reliability coefficients found in previous studies (e.g. Andrews, Qian, & Valentine, 2002).

The subscales were highly correlated (r = .62 to .78), indicating that the factors proposed by Andrews et al. (2002) were not found in the current study. This was confirmed by a factor analysis that found that one component had an initial

eigenvalue of 12.00 which accounted for 47.98% of the variance (*see figure 3.1*). The remaining components all had initial eigenvalues of less than 1.5 (% of variance = 5.97).

Figure 3.1: *Scree plot for the ESS*



A principal factors extraction analysis (with varimax rotation) indicated there were four factors with eigenvalues greater than one in the ESS. Table 3.3 shows the rotated component matrix that displays the loading of each item on the four factors. The first factor involved questions regarding 'failure, and acting or speaking incorrectly', (for

example, "*Have you worried about what other people think of you when you fail?*", "*Have you felt ashamed when you said something stupid?*" and "*Have you worried about what other people think of you when you do something wrong?*"), (which were all in the original factor of 'behavioural shame' in the adult version). The second factor was composed of items relating to 'body image' and were the same items that comprised the original 'Bodily shame' factor proposed by Andrews et al. (2002).

The third proposed factor involved items pertaining to 'personal habits and manner' (e.g. "*Have you felt ashamed of your manner with others?*" and "*Have you worried about what other people think of any of your personal habits?*"), and the fourth contained questions about 'personal ability' (e.g. "*Have you avoided people because of your inability to do things?*"). The final two proposed factors contained items that made up the original factor of 'characterological shame' in the adult ESS.

After mean scores for the four proposed factors were calculated, a correlation investigated how similar the new subscales were to each other. The four factors were highly correlated (r = .592 to .724), and high loading items were placed on more than one factor. This was to be expected considering the factor analysis performed initially which demonstrated high factor loading solely on one factor. Therefore, given these correlation results, the ESS was used as a total measure of shame in the current study, rather exploring Andrews et al's (2002) proposed separate factors of shame.

Table 3.3: Rotated factor matrix showing factor loadings for the ESS

Item	Factor			
	1	2	3	4
Have you worried about what other people think of you when you fail?	.757			
Have you worried about what other people think of you when you do something wrong?	.710			
Have you worried about what other people think of you when you said something stupid?	.682			
Have you felt ashamed when you said something stupid?	.659			
Have you felt ashamed when you failed at something which was important to you?	.639			
Do you feel ashamed when you do something wrong?	.612			
Have you avoided seeing anyone who knew you said something stupid?	.590			
Have you tried to cover up or hide things you felt ashamed of having done?	.553			
Have you avoided people who have seen you fail?	.520			
Have you wanted to hide your body or any part of it?		.793		
Have you felt ashamed of your body or any part of it?		.750		
Have you avoided looking at yourself in the mirror?		.724		
Have you worried about what other people think of your appearance?		.674		
Have you tried to hide from others the sort of person you are?		.456	.411	
Have you felt ashamed of your manner with others?			.734	
Have you worried about what other people think of any of your personal habits?			.664	
Have you avoided people because of your manner?			.619	
Have you felt ashamed of any of your personal habits?	.402		.587	
Have you worried about what other people think of your manner with others?			.548	.402
Have you tried to cover up or hide any of your personal habits?	.446		.526	
Have you worried about what other people think of your ability to do things?	.405			.768
Have you felt ashamed of your ability to do things?				.761
Have you avoided people because of your inability to do things?			.450	.684
Have you felt ashamed of the sort of person you are?		.481		.559
Have you worried about what other people think of the sort of person you are?	.417	.408		.452

3.2 The effects of age and gender on the variables

Table 3.4 contains the means and standard deviations for each variable split by gender, as well as Independent Sample T-Tests that compared the means for each variable. There was no significant difference between the levels of 'depressive symptoms' as measured by the CDI for males and females ($t(157) = 1.15$, $p = .254$). The level of 'psychological problems', indicated by the SDQ Total Difficulties score, was not significantly different between genders ($t(158) = .00$, $p = .997$), however, girls reported significantly higher levels of 'pro-social behaviour' ($t(158) = .3.41$, $p = .001$) than boys. Current shame, as measured by the ESS was approaching significance between the sexes, with girls reporting higher levels ($t(155) = 1.97$, $p = .051$).

Adolescents in Year Seven, Eight, and Nine were significantly different from each other in terms of perception of parental overprotection (with older respondents reporting lower levels), and were approaching a significant level of difference for their scores of current shame. This should be considered when continuing to analyse the data as it suggests that pupils report slightly higher levels of shame when they are in a higher age group between years seven to nine, and younger adolescents consider their parents to be more overprotective. Males and females were significantly different in terms of positive interpersonal actions. Girls reported significantly higher pro-social behaviours than boys, and also a tendency to higher shame at a level approaching significance. Later analyses that explore the relationships between these and other variables will take these results into account.

Table 3.4: Independent sample t-tests comparing means and standard deviations of variables between genders

	Boys Mean (SD) (n=63-77)	Girls Mean (SD) (n=70-83)	t (df)	p
CDI	1.19 (.54)	1.29 (.57)	1.15 (157)	n.s.
SDQ Total Difficulties	2.58 (1.09)	2.58 (1.16)	.00 (158)	n.s.
SDQ Pro-Social Behaviours	.27 (.09)	.32 (.11)	3.41 (158)	***
ESS	.70 (.15)	.75 (.16)	1.97 (155)	n.s.
EMBU				
Shaming	.49 (.30)	.50 (.28)	.09 (158)	n.s.
Favouring Participant	1.83 (.63)	2.02 (.65)	1.82 (147)	n.s.
Favouring Sibling	.43 (.35)	.41 (.35)	-.40 (147)	n.s.
Overprotection	20.92 (6.22)	20.32 (6.87)	-.58(158)	n.s.
Emotional Warmth	6.04 (.70)	5.92 (.78)	-1.08(158)	n.s.

* $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

Table 3.5: One-Way ANOVAs comparing means and standard deviations of variables between school years

	Year 7 Mean (SD) (n=61-64)	Year 8 Mean (SD) (n=57-58)	Year 9 Mean (SD) (n=38)	F (df_b,df_w)	p
CDI	1.29 (.56)	1.26 (.55)	1.11 (.55)	1.26 (2,156)	n.s.
SDQ Total Difficulties	2.57 (1.21)	2.73 (1.11)	2.37 (.99)	1.06 (2,157)	n.s.
SDQ Pro-Social Behaviours	.31 (.11)	.28 (.10)	.28 (.10)	1.67 (2,157)	n.s.
ESS Total	.76 (.17)	.72 (.16)	.68 (.13)	3.02 (2,154)	n.s.
EMBU					
Shaming	.49 (.30)	.54 (.28)	.44 (.26)	1.61 (2,157)	n.s.
Favouring Participant	1.88 (.67)	2.07 (.62)	1.81 (.61)	2.16 (2,146)	n.s.
Favouring Sibling	.37 (.37)	.49 (.32)	.37 (.34)	1.98 (2,146)	n.s.
Overprotection	21.08 (6.99)	21.79 (6.57)	18.00 (5.02)	4.30 (2,157)	*
Emotional Warmth	6.02 (.76)	5.90 (.71)	6.01 (.756)	.45 (2,157)	n.s.

* $p \leq .05$

The scores for the ESS were compared separately between genders across the age range using a regression which included the interaction term of "age*gender" in the second block. The regression indicated that there was no significant differences between the change of males' and females' levels of shame during the age range examined ($\beta = 1.88$, $t(153) = 1.43$, $p = .156$). When an ANOVA was used to explore the levels of shame between genders across the three school years, the interaction between school year and gender was significant ($F(2,151) = 4.15$, $p < .05$). The levels of shame for males decreased between years seven and eight and then increased between years eight and nine, and the levels of shame for females showed the converse pattern across the school years. However, due to the non-significant result of the regression exploring the interaction of age in years and gender, and the smaller number of respondents in year nine than the other years, the result of the ANOVA was considered to be less sensitive than the regression. The effect of the interaction between age (as a continuous variable) and gender on the levels of shame was not significant.

3.3 Shame and psychopathology

The following set of analyses explore the relationship between current feelings of shame and psychopathology in adolescents. The relationship between shame and depressive symptoms, as measured by the CDI, is investigated initially, followed by a comparison of shame and general difficulties reported via the SDQ.

The relationship between scores on the dependent variable of CDI (depressive symptoms) and independent variable of ESS (overall shame) was explored using

Linear Regression. Potential effects of age and gender were controlled for in the regression, as previous analyses uncovered slight differences in shame approaching significance between genders and school years. The regression model for overall shame was significant (R^2 = .42, F(3,152) = 36.15, p < .001). This indicates that there is a highly significant relationship between shame and depressive symptoms after age and gender have been controlled for. There was no significant effect of age or gender after shame was controlled for.

Holding age and gender constant, a moderator analysis assessed the difference of the regression coefficients between genders for the ESS scores. This was achieved by placing the interaction term of ESS score and gender in block two of the regression. It was found that gender did not have an effect on the relationship between shame and depressive symptoms (β = .08, t(151) = .26, p = .799). The procedure was repeated to investigate any possible effect of age, but no effect was identified (β = 1.10, t(151) = 1.03, p = .305).

The levels of general psychological problems for the adolescents were measured using the SDQ. The relationship of current shame to the level of 'total difficulties' was also explored. 'Total difficulties' is comprised from subscales of emotional symptoms, peer problems, conduct problems, and hyperactivity, and its interaction with shame was explored using a linear regression.

After age and gender were controlled for, a highly significant interaction between overall levels of shame and total difficulties was found (R^2 = .41, F(3,153) = 36.02, p < .001). This indicates that higher levels of shame predict higher levels of general psychological problems in adolescence, and that this interaction is not due to the age

or gender of the individual. Moderator analyses demonstrated that age and gender did not have an effect on the relationship between shame and psychological difficulties.

The SDQ subscale of 'pro-social behaviour' was employed in order to measure the level of positive interpersonal behaviours that the adolescents report they perform. In order to assess whether the level of these types of behaviour is related to shame, ESS scores were compared to pro-social scores using a linear regression, controlling for age and gender. There was no significant relationship between shame and pro-social behaviours. ($\beta = -.09$, $t(155) = -1.9$, $p = .236$).

In summary, there was a highly significant relationship between depressive symptoms and current feelings of shame. The relationship was also found between general psychological difficulties (as measured by the SDQ) and shame. There was no relationship between the 'shame - psychological problems' interaction and age. In other words, girls and boys from the ages of eleven years to fourteen years do not differ in the way that their level of psychological problems increase with their level of shame. The relationship between shame and depressive symptoms is not different to the relationship between shame and general psychological problems as measured in this study.

3.4 Parenting styles, shame, and psychopathology

3.4.i *Perception of parental rearing styles and psychopathology*

The relationship between psychological problems and parental rearing style was explored. The scores obtained from the five factors of the EMBU were compared to

the scores of the CDI and SDQ. Prior to this, the five factors were compared using a correlation (*see table 3.6*).

Table 3.6: *Correlation matrix for EMBU factors*

		Favouring Participant	Favouring Sibling	Over-protection	Emotional Warmth
Shaming	Pearson Correlation	.37**	.59**	.56**	-.47**
	N	149	149	160	160
Favouring Participant	Pearson Correlation		.52**	.30**	-.19*
	N		149	149	149
Favouring Sibling	Pearson Correlation			.48**	-.51**
	N			149	149
Over-protection	Pearson Correlation				-.16*
	N				160

* p<.05; ** p<.001

The 'parental shaming' factor correlated with the four other factors, particularly 'favouring sibling' (r = .59) and 'overprotection' (r = .56). Other high correlations were found between 'favouring participant' and 'favouring sibling' (r = .52) as well as 'emotional warmth' and 'favouring sibling' (r = -.51). The other factors were also significantly correlated with each other. The 'emotional warmth' factors correlated negatively with the other factors. This was as expected since ***lack*** of emotional

warmth could be considered a 'negative' rearing style, whereas the presence of the other styles would be considered 'negative'. There was a positive correlation found between 'favouring sibling' and 'favouring participant'.

Separately, all factors were significantly related to the CDI scores, which would be expected due to the degree of correlation found between some factors. A linear regression that included all five factors, as well as age and gender, was used to investigate the relationship between depressive symptoms and perception of parenting style, controlling for the effect of the other factors (*see table 3.7*).

The regression suggested that the factors of emotional warmth (β = -.31, t(147) = -3.86, $p < .001$).and overprotection ((β = .22, t(147) = 2.65, p = .009) predicted depressive symptoms beyond the effect of the other EMBU factors. Overprotection (β = .24, t(147) = 2.80, p = .006) was the only significant factor to affect the level of total psychological difficulties after the other factors, age and gender were controlled for. In other words, adolescents' perception of experiences of parental shaming, feeling favoured or unfavoured compared to siblings, overprotection and lack of emotional warmth all relate to depressive symptoms during adolescence. However, the latter two styles of parenting seem to have the strongest relationship with the symptoms after the effects of the other styles have been taken in to account. In terms of general psychological problems, the strongest relationship is with parental overprotection.

Table 3.7: Regression to examine the independent effect of perceived parental styles on psychological problems

Dependent Variable	Overall effect			Independent predictors			
	F	p	Proportion of variance	Variable	t	β	p
Depressive symptoms	14.58	***	.42	**Shaming**	.69	.06	n.s.
				Favouring Participant	1.86	.15	n.s.
				Favouring Sibling	1.56	.15	n.s.
				Overprotection	2.65	.22	**
				Emotional Warmth	-3.86	-.31	***
Total Difficulties	10.91	***	.35	**Shaming**	.91	.09	n.s.
				Favouring Participant	1.81	.15	n.s.
				Favouring Sibling	1.68	.17	n.s.
				Overprotection	2.80	.24	**
				Emotional Warmth	-1.90	-.16	n.s.

* $p \leq .05$; ** $p \leq .01$; *** $p \leq .001$

3.4.ii *Perception of parental rearing styles and current shame*

The relationship between perceived parental styles and current shame was explored. The scores obtained for each factor of the EMBU and the ESS were compared. Initially, a correlation between current shame and the five parenting styles was performed (*see table 3.8*). All factors of the EMBU were positively correlated with the ESS, except for emotional warmth, which was negatively correlated. This indicated that lack of parental emotional warmth, and the presence of parental shaming, overprotection and favouritism, all related to higher shame in adolescence.

Table 3.8: Correlations between current shame (ESS) and parental rearing styles (E MBU)

EMBU	N	Pearson Correlation	p
Shaming	157	.39	***
Favouring Sibling	146	.22	**
Favouring Participant	146	.39	***
Overprotection	157	.42	***
Emotional Warmth	157	-.32	***

* p≤.05; ** p≤.01; *** p≤.001

Reports of parental overprotection decreased significantly with age. Therefore a linear regression was performed in order to compare the relationship of each factor of the EMBU with ESS scores, controlling for the other parental styles and age. In these subsequent analyses, the ESS score is considered as the dependent variable.

As displayed in table 3.9, perceptions of parental styles of emotional warmth (β = -.20, t(144) = -2.20, p = .030) and overprotection (β = .29, t(144) = 3.20, p = .002) were significantly related with current feelings of shame beyond the effect of generally negative parenting (as indicated by the correlations of all the EMBU scores with ESS).

Table 3.9: *Regression to examine the independent effect of perceived parental styles on current shame*

Dependent Variable	**Overall effect**			**Independent predictors**			
	F	**p**	**Proportion of variance**	**Variable**	**t**	**β**	**p**
Shame	9.74	***	.296	**Shaming**	1.04	.11	n.s.
				Favouring Participant	.24	.02	n.s.
				Favouring Sibling	.74	.08	n.s.
				Overprotection	3.20	.29	**
				Emotional Warmth	-2.20	-.20	*

* p≤.05; ** p≤.01

All five types of parental rearing style relate to current feelings of shame. However, perception of overprotective behaviours and lack of emotional warmth interacted with levels of shame more than favouritism and parental shaming.

3.4.iii *The relationship between perceived parenting style, current shame, and psychological problems*

There is a significant relationship between negative parental rearing styles (particularly overprotection and lack of emotional warmth) and current shame. Additionally, a significant relationship between these two parental styles and depressive symptoms was shown. The relationship between shame and depressive symptoms was also found to be highly significant. In order to assess the mediation effect of shame between perceived parental rearing style and depressive symptoms, a mediation test was performed (Baron & Kenny, 1986).

Mediation is considered to be present when the following four criteria are met (Preacher & Leonardelli, 2003):

1) The independent variable (parental rearing style) significantly affects the dependent variable (depressive symptoms).
2) The independent variable significantly affects the mediator (current shame).
3) The mediator significantly affects the dependent variable after the independent variable is controlled for.
4) The effect of the independent variable on the dependent variable shrinks when the mediator is added to the model.

The first two of these criteria have been met for the parental styles of emotional warmth and overprotection with depressive symptoms, as previously reported. Controlling for the effects of age and gender, two linear regressions with CDI score

as the dependent variable, and either the EMBU factor of emotional warmth or overprotection as the independent variable were performed with the ESS score in block two of the regression (*see table 3.10*). The process was repeated for the effect of current shame (ESS) on the interaction between parental overprotection (EMBU) and psychological difficulties (SDQ) (*see table 3.11*).

For both of the independent variables, their effect on the dependent variable of depressive symptoms decreased with the addition of the mediator in to the regression. This is also true for the effect of adding the mediator to the regression involving psychological difficulties. However, their effect did not shrink to zero, therefore current shame is not completely mediating the relationship between 'parental style' and 'depressive symptoms' or 'psychological difficulties'. To assess the degree of partial mediation, a Sobel mediation test was used. The Goodman (I) version of the test was used, as suggested by Preacher and Leonardelli (2003), as "it does not make the unnecessary assumption that the product of s_a and s_b [the two standard errors of the regression coefficient (B)] is vanishingly small." Table 3.12 presents the z-scores and p-values obtained in the mediation test.

The z-score for each of the mediation tests were highly significant, indicating that current shame may have a mediating effect on the interaction of the parental rearing styles of 'overprotection' and 'emotional warmth' with 'depressive symptoms', and also on the relationship of 'overprotection' with 'psychological difficulties'. Diagrammatically, the interactions can be seen in figures 3.2, 3.3 and 3.4.

Table 3.10: Regression to examine the effects of emotional warmth and overprotection on depressive symptoms, with and without the effect of current shame

Dependent Variable *Depressive Symptoms*	Overall effect			Independent predictors			
	F	p	% variance	Variable	t	β	p
Without Mediator	11.13	***	.18	**Overprotection**	5.56	.41	***
	16.90	***	.25	**Emotional Warmth**	-6.93	-.49	***
With Mediator	29.36	***	.44	**Overprotection**	2.38	.16	*
				Current Shame	8.31	.57	***
	38.29	***	.50	**Emotional Warmth**	-5.14	-.31	***
				Current Shame	8.78	.54	***

* p≤.05; ** p≤.01; ***p≤.001

Table 3.11: Regression to examine the effects of overprotection on psychological difficulties, with and without the effect of current shame

Dependent Variable *Psychological Difficulties*	Overall effect			Independent predictors			
	F	p	% variance	Variable	t	β	p
Without Mediator	12.22	***	.19	**Overprotection**	6.05	.44	***
With Mediator	30.58	***	.45	**Overprotection**	2.96	.20	**
				Current Shame	8.33	.57	***

* p≤.05; ** p≤.01; ***p≤.001

Table 3.12: *Mediation analysis to assess the mediation of current shame for the relationships between parental rearing styles and psychological problems*

Interaction	z	p
EMBU Overprotection		
Depressive Symptoms	4.26	***
Psychological Difficulties	4.26	***
EMBU Emotional Warmth		
Depressive Symptoms	-3.81	***

* p≤.05; ** p≤.01; ***p≤.001

Figure 3.2: *The mediating effect of shame on the interaction between parental emotional warmth and adolescent depressive symptoms*

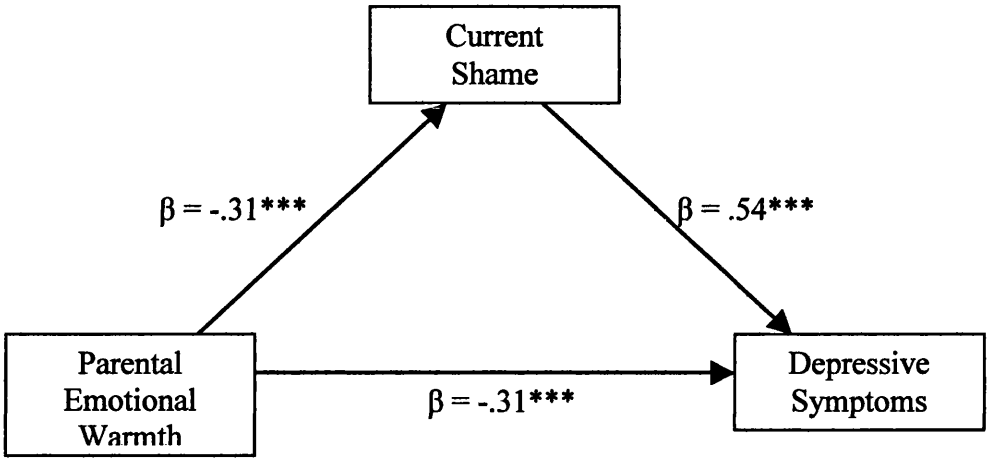


Figure 3.3: *The mediating effect of shame on the interaction between parental overprotection and adolescent depressive symptoms*

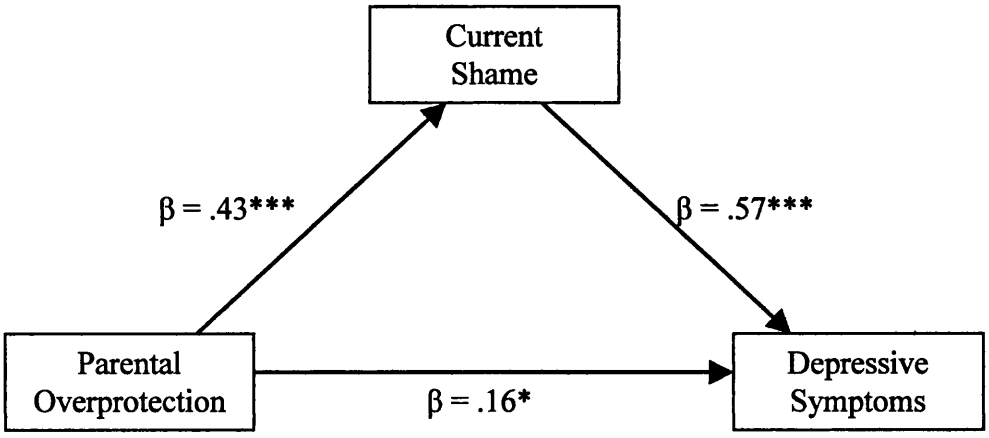
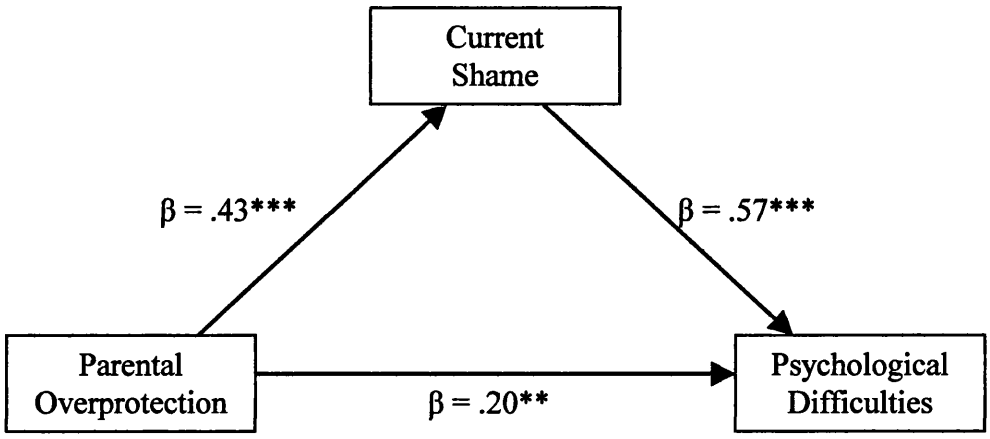


Figure 3.4: *The mediating effect of shame on the interaction between parental overprotection and adolescent psychological difficulties*



The effect of shame in the relationship between parental overprotection and psychological problems is approximately the same as with depressive symptoms. Shame seems to be mediating the relationship of depressive symptoms with overprotection to a greater degree than with emotional warmth.

3.4.iv *The mediating effect of social alliances on the pathway between parental style and depressive symptoms via shame*

Further mediation analyses were carried out in order to investigate the role of adolescents' social alliances in the pathway between parental rearing style, shame, and depressive symptoms. One of the factors of the SDQ is 'Peer Problems', which includes items such as "*Other people my age mostly like me*" and "*Other children or young people pick on me or bully me*", was used to measure the level of the adolescents' social alliance with peers.

Holding constant the effects of age and gender, two linear regressions with CDI score as the dependent variable, and either the EMBU factor of emotional warmth or overprotection as the independent variable were performed with the ESS score in block two of the regression and the SDQ score of Peer Problems in block three (*see table 3.13*). The effect of the independent variable (parental emotional warmth) on the dependent variable (depressive symptoms) decreased with the addition of the mediator (current shame), as reported above, but did not greatly decrease further after the addition of the second mediator (peer problems). The same pattern was found with the independent variable of parental overprotection. In other words, peer problems did not mediate the pathway from the parental style of emotional warmth to current depressive symptoms via current shame, and only partially mediated the pathway between shame and depressive symptoms for the parental style of overprotection.

As can be seen in figure 3.5, there was no significant relationship between peer problems and depressive symptoms after the effects of shame and emotional warmth were controlled for. Even though shame was significantly related to peer problems ($\beta = .47$, $t(155) = 6.47$, $p < .001$), the only pathway from shame to depressive symptoms was direct and not mediated by peer problems.

Table 3.13: *Regression to examine the effects of emotional warmth and overprotection on depressive symptoms, with and without the effect of current shame and peer problems*

Dependent Variable *Depressive Symptoms*	Overall effect			Independent predictors			
	F	p	Proportion of variance	Variable	t	β	p
Without Shame	11.13	*** .000	.18	Overprotection	5.56	.41	***
	16.90	*** .000	.25	Emotional Warmth	-6.93	-.49	***
With Shame	29.36	*** .000	.44	Overprotection	2.38	.16	*
				Current Shame	8.31	.57	***
	38.29	*** .000	.50	Emotional Warmth	-5.14	-.31	***
				Current Shame	8.78	.54	***
With Shame and Peer Problems	25.01	*** .000	.46	Overprotection	2.28	.15	*
				Current Shame	6.47	.50	***
				Peer Problems	2.17	.16	*
	31.44	*** .000	.51	Emotional Warmth	-4.83	-.30	***
				Current Shame	7.08	.49	***
				Peer Problems	1.58	.11	n.s

* p≤.05; ** p≤.01; ***p≤.001

Figure 3.5: *The mediating effects of shame and peer problems on the interaction between parental emotional warmth and adolescent depressive symptoms*

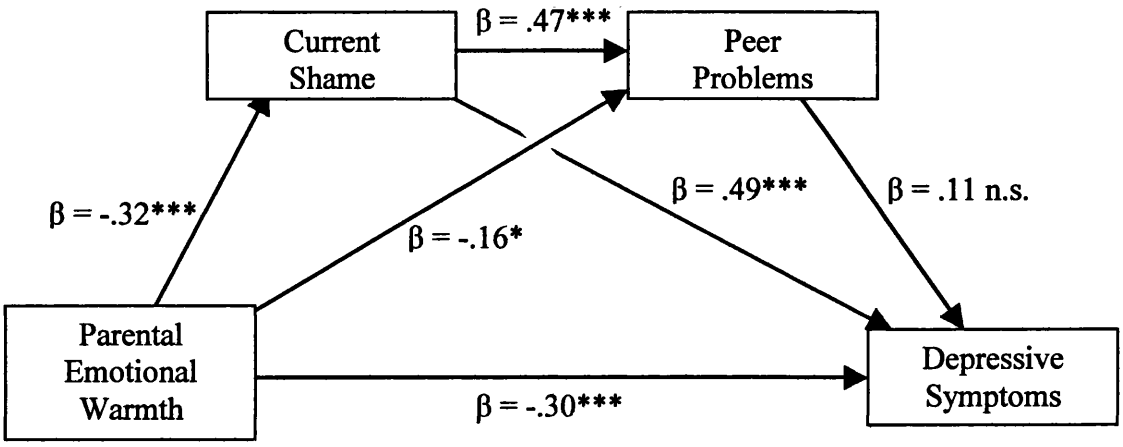
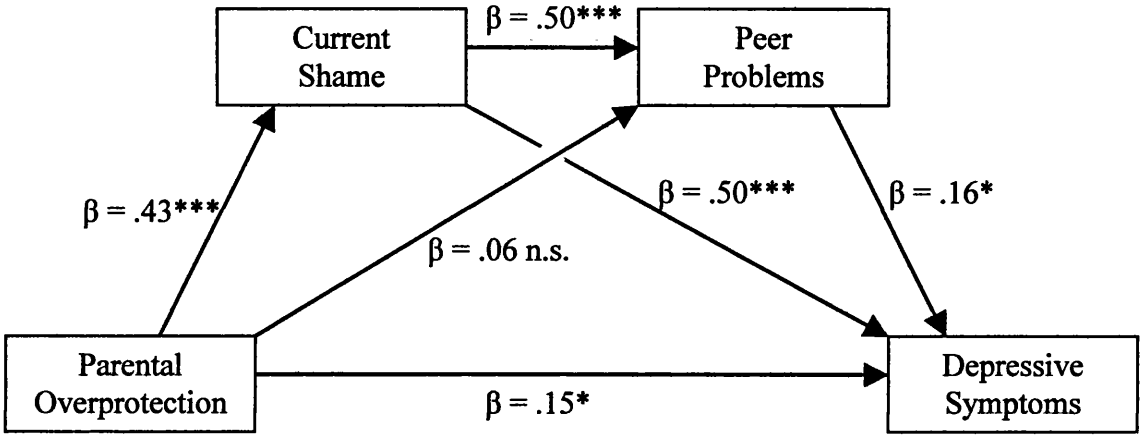


Figure 3.6 shows the mediating effects on the relationship between parental overprotection and depressive symptoms. In this case, the main mediator between overprotection and depression was shame, and this accounted for a large proportion of the relationship between the independent and dependent variable, however peer problems partially mediated the pathway between shame and depressive symptoms. There was no significant relationship between parental overprotection and peer problems once the effect of shame had been controlled for, therefore the pathway from this parental style to peer problems was mediated by shame. However, the pathway from shame to depressive symptoms was mainly direct (β = .50, $t(154)$ = 6.47, $p < .001$), with only a small (but significant) proportion being mediated by peer problems (β = .16, $t(154) = 2.17$, $p = .032$).

Figure 3.6: *The mediating effects of shame and peer problems on the interaction between parental overprotection and adolescent depressive symptoms*



3.5 Summary

There were not found to be any differences between ages or genders for levels of shame or psychological problems. Factorial analysis suggested that one factor of shame was measured as opposed to three proposed by Andrews, Qian, & Valentine (2002). Regressions showed that increased shame was associated with increased psychological problems; that increased parental overprotection related to increased psychological problems independently of other parental styles; and that lack of parental emotional warmth, as well as overprotection, related to increased depressive symptoms independently of other parental styles. Shame was found to mediate the relationship between parental style and psychological problems, and this pathway was mainly direct and not through problems with social alliance with peers.

Chapter 4

Discussion

This thesis attempted to address questions regarding the nature, course, and effect of shame in adolescence. The relationships between shame, parental style, psychological problems, and social difficulties were investigated via a cross-sectional, questionnaire-based study involving teenagers in the first three years of secondary school. After the key findings of this study are outlined, they will be more fully explored and related to the hypotheses previously presented. Following this, methodological issues, suggestions for further research, and implications of the findings are discussed.

4.1 Findings of this study

There were no significant differences in the levels of current shame or psychological problems across the age range or between genders. Opposed to multi-factored models of shame empirically investigated in adults, only one type of shame was reported by adolescents. However, in line with findings from research with adults, current shame-proneness was significantly related to psychological problems.

Parental rearing styles of overprotection and lack of emotional warmth significantly related to current shame-proneness and depressive symptoms, beyond the effect of

parental favouritism and shaming experiences. These relationships between parental rearing styles and psychological problems were partially mediated by shame. Finally, it was found that peer problems are not the main factor through which shame, associated with negative parental styles, leads to depressive symptoms in adolescents.

4.2 Shame in adolescence

4.2.i *The effects of gender and age*

The first question addressed by this study regarded the nature and course of shame during adolescence. More specifically, whether there is a difference in the levels of shame experienced by males and females, and whether the levels change across the age range investigated.

Shame has been closely linked to depression in previous studies, both theoretically and empirically (e.g. Tangney, Wagner, & Gramzow, 1992), therefore it has been assumed that levels of shame would correlate highly with levels of depression. Rates of depression are accepted to be higher in adult females than males, and this has also been found for older adolescents (Petersen, Sarigiani, & Kennedy, 1991). The increase in depression amongst girls, but not boys, has been linked to, amongst other factors, decreasing levels of self-esteem during puberty and intensified gender identity. The discrepancy of level of depression between genders has been shown to emerge at thirteen years of age and increase up to seventeen years old (Kandel & Davies, 1982).

The hypothesis that levels of shame would follow a similar pattern to depression and self-esteem during adolescence between genders was not supported in the current study. No differences of the level of shame between girls and boys, or across the age range of eleven years and nine months to fourteen years and eight months were found.

This does not necessarily imply that the differing relationship of shame and depression between genders does not apply to adolescents as it does to adults, as it was also found, in the current study, that levels of depression did not vary with age or gender. Although the age range investigated would have been hypothesised to have displayed the emerging increase in depression (and therefore, shame), it may be that, to identify the effect, a larger range of ages need to be assessed. Extending the study to include sixteen or seventeen year olds may show a greater difference of levels between genders, and therefore, demonstrate the expected effect.

Although levels of depression were not significantly different between ages and genders, differences in levels of shame were approaching significance, whereby girls tended to report higher levels of shame than boys. Although it may be that the effect was not significant due to the reasons discussed above, it may also be due to a cohort effect. It has been argued that the hypothesised relation of shame to gender is due to socially defined roles to which males and females are expected to adhere (Lindisfarne, 1998). Perhaps gender-roles are becoming increasingly blurred, or, more likely, there is increasing 'permission' for each gender to stray from the traditional roles of male and female. For example, the gap between the unequal values placed on males and females in terms of the importance of appearance and sexual

exploration could be argued to be narrowing. This may be having the effect of decreasing the differences between genders and, therefore, the levels of shame and subsequent depression.

On the one hand, teenage females may be experiencing a relative reduction of shame as they are given more opportunity for equality. On the other, shame may be increasing for teenage males who are beginning to experience, for example, the social pressure to attend to physical appearance to the same level that previously was mainly applied to females. It may be possible to investigate this hypothesis empirically, for example, by exploring recent trends in rates of shame, depression and eating disorders between teenage males and females, and relating it to previous theories regarding these phenomena and social pressure.

4.2.ii *The structure of shame in adolescence*

Andrews, Qian, and Valentine (2002) found three types of shame: characterological shame, behavioural shame, and bodily shame. It was hypothesised that these three factors would be found in the adolescent sample investigated in the current study. However, only one type of shame was identified. The factor analysis carried out in the previous chapter initially suggested four factors, however, at closer inspection, it seemed more plausible that the shame scale was measuring overall shame in this study.

There are several possible explanations for this finding. One reason could have been that the measure used was not designed for the population of which the sample was

gained. The measure was developed using a sample of one hundred and sixty-three psychology undergraduates. The participants had a mean age of twenty-three years and eleven months, and eighty-two percent were female. The current study had approximately equal numbers of males and females who were between early to mid adolescence. Perhaps the three types of shame found by Andrews et al. (2002) develop after the age of fourteen years and are more distinguishable among females. The younger age of the participants in this study and the fact that there were proportionately less females may explain why the factors were not identified.

It may also be that (even with additional wording to explain some items) the measure was not fully understood by adolescents due to their ability to distinguish between different types of shame not yet being developed. Even though the adolescents should have been able to distinguish shame from guilt and other self-conscious emotions (Ferguson, Stegge, & Damhuis, 1991), they may not yet be able to separate types of shame from a global feeling of shame. In other words, it was not that the factor structure of shame proposed by Andrews et al. does not hold true for adolescents, rather that they do not yet have the ability to report it accurately. Another possibility is that adolescents are at a developmental stage where they are experiencing new cognitive abilities of self-reflection that are not fully developed and therefore only experience an overall feeling of shame.

Originally, the Experience of Shame Scale was developed from an interview that was mainly used to explore the relationship between early experiences, eating disorders and shame. The current study was not directly concerned with these areas of research, which may also explain why the factors of shame were not found.

4.3 Shame and psychological problems

The hypothesis that higher levels of shame would relate to higher levels of psychological problems was supported. Depressive symptoms were measured via the Children's Depression Inventory (Kovacs, 1981) and general psychological problems were assessed using the Strengths and Difficulties Questionnaire (SDQ: Goodman, 1997) which looked at problems occuring with peers, conduct, emotions, and hyperactivity. The regressions used suggested approximately the same strength of relationship between shame and general psychological problems as suggested for the relationship between shame and depressive symptoms. Age and gender were found to have no effect on these relationships.

These findings demonstrate that shame relates to depressive symptoms in adolescents and echoes findings regarding this relationship in several studies investigating adult populations (e.g. Tangney, Wagner, & Gramzow, 1992). Theoretically, this relationship was expected as the cognitive style associated with shame, for example, the global, stable, internal attribution of blame (Lewis, 1992), is similar to the cognitive style related to depression (Robins, 1988). It could be that for adolescents, as for adults, the 'shame' cognitive style provides a greater proneness to depression following negative life events.

General psychological problems were associated with shame in the current study. There may be an overlap between various psychological problems in adolescence, which only become more distinct in adulthood. For example, conduct disorders are

part of the problems measured by the SDQ. The 'shamed' adolescent may experience depression and attempt to counteract this feeling by boosting their self-esteem in the short-term through behaviours that either provide positive attention from peers or distract the adolescent from their internal world temporarily. Examples of these behaviours could be bullying or defiance against teachers. Therefore, it may be difficult to separate psychological problems in to discreet entities rather than viewing them as manifestations of, or defences against, the painful feelings of depression, thereby possibly all relating to an underlying shame-proneness. In terms of conduct disorder, the findings of this study may support evidence of increased anger in shame-prone individuals (Tangney, Wagner, Fletcher, & Gramzow, 1992), and suggests that this anger may, at times, be directed outwards.

It could also be possible that different types of shame increase the probability of experiencing specific types of psychological problems, but that this study only assessed an overall shame-proneness (for reasons discussed above), therefore combining the effects of various potential types of shame. Further research, which includes different measures of shame linked to theoretical shame types, may explain whether there is a link between certain problems and certain types of shame in adolescence or whether shame is more diffuse and general in this population.

The findings of this study do suggest that shame is an important factor in adolescent psychological problems and may indicate that a useful focus of therapeutic interventions could be addressing the cognitive style attributed to shame. This recommendation has been made for adult clinical populations, however, the present study may suggest that the recommendation be extended to adolescents as young as eleven years old.

4.4 Parenting, shame, and psychological problems

4.4.i *Parenting style and psychological problems*

Perception of five parental rearing factors were explored in this study: Overprotection; Favouring the sibling over the participant; Favouring the participant over the sibling; Emotional warmth; and Shaming the participant. All five factors were found to contribute to depressive symptoms, however, a regression which controlled for the effects of each parenting style found that 'lack of emotional warmth' and 'overprotection' were related to depressive symptoms beyond the effect of the other factors. When exploring the relationship with general psychological problems, 'overprotection' was the only significant factor after the effects of the other styles were controlled for in the regression.

The findings concerning depressive symptoms support other research that has suggested that the perceived lack of parental emotional warmth and an overprotective parenting style relate to depression (e.g. Duggan, Sham, Minne, Lee, & Murray, 1998; Gerlsma, Emmelkamp, & Arrindell, 1990; Parker, 1979; Shah et al., 2000). However, this study demonstrated that the relationship is present and can be detected during adolescence, at least as early as the age of eleven years and nine months. Adult studies have examined the effect of *recalled* parental styles, whereas the current study involved questions concerning current perceptions of parenting. This may be useful for the following reason. Since a similar relationship was found as has been found in studies concerning recall, it may suggest that adults' recall of parenting style is an

accurate measure of the actual parenting style, or at least of the individuals' perception of the parenting style when they were still adolescents.

The findings of the current study do not support research conducted by Gilbert and Gerlsma (1999), which found that recall of parental rearing styles that were shaming and showed favouritism towards a sibling were more pathogenic than styles involving overprotection and lack of emotional warmth. It may be that the sample in the research by Gilbert and Gerlsma were much older than in the current study (i.e. mean age of forty-six years and nine months as opposed to adolescence), and included a clinical sample. Perhaps clinically depressed adolescents will perceive a similar pattern of parenting style as found in the adult study, and that there is a 'cut-off' level of parental shaming, above which significantly increases vulnerability to depression. Further possible explanations for the difference in findings are discussed below in the context of the relationship between parenting style and current shame-proneness.

In terms of general psychological problems, parental overprotection was found to be the only significantly related rearing style after the effects of the other styles were controlled for. This indicates that the perceived experience of overprotective parenting is the most pathogenic for adolescents. The items that measure overprotection in the EMBU relate to controlling the individual (e.g. "*Do your parents ever say which clothes you should wear and what you should look like?*"), being over-anxious about the individual (e.g. "*Do you find that your parents are over-scared that something will happen to you?*"), and expecting too much from the individual (e.g. "*Do your parents think that you have to be the best at everything?*").

It may be that pressure the adolescents feel from parents that attempt to control their activities, expect high achievements, and do not allow them the freedom to 'explore' (due to the parents' anxiety), lead them to 'rebel' against this environment by experimenting with behaviours that may be labelled as psychological problems (e.g. conduct disorder). 'Rebellion', borne out in risk-taking and disruptive behaviours, is a feature often associated with adolescence (Adams, 2000). Adolescents in the current study could be particularly concerned with their 'freedom' and developing identity and therefore those who reported more overprotective parents also experience higher levels of psychological problems as they attempt to manage the conflict between their wishes and those of their parents. Perhaps, those adolescents who also experience low emotional warmth from their parents are more vulnerable to depressive symptoms specifically as the lack of parental affection means that they do not internalise a sense of self-worth.

4.4.ii *Parenting style and shame*

Although all the parental rearing styles correlated with current shame-proneness, the styles that were more strongly related (after other styles were controlled for in a linear regression) were overprotection and lack of emotional warmth. In other words, parental over-control and emotional unavailability were more related than parental shaming to adolescents' current shame.

The finding that parental over-control and lack of emotional warmth relates to shame in the individual provides support for theories that link perceptions of inadequate parental responsiveness with shame in adults (e.g. Kohut, 1978; Lewinsohn et al.,

1987). This is similar to the findings of Lutwak and Ferarri (1997) that shame is associated with memories of parents being demanding, over-controlling, and non-nurturing. However, to my knowledge, this is the first study to explore this relationship using current perceptions of parenting (from adolescents) as opposed to adults' recall of their parents' rearing style. Therefore it may be possible that the current study could be considered to demonstrate how parental rearing style predicts shame proneness, rather than how shame proneness affects recall of parenting style. However, parenting style is measured via an adolescent self-report measure and therefore is still the individual's subjective view on parenting. In which case, these findings suggest that the relationship between shame and parenting that has been previously shown in adults is already occurring in early adolescence.

One implication of this is that preventative interventions aimed at parents, designed to adjust their behaviour towards their children in order to reduce the possibility of shame and depression in their offspring, should be conducted when the children are younger than eleven years old. Further research with younger children may better pinpoint at which age negative parenting styles begin to engender shame-proneness in children.

Perceived experiences of parental shaming did not predict adolescents' current shame levels to a greater degree than overprotection and lack of emotional warmth. This seemingly paradoxical finding can be explained in several ways. The study which found that parental shaming and feeling unfavoured compared to a sibling were the most pathogenic parental styles involved adult participants (Gilbert & Gerlsma, 1999). It may be that, as an individual becomes an adult, they evaluate the parenting

they received in terms of their current understanding of the constraints and anxieties of adulthood and parenthood.

Perhaps adults view 'overprotection' more as caring than unreasonably restrictive which may have been the view they took as adolescents. For example, items from the overprotection factor of the EMBU such as "*Do you wish your parents would worry less about what you are doing?*" and "*Do you feel that your parents expect a lot from you in the way of report grades, sporting achievements and so on?*" may be rated highly by an adolescent who feels that their parents are too intrusive, however, when they become adults, they may rate these items as lower as they reevaluate the intention of their parents (for example, feeling that their parents worried at a reasonable level about them). If this is the case, then it may be that recall of parental shaming becomes more strongly associated with current shame in adulthood as the level of recall of overprotection lessens and therefore becomes less strongly associated. However, this does not explain why recall of emotional unavailability becomes less associated with shame than parental shaming in adulthood.

Another possible reason for why the relationship between parental shaming (above other parental styles) and current shame-proneness was not detected in this study is that the items that measure shaming (e.g. "*Do your parents ever tell you off when there are other people present?*" and "*Do your parents say unpleasant things about you to other people, for example, that you are lazy or difficult?*") do not actually measure the types of experience that contribute to shame and therefore depression. These items may be measuring parental criticism, but not necessarily shaming. Parental shaming may have been measured by other factors of the EMBU, for example, parental protectiveness that was not appropriate for the age of the

adolescent may be seen as controlling, devaluing of the adolescent's own abilities, and therefore shaming (Gilbert & Gerlsma, 1999).

Theories that describe the purpose of shame as an inhibitor of positive affect associated with negative appraisal of the self (e.g. Gilbert, 1998) may explain the relationship between recall of emotional unavailability and current shame. In a similar manner as proposed in attachment theory, lack of emotional warmth may be related to failures of parent-infant attachment which could lead to shame in the infant (Kaufman, 1989). The role of shame as an inhibitor of the infant's positive affect may be necessary in order to teach the child how to regulate positive and negative affect for themselves. However, continual, generalised inhibition of positive affect through a parental style characterised by lack of emotional warmth could disrupt the child internalising a sense of self-worth as they are continually met with a lack of parental approval. These repeated experiences of lack of parental emotional warmth, which are theorised to provoke an innate shame response (Schore, 1998), may eventually lead the child to become practised at responding to events with a shame response, leading to an increased shame proneness which continues through adolescence and adult life.

4.4.iii *The role of shame in the relationship between parental style and psychological problems.*

A relationship was found between parenting styles that were overprotective or emotionally unavailable and adolescents' current shame as well as psychological problems. Current shame was also found to be related to psychological problems. In

order to provide more information about this relationship, a mediation analysis was conducted which suggested that shame was a partial mediator in the path between parenting styles and adolescent psychological problems.

Although shame and self-esteem are different constructs, they may overlap to some degree, as they both concern self-conscious emotions based on evaluations of self-worth. Previous theories and empirical research have suggested a mediating effect of self-esteem in the pathway between parental style and adult depression (e.g. Brown & Harris, 1978; Lloyd & Miller, 1997). The current study has found partial mediation effects of shame in this pathway. This may provide support for research that has suggested that shame mediates the pathway between early experiences and adult depression (e.g. Andrews, 1995; Gilbert, Allan, & Goss, 1996).

The findings may suggest that, to some degree, the psychological problems experienced by adolescents, which are due to their perception of their parenting, occur through an increased shame proneness. The mediating affect of shame seems to be similar for the pathway between the parental style of overprotection and general psychological problems as it is for the pathway to depressive symptoms. It could be that parental over-controlling style leads to shame in adolescence that generally increases vulnerability to psychological problems. The pathway between lack of parental emotional warmth and depressive symptoms was mediated by shame to less of a degree than found for parental overprotection. It may be that the shame that adolescents develop through emotional unavailability of their parents is particularly associated with depression above the shame that predisposes them to general psychological problems brought about by parental overprotection. In order to explore

this hypothesis more fully, further studies need to be conducted which include shame scales that accurately assess different subtypes of shame within adolescents.

The mediating effect of shame was only partial, indicating that there are other factors that need to be explored in order to fully understand how parenting styles affect the offspring's psychological well-being. Examples of other factors that could be explored are the individual's coping style and the protective effect of a positive relationship with other adults (e.g. other family members or teachers etc).

Interestingly, it seems that shame mediated the effect of parental overprotection to a greater degree than parental emotional unavailability, which may be due to social rank theories of shame (Gilbert, 1992; 1998). Parents' 'over-controlling' of their children may be reducing the child's sense of independence. During adolescence (a time where individuals are attempting to gain independence whilst also attempting to maintain a relationship with parents) if the level of parental protection is greater than is age-appropriate, the adolescent may be feeling demoted in terms of their rank within the family. In other words, the new, more equal, adult relationship that they are attempting to form with their parents becomes disrupted as they are reminded of their position as child (with the associated power imbalance), therefore, shame is experienced as social rank is perceived as lost. This 'social rank related shame' may lead to psychological problems as the adolescent either attempts to gain social rank in other situations through inappropriate means (e.g. bullying or risk-taking to impress peers) or feels helpless to regain social rank, becoming depressed. Clearly, these hypotheses are not answered in the current study, but will require further research in order to test their accuracy.

4.4.iv *The role of peer problems in the relationship between parenting style, shame, and depressive symptoms*

Shame has been shown to mediate the relationship between parental rearing styles and depressive symptoms. Further analyses found that the mediation was mainly through shame rather than peer problems. The parental style of emotional warmth seems to relate to shame and (to a lesser degree) peer problems, however, peer problems were not found to relate to depressive symptoms. In other words, although an emotionally unavailable parental style may predict shame proneness in the teenager, and this shame proneness does seem to contribute to difficulties forming good social alliances, the resulting depressive symptoms are more likely to be directly due to the shame rather than the social problems. Parental overprotection only seemed to relate to peer problems through shame, and the main path to depressive symptoms was via shame with less of an effect via peer problems. The effect of an over-controlling parental style may affect the adolescent's social functioning due to their increased shame proneness, however, it is mainly their level of shame that relates to depressive symptoms and their problems socially relate to less of a degree. For both parental styles, there was still found to be a direct effect of parenting on depressive symptoms, which may indicate that there are other factors that need to be explored in future research in order to fully understand the pathway between parenting style and depression.

These findings provide some support for the theory that self-conscious emotion mediates the relationship between lack of parental emotional warmth and

psychological problems, and that social difficulties mediate the relationship between overprotective parenting and psychological problems (Parker, Barrett & Hickie, 1992). However, the current study found that the overprotective parenting-depressive symptoms relationship was only partially mediated by social difficulties and the main effect was through shame.

The theory proposed by Gilbert and Gerlsma (1999) was not fully supported by the findings of the current study. They proposed that negative parental rearing styles would disrupt an internalisation of self-worth and attractiveness in the child, which would lead them to behave in an over-aggressive or over-timid manner within their peer group. The resulting poor peer relations being a vulnerability factor to psychopathology. The current study suggests that even though negative parenting styles seem to affect the adolescents' peer relations, and that this is via shame (internalisation of low self-worth and attractiveness), it is the shame itself that leads to depressive symptoms, rather than the resulting social problems. In other words, it may be the adolescent's own internalised models of their self and associated cognitive style that are mainly predictive of depressive symptoms and not problems with their interpersonal relationships.

A recent study highlighted the importance of parental relationships with adolescents, over peer relationships, in terms of vulnerability to depression (Stice, Ragan, & Randall, 2004). It was found that support from parents was more protective against risk of depression than support from peers for individuals in early adolescence. In a similar vein, the current study may also be suggesting that for adolescents, interactions with parents provide more of a vulnerability to, or protective factor against, depressive symptoms, than do interactions with peers.

4.5 Methodological issues

There are several methodological issues that could have an impact on the interpretations of the findings. The current study is cross-sectional; therefore it is difficult to attribute causality to the relationships that have been suggested. This may be particularly important to the relationship explored between parental style, shame, peer problems, and depressive symptoms. It is also plausible that interpersonal problems could be contributing to adolescents' level of shame rather than vice versa. However, in the current study, findings have been interpreted according to previous theories regarding the direction of the relationship.

All measures in the current study were self-report. This means that it was the subjective view of the adolescent that was gained rather than objective reports from parents or teachers. Many investigations of this nature involving children and adolescents contain both self-rated and other-rated scales. While this may provide adults' opinions of the children's behaviours, it does mean that reporting is potentially inconsistent, as the views of a parent and child, for example, of their psychological state, may be differ between respondent. A purely self-reported design may provide more reliable data as it is gained solely from one source. In the current study, it was assumed that the subjective experience of an individual is the factor that is important in terms of psychological problems or shame-proneness. Therefore, even though the views of others may provide an objective view of, for example, parenting

style, it could be argued that it is how the adolescent *experiences* their parenting that affects their cognitions and emotions.

Gender and age were not found to affect the levels or relationships between the variables. Even though adolescents from eleven years and nine months to fourteen years and eight months were included in the study, a wider range of ages across adolescence may have found the effects of age or gender that have been proposed in previous studies. Another issue is that the questionnaire booklets involved many items and therefore the adolescents that managed to complete the booklet may have been of a higher ability academically. This may mean that the final sample could have been slightly biased in terms of scholastic ability. To counteract this potential bias, participants were given a second chance to complete the booklet in order to obtain data from pupils who took longer to complete the questionnaires. There may still have been a slight bias, even after this precautionary step. However it could be expected that higher academic ability may be a protective factor against psychological problems, which could actually add weight to the findings of the study.

A final issue could have been Type I errors due to the number of statistical investigations involved in the study. In order to minimise this potential effect, conservative routes were taken wherever possible (e.g. missing value analysis), and statistical analyses were only conducted for relationships hypothesised to occur.

4.5.i *Future research directions*

Further research suggested by the limitations discussed above may provide a more complete understanding of the course of psychopathology through the lifespan. Firstly, a longitudinal study would be the best method to employ in order to be more confident of the direction of relationships between variables. A study which compared objective ratings of parental rearing styles at various points from the birth of the child up to adolescence could then further explore whether it is the actual style of parenting or the adolescent's perception of parenting that is important in the development of shame and psychological problems. It could also investigate how accurate the adolescent's perception of their parenting is compared to the actual rearing styles their parents adopted.

The current study involved adolescents from a non-clinical population. A study which includes a clinical sample may provide further information regarding the relationship between parental styles, shame, and psychopathology. Even though the current study may have provided evidence regarding shame and mood in non-clinical adolescents, a clinical sample may be useful to assess whether the relationships are different for adolescents that meet criteria for diagnoses of psychological problems.

Another potential study involving a clinical sample that may provide further information regarding the role of shame in adolescent psychological problems involves measuring the outcome of therapeutic interventions. If an intervention that specifically targeted feelings of shame was devised and evaluated, it may explore the effect of manipulating levels of shame on an adolescent's psychological well-being.

4.6 Implications of findings

The current study empirically explored the role of shame in adolescence. To date, there have been very few studies that have explicitly investigated this area. Research of shame in adulthood has increased in frequency over the last few decades and this study explores whether some of the findings of research with adults could be applicable to adolescents. Within an adolescent population, shame appears to be an important factor in the development of psychological problems and accounts partly for how perceptions of parenting may lead to such problems. One implication of this finding could be that therapy with adolescents might benefit from a focus on the affect of shame.

Another finding of this study was that parental overprotection and lack of emotional warmth seemed to be important factors in adolescent psychological problems and shame. This could suggest that preventative interventions designed to reduce psychological problems in adolescence could identify these parenting styles and might benefit from being aimed at families before the child becomes an adolescent.

Shame and parental style seemed to relate to psychological problems in adolescence with a greater effect than peer problems. One implication of this may be that, although there may be an effect of shame and parenting on the adolescent's social relationships, it is the adolescent's internal model of their self, rather than their interpersonal functioning, that affects their psychological well-being. A further implication may be that it highlights the continuing importance of parents to the developing adolescent while they are striving for their own independence.

References

Achenbach, T. M. (1991). *Manual for the Child Behaviour Checklist/4-18 and 1991 profile*. Burlington: University of Vermont, Department of Psychiatry.

Adams, G. (2000). *Adolescent development: The essential readings*. Oxford: Blackwell Publishers Ltd.

Andrews, B. (1995). Bodily shame as a mediator between abusive experiences and depression. *Journal of Abnormal Psychology, 104,* 277-285.

Andrews, B. & Hunter, E. (1997). Shame, early abuse, and course of depression in a clinical sample: A preliminary Study. *Cognition and Emotion, 11,* 373-381.

Andrews, B., Qian, M., & Valentine, J. D. (2002). Predicting depressive symptoms with a new measure of shame: The experience of shame scale. *British Journal of Clinical Psychology, 41,* 29-42.

Arrindell, W. A., Emmelkamp, P. M. G., Brilman, E., & Monsma, A. (1983). Psychometric evaluation of an inventory for assessment of parental rearing practices: A Dutch form of the EMBU. *Acta Psychiatrica Scandinavica, 67,* 177.

Arrindell, W. A., Gerlsma, C., Vandereycken, W., Hageman, W. J. J. M., & Daeseleire, T. (1998). Convergent validity of the dimensions underlying the Parental Bonding Instrument (PBI) and the EMBU. *Personality and Individual Differences, 24,* 341-350.

Arrindell, W. A., Perris, C., Eisemann, M., Van der Ende, J., Gaszner, P., Iwawaki, S. et al. (1994). Parental rearing behaviour from a cross-cultural perspective: A summary of data obtained in 14 nations. In C.Perris, W. A. Arrindell, & M. Eisemann (Eds.), *Parenting and Psychopathology* (Chichester: Wiley. Cited in: Arrindell, W., Gerlsma, C., Vandereycken, W., Hageman, W., & Daeseleire, T. (1998). Convergent validity of the dimensions underlying the Parental Bonding Instrument (PBI) and the EMBU. *Personality and Individual Differences. 24.* 341-350.

Baron, R. M. & Kenny, D. A. (1986). The moderator-mediator distinction in social psychology: Conceptual, strategic and statistical considerations. *Journal of Personality and Social Psychology, 51,* 1173-1182.

Barrett, K. C. (1995). A functionalist approach to shame and guilt. In J.P.Tangney & K. W. Fisher (Eds.), *Self-conscious emotions: the psychology of shame, guilt, embarrassment, and pride* (pp. 25-63). New York: The Guilford Press.

Barrett, K. C., Zahn-Waxler, C., & Cole, P. M. (1993). Avoiders vs. amenders: Implications for the investigation of guilt and shame during toddlerhood? *Cognition and Emotion, 7,* 481-505.

Bateman, A. & Holmes, J. (1995). *Introduction to psychoanalysis.* London: Routledge.

Beck, A. T. (1967). *Depression: Clinical, experimental, and theoretical aspects.* New York: Hoeber.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders.* New York: International Universities Press.

Beck, A. T., Emery, G., & Greenberg, R. L. (1985). *Anxiety disorders and phobias: A cognitive approach.* New York: Basic Books.

Beck, A. T., Epstein, N., & Harrison, R. P. (1983). Cognitions, attitudes and personality dimensions in depression. *British Journal of Cognitive Psychotherapy, 1,* 1-16.

Bell, J. H. & Bromnick, R. D. (2003). The social reality of the imaginary audience: A ground theory approach. *Adolescence, 38,* 205-219.

Berndt, D. J., Schwartz, S., & Kaiser, C. F. (1983). Readability of self-report depression inventories. *Journal of Consulting and Clinical Psychology, 51,* 627-628.

Berzonsky, M. D. (2000). Theories of adolescence. In G.Adams (Ed.), *Adolescent Development: The essential readings* (pp. 11-27). Oxford: Blackwell Publishers Ltd.

Bowlby, J. (1969). *Attachment and loss: Vol 1. Attachment.* New York: Basic Books.

Bowlby, J. (1980). *Attachment and Loss: Vol 3. Loss, Sadness and Depression.* London: Hogarth Press.

Brewin, C. R., Andrews, B., & Gotlib, I. H. (1993). Psychopathology and early experiences: A reappraisal of retrospective reports. *Psychological Bulletin, 113,* 82-98.

Brooks-Gunn, J. & Reiter, E. O. (1990). The role of pubertal processes. In S.S.Feldman & G. R. Elliott (Eds.), *At the threshold: The developing adolescent* (Cambridge: Harvard University Press.

Brown, G. W. & Harris, T. O. (1978). *Social origins of depression: A study of psychiatric disorder in women.* London: Free Press.

Carver, C. S. & Ganellen, R. J. (1983). Depression and components of self-punitiveness: High standards, self-criticism, and overgeneralisation. *Journal of Abnormal Psychology, 92,* 330-337.

Cheung, M. S.-P., Gilbert, P., & Irons, C. (2004). An exploration of shame, social rank and rumination in relation to depression. *Personality and Individual Differences, 36,* 1143-1153.

Darwin, C. (1969). *The expression of emotions in man and animals.* Chicago: University of Illinois Press. (Originally published 1872).

Duggan, C., Sham, P., Minne, C., Lee, A., & Murray, R. (1998). Quality of parenting and vulnerability to depression: Results from a family study. *Psychological Medicine, 28,* 185-191.

Dutton, G. D., van Ginkel, C., & Starzomski, A. (1995). The role of shame and guilt in the intergeneration transmission of abusiveness. *Violence and Victims, 10,* 121-131.

Elander, J. & Rutter, M. (1996). Use and development of the Rutter parents' and teachers' scales. *International Journal of Methods in Psychiatric Research, 6,* 63-78.

Elkind, D. & Bowen, R. (1979). Imaginary audience behavior in children and adolescents. *Developmental Psychology, 15,* 38-44.

Erikson, E. H. (1968). *Identity: Youth and crisis.* New York: Norton.

Ferguson, T. J. & Stegge, H. (1995). Emotional states and traits in children: The case of guilt and shame. In J.P.Tangney & K. W. Fischer (Eds.), *Self-conscious emotions: The psychology of shame,guilt,embarrassment,and pride* (pp. 174-197). New York,NY,US: Guilford Press.

Ferguson, T. J., Stegge, H., & Damhuis, I. (1991). Children's understanding of guilt and shame. *Child Development, 62,* 827-839.

Finch, A. J., Saylor, C. F., Edwards, G. L., & McIntosh, J. A. (1987). Children's Depression Inventory: Reliability over repeated administrations. *Journal of Clinial Child Psychology, 16,* 339-341.

Gerlsma, C., Arrindell, W. A., van der Veen, N., & Emmelkamp, P. M. G. (1991). A parental rearing style questionnaire for use with adolescents: Psychometric evaluation of the EMBU-A. *Personality and Individual Differences, 12,* 1245-1253.

Gerlsma, C., Emmelkamp, P. M. G., & Arrindell, W. A. (1990). Anxiety, depression, and perception of early parenting: A meta-analysis. *Clinical Psychology Review, 10,* 251-277.

Gilbert, P. (1989). *Human nature and suffering.* Hove, UK.: Erlbaum.

Gilbert, P. (1992). *Depression: The evolution of powerlessness.* Hove: Erlbaum.

Gilbert, P. (1997). The evolution of social attractiveness and its role in shame, humiliation, guilt and therapy. *British Journal of Medical Psychology, 70,* 113-147.

Gilbert, P. (1998). What is shame? Some core issues and controversies. In P.Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 3-38). New York: Oxford University Press.

Gilbert, P. (2003). Evolution, social roles, and the differences in shame and guilt. *Social Research, 70,* 1205-1230.

Gilbert, P., Allan, S., Brough, S., Melley, S., & Miles, J. (2002). Anhedonia and positive affect: Relationship to social rank, defeat and entrapment. *Journal of Affective Disorders, 71,* 141-151.

Gilbert, P., Allan, S., & Goss, K. (1996). Parental representations, shame, interpersonal problems, and vulnerability to psychopathology. *Clinical Psychology and Psychotherapy, 3(1),* 23-34.

Gilbert, P., Cheung, M. S.-P., Grandfield, T., Campney, F., & Irons, C. (2003). Recall of threat and submissiveness in childhood: Development of a new scale and its relationship with depression, social comparison and shame. *Clinical Psychology and Psychotherapy, 10,* 108-115.

Gilbert, P. & Gerlsma, C. (1999). Recall of shame and favouritism in relation to psychopathology. *British Journal of Clinical Psychology, 38,* 357-373.

Gilbert, P. & McGuire, M. T. (1998). Shame, status, and social roles: Psychobiology and evolution. In P.Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (New York: Oxford University Press.

Gilbert, P., Pehl, J., & Allan, S. (1994). The phenomenology of shame and guilt: An empirical investgation. *British Journal of Medical Psychology, 67,* 23-36.

Goodman, R. (1997). The strengths and difficulties questionnaire: A research note. *Journal of Child Psychology and Psychiatry, 38,* 581-586.

Goodman, R., Meltzer, H., & Bailey, V. (2003). The Strengths and Difficulties Questionnaire: A pilot study on the validity of the self-report version. *International Review of Psychiatry, 15,* 173-177.

Goodman, R. & Scott, S. (1999). Comparing the Strengths and Difficulties Questionnaire and the Child Behaviour Checklist: Is small beautiful? *Journal of Abnormal Child Psychology, 27,* 17-24.

Goodyer, I. M. (1990). *Life Experiences, Development and Childhood Psychopathology.* Chichester: Wiley.

Henderson, V. L. & Dweck, C. S. (1990). Motivation and achievement. In S.S.Feldman & G. R. Elliott (Eds.), *At the threshold: The developing adolescent* (Cambridge: Harvard University Press.

Hewitt, P. L., Caelian, C. F., Flett, G. L., Sherry, S. B., Collins, L., & Flynn, C. A. (2002). Perfectionism in children: Associations with depression, anxiety and anger. *Personality and Individual Differences, 32,* 1049-1061.

Heyman, G. D., Dweck, C. S., & Cain, K. M. (1992). Young children's vulnerability to self-blame and helplessness: Relationship to beliefs about goodness. *Child Development, 63,* 401-415.

Higgins, A. T. (1987). Self-discrepancy: A theory relating self and affect. *Psychological Review, 94,* 319-340.

Irons, C. & Gilbert, P. Evolved mechanisms in adolescent anxiety and depression: The role of the attachment and social rank systems. *Journal of Adolescence,* (in press).

Izard, C. E. (1984). Emotion-cognition relations and human development. In C.E.Izard, J. Kagan, & R. B. Zajonc (Eds.), *Emotions, cognitions, and behavior* (pp. 17-37). New York: Cambridge University Press.

Izard, C. E. & Malatesta, C. Z. (1987). Perspectives on emotional development 1: Differential emotions theory of early emotional development. In J.Osofsky (Ed.), *Handbook of infant development. 2nd ed.* (pp. 494-554). New York: Wiley.

Janoff-Bulman, R. (1979). Characterological versus behavioural self-blame: Inquiries into depression and rape. *Journal of Personality and Social Psychology, 37,* 1798-1809.

Johnson, R. C., Danko, G. P., Huang, Y. H., Park, J. Y., Johnson, S. B., & Nagoshi, C. T. (1987). Guilt, shame and adjustment in three cultures. *Personality and Individual Differences, 8,* 357-364.

Kandel, D. B. & Davies, M. (1982). Epidemiology of depressive mood in adolescents. *Archives of General Psychiatry, 39,* 1205-1212.

Katchadourian, H. (1990). Sexuality. In S.S.Feldman & G. R. Elliott (Eds.), *At the threshold: The developing adolescent* (Cambridge: Harvard University Press.

Kaufman, G. (1989). *The psychology of shame: Theory and treatment of shame-based syndromes.* New York: Springer.

Keating, D. P. (1990). Adolescent thinking. In S.S.Feldman & G. R. Elliott (Eds.), *At the threshold: The developing adolescent* (Cambridge: Harvard University Press.

Keitner, G. I., Ryan, C. E., Miller, I. W., Kohn, R., Bishop, D. S., & Epstein, N. B. (1995). Role of the family in recovery and major depression. *American Journal of Psychiatry, 152,* 1002-1008.

Kohut, H. (1978). *The Search for the self.* New York: International Universities Press.

Kovacs, M. (1985). The children's depression inventory (CDI). *Psychopharmacology Bulletin, 21,* 995-998.

Kovacs, M. (1992). *The children's Depression Inventory (C.D.I.) Manual.* New York: Multi-Health Systems Inc.

Lewinsohn, P. M. & Rosenbaum, M. (1987). Recall of parental behaviour by acute depressives, remitted depressives, and non-depressives. *Journal of Personality and Social Psychology, 52,* 611-619.

Lewis, H. B. (1971). *Shame and guilt in neurosis.* New York: International Universities Press.

Lewis, H. B. (1987). Shame and the narcisstic personality. In D.Nathanson (Ed.), *The many faces of shame* (New York: Guilfrod Press. Cited in: Tangney, J., Wagner, P., Fletcher. C., & Gramzow, R. (1992). Shamed into anger? The relation of shame and guilt to anger and self-reported aggression. *Journal of Personality and Social Psychology. 62:* 669-675.

Lewis, M. (1992). *Shame: The exposed self.* New York: The Free Press.

Lewis, M. (1995). Embarrassment: The Emotion of Self-Exposure and Evaluation. In J.P.Tangney & K. W. Fisher (Eds.), *Self-conscious emotions: The psychology of shame, guilt, embarrassment, and pride* (New York: The Guilford Press.

Lewis, M., Alessandri, S. M., & Sullivan, M. W. (1992). Differences in shame and pride as a function of children's gender and task difficulty. *Child Development, 63,* 630-638.

Lindisfarne, N. (1998). Gender, shame, and culture: An anthropological perspective. In P.Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behaviour, psychopathology, and culture* (London: Oxford University Press.

Lindsay-Hartz, J., de Rivera, J., & Mascolo, M. F. (1995). Differentiating Guilt and Shame and Their Effects on Motivation. In J.P.Tangney & K. W. Fisher (Eds.), *Self-conscious emotions: The psychology of shame, guilt, embarrassment, and pride* (New York: The Guilford Press.

Lloyd, C. & Miller, P. (1997). The relationship of parental style to depression and self-esteem in adulthood. *The Journal of Nervous and Mental Disease, 185(11),* 655-663.

Lutwak, N. & Ferrari, J. R. (1997). Understanding shame in adults: Retrospective perceptions of parental-bonding during childhood. *The Journal of Nervous and Mental Disease, 185(10),* 595-598.

Lutwak, N., Panish, J. B., Ferrari, J. R., & Razzino, B. E. (2001). Shame and guilt and their relationship to positive expectations and anger expressiveness. *Adolescence, 36,* 641-653.

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

Morrison , A. (1989). *Shame: The underside of narcissism.* Hillsdale, New Jersey.: The Analytic Press.

Nathanson, D. L. (1992). *Shame and pride: Affect, sex and the birth of the self.* New York: Norton.

Nolen-Hoeksema, S., Grayson, C., & Larson, J. (1999). Explaining the gender difference in depressive symptoms. *Journal of Personality and Social Psychology, 77,* 1061-1072.

Oakley-Browne, M. A., Joyce, P. R., Wells, J. E., Bushnell, J. A., & Hornblow, A. R. (1995). Adverse parenting and other childhood experiences as risk factors for depression in women aged 18-44 years. *Journal of Affective Disorders, 34,* 13-23.

Parker, G. (1979). Parental characteristics in relation to depressive disorders. *British Journal of Psychiatry, 134,* 138-147.

Parker, G. (1981). Parental reports of depressives: An investigation of several explanations. *Journal of Affective Disorders, 3,* 140.

Parker, G., Barrett, B. A., & Hickie, I. (1992). From nurture to network: Examining links between perceptions of parenting received in childhood and social bonds in adulthood. *American Journal of Psychiatry, 149,* 877-885.

Parker, G., Tupling, H., & Brown, L. B. (1979). A parent bonding instrument. *British Journal of Medical Psychology, 52,* 1-10.

Perris, C., Jacobsson, L., Lindström, H., Von Knorring, L., & Perris, H. (1980). Development of a new inventory for assessing memories of parental rearing behaviour. *Acta Psychiatrica Scandinavica, 61,* 265-274.

Petersen, A. C., Sarigiani, P. A., & Kennedy, R. E. (1991). Adolescent depression: Why more girls? *Journal of Youth and Adolescence, 20,* 247-271.

Piers, G. & Singer, M. B. (1971). *Shame and guilt.* New York: Norton.

Preacher, K. J. & Leonardelli, G. J. (2003). Calculation for the Sobel Test: An interactive calculation tool for mediation tests. http://www.unc.edu/~preacher/sobel/sobel.htm [On-line].

Reimer, M. S. (1996). "Sinking into the ground": The development and consequences of shame in adolescence. *Developmental Review, 16,* 321-363.

Riggs, J. (1992). Self-Handicapping and achievement. In A.K.Boggiano & T. S. Pittman (Eds.), *Achievement and motivation: A social-developmental perspective.* (Cambridge: Cambridge University Press.

Robins, C. J. (1988). Attributions and depression: Why is the literature so inconsistent? *Journal of Personality and Social Psychology, 54,* 880-889.

Rodgers, B. (1996). Reported parental behaviour and adult affective symptoms: 1. Associations and moderating factors. *Psychological Medicine, 26,* 51-61.

Ross, M. W., Campbell, R. L., & Clayer, J. R. (1982). New inventory for measurement of parental rearing patterns: An English form of the EMBU. *Acta Psychiatrica Scandinavica, 66,* 499-507.

Rutter, M. (1986). The developmental psychopathology of depression: Issues and perspectives. In M.Rutter, C. E. Izard, & P. Read (Eds.), *Depression in young people* (New York: Guilford Press.

Schore, A. N. (1991). Early superego development: The emergence of shame and narcissistic affect regulation in the practicing period. *Psychoanalysis and Contemporary Thought, 14,* 187-250.

Schore, A. N. (1998). Early shame experiences and infant brain development. In P.Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture* (pp. 57-77). New York: Oxford University Press.

Shah, R. & Waller, G. (2000). Parental style and vulnerability to depression. *The Journal of Nervous and Mental Disease, 188,* 19-25.

Smucker, M. R., Craighead, W. E., Craighead, L. W., & Green, B. J. (1986). Normative and reliability data for the Children's Depression Inventory. *Journal of Abnormal Child Psychology, 14,* 25-39.

Steinberg, L. (1990). Autonomy, conflict, and harmony in the family relationship. In S.S.Feldman & G. R. Elliott (Eds.), *At the threshold: The developing adolescent* (pp. 255-276). Cambridge: Harvard University Press.

Stice, E., Ragan, J., & Randall, P. (2004). Prospective relations between social support and depression: Differential direction of effects for parent and peer support? *Journal of Abnormal Psychology, 113,* 115-159.

Stipek, D. J. & De Cotis, K. M. (1988). Children's understanding of the implications of causal attributions for emotional experiences. *Child Development, 59,* 1601-1616.

Tangney, J. P. (1995). Shame and guilt in interpersonal relationships. In J.P.Tangney & K. W. Fisher (Eds.), *Self-conscious emotions: The psychology of shame, guilt, embarrasment and pride.* (New York: Guilford.

Tangney, J. P., Burggraf, S. A., & Wagner, P. E. (1995). Shame-proneness, guilt-proneness, and psychological symptoms. In J.P.Tangney & K. W. Fisher (Eds.), *Self-conscious emotions: The psychology of shame, guilt, embarrassment, and pride* (New York: The Guilford Press.

Tangney, J. P. & Dearing, R. L. (2002). *Shame and guilt.* New York: The Guilford Press.

Tangney, J. P., Hill-Barlow, D., Wagner, P. E., Marschall, D. E., Borenstein, J. K., Sanftner, J. et al. (1996a). Assessing individual differences in constructive versus destructive responses to anger across the lifespan. *Journal of Personality and Social Psychology, 70,* 780-796.

Tangney, J. P., Wagner, P. E., Fletcher, C., & Gramzow, R. (1992). Shamed into anger? The relation of shame and guilt to anger and self-reported aggression. *Journal of Personality and Social Psychology, 62,* 669-675.

Tangney, J. P., Wagner, P. E., & Gramzow, R. (1989). *The Test of Self-Conscious Affect.* Fairfax, VA: George Mason University.

Tangney, J. P., Wagner, P. E., & Gramzow, R. (1992). Proneness to shame, proneness to guilt, and psychopathology. *Journal of Abnormal Psychology, 101,* 469-478.

Tangney, J. P., Wagner, P. E., Hill-Barlow, D., Marschall, D. E., & Gramzow, R. (1996b). Relation of shame and guilt to constructive versus destructive

responses to anger across the lifespan. *Journal of Personality and Social Psychology, 70,* 797-809.

Tomkins, S. S. (1963). *Affect, imagery, consciousness. Vol 2: The negative affects.* New York: Springer-Verlag.

Tomkins, S. S. (1987). Shame. In D.Nathanson (Ed.), *The many faces of shame* (pp. 133-161). New York: The Guilford Press.

Uchino, B. N., Cacioppo, J. T., & Kiecolt-Glaser, J. K. (1996). The relationship between social support and physiological processes: A review with emphasis on underlying mechanisms and implications for health. *Psychological Bulletin, 119,* 488-531.

Vartanian, L. R. (2001). Adolescents' reactions to hypotheical peer group conversations: Evidence for an imaginary audience? *Adolescence, 36,* 347-380.

Weiss, B. & Weisz, J. R. (1988). Factor structure of self-reported depression: Clinic-referred children versus adolescents. *Journal of Abnormal Psychology, 97,* 492-495.

Wichstrøm, L. (1999). The emergence of gender difference in depressed mood during adolescence: The role of intensified gender socialisation. *Developmental Psychology, 35,* 232-245.

Wurmser, L. (1981). *The mask of shame.* Baltimore: John Hopkins University Press.

Appendix A:

Notification of Ethical Approval

The Graduate School
University College London
Gower Street London WC1E 6BT

Professor Leslie C Aiello
Head of the Graduate School

Tel:
Fax:
Email: gradschoolhead@ucl.ac.uk

13 February 2004

Dr Chris Barker
Sub-Department of Clinical Health Psychology
University College London
Gower Street
London WC1E 6BT

Dear Dr Barker

Re: Notification of Ethical Approval

Project ID: 0123/001: Factors Involved in Adolescent Psychological Problems

Further to the email from the Committee Secretary on 23 January 2004, the above research has been given ethical approval following review by the UCL Committee for the Ethics of non-NHS Human Research for the duration of the project (30 January 2004 – 31 December 2004) subject to the following conditions:

1. You must seek Chair's approval for proposed amendments to the research for which this approval has been given. Ethical approval is specific to this project and must not be treated as applicable to research of a similar nature. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing the 'Amendment Approval Request Form'.

The form identified above can be accessed by logging on to the ethics website homepage: http://www.grad.ucl.ac.uk/ethics/ and clicking on the button marked 'Key Responsibilities of the Researcher Following Approval'.

2. It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. Both non-serious and serious adverse events must be reported.
   Reporting Non-Serious Adverse Events.
   For non-serious adverse events you will need to inform Ms Taki Austin, Ethics Committee Administrator (**taki.austin@ucl.ac.uk**), within ten days of an adverse incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Chair or Vice-Chair of the Ethics Committee will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Reporting Serious Adverse Events
The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator immediately the incident occurs. Where the adverse incident is unexpected and serious, the Chair or Vice-Chair will decide whether the study should be terminated pending the opinion of an independent expert. The adverse event will be considered at the next Committee meeting and a decision will be made on the need to change the information leaflet and/or study protocol.

3. On completion of the research you MUST submit a brief report (maximum of two sides of A4) of your findings to the Committee. Please comment in particular on any ethical issues you might wish to draw to the attention of the Committee. We are particularly interested in comments that may help to inform the ethics of future similar research.

Yours sincerely

Sir John Birch
Chair of the UCL Committee for the Ethics of Non-NHS Human Research

Appendix B:

Letter and Information for Schools

Sub-Department of Clinical Health Psychology
UNIVERSITY COLLEGE LONDON
GOWER STREET LONDON WC1E 6BT

General Enquiries:
Clinical Tutor Team:
Senior Secretary:
UCL Switchboard: 020-7679 2000
Code from overseas: +44 20
Fax: 020-7916 1989
www.ucl.ac.uk/clinical-health-psychology/

Letter for School

Dear (Head Teacher),

Re: Clinical Psychology Investigation of Psychological Problems in Adolescence

I am a Trainee Clinical Psychologist based at University College London and am currently designing a study that aims to investigate psychological aspects of emotional and behavioural problems amongst adolescent school children. The study will provide valuable information for schools and clinical services regarding:

- The extent of clinically significant psychological problems amongst adolescent school children.
- The relationship between the adolescent's experiences of shame and their current psychological states.
- The role of parenting factors in adolescent psychological problems.

The research will involve administering a set of standardised questionnaires to students in years 7 and 10, which ask questions regarding their recall of upbringing, their view of their current friendships, experiences of shame, and their current feelings.

I would be most grateful for the opportunity to conduct this research within your school. This proposal has been approved in principle by Andrew Lee, Principal Educational Psychologist, The Learning Trust, Hackney, as well as Chris Barker, Research Coordinator, Sub-Dept of Clinical Health Psychology, UCL. However it is for each individual school to decide whether to participate.

I have enclosed an information sheet outlining the study, and also a consent form and information sheet for parents and a consent form and information sheet for students. The research has been approved by the UCL Research Ethics Committee. I hope it will be acceptable for me to contact you shortly in order to ascertain whether you would be happy for this research to commence.

I will be happy to answer any questions you may have about this research. Please contact me at the address above or via email: r.bennett@ucl.ac.uk .

Yours sincerely,

Robin Bennett
Trainee Clinical Psychologist

Sub-Department of Clinical Health Psychology
UNIVERSITY COLLEGE LONDON
GOWER STREET LONDON WC1E 6BT

General Enquiries:
Clinical Tutor Team:
Senior Secretary:
UCL Switchboard: 020-7679 2000
Code from overseas: +44 20
Fax: 020-7916 1989
www.ucl.ac.uk/clinical-health-psychology/

Information for School

Study Title: Factors Involved in Adolescent Psychological Problems.

Name of Investigators: Robin Bennett, Dr Chris Barker.

What will the research involve for your school?

The investigator would require a 30 minute time slot within the school day to administer the questionnaires to the students. The questionnaires can be administered to all consenting students within a class at the same time.

The students will be asked about their memories of their upbringing, their perceived strengths and difficulties, friendships, and current mood.

Parental consent and confidentiality

All parents will be sent an information sheet about the study and asked to sign and return a reply slip if they do not wish their child to participate in the study. If possible, we would like information regarding the study to be sent out from the school. Students will also be asked for their informed consent before participating.

The completed questionnaires will be used for research purposes only, and no names will be attached to them. Teachers will not see students' completed forms and we cannot provide information to parents or teachers about individual student's responses. However, if a student appears to have serious psychological problems, parents and the school will be consulted, and if appropriate, the child will be referred to local child clinical psychology services.

Who is doing the research?

This research is being conducted by Robin Bennett, an employee of Camden and Islington Community Health Services NHS Trust, as part of a Doctorate in Clinical Psychology. Robin Bennett is being supervised by Dr Chris Barker, Senior Lecturer, University College London.

Are there any drawbacks in this research for the children?

All the questionnaires have been developed and tested with adolescents and ask about good and bad experiences. It is highly unlikely that any of the questions being asked will cause new problems or distress to the students. However, should any student wish to discuss any worries raised by participating in the research, the investigator will be available to do so. Students will be informed that their teacher or parent may be notified if significant concerns are raised and the investigator will be able to facilitate referrals to local services if this is indicated.

All proposals for research in which people take part are reviewed by an ethics committee before they can begin. This proposal has been reviewed by the UCL Committee on the Ethics of Non-NHS Human Research. However, if you do have any concerns, you are welcome to contact me at the address below.

I would be most grateful for the opportunity to conduct this research within your school.

Thank you for attending to this information sheet.

Yours sincerely,

Robin Bennett

Email: r.bennett@ucl.ac.uk

Appendix C:

Information and Consent Form for Parents

Sub-Department of Clinical Health Psychology
UNIVERSITY COLLEGE LONDON
GOWER STREET LONDON WC1E 6BT

General Enquiries: 020-7679 1897
Clinical Tutor Team: 020-7679 1258
Senior Secretary: 020-7679 5699
UCL Switchboard: 020-7679 2000
Code from overseas: +44 20
Fax: 020-7916 1989
www.ucl.ac.uk/clinical-health-psychology/

Information for Parents and Consent Form

Factors Involved in Adolescent Psychological Problems

Dear Parent,

Your child's school is co-operating with research looking at factors involved in the development of psychological problems in adolescents. The research should help the Local Education Authority, schools and other professionals help adolescents who develop or may develop psychological problems. This letter is to invite your child to take part.

Before you decide whether your child can take part in the current study, it is important for you to understand what the research will involve. Please take time to read the following information carefully and discuss it with others if you wish.

What is the purpose of the study?

Adolescence can be a turbulent time of life and sometimes psychological problems can develop during this period. The aim of the current study is to try to find out what contributes to adolescents' developing these problems and what helps them to avoid developing them.

Why is my child being asked to take part?

We are approaching all children in years 7 and 10 at your child's school. This school has been chosen because it is big and takes both boys and girls.

What does the research involve?

Children will be seen in school time and will be asked to fill in some brief questionnaires which are especially designed for their age and have been used before in other studies. These questionnaires ask about children's thoughts and feelings and their view of friendships and memories of upbringing. Completing the questionnaires will take no longer than about 30 minutes and will take place within lesson time.

Is the research confidential?

Yes. The questionnaires completed by the children will be used for research purposes only and names will be removed to keep answers confidential. Teachers will not see the forms the children complete. However, if we find a child is having problems, we will discuss how best to help them with parents and schools.

Are there any risks from taking part?

There is no reason to believe that taking part in this study would be harmful in any way and taking part in the study will not affect your child's schooling.

All proposals for research in which people take part are reviewed by an ethics committee before they can begin. This proposal was reviewed by the UCL Committee on the Ethics of Non-NHS Human Research. If you did have any concerns, however, you are free to contact us at the address given below.

What happens now?

Your child does not have to take place in this study if he or she does not want to. If your child does decide to take part, they may withdraw at any time without having to give a reason. Your child's decision to take part or not, will not affect their schooling or teaching in any way. Please sign and return the slip at the bottom of this information sheet if you do not want your child to participate in the study.

Who should I contact if I have any questions?

Please contact Robin Bennett if there is anything that is not clear or if you would like more information.

Thank you for taking the time to read this information sheet.

Yours sincerely

Robin Bennett
Sub-Department of Clinical Health Psychology
University College London
Gower Street
WC1 6BT
Email: r.bennett@ucl.ac.uk

Factors Involved in Adolescent Psychological Problems
Robin Bennett & Dr Chris Barker
Please complete this slip and return it to your child's class teacher if you **DO NOT** wish your child to take part in the study.

I have read the information sheet, but I do not wish my child to take part in this study.

Signed ..... Date .....
Name in capital letters .....

If you are happy for your child to take part, you do not have to return this slip.

Appendix D:

Consent Form for Participants

Consent Form for Participants

Feelings about Friendships and Childhood

Investigators: Robin Bennett and Dr Chris Barker

Please put a circle round your answer

I have been told about this study and had the chance to ask questions.	**YES**	**NO**
I agree to take part and know that I can stop at any time.	**YES**	**NO**

Please write your name here _____

Thank you for your help.

Appendix E:

Information for Participants

Information for Participants

Information for Participants
(to be read by the investigator, prior to questionnaire administration)

My name is Robin Bennett. I am interested in how adolescents feel about their friendships and childhood. I want to find out what helps adolescents to feel well. I am trying to meet as many adolescents as I can in your year.

I am inviting you to help me. If you decide that you would like to take part, I will ask you to fill out some questionnaires that have been especially designed for people your age which ask you about what you think about your friendships, childhood, and how you feel. What you tell me will not be given to your teachers or parents. However, if I feel an adolescent might be helped by other people knowing about their worries, I may talk to their parents or school about my concern and how best to help them.

If you find anything hard to understand, or you would prefer to do the questions with me, just ask. This is not a test, and there are no right answers.

I would be very pleased if anyone wants to ask about what I have said. If you have any worries about the questionnaires, I hope you'll be able to tell me straight away.

If after you have started you feel that you want to stop, then that will be fine.

Do you have any questions?

Appendix F:

Questionnaire Booklet

How old are you?

Years: _____ Months: _____

Who lives at home with you? *(Please tick the boxes)*

- ❑ Mother
- ❑ Father
- ❑ Older brothers. How many? _____
- ❑ Older sisters. How many? _____
- ❑ Younger brothers. How many? _____
- ❑ Younger sisters. How many? _____
- ❑ Other: *(please write in)*_____

How would you describe your ethnic background? *(Please tick the box)*

White
- ❑ British
- ❑ Irish
- ❑ Any other White background: *(please write in)*_____

Mixed
- ❑ White and Black Caribbean
- ❑ White and Black African
- ❑ White and Asian
- ❑ Any other Mixed background: *(please write in)*_____

Asian or Asian-British
- ❑ Indian
- ❑ Pakistani
- ❑ Bangladeshi
- ❑ Any other Asian background: *(please write in)*_____

Black or Black-British
- ❑ Caribbean
- ❑ African
- ❑ Any other Black background: *(please write in)*_____

Chinese or other ethnic group
- ❑ Chinese
- ❑ Any other ethnic group: *(please write in)*_____

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Children's Depression Inventory (CDI)

People sometimes have different feelings and ideas.

This form lists the feelings and ideas in groups. From each group of three sentences, pick ***one*** sentence that describes you best for the past two weeks. After you pick a sentence from the first group, go on to the next group.

There are no right or wrong answers. Just pick the sentence that best describes the way you have been for the last two weeks.
Put a mark like this – **X** in the box next to your answer.

Remember to pick out the sentences that describe you best in the **PAST TWO WEEKS.**

Item 1
- ☐ I am sad once in a while.
- ☐ I am sad many times.
- ☐ I am sad all the time

Item 2
- ☐ Nothing will ever work out for me.
- ☐ I am not sure if things will work out for me.
- ☐ Things will work out for me OK.

Item 3
- ☐ I do most things OK.
- ☐ I do many things wrong.
- ☐ I do everything wrong.

Item 4
- ☐ I have fun in many things.
- ☐ I have fun in some things.
- ☐ Nothing is fun at all.

Item 5
- ☐ I am bad all the time.
- ☐ I am bad many times.
- ☐ I am bad once in a while.

Item 6
- ☐ I think about bad things happening to me once in a while.
- ☐ I worry that bad things will happen to me.
- ☐ I am sure that terrible things will happen to me.

Item 7
- ☐ I hate myself.
- ☐ I do not like myself.
- ☐ I like myself.

Item 8
- ☐ All bad things are my fault.
- ☐ Many bad things are my fault.
- ☐ Bad things are not usually my fault

Item 9
- ☐ I feel like crying everyday.
- ☐ I feel like crying many days.
- ☐ I feel like crying once in a while.

Item 10
- ☐ Things bother me all the time.
- ☐ Things bother me many times.
- ☐ Things bother me once in a while.

Item 11
- ☐ I like being with people.
- ☐ I do not like being with people many times.
- ☐ I do not like being with people at all.

Item 12
- ☐ I cannot make up my mind about things.
- ☐ It is hard to make up my mind about things.
- ☐ I make up my mind about things easily.

Remember to pick out the sentences that describe you best in the **PAST TWO WEEKS.**

Item 13
- ☐ I look OK.
- ☐ There are some bad things about my looks.
- ☐ I look ugly.

Item 14
- ☐ I have to push myself all the time to do my schoolwork.
- ☐ I have to push myself many times to do my schoolwork.
- ☐ Doing schoolwork is not a big problem.

Item 15
- ☐ I have trouble sleeping every night
- ☐ I have trouble sleeping many nights.
- ☐ I sleep pretty well.

Item 16
- ☐ I am tired once in a while.
- ☐ I am tired many days.
- ☐ I am tired all the time.

Item 17
- ☐ Most days I do not feel like eating.
- ☐ Many days I do not feel like eating.
- ☐ I eat pretty well.

Item 18
- ☐ I do not worry about aches and pains.
- ☐ I worry about aches and pains many times.
- ☐ I worry about aches and pains all the time.

Item 19
- ☐ I do not feel alone.
- ☐ I feel alone many times.
- ☐ I feel alone all the time.

Item 20
- ☐ I never have fun at school.
- ☐ I have fun at school once in a while.
- ☐ I have fun at school many times.

Item 21
- ☐ I have plenty of friends.
- ☐ I have some friends but I wish I had more.
- ☐ I do not have any friends.

Item 22
- ☐ My schoolwork is alright.
- ☐ My schoolwork is not as good as before.
- ☐ I do very badly in subjects I used to be good in.

Item 23
- ☐ I can never be as good as other kids.
- ☐ I can be as good as other kids if I want to.
- ☐ I am just as good as other kids.

Item 24
- ☐ Nobody really loves me.
- ☐ I am not sure if anybody loves me.
- ☐ I am sure that somebody loves me

Item 25
- ☐ I usually do what I'm told.
- ☐ I do not do what I'm told most times.
- ☐ I never do what I'm told.

Item 26
- ☐ I get along with people.
- ☐ I get into fights many times.
- ☐ I get into fights all the time.

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Experience of Shame Scale (ESS)

Everybody at times can feel embarrassed, self-conscious or ashamed. These questions are about these feelings if they have happened **at any time in the past year**. There are no 'right' or 'wrong' answers. For each question, please circle which number applies to you.

1 = not at all

2 = a little

3 = moderately (some)

4 = very much

		not at all → very much			
1.	Have you felt ashamed of any of your personal habits?	1	2	3	4
2.	Have you worried about what other people think of any of your personal habits?	1	2	3	4
3.	Have you tried to cover up or hide any of your personal habits?	1	2	3	4
4.	Have you felt ashamed of your manner with others? (the way you are with other people)	1	2	3	4
5.	Have you worried about what other people think of your manner with others? (the way you are with other people)	1	2	3	4
6.	Have you avoided people because of your manner? (your way of being and doing things)	1	2	3	4
7.	Have you felt ashamed of the sort of person you are?	1	2	3	4
8.	Have you worried about what other people think of the sort of person you are?	1	2	3	4
9.	Have you tried to hide from others the sort of person you are?	1	2	3	4
10.	Have you felt ashamed of your ability to do things? (of being able to do things)	1	2	3	4
11.	Have you worried about what other people think of your ability to do things?	1	2	3	4
12.	Have you avoided people because of your inability to do things? (because of not being able to do things)	1	2	3	4

		not at all → very much			
13.	Do you feel ashamed when you do something wrong?	1	2	3	4
14.	Have you worried about what other people think of you when you do something wrong?	1	2	3	4
15.	Have you tried to cover up or hide things you felt ashamed of having done?	1	2	3	4
16.	Have you felt ashamed when you said something stupid?	1	2	3	4
17.	Have you worried about what other people think of you when you said something stupid?	1	2	3	4
18.	Have you avoided seeing anyone who knew you said something stupid?	1	2	3	4
19.	Have you felt ashamed when you failed at something which was important to you?	1	2	3	4
20.	Have you worried about what other people think of you when you fail?	1	2	3	4
21.	Have you avoided people who have seen you fail?	1	2	3	4
22.	Have you felt ashamed of your body or any part of it?	1	2	3	4
23.	Have you worried about what other people think of your appearance? (what you look like)	1	2	3	4
24.	Have you avoided looking at yourself in the mirror?	1	2	3	4
25.	Have you wanted to hide your body or any part of it?	1	2	3	4

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My Strengths and Difficulties (SDQ)

These questions are about how you have been for the last six months. Please tick the box to show if each sentence is **not true**, **a bit true**, or **very true** if it is about you.

Please try to answer all the questions, even if you are not sure or the sentence seems daft!

If you are not sure what a sentence means, please ask me. There are no right or wrong answers to these questions.

		not true	a bit true	very true
1.	I try to be nice to people, I care about their feelings	not true	a bit true	very true
2.	I can't stay still for long	not true	a bit true	very true
3.	I get a lot of headaches, stomach-aches or sickness	not true	a bit true	very true
4.	I usually share with others (for example food, games, pens, etc)	not true	a bit true	very true
5.	I get very angry and often lose my temper	not true	a bit true	very true
6.	I am usually on my own. I play alone or keep to myself	not true	a bit true	very true
7.	I usually do as I'm told	not true	a bit true	very true
8.	I worry a lot	not true	a bit true	very true
9.	I am helpful if someone is hurt, upset, or feeling ill	not true	a bit true	very true
10.	I am always fidgeting or squirming	not true	a bit true	very true
11.	I have one good friend or more	not true	a bit true	very true
12.	I fight a lot. I can make other people do what I want	not true	a bit true	very true
13.	I am often unhappy, down-hearted or tearful	not true	a bit true	very true
14.	Other people my age mostly like me	not true	a bit true	very true
15.	I find it hard to concentrate	not true	a bit true	very true
16.	I am nervous in new situations. I easily lose confidence	not true	a bit true	very true
17.	I am kind to younger children	not true	a bit true	very true

18.	I am often told off for lying and cheating	not true	a bit true	very true
19.	Other children or young people pick on me or bully me	not true	a bit true	very true
20.	I often try to help other people (parents, teachers, children)	not true	a bit true	very true
21.	I think before I do things	not true	a bit true	very true
22.	I take things that are not mine from home, school, or other places	not true	a bit true	very true
23.	I get on better with adults than people my own age	not true	a bit true	very true
24.	I have fears. I am easily scared	not true	a bit true	very true
25.	I finish the work I'm doing. I am good at paying attention	not true	a bit true	very true

Confidential

My Memories of Upbringing (EMBU)

These questions are about how you see your parenting.

Please mark the box to show how true each question is for you. You can choose from **No, never**, **Yes, sometimes**, **Yes, often**, or **Yes, usually**.

Answer each question twice. Once for how it applies to your **Mother** (pink lines) and once for how it applies to your **Father** (blue lines). If you are not in contact with both parents, just fill in the lines for the parent that you are in contact with. Here's an example for someone who gets collected most days from school by their mother, but never by their father.

Do your parents collect you from school?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually

Some questions talk about brother(s) and sister(s). If you do not have any brothers or sisters, please leave these questions out.

Please try to answer all the questions, even if you are not sure or the sentence seems daft!

If you are not sure what a sentence means, please ask me. There are no right or wrong answers to these questions.

		No, never	Yes, sometimes	Yes, often	Yes, usually
1.	Do your parents interfere in everything you do?	No, never	Yes, sometimes	Yes, often	Yes, usually
		No, never	Yes, sometimes	Yes, often	Yes, usually
2.	Do your parents show that they love you?	No, never	Yes, sometimes	Yes, often	Yes, usually
		No, never	Yes, sometimes	Yes, often	Yes, usually
3.	Compared to your brother(s) and sister(s), are you spoiled by your parents?	No, never	Yes, sometimes	Yes, often	Yes, usually
		No, never	Yes, sometimes	Yes, often	Yes, usually
4.	Do your parents think that you have to try and go far in the world?	No, never	Yes, sometimes	Yes, often	Yes, usually
		No, never	Yes, sometimes	Yes, often	Yes, usually

5. Do you get things from your parents that your brother(s) and sister(s) don't get?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
6. If you've done something stupid, can you then make it up to your parents?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
7. Do your parents ever say which clothes you should wear and what you should look like?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
8. Do you get the feeling that your parents are more fond of your brother(s) and sister(s) than of you?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
9. Are your parents more unfair to you than to your brother(s) and sister(s)?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
10. Do your parents forbid you to do things that your class-mates are allowed to do because they are afraid that something will happen to you?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
11. Do your parents tell you off when there are other people present?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
12. Do your parents worry about what you are doing after school has finished?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
13. If things aren't going well for you, do your parents try to make you feel better or help you?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
14. If you have done something which isn't allowed, do your parents act so unhappy that you start to feel guilty?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
15. Do you feel that is difficult to talk to your parents?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
16. Do your parents talk about something you have said or done in front of others so that you feel ashamed?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually

17. Do you feel that your parents love you more than your brother(s) and sister(s)?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
18. Are your parents interested in your school grades?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
19. Do you feel that your parents mind helping you if you have to do something difficult?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
20. Do your parents treat you like the "black sheep" or the "scapegoat" of the family?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
21. Do your parents usually criticise the friends that you like?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
22. Do your parents think that you have to be the best at everything?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
23. Do your parents make it clear that they love you?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
24. Do you think that your parents take your opinion into account?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
25. Do you feel that your parents like being with you?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
26. Do your parents say things like "If you do that, you will make me sad".	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
27. Do you have to tell your parents what you've been doing when you get home?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually

28.	Do you feel that your parents are trying to provide you with a happy youth during which you can learn about all sorts of different things (for example, through books and excursions and so on)?	No, never	Yes, sometimes	Yes, often	Yes, usually
		No, never	Yes, sometimes	Yes, often	Yes, usually
29.	Do your parents ever pay you compliments?	No, never	Yes, sometimes	Yes, often	Yes, usually
		No, never	Yes, sometimes	Yes, often	Yes, usually
30.	Do you ever feel guilty because you're behaving in a way that your parents don't approve of?	No, never	Yes, sometimes	Yes, often	Yes, usually
		No, never	Yes, sometimes	Yes, often	Yes, usually
31.	Do you feel that your parents expect a lot from you in the way of report grades, sporting achievements and so on?	No, never	Yes, sometimes	Yes, often	Yes, usually
		No, never	Yes, sometimes	Yes, often	Yes, usually
32.	Can you count on help and understanding from your parents if you're unhappy?	No, never	Yes, sometimes	Yes, often	Yes, usually
		No, never	Yes, sometimes	Yes, often	Yes, usually
33.	Do your parents allow you to do the same things as your friends do?	No, never	Yes, sometimes	Yes, often	Yes, usually
		No, never	Yes, sometimes	Yes, often	Yes, usually
34.	Do your parents say unpleasant things about you to other people, for example, that you are lazy or difficult?	No, never	Yes, sometimes	Yes, often	Yes, usually
		No, never	Yes, sometimes	Yes, often	Yes, usually
35.	When something happens, do your parents put the blame mainly on you?	No, never	Yes, sometimes	Yes, often	Yes, usually
		No, never	Yes, sometimes	Yes, often	Yes, usually
36.	Do you wish your parents would worry less about what you are doing?	No, never	Yes, sometimes	Yes, often	Yes, usually
		No, never	Yes, sometimes	Yes, often	Yes, usually
37.	Are your parents interested in your hobbies and what you like doing?	No, never	Yes, sometimes	Yes, often	Yes, usually
		No, never	Yes, sometimes	Yes, often	Yes, usually
38.	Are you usually allowed to go where you like without your parents caring too much?	No, never	Yes, sometimes	Yes, often	Yes, usually
		No, never	Yes, sometimes	Yes, often	Yes, usually

39. Do your parents tell you exactly what you are and are not allowed to do – and then they stick to this strictly?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
40. Do your parents ever treat you in a way that makes you feel small?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
41. Do your parents let your sister(s) and brother(s) have things which you're not allowed to get?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
42. Do you find that your parents are over-scared that something will happen to you?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
43. Do you feel that your parents and you like each other?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
44. Do your parents allow you to have different opinions from their own?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
45. Do you feel that your parents are proud of you if you do something really well?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
46. Do your parents treat you better than they treat your brother(s) and sister(s)?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
47. Do your parents blame your brother(s) and sister(s) when it was actually your fault?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually
48. Do your parents show that they love you, for example by giving you a hug?	No, never	Yes, sometimes	Yes, often	Yes, usually
	No, never	Yes, sometimes	Yes, often	Yes, usually

Overprotection:	Items 1, 4, 7, 10, 12, 14, 21, 22, 26, 27, 30, 31, 36, 38, 39, 42
Emotional Warmth:	Items 2, 6, 13, 15, 18, 19, 23, 24, 25, 28, 29, 32, 33, 37, 43, 44, 45, 48
Favouring Sibling:	Items 8, 9, 20, 35, 41
Favouring Subject:	Items 3, 5, 17, 46, 47
Shaming:	Items 11, 16, 34, 40