

Shame, Guilt, and Depressive Symptoms: A Meta-Analytic Review

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Recent theoretical and empirical work has facilitated the drawing of sharp conceptual distinctions between shame and guilt. A clear view of these distinctions has permitted development of a research literature aimed at evaluating the differential associations of shame and guilt with depressive symptoms. This study quantitatively summarized the magnitude of associations of shame and guilt with depressive symptoms. Two hundred forty-two effect sizes were obtained from 108 studies employing 22,411 participants. Shame showed significantly stronger associations with depressive symptoms ($r = .43$) than guilt ($r = .28$). However, the association of shame and depressive symptoms was statistically indistinguishable from the associations of 2 maladaptive variants of guilt and depressive symptoms (*contextual-maladaptive guilt*, involving exaggerated responsibility for uncontrollable events, $r = .39$; *generalized guilt*, involving “free-floating” guilt divorced from specific contexts, $r = .42$). Other factors also moderated the effects. *External shame*, which involves negative views of self as seen through the eyes of others, was associated with larger effect sizes ($r = .56$) than *internal shame* ($r = .42$), which involves negative views of self as seen through one’s own eyes. Depressive symptom measures that invoked the term *guilt* yielded stronger associations between guilt and depressive symptoms ($r = .33$) than depressive symptom measures that did not ($r = .21$). Age, sex, and ethnicity (proportion of Whites to Asians) did not moderate the effects. Although these correlational data are ambiguous with respect to their causal interpretation, results suggest that shame should figure more prominently in understandings of the emotional underpinnings of depressive symptoms.

Keywords: shame, guilt, depressive symptoms, meta-analysis

Major depressive disorder (MDD) is a debilitating psychiatric condition that affects millions of people across the world (World Health Organization, 2001). Even more common are subclinical levels of depressive symptoms which, like MDD, have profound negative implications for functioning in a variety of important life domains (Kessler, Zhao, Blazer, & Swartz, 1997). Research aimed at further understanding the causes, consequences, and correlates of depressive symptoms is especially important in light of the urgency of the wide-ranging problems they pose.

Illuminating the emotional experiences linked to depressive symptoms is a major area of inquiry (Greenberg & Watson, 2006; Rottenberg, 2005). Indeed, the depressive symptoms considered most critical to an MDD diagnosis are inherently emotional in nature, that is, the presence of increased negative emotion (depressed mood) and decreased positive emotion (loss of pleasure; American Psychiatric Association, 2000). A richer accounting of the emotional phenomenology of depressive symptoms requires examination of specific emotions that are less often the central

targets of clinical intervention and empirical research. Shame and guilt are two such emotions. Until fairly recently, the failure to clearly distinguish shame and guilt impeded the examination of the differential involvement of these emotions in depressive symptoms. More recent theoretical and empirical advances demonstrate that shame and guilt are separate emotions with different implications for psychological adjustment (see Tangney & Dearing, 2002, for a review). The formulation of sharp conceptual distinctions between shame and guilt, along with the construction of assessment tools that are sensitive to these distinctions, have facilitated the development of a research literature that attempts to answer an important question posed by the current meta-analytic review: To what extent are shame and guilt differentially involved in the experience of depressive symptoms?

We begin by offering background information necessary to situate the current study into its proper context. First, we briefly discuss distinctions between the so-called “basic” emotions and “self-conscious” emotions, a category to which shame and guilt are widely considered to belong (Tangney & Fischer, 1995; Tracy, Robins, & Tangney, 2007). Second, because examination of differential associations of shame and guilt with depressive symptoms is impossible without a clear view of their distinctions, we compare and contrast shame and guilt with respect to the dimensions most commonly discussed in the theoretical and empirical literatures. Third, we articulate a detailed rationale for the current study’s chief prediction, namely, that shame should be more

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strongly associated with depressive symptoms compared to guilt.¹ Fourth, we discuss subtypes of shame and guilt that might vary in the strength of their associations with depressive symptoms. Likewise, we discuss theoretical and methodological factors that might influence the strength of associations of shame and guilt with depressive symptoms. Finally, we outline our specific aims and hypotheses.

“Basic” Versus “Self-Conscious” Emotions

A common assumption held by a large number of emotion scientists is that there is a small set of “basic” or “primary” emotions that deserve privileged status. Numerous writers, dating back at least as far as William James (1884), have formulated lists of emotions considered good candidates for basic status (e.g., Ekman, Friesen, & Ellsworth, 1982; Izard, 1971; Oatley & Johnson-Laird, 1987; Panksepp, 1982; Plutchik, 1980; Tomkins, 1984). Substantial divergence across lists in the emotions that qualify for basic status is evident, but some consensus is noted. The emotional states that are labeled with the English words *anger* (or *rage*), *fear*, and *happiness* (or *joy*) almost always appear; *sadness*, *disgust*, and *surprise* enjoy less widespread, but still considerable, acceptance. The so-called “self-conscious” emotions (e.g., *pride*, *shame*, *guilt*, *embarrassment*), which are defined by self-evaluative processes in relation to important standards for behavior (Tangney & Fischer, 1995; Tracy et al., 2007), are rarely regarded as basic (but see Izard, 1971; Tomkins, 1984). Emotions have generally been considered basic to the extent that they are biologically given (although other criteria are noted; see Ortony & Turner, 1990). The biological criterion, and the assumptions that flow from it, bring distinctions between basic and self-conscious emotions into sharp relief.

Developmental Timing and Cognitive Complexity

Basic emotions are assumed to appear very early in development. Indeed, by around 6 to 8 months of age, infants show facial evidence of anger (M. Lewis, Alessandri, & Sullivan, 1990; Stenberg, Campos, & Emde, 1983), sadness (Izard, Hembree, Dougherty, & Spizzirri, 1983), disgust (Rosenstein & Oster, 1988), and joy (Bennett, Bendersky, & Lewis, 2002), all emotions that are routinely afforded basic status. The biological criterion also holds that complex cognitive operations are not required for the elicitation of basic emotions. Instead, it is commonly argued that specific environmental stimuli activate, in a more or less reflexive manner, brain-based “affect programs” (e.g., Tomkins, 1962) that trigger the cascade of coordinated responses characteristic of basic emotions.

In contrast, self-conscious emotions appear later on the developmental scene and are more cognitively complex. Shame and guilt develop by the end of the second year or beginning of the third year (Lagattuta & Thompson, 2007; but see Schore, 1998, for arguments related to earlier emergence). These self-conscious emotions are dependent on a fairly sophisticated cognitive apparatus that enables the self-evaluative processes that are widely seen as hallmarks of shame and guilt. The cognitive prerequisites for shame and guilt include self-awareness and a stable sense of self-as-separate-from-other (M. Lewis & Brooks-Gunn, 1979); the ability to direct attention toward the self and to self-reflect; an

understanding that the self is the agent of behavior (Kagan, 1981); the apprehension, endorsement, and internalization of standards for behavior (Stipek, Recchia, & McClintic, 1992); an ability to identify discrepancies between these standards and the self or its behavior; and attributions regarding the causes of events (Weiner, 1985). In sum, self-conscious emotions require an array of developmentally advanced cognitive skills that are seen as unnecessary for basic emotions.

Functions

Third, basic emotions are assumed to have primarily evolved to address immediate and typically urgent threats and opportunities related to physical survival and reproduction (Levenson, 1999; Plutchik, 1980; Tooby & Cosmides, 1990). Basic emotions are seen as useful in orchestrating diverse responses (e.g., behavioral, attentional, cognitive, physiological) required to confront these challenges.

In contrast, self-conscious emotions are assumed to address problems and opportunities related to “social survival.” That is, self-conscious emotions are widely viewed as being useful in negotiating problems of cooperation, group living, and maintenance of social relationships (Fessler, 2004; Gilbert, 1998; Gruenewald, Dickerson, & Kemeny, 2007; Keltner & Buswell, 1996; Leary, 2007). In fact, for some writers, self-conscious emotions are defined by their social and interpersonal functions. Numerous theoretical perspectives converge on the notion that self-conscious emotions evolved as part of a package of adaptations that prioritized maintenance of status, prevention of group rejection, and negotiation of complex social structures, all of which have been critical to the evolutionary success achieved by the human species.

Cultural Contributions

Basic emotions are also widely assumed to be pancultural. That is, there is assumed to be substantial cross-cultural consistency in the antecedent conditions, subjective experience, expressive displays, and functions of basic emotions. To the extent that basic emotions evolved to help address universal, pancultural tasks of physical survival and reproduction (e.g., defend against predatory threat, obtain and consume wholesome food, reproduce, confront

¹ Our focus on depressive symptoms is not meant to imply that shame and guilt are unrelated to other types of psychological disturbances. Shame, in particular, has been linked to eating disorders (see Goss & Allan, 2009, for a review), anxiety disorders (e.g., posttraumatic stress disorder; Lee, Scragg, & Turner, 2001), and body image difficulties (e.g., Grabe, Hyde, & Lindberg, 2007), among other problems (see also Tangney, Burggraf, & Wagner, 1995). There is a paucity of research examining the conditions under which shame is linked to depressive symptoms versus these other psychological disturbances. Our singular focus on depressive symptoms was initially inspired by a desire to determine whether the longstanding emphasis on guilt (at the expense of shame) in conventional diagnostic criteria for depression is justified by the empirical data. We also weighed practical considerations in the decision to focus strictly on depressive symptoms. Specifically, the empirical database devoted to associations of shame and guilt with depressive symptoms dwarfs the database on other psychological disturbances. Indeed, literatures exploring shame, guilt, and other psychological disturbances are very small, rendering meta-analytic aims more difficult to pursue.

rivals), basic emotions should be experienced similarly across cultures subject to the same universal concerns (Ekman & Friesen, 1975; Ellsworth, 1994).

In contrast, there is substantial cross-cultural divergence with respect to several elements of self-conscious emotions, including the value ascribed to self-conscious emotions, subjective experience, the extent to which emotions are elaborated at the lexical level, and the antecedent events that give rise to self-conscious emotions (see Y. Wong & Tsai, 2007, for a review).

Expression

The biological imperatives thought to drive evolution of basic emotions are also assumed to have facilitated efficient means for their expression. Empirical work on expressive displays associated with basic emotions has been dominated by research on facial expressions. This evidence strongly suggests that a small number of facial expressions are both universally recognized and reliably linked to internal emotional states (Keltner, Ekman, Gonzaga, & Beer, 2003; but see Russell, 1994).

In contrast, the communication of self-conscious emotions via expressive channels is more complicated, and consequently, there is less evidence that observers can readily recognize them. Although recent work suggests that pride may have a cross-culturally recognized expression (Tracy & Robins, 2004, 2006), there is less consistent evidence for the negative self-conscious emotions. Keltner and Buswell (1996) found modest evidence for a recognizable shame expression among participants in the United States, but further research demonstrated that this display was very often labeled as sadness among participants in India (Haidt & Keltner, 1999). There exists no compelling evidence that guilt has a recognizable expression.

Continuity Across Species

The biological argument holds that basic emotions can be readily inferred in other species. The selection pressures and fundamental life concerns that sculpted evolution of basic emotions were in place well prior to the divergence of the human evolutionary lineage, and as such, basic emotions should be present in nonhuman animals. Consistent with this logic, there is strong evidence to suggest that several primate species show facial expressions that are similar to human facial expressions, and that they show them in similar motivationally relevant situations (Darwin, 1872/1998; Parr & Waller, 2006).

On the other hand, it is possible that self-conscious emotions are uniquely human. Although nonhuman animals with complex social structures show behaviors that could be viewed as building blocks of self-conscious emotions (e.g., dominance, appeasement, submission; see Fessler, 2004; Weisfeld, 1997), it is unclear if these behaviors reflect shame or guilt, *per se*. And although some primates may possess a rudimentary capacity for self-awareness (Gallup, 1977), they do not possess the complex cognitive apparatus often seen as critical to the experience of self-conscious emotions.

How Are Shame and Guilt Different?

The foregoing discussion demonstrates that self-conscious emotions are distinguishable from basic emotions. Of course, not all

self-conscious emotions are the same. Our aim of examining differential associations of two self-conscious emotions, shame and guilt, with depressive symptoms requires clarity with respect to their key distinctions. Historically, scholarship on shame and guilt has suffered from inadequate conceptual definitions of the two emotions and distinctions that were either absent or poorly articulated. In the psychological literature, the terms *shame* and *guilt* have frequently been used interchangeably, and some writers have explicitly conflated the two emotions (e.g., Tomkins, 1962). These conceptual problems impeded the accumulation of a scientific literature sensitive to the differential involvement of shame and guilt in a variety of psychological domains (Tangney & Dearing, 2002). More recently, however, social scientists have expended considerable effort formulating precise conceptual definitions of shame and guilt that underscore their critical differences. This theoretical and conceptual work has offered a useful framework that has guided scholarship on shame and guilt over the last roughly 20 years. In this section, we identify and examine critical distinctions that have been drawn between shame and guilt and inform the validity of these distinctions by examining relevant empirical research. Table 1 summarizes these distinctions and serves to guide our discussion.

Object of Negative Evaluation

In pioneering work that eventually became highly influential in the empirical study of shame and guilt, H.B. Lewis (1971) argued that the object of negative evaluation is different in shame versus guilt. In shame, the entire self is the central focus of negative evaluation (e.g., "Look at what an awful person I am"), whereas in guilt, specific behaviors represent the central focus of negative evaluation (e.g., "Look at the awful thing I did"). Shame strikes at the core of a person's identity, and as a result, forces the individual to contemplate the possibility of a defective, unworthy, or damaged self. Guilt, on the other hand, leaves identity intact by implicating only specific behaviors.

There is ample empirical support for the self versus behavior distinction. In one series of studies (Niedenthal, Tangney, & Gavanski, 1994), participants were asked to imagine themselves in hypothetical situations evocative of shame or guilt and then to imagine how these distressing emotions could have been avoided by engaging in *counterfactual thinking* (Mandel, Hilton, & Catellani, 2005). Results indicated that participants who contemplated shame situations showed a tendency to rectify aspects of the global self (e.g., "If only I weren't so stupid, I would have passed the exam"), whereas participants who contemplated guilt situations showed a tendency to rectify aspects of specific behaviors (e.g., "If only I had studied more, I would have passed the exam"). Conceptually similar results have been obtained on the basis of qualitative, interview-based studies (e.g., Lindsay-Hartz, 1984) and studies soliciting quantitative ratings of shame and guilt on a number of dimensions relevant to the self versus behavior distinction (e.g., Tangney, Miller, Flicker, & Barlow, 1996). The available evidence is consistent with H.B. Lewis's (1971) formulations regarding the object of negative evaluation in shame versus guilt (see Tangney & Dearing, 2002, for a review).

Table 1
Critical Distinctions Between Shame and Guilt

Dimension	Shame	Guilt	Selected references
Object of negative evaluation	The global self	Specific behavior	H. B. Lewis (1971); Tangney & Dearing (2002)
Direction of attentional focus and focus of distress	Inward, toward the self	Outward, toward relationship partners	Leith & Baumeister (1998); Tangney (1991a)
Phenomenology	Feeling "small" and inferior, helpless, powerless, feeling exposed	Tension, regret, remorse, other-oriented concern	Lindsay-Hartz (1984); Tangney & Dearing (2002); Tangney et al. (1996); Wicker et al. (1983)
Action tendencies	Avoid, hide, withdraw, escape, isolate, a desire to disappear	Approach, amend, repair, confess, apologize	Frijda et al. (1989)
Accompanying emotions	Anger, anxiety, (self-)disgust; typically more painful	Sorrow, empathy; typically less painful	Gilbert (1998)
Centrality of public exposure	High	Low	R. H. Smith et al. (2002)
Attributional pattern	Internal, stable, global, uncontrollable	Internal, unstable, specific, controllable	Tracy & Robins (2004, 2006)
Evolutionary origins	Evolved as part of the rank system	Evolved as part of the caring system	Crook (1980); Gilbert (1992)
Function	Repair reputation	Repair damaged relationship	Crook (1980); Gilbert (1992)

Direction of Attentional Focus and Focus of Distress

The self versus behavior distinction has implications for other distinctions often seen as key to distinguishing shame and guilt. For instance, differences in the attentional focus arising from shame versus guilt have been shown to exert strong influences on subsequent interpersonal behavior. That is, the internally directed attention to perceived defects in shame yields a preoccupation with one's own personal distress at the expense of interpersonal attentiveness and empathic understanding (Tangney, 1991a; Tangney & Dearing, 2002). In contrast, the outwardly directed attention to troublesome behavior in guilt facilitates other-oriented distress arising from acknowledgment of the deleterious effects of behavior on others. Consistent with this view, guilt has been consistently linked to relationship-enhancing qualities, such as a greater ability to adopt the perspective of another person (Leith & Baumeister, 1998), and to empathy (Hoffman, 1977; Thompson & Hoffman, 1980). In short, shame involves internally focused attention to one's own emotional pain, whereas guilt involves externally focused attention to the emotional pain of other people. In parallel fashion, shame disrupts interpersonal sensitivity whereas guilt enhances it.

Phenomenology, Action Tendencies, and Accompanying Affect

Phenomenological experiences and action tendencies can also distinguish shame from guilt (H.B. Lewis, 1971; Lindsay-Hartz, 1984; Tangney & Dearing, 2002; Tangney et al., 1996; Wicker, Payne, & Morgan, 1983). Shame, which may be the more painful emotion, is characterized by feelings of being small, worthless, powerless, exposed, and inferior. Shame generally facilitates action tendencies geared toward escape or withdrawal. Individuals in a state of shame often report a desire to hide, a finding that underscores the notion that an actual or merely perceived condemning audience is central to the shame experience (R. H. Smith, Webster, Parrott, & Eyre, 2002). Guilt, on the other hand, involves tension, regret, and remorse over the effects of one's negative

behavior on other people. The pain of guilt may be more tolerable because, as mentioned previously, the global self is spared from devaluation. Guilt is characterized by an approach-and-amend strategy that facilitates reparation, confession, and apology.

In the previous section, we outlined a variety of dimensions along which basic and self-conscious emotions differed. These differences notwithstanding, the affective tone of self-conscious emotions can be altered by any of several basic emotions that are experienced concurrently (see Gilbert, 1998). There may be an especially tight link between shame and anger. Although internal attributions for events are required for the initial elicitation of shame (Tracy & Robins, 2006), some individuals appear to cope with the painful affect of shame by shifting blame for untoward outcomes to external agents, a tendency that may lend itself to the experience of anger (H.B. Lewis, 1971; Tangney, Wagner, Fletcher, & Gramzow, 1992). Klein (1991) has suggested that anger and shame represent complementary responses to social threat. In this view, anger is the dominant response, whereas shame is the submissive response. Shame or guilt may also become infused with anxiety. The actual or perceived public exposure inherent to shame (e.g., H.S. Smith et al., 2002) seems to suggest an obvious link to social anxiety, in particular (Beck, Emery, & Greenberg, 1985; Gilbert, 1998). Finally, there may be a connection between disgust and shame. Whereas disgust involves the rejection of an offensive object, shame may be regarded as involving the rejection of an offensive self. Indeed, it has been argued that disgust is the foundation of shame (Power & Dalglish, 1997).

Centrality of Public Exposure

One commonly applied distinction that dates back many years (Ausubel, 1955) relates to the public versus private nature of the transgressions involved. Shame, it has been argued, is the more public emotion, arising from situations in which one's failings are put on display for social evaluation. Guilt, on the other hand, has been said to involve private deliberation on transgressions of which only the individual is aware. This distinction remains con-

traversal, and data can be brought to bear both for it and against it. On the one hand, there is evidence that both shame *and* guilt are overwhelmingly elicited in public situations (Tangney & Dearing, 2002). This suggests that although shame may *feel* more public and involve a greater sensitivity to social evaluation, a physical audience is no more likely to be present for shame than for guilt. On the other hand, numerous theoretical views of shame emphasize its value in helping to inform individuals as to their social standing (Fessler, 2004; Gilbert, 1998; Gruenewald et al., 2007; Keltner & Buswell, 1996; Leary, 2007). Of course, if a physical audience is either absent or unaware of an individual's transgressions, social standing presumably would be unaffected, and these views assert that shame would not result. Supportive empirical data are available for this view, as well. Across several studies that examined participants' responses to hypothetical or personally recalled shame and guilt scenarios, R. H. Smith et al. (2002) obtained support for the notion that shame is more public than guilt. In the scenario studies, participants expected more shame than guilt to arise under conditions of high versus low public exposure. In the study of personal recollections, participants reported more shame than guilt in public situations and more guilt than shame in private situations.

Attributional Pattern

According to a recently formulated appraisal model of self-conscious emotions (Tracy & Robins, 2004), attributions regarding the causes of self-relevant events represent a primary basis for distinguishing shame and guilt (see also M. Lewis, 1992). At the broadest level, events can be attributed to internal or external causes (Heider, 1958; Rotter, 1966; Weiner, 1985). Internal attributions situate the causal locus within the individual, whereas external attributions situate the causal locus outside the individual. Internal attributions are seen as critical to both emotions (Tracy & Robins, 2004, 2006), and as such, additional attributional dimensions are required to distinguish them. Causal attributions related to stability, controllability, and globality have received the most attention. The stability dimension reflects the idea that some causes fluctuate (unstable attribution), whereas others do not (stable attribution). The controllability dimension reflects the idea that individuals are capable of exerting control over some causes (controllable attribution) but not others (uncontrollable attribution). The globality dimension reflects the idea that some causes are specific to a small number of circumscribed situations (specific attribution), whereas others generalize across situations (global attribution; Abramson, Seligman, & Teasdale, 1978). Previous research has shown that shame is associated with global, stable, and uncontrollable attributions, whereas guilt is associated with specific, unstable, and controllable attributions (Tracy & Robins, 2006).

Evolutionary Origins and Function

Shame and guilt likely have separate evolutionary origins. Shame appears to have evolved out of a system that regulates psychobiological responses to social rank. A number of writers have suggested that the earliest evolutionary precursors of human shame are the subordination (i.e., appeasement and submission) displays exhibited by nonhuman primates in response to the oc-

cupation of low status in the social hierarchy (e.g., Fessler, 2004; Gilbert & McGuire, 1998). In the nonhuman primate context, negotiation of status is a perilous affair, and rank is determined on the basis of physical size and strength, ability to strike fear in rivals, and so on. In this context, the ability to unambiguously signal submission prevents further attacks from an aggressor, promotes withdrawal in the service of surviving to fight another day, and at least temporarily stabilizes and affirms the dominance hierarchy. However, Gilbert and his colleagues (e.g., Gilbert & McGuire, 1998) have noted that the determinants of social rank have changed over the course of human evolution. In the present evolutionary context, social rank is obtained on the basis of talent, charm, prestige, and an ability to win the favor of others in the social landscape. To monitor the success with which one is achieving such favor, Gilbert hypothesized that natural selection co-opted the rank-related affect that first arose in the dominance hierarchy and applied it to these different conditions of social competition. In this view, shame permits an assessment of how favorably one is viewed by others. Experienced shame alerts the individual to start the work of repairing a damaged reputation or restoring compromised social standing.

Guilt appears to have evolved out of a separate system that mediates caring, affection, empathy, and motivations to avoid harming important others (Crook, 1980; Gilbert, 2004). Humans, perhaps more than any other species, have profited enormously from the fruits of group living, cooperative bonds, and reciprocal commitments. Natural selection seems to have favored genes that facilitated the forging of close relationships that permit cooperation with respect to the procurement of resources (e.g., food, information, shelter), defense from external threats, and other important tasks (Baumeister & Leary, 1995; Williams, 1966). A large portion of the human affective apparatus is devoted to support of the formation, maintenance, and regulation of close bonds (Keltner & Haidt, 1999). Regulatory mechanisms aimed at addressing actual or potential damage to these bonds are equally important. Guilt is one such mechanism. Anticipated guilt promotes sensitivity to the mere prospect of harm, thereby supplying an affective prohibition against socially destructive behavior. Experienced guilt in the aftermath of harm marshals appropriate responses (e.g., apology, confession, repair) aimed at restoring relationships. As such, whereas shame is fundamentally about reparation of a damaged self, guilt is fundamentally about reparation of a damaged relationship.

Associations of Shame and Guilt With Depressive Symptoms

In short, shame and guilt are different emotions. A clear view of their distinctions enables consideration of the question at the heart of this article: Are shame and guilt differentially involved in the experience of depressive symptoms? Our thesis that shame should show more robust links to depressive symptoms compared with guilt hinges upon the successful identification of psychological mechanisms that link shame, but not guilt, with depressive symptoms. Numerous strands of theory and research converge to illuminate several plausible explanations of the predicted strong links between shame and depressive symptoms.

First, shame has been conceived as a signal that alerts the individual to problems of social rejection and low social status

(Fessler, 2004; Gilbert, 1998; Gruenewald et al., 2007; Keltner & Buswell, 1996; Leary, 2007). There is abundant evidence that these theoretically critical determinants of shame (i.e., social rejection, occupation of a low status position, persistent social conflict) show strong ties to depressed affect (see Gruenewald et al., 2007, for a review). Shame is indicative of a perilous state of social rejection that threatens the fundamental need of belongingness and, in an earlier evolutionary context, could have threatened physical survival. Such serious threats are likely to be paralleled by equally serious untoward consequences for psychological functioning and may be especially likely to predict depressive symptoms. In sum, shame may be uniquely linked to depressive symptoms by means of the theoretically dire circumstances surrounding its elicitation. Guilt, because it is unlikely to signal such a serious state of social threat, may show weaker or less consistent links to depressive symptoms.

Second, the intense and inwardly directed focus on the “bad self” in shame, but not guilt, is likely to elicit ruminative processes that have been shown to predict depressive reactions to negative events (Nolen-Hoeksema, 2000; Nolen-Hoeksema, Parker, & Larson, 1994). Such rumination may be further fueled by the unavailability of appropriate means to repair a globally “bad self.” In the absence of corrective intervention, shamed individuals may engage in a passive, counterproductive dwelling on distress. Guilt, with its focus on damaging behavior, is much more easily rectified through apology and other avenues of relationship repair. Guilt facilitates concrete reparative actions and is thus likely to counter the passivity thought to promote rumination and, in turn, depressive symptoms. Data support these contentions. In one study (Joireman, 2004), shame (with guilt partialled out) showed a moderate association with rumination, whereas guilt (with shame partialled out) showed a near-zero relationship. There is also direct evidence that rumination mediates the link between shame and depressive symptoms (Orth, Berking, & Burkhardt, 2006).

Third, shame but not guilt is characterized by causal attributions that overlap substantially with attributions known to predict depressive symptoms. Guilt is associated with causal attributions that reflect a focus on specific behaviors that are transient and changeable (i.e., unstable, controllable, and specific attributions). In contrast, shame is associated with causal attributions that reflect a focus on an intractable and enduring “bad self” (i.e., stable, uncontrollable, and global attributions). It is important to note that theory proposes (Abramson, Seligman, & Teasdale, 1978; Peterson & Seligman, 1984) and research demonstrates (see Abramson et al., 2002, for a review) that a similar attributional pattern is causally related to depressed mood. Thus, the frequent experience of shame may facilitate causal attributions for events that have documented depressogenic properties.

Fourth, escape-related action tendencies associated with shame may predict depressive symptoms by means of decreased social support (Joiner, Coyne, & Blalock, 1999), diminished contact with positively reinforcing stimuli (Lewinsohn, Gotlib, & Hautzinger, 1998), or some other mechanism (Orth et al., 2006). In contrast, the approach-related action tendencies associated with guilt appear to be fundamentally incompatible with the behavioral inertia, withdrawal, and social isolation that often figure prominently in depressed mood.

Finally, a number of other points of overlap between shame and depressive symptoms are evident. The phenomenology of shame is

very similar to that of depression. Both involve subjective feelings of being small and insignificant, worthless, and helpless. Moreover, the proposed functions of shame and depressed mood are conceptually related. Evolutionary approaches to both phenomena emphasize interruption of ongoing behavior. Shame is thought to be adaptive partly insofar as it interrupts behavior that might otherwise provoke continued attacks from a dominant individual, additional decrements in social standing, or both (e.g., Fessler, 2004). Depression is thought to be adaptive insofar as it interrupts the wasteful and fruitless pursuit of goals that are unattainable (Nesse, 2000; see also Pyszczynski & Greenberg, 1987). Last, shame and depressive symptoms involve similar alterations of the internal biological milieu. The robust activation of the hypothalamic-pituitary-adrenal axis and proinflammatory immune processes known to characterize shame-related threats to the social self (Dickerson, Kemeny, Aziz, Kim, & Fahey, 2004) also characterize depression (see Holsboer, 2000, and Schiepers, Wichers, & Maes, 2005, for reviews).²

Subtypes of Shame, Subtypes of Guilt, and Their Associations With Depressive Symptoms

Up to this point, we have treated shame and guilt as monolithic constructs. In this section, we nuance our treatment of shame and guilt by identifying specific subtypes that are especially relevant to our focus on depressive symptoms.

Shame

Shame appears to be characterized by disparate elements that, on the surface, seem paradoxical. As noted previously, numerous theoretical accounts hold that shame is a fundamentally social emotion, arising in instances of threats to the “social self,” and motivating behaviors aimed at limiting damage to social standing.

² It has been suggested that self-discrepancy theory (Higgins, 1987) may also help explain why shame but not guilt should show especially strong links to depressive symptoms (see also Tangney, Burggraf, & Wagner, 1995). Self-discrepancy theory proposes that different types of discrepancies between the actual self and various possible selves have implications for the type of psychological discomfort experienced. Namely, discrepancies between the actual self and the ideal self (which contains representations of the attributes one *would ideally* possess) are hypothesized to lead to dejection-related emotions (e.g., depression, disappointment, sadness). On the other hand, discrepancies between the actual self and the ought self (which contains representations of the attributes one *ought to* possess) are hypothesized to lead to agitation-related emotions (e.g., anxiety, fear). Higgins (1987), in his original formulation, suggested that shame involves actual-ideal discrepancies of the sort hypothesized to underlie depressed affect, whereas guilt involves actual-ought discrepancies that are hypothesized to be unrelated to depressed affect. It is worth noting, however, that this view has been contested on both theoretical and empirical grounds. For instance, Lindsay-Hartz (1984) noted that “What we realize about ourselves when ashamed is that we are who we do not want to be” (p. 697). Similarly, Gilbert (1998) argued that close proximity to an “undesired self” is more likely to elicit shame than a large discrepancy between the actual self and an ideal self. In what appears to be the only empirical test of Higgins’s hypotheses, one group (Tangney, Niedenthal, Covert, & Barlow, 1998) reported that shame was associated with all types of self-discrepancies, whereas guilt was not consistently associated with self-discrepancies at all.

This analysis implies that the critical elements of shame are externally oriented insofar as they heighten attention to the social world and increase sensitivity to others' evaluations of the self. At the same time, shame is also accompanied by the painful internal experience of self-criticism and negative self-evaluations accessible only to the shamed individual. Consistent with these two apparently distinct elements of the shame experience, numerous writers have postulated the existence of two varieties of shame, called "external shame" and "internal shame" (Gilbert, 1998; see also R. H. Smith et al., 2002). The pain of external shame is attributable to knowledge that others view the self negatively, and it motivates the gathering of social information aimed at answering the question, "What do others think of me?" In contrast, the pain of internal shame is about self-persecution and the possession of negative views of self as seen through the individual's own eyes.

Of course, shame episodes typically involve both external and internal elements that likely fuel one another. That is, the pain arising from knowledge that one's social attractiveness has declined is likely to be compounded by the private devaluations and stinging self-blame that individuals inflict upon themselves. On the other hand, the painful affect of private devaluation is unlikely to assume emergency status unless it is accompanied by awareness that important others are joining in the rebuke. However, shame episodes can vary with respect to which element is experienced as most salient, and certain individuals may be predisposed to the frequent experience of one or the other type.

Most important for the present article are implications of the internal versus external distinction for the experience of depressive symptoms. External shame may show stronger associations with depressive symptoms compared with internal shame. To the extent that external shame involves the acute awareness that one has lost the favor of important others in the social landscape, it reflects evolutionarily primitive anxieties related to the dangerous possibility of abandonment or rejection. Such serious threat may be more distressing and may carry with it more profound consequences for psychological maladjustment (including, most notably, depressive symptoms). And although the self-persecution inherent to internal shame may be painful, one's own views of self may ultimately be less important than others' views of self (see Leary, 2004, 2007).

Guilt

One distinction that is particularly relevant to depressive symptoms relates to the conditions under which guilt should be seen as adaptive versus maladaptive. Recent scholarship has encouraged a rather rosy view of guilt, its usefulness, and its distinctly prosocial flavor. Nonetheless, numerous writers have wondered about the conditions under which guilt can become maladaptive. In this regard, it is noted that guilt is sometimes experienced in contexts that do not justify it. The experience of personal responsibility for negative outcomes over which the individual had no control may yield an inherently maladaptive guilt that would be predicted to show robust links to psychological maladjustment, including depressive symptoms. The experience of guilt in the aftermath of an uncontrollable traumatic event is one such example of guilt involving an inappropriate attribution of responsibility. Similarly, O'Connor and her colleagues (O'Connor, Berry, & Weiss, 1999; O'Connor, Berry, Weiss, Bush, & Sampson, 1997) have written

extensively on the construct of interpersonal guilt, a maladaptive type of guilt that involves the possession of irrational beliefs about responsibility for perceived harm inflicted upon others. Guilt arising from inappropriate responsibility can even assume a delusional/psychotic quality. In fact, *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000) major depressive disorder with psychotic features includes a description of guilt marked by a sort of omnipotent responsibility. These types of guilt appear to share very little conceptual overlap with the situationally appropriate, contextually bounded guilt experienced in the aftermath of a genuine transgression described by Tangney and her colleagues (e.g., Tangney & Dearing, 2002; Tangney et al., 1996). In this article, we use the term *legitimate guilt* to refer to guilt that is situationally appropriate, characterized by accurate attributions of responsibility, and firmly grounded in reality. We use the term *maladaptive guilt* to refer to guilt that is marked by inappropriate attributions of responsibility. Whereas legitimate guilt should show very modest links to depressive symptoms, maladaptive guilt should show stronger links.

Factors That May Influence the Strength of Associations of Shame and Guilt With Depressive Symptoms

In addition to specific types of shame and guilt, there are theoretical and methodological factors that might also influence the strength of associations of shame and guilt with depressive symptoms.

Measurement of Shame, Guilt, and Depressive Symptoms

Several of the more frequently used scales in the empirical literature measure what we refer to as *generalized* shame and guilt. These scales divorce shame and guilt from the specific contexts in which they arise and make no reference to specific elements (e.g., phenomenological, motivational, behavioral) of either emotion. Perhaps the best examples of generalized measurements are adjective-based scales that require respondents to rate the extent to which shame- and/or guilt-related adjectives describe the self. The Personal Feelings Questionnaire-2 (PFQ-2; Harder & Zalma, 1990) is a commonly used adjective-based measure. The PFQ-2 asks respondents to rate the frequency with which they experience feelings, encoded in specific terms, associated with shame (e.g., *embarrassed*, *feeling humiliated*, *feelings of blushing*) and guilt (e.g., *intense guilt*, *regret*, *remorse*). Similarly, in the Adapted Shame/Guilt Scale (ASGS; Hoblitzelle, 1987), respondents use a 7-point scale to rate the extent to which 10 shame-related adjectives and 12 guilt-related adjectives describe the self. The Perceived Guilt Index (PGI; Otterbacher & Munz, 1973) taps the self-reported severity of guilt by asking respondents to select one of 11 guilt-related terms arranged along a continuum of no guilt (1 = *innocent*) to severe guilt (11 = *unforgivable*).

On the other hand, numerous scales measure what we refer to as *contextual* shame and guilt. In contrast to the generalized approach mentioned previously, contextual scales tap specific elements of shame and guilt experiences and embed these experiences in specific contexts. The Test of Self-Conscious Affect-3

(TOSCA-3; Tangney, Dearing, Wagner, & Gramzow, 2000) is one commonly used contextual scale. The TOSCA-3 contains 16 scenarios describing situations in which an actor has committed some shame- or guilt-relevant transgression. Following the scenario, respondents indicate their likelihood of reacting to the transgressions in ways that reflect the theoretically relevant cognitive, affective, motivational, or behavioral elements of shame and guilt. There are numerous other scales that do not invoke particular scenarios but are nonetheless sensitive to specific elements of shame and/or guilt and the contexts in which they arise. For instance, the Internalized Shame Scale (ISS; Cook, 1994) requires respondents to rate the frequency with which they experience specific phenomenological elements of shame in certain contexts (e.g., "I would like to shrink away when I make a mistake").

The implications of generalized versus contextual measurement approaches should be different for shame versus guilt. For shame, we would not expect differences in links to depressive symptoms for generalized versus contextual measurements. Shame is fundamentally about the condemnation of a globally "bad" self (H.B. Lewis, 1971; Tangney & Dearing, 2002), and both types of measurement approaches effectively capture this important aspect of shame. Generalized measurements that require ratings of the extent to which a person generally experiences shame-related feelings are consistent with the global nature of shame. For example, respondents who indicate that they generally feel "stupid" (one item from the PFQ-2 shame subscale) are rendering judgments about the global self. Contextual approaches embed these feelings into particular contexts, but respondents ultimately make judgments that similarly bear on the global self. For instance, one scenario from the TOSCA-3 reads, "You make plans to meet a friend for lunch. At 5 o'clock, you realize you stood your friend up." Similar to generalized measurements, the shame-related response ("You would think: 'I'm inconsiderate'") focuses on shortcomings of the global self.

For guilt, there is ample reason to suspect differences in links to depressive symptoms for generalized versus contextual measurements. Generalized guilt measurements should show robust links to depressive symptoms because, as noted elsewhere (Tangney & Dearing, 2002), they confront respondents with the shame-like task of evaluating the global self in a manner that contradicts notions of guilt as involving specific offensive behaviors arising in specific contexts.³ Contextually nonspecific guilt that is "free-floating" and diffuse should show a strong association with depressive symptoms that approximates that of shame. Contextual guilt should show much weaker links to depressive symptoms unless characteristics of the specific contexts lend themselves to one or more forms of maladaptive guilt mentioned previously. For instance, the Trauma-Related Guilt Inventory (TRGI; Kubany et al., 1996) taps guilty feelings embedded in a specific context (i.e., guilt experienced in the aftermath of a trauma to which a person has been subjected), but one that involves typically inappropriate attributions of personal responsibility for an uncontrollable event. Similarly, the Interpersonal Guilt Questionnaire (IGQ-67; O'Connor et al., 1997) measures several varieties of guilt that are generally contextually bounded but necessarily maladaptive (e.g., omnipotent responsibility guilt, survivor guilt).

With respect to the measurement of depressive symptoms, one important issue merits attention. Guilt has long been a diagnostic

criterion for MDD. The current DSM lists "inappropriate or excessive guilt" (American Psychiatric Association, 2000) as one criterion for the disorder. This historical emphasis on guilt has led to the appearance of guilt-related items in many (e.g., Beck Depression Inventory; Beck, Steer, & Brown, 1996; Hamilton Depression Rating Scale; Hamilton, 1960), but not all (e.g., Center for Epidemiological Studies—Depression Scale; Radloff, 1977; Self-Rating Depression Scale; Zung, 1965) self-report instruments designed to measure depressive symptoms. Many scales that do contain such items explicitly use the term *guilt*. This is important in the current context, because the presence of guilt items in self-report depression scales could conceivably inflate associations of guilt and depressive symptoms. We would expect stronger associations of guilt and depressive symptoms when the latter are measured using scales that include guilt items compared to scales that do not. It should also be noted that although many scales contain items that tap self-evaluative judgments that could relate to shame (e.g., worthlessness), none of the most commonly used self-report depression scales include items that explicitly use the term *shame*. As such, if our prediction that shame should be more strongly linked to depressive symptoms compared to guilt is confirmed, it would be *in spite of* measurement-related factors that bias results in favor of inflated associations of guilt and depressive symptoms.

Sex

It is possible that shame and guilt show stronger associations with depressive symptoms among women compared with men. In the psychological and sociological literatures, women have been frequently characterized as more heavily invested in interpersonal relationships and as more likely to construct their identities with respect to their social/interpersonal roles (Gilligan, 1982; MacCoby, 1990; Miller, 1976). To the extent that both shame and guilt signal disruptions in the interpersonal relationships and/or social acceptance with which women are reportedly more concerned, shame and guilt could show tighter links to depressive symptoms among women compared with men.

Ethnicity

Very few studies have systematically explored the moderating influence of participants' ethnic background on associations of shame or guilt with depressive symptoms. However, theory and research on cross-cultural differences permit the speculative hypothesis that shame should show stronger associations with depressive symptoms among European Americans than among Asians. European American cultural contexts facilitate an independent construal of self that emphasizes uniqueness, individual autonomy, and personal agency. On the other hand, Asian cultural contexts facilitate an interdependent construal of self that emphasizes social connectedness, interpersonal harmony, and group

³ Moreover, the PFQ-2 and other adjective-based measurement tools rest on the dubious assumption that ordinary people can define and distinguish shame and guilt in the abstract. An abundance of evidence suggests that even highly literate, intelligent laypersons cannot do so (Lindsay-Hartz, 1984; Tangney & Dearing, 2002). Ultimately, then, adjective-based scales may be ill-suited to the task of distinguishing shame and guilt.

commitment (Heine, Lehman, Markus, & Kitayama, 1999; Singelis, 1994). The self-devaluation that defines shame may have more negative consequences for psychological well-being among European Americans whose identities are heavily invested in an intact autonomous self. In support of this view, shame is said to be undervalued, actively avoided, and “invisible” in European American cultural contexts (Mesquita & Karasawa, 2004; Scheff, 1988). In contrast, there is evidence that Asian cultures endorse shame as a socially useful emotion that facilitates interpersonal relationships (Fung, 1999; Li, Wang, & Fischer, 2004). These arguments suggest that shame could show stronger associations with depressive symptoms among European Americans compared with Asians.

The Current Study

The current study aimed to provide the first quantitative summary of the magnitude of associations of shame and guilt with depressive symptom severity. In our integration of this research literature, we sought to offer the most rigorous empirical test to date of the hypothesis that shame should be more strongly associated with depressive symptoms compared to guilt. To more clearly discern unique associations of shame and guilt with depressive symptoms, we also performed a set of analyses aimed at isolating and directly comparing their individual effects. Finally, we evaluated the extent to which several theoretical and methodological factors might influence the strength of associations of shame and guilt with depressive symptoms.

Method

Literature Search

The first author conducted a computerized literature search of PsycINFO and MEDLINE online databases using the search terms depress* (for depression, depressed, and depressive) with shame* (for shame, shamed, and shaming) or guilt* (for guilt and guilty). In addition, reference lists of articles obtained using these means were reviewed to locate additional published articles. The second author independently conducted a second literature search, using identical search procedures, in an attempt to locate additional articles. Studies published by March 2010 were included in the meta-analysis. The two independent literature searches resulted in the identification of 101 studies reporting 119 effect sizes capturing shame-depressive symptom associations and 107 effect sizes capturing guilt-depressive symptom associations.

In addition to our search of the published research literature, we also executed a strategy aimed at identifying unpublished data for inclusion in the meta-analysis. We contacted (via e-mail) every corresponding author of an article eventually included in the meta-analysis on the basis of the first author’s search ($k = 51$). In the e-mail correspondence, we inquired as to the possession of unpublished data (e.g., raw data, unpublished manuscripts, conference presentations) by that author or other researchers with whom the author was familiar. In instances where names of other researchers were forwarded, we sent inquiries that mirrored those sent to corresponding authors. Twenty-five of the 32 corresponding authors responded to our inquiry by March 21, 2010, the date on which we terminated our search and initiated data reduction and analysis. These efforts resulted in the identification and inclusion

of seven large, raw datasets capturing associations of both shame and guilt with depressive symptoms (Kim, Jorgensen, & Remedios, 2010; Nagoshi, 2008; Orth, 2010; Tangney, 1991b, 1998, 1999, 2000).

Inclusion Criteria

Studies were included in the meta-analysis if they (a) were published in an English language journal or book, or were obtained using previously described procedures for the identification of unpublished data; (b) measured shame and/or guilt and depressive symptoms using self-report, paper-and-pencil scales that produced quantitative values of all constructs; and (c) reported information necessary for computation of an effect size, or information absent from the published article was obtained through contact with corresponding authors.

Recorded Variables

A standard coding sheet was completed for each study, and the following information was recorded: (a) publication information (author, article title, publication year, and source), (b) number of participants, (c) mean age of participants, (d) percentage of female participants, (e) percentages of White and Asian participants, (f) the specific shame and/or guilt scales used, (g) the categorization of shame and guilt scales for purposes of moderator analyses (for shame: generalized vs. contextual, internal vs. external; for guilt: generalized vs. contextual-legitimate vs. contextual-maladaptive), (h) the specific depressive symptom scale used, and (i) whether or not depressive symptom scales explicitly invoked the term *guilt*. In addition, correlation coefficients of shame and guilt with depressive symptoms were coded. Two trained coders independently recorded all information across the studies included in the meta-analysis. The agreement rate was 98%; all disagreements were discussed and resolved by consensus.

Computation and Analysis of Effect Sizes

The effect size index used in this study was Fisher’s Z transformation of r (Z_{Fisher}) to capture the magnitude of association between two continuous variables. Pearson product-moment correlations (r) between shame and/or guilt and depressive symptoms were transformed into Z_{Fisher} , which is more suitable for statistical operations because the r distribution becomes skewed at the extreme ends of its scale. To facilitate interpretation, Z_{Fisher} was transformed back to r upon completion of statistical operations. To estimate the mean effect sizes across studies, each Z_{Fisher} was weighted by the inverse of its variance and averaged. Two mean weighted effect sizes were obtained: one for the association of shame and depressive symptoms, and another for the association of guilt and depressive symptoms. We constructed 95% confidence intervals around the mean weighted effect sizes using random effects models (Hedges & Olkin, 1985), and we rejected the null hypotheses of no associations of shame and guilt with depressive symptoms when the intervals did not include zero. A parallel set of analyses was performed on the smaller subset of studies that

permitted computation of partial correlations, reflecting “guilt-free” shame and “shame-free” guilt.

After grouping effect sizes into two categories (shame and depressive symptoms, guilt and depressive symptoms), meta-analytic analysis of variance (ANOVA) analog procedures (Lipsey & Wilson, 2001) were employed to partition the total variance in effect sizes to within- and between-category sources. Within-category heterogeneity was estimated using the Q_w statistic. Q_w statistics that crossed the $p < .05$ threshold were interpreted as reflecting statistically significant heterogeneity in effect sizes within categories. Likewise, between-category heterogeneity was estimated using the Q_B statistic. Q_B statistics that crossed the $p < .05$ threshold were interpreted as reflecting statistically significant differences in the size of mean weighted effect sizes between categories.

To estimate tolerance for null results, failsafe numbers (Rosenthal, 1991) accompany reporting of mean weighted effect sizes. These statistics represent the number of additional studies averaging null results that would be required to bring the significance level of a given combination of effect sizes down to a specified level ($p < .05$ for the current study). A funnel plot (Light & Pillemer, 1984) was also constructed to evaluate the extent to which the research literature under review evidences a systematic bias in favor of publishing significant results.

Moderator Analyses

Two continuous moderating variables were tested to address a priori theoretical predictions (i.e., sex, ethnicity). Sex was operationalized as the percentage of women in study samples. To tighten conceptual links to the cross-cultural literature comparing Whites with Asians with respect to self-related processes, ethnicity was operationalized as the proportion of Whites to Asians in study samples. One continuous moderating variable, the mean age of study samples, was tested for exploratory purposes only. The three continuous moderators were tested using multiple metaregression models capable of addressing correlated effects among the predictors. As such, statistically significant effects of individual predictors would reflect unique moderating effects on the relationship between shame or guilt and depressive symptoms.

Categorical moderating variables were analyzed separately using the blocking approach described by Rosenthal (1991). Effect sizes were grouped into subdivisions that represent different levels of the categorical moderator and mean weighted effect sizes associated with each level were evaluated for statistically significant differences using the ANOVA analog procedures described previously. For shame, the internal versus external and generalized versus contextual moderating variables were analyzed in this manner. For guilt, the generalized versus contextual-legitimate versus contextual-maladaptive moderating variable was analyzed in this manner. Likewise, depressive symptom measures were categorized according to the presence or absence of the term *guilt*.⁴ We deemed entry of the categorical moderators into the multiple regression models unfeasible because numerous studies contained multiple effect sizes that spanned multiple levels (e.g., a single study permits evaluation of links between depressive symptoms and both internal *and* external shame). We also performed a parallel set of continuous and categorical moderator analyses on the “guilt-free” shame and “shame-free” guilt effect sizes, to the

extent that it was feasible. In some instances, limiting analyses to partialled effect sizes rendered some levels of the categorical moderators so small as to preclude meaningful interpretation. In these instances, we do not report results of the analyses but we offer detailed information sufficient to justify our decision.

Addressing Statistical Dependence

We employed procedures that addressed two types of statistical dependence in the meta-analysis. First, numerous studies reported multiple effect sizes capturing associations of shame, guilt, or both

⁴ We began the work of categorizing scales by completing a detailed content analysis of items for all scales. For purposes of the moderator analyses, we included only those scales for which our content analysis permitted unambiguous placement into only one category. Scales that included items that could reasonably fall into multiple categories (e.g., a shame scale that contains both internal *and* external items) were omitted. The specific categorization of scales is as follows (see Table 2 for full references):

Internal shame: the body shame subscale of the Objectified Body Consciousness scale; Test of Self-Conscious Affect; Personal Feelings Questionnaire; Event-Related Shame and Guilt scale; Adolescent Shame Measure; Adapted Shame/Guilt scale; State Shame and Guilt scale. *External shame:* Other as Shamer scale.

Generalized shame: Personal Feelings Questionnaire; Adapted Shame/Guilt scale; State Shame and Guilt scale.

Contextual shame: the body shame subscale of the Objectified Body Consciousness scale; Dimensions of Conscience Questionnaire; Adapted Dimensions of Conscience Questionnaire; Experience of Shame Scale; Shame and Guilt scale; Test of Self-Conscious Affect; Caring Shame and Guilt scale; Event-Related Shame and Guilt scale; Adolescent Shame Measure; Weight- and Body-Related Shame and Guilt scale; Shame About Sexual Abuse Scale; Beall Shame and Guilt scale.

Generalized guilt: Guilt Inventory; Personal Feelings Questionnaire; State Shame and Guilt scale; Trait Shame and Guilt scale; Adapted Shame/Guilt scale; Perceived Guilt Index.

Contextual-legitimate guilt: Dimensions of Conscience Questionnaire; Shame and Guilt scale; Test of Self-Conscious Affect; Self-Conscious Affect and Attribution Inventory; Adolescent Shame Measure; Beall Shame and Guilt scale.

Contextual-maladaptive guilt: Weight- and Body-Related Shame and Guilt scale; Trauma-Related Guilt Inventory; Interpersonal Guilt Questionnaire.

Depressive symptom scales that invoke the term guilt: Hamilton Depression Rating Scale; Beck Depression Inventory; Brief Symptom Inventory; Symptom Checklist-90.

Depressive symptom scales that do not invoke the term guilt: Children's Depression Inventory; Depression Anxiety Stress Scales; General Health Questionnaire, Hospital Anxiety and Depression Scale; Inventory for Depressive Symptomatology; Self-Rating Depression Scale; Center for Epidemiological Studies—Depression scale; Hopkins Symptom Check List; Multiple Affect Adjective Check List; Personality Assessment Inventory; Present State Examination.

with depressive symptoms. This was attributable to the concurrent administration of multiple shame, guilt, or depressive symptom scales. In these instances, we averaged multiple effect sizes so that each study would contribute, at most, one effect size capturing the association of shame with depressive symptoms and one effect size capturing the association of guilt with depressive symptoms (Lipsey & Wilson, 2001; Rosenthal & Rubin, 1986). As such, no statistical dependence was present *within* categories of effect sizes. However, testing the hypothesis that shame exhibits a stronger association with depressive symptoms compared with guilt required evaluation of the difference *between* categories of effect sizes that were based on overlapping studies. The chief reason that we employed ANOVA analog procedures in the statistical treatment of our meta-analytic data is that these procedures are capable of accommodating this second type of dependence (Lipsey & Wilson, 2001; D. B. Wilson, personal communication, May 5, 2010). The ANOVA analog is maximally powerful when the categories are independent (i.e., when zero covariance between effect sizes that comprise the separate categories can be assumed). In the present study, however, we assumed a positive covariance between the two categories insofar as effect sizes from the same study should be more similar to one another than effect sizes from different studies. Under these conditions of positive covariance, the standard error of the significance test increases and the size of test statistic (Q_B) decreases. It was our judgment that the increased probability of Type II error inherent to these tests is acceptably balanced by a substantially decreased probability of Type I error. Of course, emergence of significant between-category differences in mean weighted effect sizes would be *in spite of*, not *because of*, modest Type II error inflation.

Results

Overall, 242 effect sizes were computed from the 108 studies included in the meta-analysis (127 for the association of shame and depressive symptoms, 115 for the association of guilt and depressive symptoms). Studies included in the meta-analysis were published between 1987 and 2010. A total of 22,411 participants were employed in the studies integrated here. Participant age was reported in 98 studies; the mean age of participants in these studies was 26.8 years. Participant sex was reported in 103 studies; in these studies, 66.6% of participants were female. Participant ethnicity was reported in 73 studies; in these studies, 73.8% of participants were White. The most frequently used depressive symptom scale was the BDI, followed by the CES-D. The TOSCA was used most frequently to measure both shame and guilt, followed by the PFQ. Table 2 displays the information coded from studies included in the meta-analysis. Forest plots of individual study effect sizes and 95% confidence intervals are displayed in Figures 1 (shame–depressive symptoms) and 2 (guilt–depressive symptoms).

Study-Level Analyses of Effect Sizes

The mean weighted effect size across $k = 86$ studies that tested the association of shame and depressive symptoms was $r = .43$ (95% confidence interval [CI] = .41, .46; failsafe $n = 82,529$). The mean weighted effect size across $k = 74$ studies that tested the association of guilt and depressive symptoms was $r = .28$ (95%

CI = .22, .32; failsafe $n = 18,520$). The association of shame and depressive symptoms was significantly larger than the association of guilt and depressive symptoms, $Q_B(1) = 31.62$, $p < .001$. These data are summarized in Table 3.

A parallel set of analyses was performed using partial correlations between shame (with guilt partialled out) and guilt (with shame partialled out) and depressive symptoms (see Table 3). Only studies that used the same scale to measure both shame and guilt (e.g., PFQ, TOSCA) were included in these analyses. The mean weighted effect size for the association of “guilt-free” shame and depressive symptoms ($k = 45$; $r = .36$; 95% CI = .33, .39; failsafe $n = 13,695$) was significantly larger than the mean weighted effect size for the association of “shame-free” guilt and depressive symptoms ($k = 45$; $r = -.03$; 95% CI = $-.08$, .02; failsafe $n = 0$), $Q_B(1) = 169.70$, $p < .001$.⁵ In fact, the association of “shame-free” guilt and depressive symptoms did not differ significantly from zero.

Significant within-category heterogeneity was found for the association of shame and depressive symptoms, $Q_w(85) = 380.73$, $p < .001$, and the association of guilt and depressive symptoms $Q_w(73) = 789.68$, $p < .001$. Therefore, moderator analyses were conducted in an effort to help systematically account for the heterogeneity of effect sizes.

Continuous Moderator Analyses

Metaregression analyses revealed that the omnibus effect for the model predicting variation in associations of shame and depressive symptoms was not significant, $R^2 = .12$, $Q(3) = 3.35$, $p > .05$. Likewise, metaregression analyses revealed that the omnibus effect for the model predicting variation in associations of guilt and depressive symptoms was also not significant, $R^2 = .17$, $Q(3) = 5.26$, $p > .05$. These findings indicated that none of the continuous moderator variables (age, ethnicity, sex) significantly predicted variation in associations of shame or guilt with depressive symptoms.

A parallel set of metaregression analyses was conducted using only the partial correlation data. Omnibus effects for models predicting variation in associations of “guilt-free” shame and depressive symptoms, $R^2 = .09$, $Q(3) = 1.93$, $p > .05$, and “shame-free” guilt and depressive symptoms, $R^2 = .30$, $Q(3) = 4.85$, $p > .05$ were nonsignificant. Results of the uncorrected and partial models remained unchanged when ethnicity was operationalized as the total percentage of White participants in study samples.

Categorical Moderator Analyses

Results of categorical moderator analyses are summarized in Table 4. The specific scales that served as the basis of categories subjected to analysis are listed in Footnote 4.

Internal versus external shame. The mean weighted effect size across studies using external shame scales ($k = 11$; $r = .56$;

⁵ We also examined the bivariate effect sizes for subset of $k = 45$ studies upon which the partial analyses were based. The mean weighted effect size for the association of shame and depressive symptoms ($r = .40$, 95% CI = .36–.43) was once again significantly larger than the mean weighted effect size for the association of guilt and depressive symptoms ($r = .18$, 95% CI = .12–.24), $Q_B(1) = 42.82$, $p < .001$.

Table 2
Description of Studies in the Meta-Analysis

Authors/Year	N	Mean age	% female	% White	Shame scale	Guilt scale	Depressive symptoms scale	Shame-DS <i>r</i>	Partial Shame-DS <i>r</i> ^a	Guilt-DS <i>r</i>	Partial Guilt-DS <i>r</i> ^a
Alexander et al. (1999)	86	39.2	66.0	95.0	SGS	SGS	BDI	.07	.06	.28	.28
Allan et al. (1994)	111	24.7	76.0	—	ISS OAS DCQ ADCQ		BDI GHQ	.36			
Andrews (1995)	84	44.0	100.0	95.0	BS		PSE	.30			
Andrews et al. (2002)	163	23.9	82.0	—	TOSCA ESS	TOSCA	SCL90	.56	.48	.25	-.03
Ashby et al. (2006)	215	22.9	81.0	94.0	ISS		BDI	.53			
Averill et al. (2002)	82	33.3	51.0	65.0	TOSCA PFQ	TOSCA PFQ	SCL90 BDI	.41	.19	.39	.18
Backenstrass et al. (2010)	164	28.2	66.5	100.0	TOSCA	TOSCA	BDI	.45	.41	.21	.01
Bögner et al. (2007)	27	41.2	59.0	—	ESS		HSCL	.58			
Bybee et al. (2009) SAMPLE 1	86	25.9	0	80.0	PFQ	PFQ GI	BDI	.41	—	.35	—
SAMPLE 2	81	28.3	0	78.0	PFQ	PFQ GI	BDI	.43	—	.52	—
Bybee et al. (1996)	85	—	100.0	—		MFCGS	BDI			.15	
Cheung et al. (2004)	125	22.3	55.0	—	OAS ESS		CES-D	.53			
Choma et al. (2009)	314	20.0	100.0	90.8	BS		CES-D	.44			
Conradt et al. (2007)	331	45.5	68.9	100.0	WEBSG	WEBSG	CES-D	.48	.35	.37	.08
Cogle et al. (2008)	82	19.5	75.3	64.3		GI	BDI			.56	
Crossley & Rockett (2005)	50	77.0	74.0	—	PFQ OAS ESS	PFQ	BDI	.32	—	.26	—
De Rubeis & Hollenstein (2009)	141	13.1	63.0	89.0	TOSCA		CDI	.57			
Dezutter et al. (2006)	472	43.0	58.9	95.0	PFQ	PFQ	CES-D	.43	.24	.41	.21
Dorahy et al. (2007)	64	35.6	100	—		GI	BSI			.69	
Farmer & Andrews (2009) SAMPLE 1	60	19.3	0	95.0	ESS		HADS	.53			
SAMPLE 2	56	19.1	0	—	ESS		HADS	-.03			
Feiring et al. (2002)	147	11.3	73.0	34.0	SASA		CDI	.43			
Fontaine et al. (2001)	1232	30.7	60.0	95.0	TOSCA	TOSCA	BDI	.32	.33	.06	-.08
Fornells-Ambrojo & Garety (2009)	73	31.4	27.4	54.8		GI	BDI			.69	
Gee & Troop (2003)	70	27.0	100.0	—	OAS TOSCA		BDI	.52			
Ghatavi et al. (2002)	56	41.2	71.0	—	SSGS	SSGS GI	Ham-D	.53	—	.43	—
Gilbert et al. (1996)	80	24.9	78.0	—	OAS		CES-D	.43			
Gilbert et al. (2003)	119	22.3	76.0	—	OAS		CES-D	.54			
Gilbert et al. (2005)	166	22.1	83.0	88.0	OAS		CES-D	.56			
Gilbert et al. (2009)	62	44.3	58.0	—	OAS		DASS	.54			
Gilbert & Miles (2000)	155	24.5	79.0	—	PFQ OAS	PFQ	CES-D	.59	.39	.47	.16
Gilbert et al. (1994)	125	—	73.0	—	DCQ ADCQ	DCQ	BDI	.28	.20	-.07	-.16
Grabe et al. (2007)	299	11.2	53.0	89.4	BS		CDI	.34			
Haines et al. (2008)	150	35.1	100.0	83.7	BS		CES-D	.43			
Hall & Fincham (2009) SAMPLE 1	287	19.5	67.0	65.0	SSGS	SSGS	CES-D	.31	.24	.21	-.03
SAMPLE 2	284	19.4	67.0	65.0	SSGS	SSGS	CES-D	.66	.51	.50	.11
Harder et al. (1992) SAMPLE 1	58	18.6	52.0	78.0	ASGS PFQ TOSCA	PFQ TOSCA	BDI	.42	—	.20	—
SAMPLE 2	71	18.6	59.0	78.0	ASGS	PFQ SCAAI	SCL90 BDI	.38		.23	
Harder & Lewis (1987)	120	—	57.0	—	BSGS PFQ	BSGS PFQ MFCGS	MAACL BDI	.36	.30	.21	.12

(table continues)

Table 2 (continued)

Authors/Year	<i>N</i>	Mean age	% female	% White	Shame scale	Guilt scale	Depressive symptoms scale	Shame-DS <i>r</i>	Partial Shame-DS <i>r</i> ^a	Guilt-DS <i>r</i>	Partial Guilt-DS <i>r</i> ^a
Harder & Zalma (1990)	63	18.5	41.0	—	PFQ ASGS	PFQ ASGS	BDI	.40	.31	.30	.15
Harper & Arias (2004)	294	19.0	59.0	85.0	TOSCA		CES-D	.27			
Hayaki et al. (2002)											
SAMPLE 1	137	18.6	100.0	55.8	TOSCA	TOSCA	BDI	.47	.46	.12	-.05
SAMPLE 2	58	28.2	100.0	94.1	TOSCA		BDI	.71			
Hoblitzelle (1987)											
SAMPLE 1	71	—	—	—	ASGS BSGS	ASGS BSGS MFCGS	SRDS	.25	.25	.11	-.04
SAMPLE 2	124	—	—	—	ASGS BSGS	ASGS BSGS PGI	BDI SRDS	.41	.39	.21	.01
Hook & Andrews (2005)	85	46.5	66.0	94.0	ESS		BDI	.39			
Hurt et al. (2007)	282	25.0	100.0	81.9	BS		CES-D	.36			
Jarrett & Weissenburger (1990)	89	40.6	58.0	94.0		KSGS	Ham-D IDS BDI			.41	
Jones & Kugler (1993)	230	19.0 ^b	—	88.0		GI	BDI			.57	
Keith et al. (2009)	52	33.0	100.0	—	ESS		HADS	.49			
Kelly et al. (2009)	75	22.0	77.3	75.0	ESS		BDI	.52			
Kim et al. (2010)	246	18.6	63.4	61.0	TOSCA	TOSCA	CES-D	.44	.48	.03	-.18
Klibert et al. (2005)	475	20.9	71.0	68.0	PFQ	PFQ	BDI	.47	.27	.51	.34
Kubany et al. (1996)											
SAMPLE 1	100	33.8	100.0	38.0		TRGI	BDI			.47	
SAMPLE 2	74	47.2	—	53.0		TRGI	BDI SRDS			.58	
SAMPLE 3	68	34.2	100.0	24.0		TRGI	BDI SRDS			.55	
Kuhn & Carter (2006)	159	37.0	100.0	84.0		MGQ	CES-D			.32	
Luyten et al. (2002)	852	33.9	53.0	—	TOSCA	TOSCA	BDI	.32	.33	.04	-.12
Mahalingam & Jackson (2007)	785	—	50.1	—	ISS		BDI	.57			
Martin et al. (2006)	70	—	76.0	—	CSGS	CSGS	CES-D	.39	.38	.14	-.07
Matos & Pinto-Gouveia (2010)	811	27.8	59.9	90.0	OAS ESS		DASS	.42			
McMurrich & Johnson (2009)	38	55.6	69.0	71.4	TOSCA	TOSCA	BDI	.48	.52	.07	-.21
Moreno et al. (1993)	69	35.0	45.0	—		BDHI	Ham-D BDI			.56	
Muehlenkamp et al. (2005)	391	19.2	100.0	88.6	BS		CES-D	.47			
Nagoshi (2008)	202	19.2	54.0	71.0	TOSCA	TOSCA	HSCL	.32	.28	.18	.10
Niler & Beck (1989)	76	20.7	53.0	—		PGI	BDI			.26	
O'Connor et al. (1999)											
SAMPLE 1	223	20.1	57.1	24.2	TOSCA	TOSCA IGQ	BSI	.26	.38	.31	-.32
SAMPLE 2	61	19.8	65.6	16.7	TOSCA	TOSCA IGQ	BDI	.32	.25	.36	.09
O'Connor et al. (1997)											
SAMPLE 1	108	33.0	31.0	26.0		IGQ	BDI			.23	
SAMPLE 2	111	23.0	50.0	33.0		IGQ	BDI			.52	
O'Connor et al. (2002)	102	29.5	53.0	100.0		IGQ	BDI			.39	
Orth (2010)	2611	33.6	69.0	74.0	TOSCA	TOSCA	CES-D	.41	.47	-.04	-.23
Orth et al. (2006)	149	43.8	49.0	95.0	ESG	ESG	CES-D	.55	.40	.42	-.02
Owens et al. (2008)	99	52.8	20.0	63.0		TRGI	BDI			.18	
Pineles et al. (2006)	156	18.7	100.0	74.0	TOSCA	TOSCA	BSI	.41	.39	.16	-.02
Quiles & Bybee (1997)	101	—	52.0	80.0		Comp.	BDI SCL90			.50	
Resick et al. (2008)	150	35.4	100.0	62.0	ESS	TRGI	BDI	.58		.31	
Resick et al. (2002)	171	32.0	100.0	71.0		TRGI	BDI			.40	
Reynolds & Salkovskis (1991)	169	—	77.0	—		PGI	BDI			.23	
Rohleder et al. (2008)	56	17.4	100.0	33.0	TSGS	TSGS	BDI	.66	.55	.51	.28

Table 2 (continued)

Authors/Year	<i>N</i>	Mean age	% female	% White	Shame scale	Guilt scale	Depressive symptoms scale	Shame-DS <i>r</i>	Partial Shame-DS <i>r</i> ^a	Guilt-DS <i>r</i>	Partial Guilt-DS <i>r</i> ^a
Rüsch et al. (2007)											
SAMPLE 1	60	27.8	100.0	100.0	TOSCA PFQ	TOSCA PFQ	CES-D	.22	.12	.24	.15
SAMPLE 2	60	26.6	100.0	100.0	TOSCA PFQ	TOSCA PFQ	CES-D	.37	.26	.29	.13
Rüsch et al. (2009)	85	44.3	31.0	35.0	TOSCA	TOSCA	CES-D	.46	.54	-.06	-.32
Shafran et al. (1996)											
SAMPLE 1	30	35.2	60.0	—		GI	BDI			.49	
SAMPLE 2	30	36.3	60.0	—		GI	BDI			.41	
Stuewig & McCloskey (2005)	254	16.9	52.0	53.6	ASM	ASM	CES-D	.19	.26	-.01	-.17
Swan & Andrews (2003)	140	28.4	100.0	97.0	ESS		SCL90	.71			
Szymanski & Henning (2007)	217	32.7	100.0	84.0	BS		SRDS	.43			
Tangney (1991b)	311	10.6	50.5	46.0	TOSCA	TOSCA	CDI	.23	.32	-.11	-.25
Tangney (1998)	287	20.1	72.5	48.1	TOSCA	TOSCA	SCL90	.36	.38	.06	-.13
Tangney (1999)	384	20.5	71.9	53.9	TOSCA	TOSCA	SCL90	.42	.45	.08	-.13
Tangney (2000)	280	20.1	80.7	55.0	TOSCA	TOSCA	BDI	.26	.26	.06	-.06
Tangney & Dearing (2002)											
SAMPLE 1	380	10.6	55.0	57.4	TOSCA	TOSCA	CDI	.21	.25	-.04	-.14
SAMPLE 2	252	12.7	55.6	62.3	TOSCA	TOSCA	CDI	.28	.31	-.02	-.14
Tangney et al. (2007)	515	32.5	29.9	35.9	TOSCA	TOSCA	PAI	.40	.38	-.16	-.10
Tangney et al. (1992)											
SAMPLE 1	245	21.1	71.1	77.7	SCAAI	SCAAI	BDI	.33	.27	.20	.05
SAMPLE 2	234	19.5	72.0	83.0	SCAAI	SCAAI	SCL90	.46	.41	.20	-.06
Tiggemann & Kuring (2004)											
SAMPLE 1	115	22.4	0	—	BS		BDI	.23			
SAMPLE 2	171	21.9	100.0	—	BS		BDI	.46			
Tilghman-Osborne et al. (2008)	221	13.0	60.0	84.1	TOSCA	TOSCA	CDI	.56	.54	.15	-.12
					SSGS	SSGS	CES-D				
Troop et al. (2008)	224	31.6	100.0	—	PFQ		BDI	.65			
					OAS						
Walters-Champman et al. (1995)	63	46.0	70.0	—		Scalar GAD	CES-D			.53	
Webb et al. (2007)	280	20.9	65.0	76.1	TOSCA	TOSCA	CES-D	.46	.42	.21	-.01
Wei et al. (2005)	299	19.7	65.0	81.3	PFQ		CES-D	.44			
							SRDS				
							DASS				
Woien et al. (2003)	338	19.4	56.0	78.0	TOSCA	TOSCA	HSCL	.44	.44	.12	-.11
Wong & Cook (1992)	47	—	—	—	ISS		BDI	.70			
Wright et al. (1989)	100	26.9	62.0	—	ASGS	ASGS	SRDS	.49	.46	.18	-.01
Wyatt & Gilbert (1998)	113	24.9	78.0	—	OAS		CES-D	.54			

Note. DS = depressive symptoms; ADCQ = Adapted Dimensions of Conscience Questionnaire (Johnson, Kim, & Danko, 1989); ASGS = Adapted Shame/Guilt Scale (Hobfelle, 1987); ASM = Adolescent Shame Measure (Reimer, 1995); BDHI = Buss-Durkee Hostility Inventory (Buss & Durkee, 1957); BDI = Beck Depression Inventory (Beck, Steer, & Brown, 1996); BS = Body Shame (McKinley & Hyde, 1996); BSGS = Beall Shame and Guilt Scale (R. L. Smith, 1972); BSI = Brief Symptom Inventory (Derogatis, 1993); CDI = Children's Depression Inventory (Kovacs, 1981); CES-D = Center for Epidemiological Studies—Depression scale (Radloff, 1977); Comp. = guilt measured using a composite of the PFQ, GI, TOSCA, and MFCGS scales; CS GS = Caring Shame and Guilt Scale (Martin, Gilbert, McEwan, & Irons, 2006); DASS = Depression Anxiety Stress Scales (Lovibond & Lovibond, 1995); DCQ = Dimensions of Conscience Questionnaire (Johnson et al., 1987); ESG = Event-related shame and guilt (Orth, Berkling, & Burkhardt, 2006); ESS = Experience of Shame scale (Andrews, Qian, & Valentine, 2002); GAD = Guilt About Divorce (Walters-Champman, Price, & Serovich, 1995); GHQ = General Health Questionnaire (Goldberg & Hillier, 1979); GI = Guilt Inventory (Kugler & Jones, 1992); HADS = Hospital Anxiety and Depression scale (Zigmond & Snaith, 1983); Ham-D = Hamilton Depression Rating Scale (Hamilton, 1960); HSCL = Hopkins Symptom Checklist (Parloff, Kelman, & Frank, 1954); IDS = Inventory for Depressive Symptomatology (Rush et al., 1986); IGQ = Interpersonal Guilt Questionnaire (O'Connor, Berry, Weiss, Bush, & Sampson, 1997); ISS = Internalized Shame Scale (Cook, 1994); KSGS = Klass's Situational Guilt Scale (Klass, 1987); MAACL = Multiple Affect Adjective Check List (Zuckerman, Lubin, & Rinck, 1983); MFCGS = Mosher Forced-Choice Guilt Scale (Mosher, 1966); MGQ = Maternal Guilt Questionnaire (Kuhn & Carter, 2006); OAS = Other as Shamer (Goss, Gilbert, & Allan, 1994); PAI = Personality Assessment Inventory (Morey, 2007); PFQ = Personal Feelings Questionnaire (Harder & Zalma, 1990); PGI = Perceived Guilt Index (Otterbacher & Munz, 1973); PSE = Present State Examination (J. E. Cooper, Copeland, Brown, Harris, & Gourley, 1977); SASA = Shame about sexual abuse (Feiring, Taska, & Lewis, 2002); SCAAI = Self-Conscious Affect and Attribution Inventory (Tangney, Burggraf, Hamme, & Domingos, 1988); Scalar (Walters-Champman et al., 1995); SCL90 = Symptom Checklist-90 (Derogatis, 1983); SGS = Shame and Guilt Scale (Alexander, Brewin, Veamals, Wolff, & Leff, 1999); SRDS = Self-Rating Depression Scale (Zung, 1965); SSGS = State Shame and Guilt Scale (Marschall, Sanftner, & Tangney, 1994); TOSCA = Test of Self-Conscious Affect (Tangney, Dearing, Wagner, & Gramzow, 2000); TRGI = Trauma-Related Guilt Inventory (Kubany et al., 1996); TSGS = Trait Shame and Guilt Scale (Rohleder, Chen, Wolf, & Miller, 2008); WEB SG = Weight- and Body-Related Shame and Guilt Scale (Conradt et al., 2007). Dashes indicate that data were either not collected or not reported. In instances where studies reported multiple correlations of shame or guilt with depressive symptoms, the mean correlations are reported in the table.

^a Only studies that used the same scale to measure both shame and guilt were included in the partial correlation analyses. ^b Median age of the study sample.

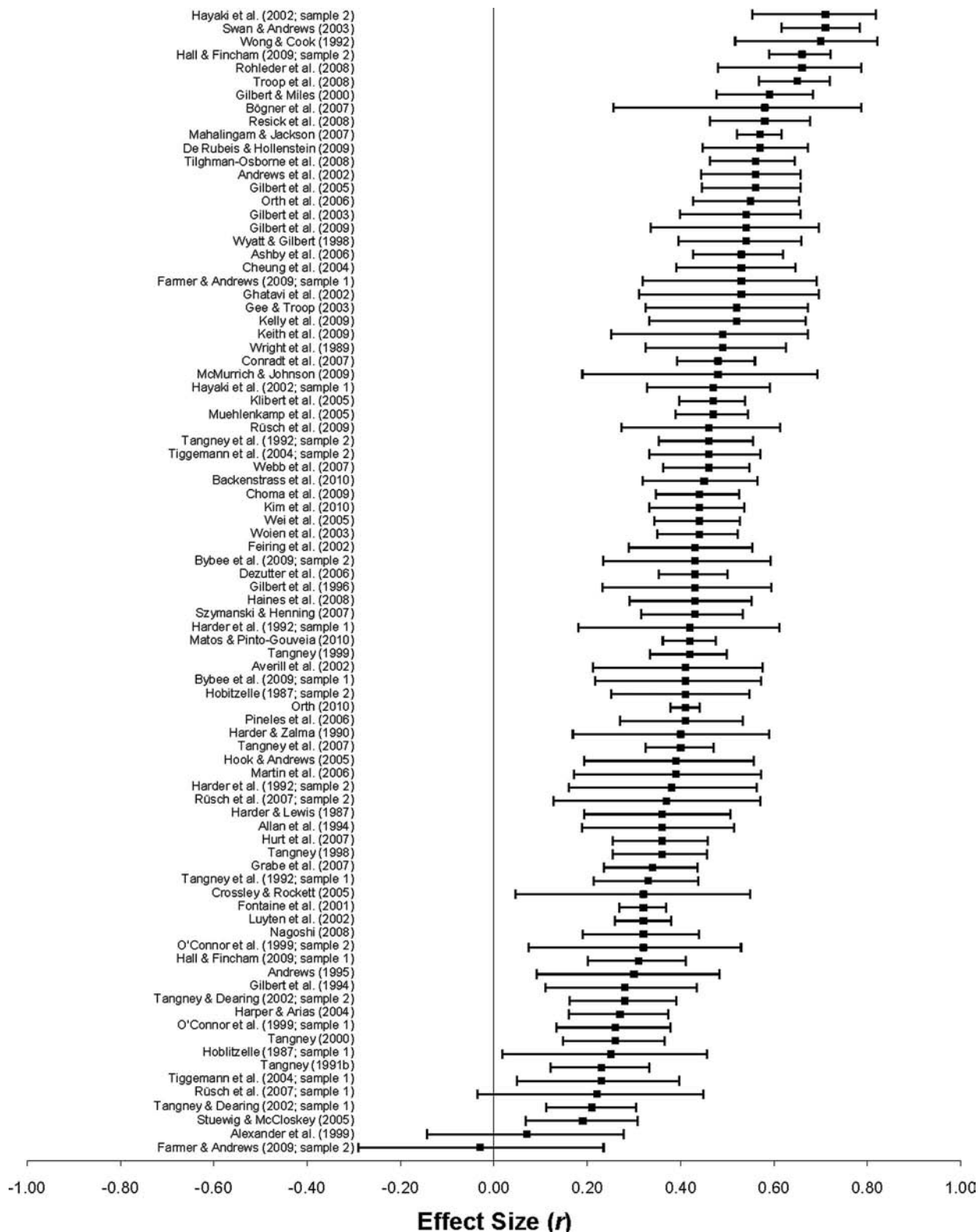


Figure 1. Forest plot representing mean weighted effect sizes and 95% confidence intervals for associations of shame and depressive symptoms. Confidence intervals are asymmetrical because of skewness in the r distribution.

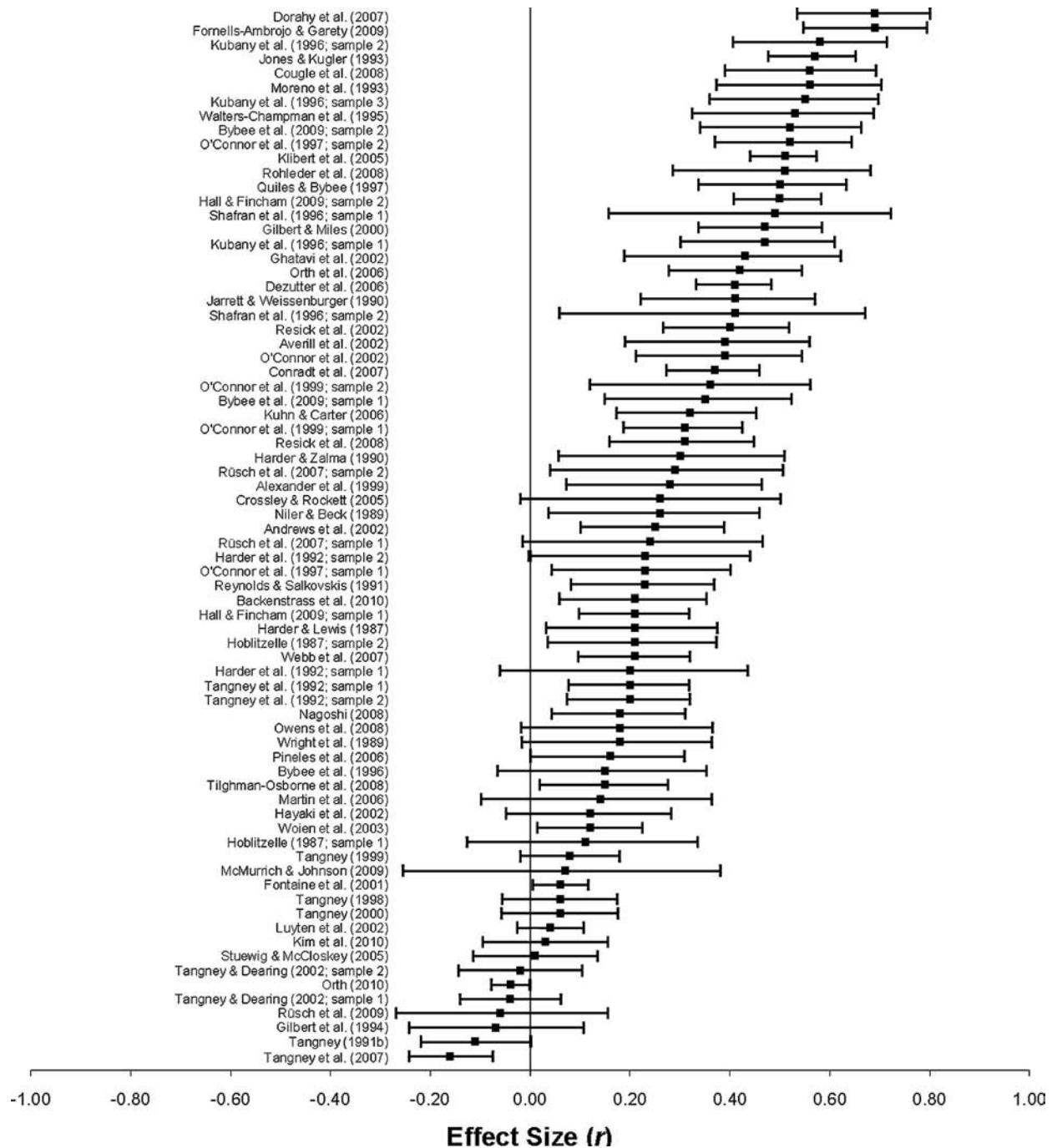


Figure 2. Forest plot representing mean weighted effect sizes and 95% confidence intervals for associations of guilt and depressive symptoms. Confidence intervals are asymmetrical because of skewness in the r distribution.

95% CI = .52, .60; failsafe $n = 1,716$) was significantly larger than the mean weighted effect size across studies using internal shame scales ($k = 63$; $r = .42$; 95% CI = .39, .45; failsafe $n = 58,416$), $Q_B(1) = 31.74$, $p < .001$. Because none of the studies measuring external shame reported partial correlation data, the moderating effect of internal versus external shame on associations of “guilt-free” shame and depressive symptoms could not be explored.

Generalized versus contextual shame. The mean weighted effect size across studies using generalized shame scales ($k = 23$; $r = .49$; 95% CI = .44, .54; failsafe $n = 7,047$) was significantly larger than the mean weighted effect size across studies using contextual shame scales ($k = 64$; $r = .39$; 95% CI = .36, .42; failsafe $n = 46,578$), $Q_B(1) = 11.42$, $p < .01$. A different pattern of results emerged when only the partial correlation data were analyzed; the mean weighted effect size across studies using

Table 3
Summary of Meta-Analytic Data for Associations of Shame and Guilt With Depressive Symptoms

Analysis type	<i>k</i>	<i>r</i>	95% CI	Failsafe <i>n</i>	<i>Q_w</i>	<i>Q_B</i>
Bivariate						31.62*
Shame–Depressive Symptoms	86	.43	.41, .46	82,529	380.73*	
Guilt–Depressive Symptoms	74	.28	.22, .32	18,520	789.68*	
Partial ^a						169.70*
Shame–Depressive Symptoms	45	.36	.33, .39	13,695	154.97*	
Guilt–Depressive Symptoms	45	–.03	–.08, .02	0 ^b	314.44*	

Note. *k* = the number of independent effect sizes upon which the analysis was based; *r* = the mean effect size, expressed as a correlation coefficient; CI = confidence interval; failsafe *n* = the number of additional studies averaging null results that would be required to bring the significance level of the specified combination of effect sizes down to *p* = .05; *Q_w* = a statistical estimate of the amount of heterogeneity within the specified combination of effect sizes; *Q_B* = a statistical test of differences between the specified categories of effect sizes. 95% CIs were constructed using random effects models.

^a For the partial analyses, guilt variance was removed from shame and shame variance was removed from guilt. ^b The failsafe number is zero because the combined significance level of these effect sizes already exceeded *p* = .05.

**p* < .001.

generalized shame scales (*k* = 15; *r* = .36; 95% CI = .28, .44; failsafe *n* = 1,668) was identical to the mean weighted effect size across studies using contextual shame scales (*k* = 37; *r* = .36; 95% CI = .32, .39; failsafe *n* = 16,570), *Q_B*(1) = 0.03, *p* > .05.

Generalized versus contextual-legitimate versus contextual-maladaptive guilt. Statistically significant variation in mean weighted effect sizes was observed across studies using generalized (*k* = 30; *r* = .42; 95% CI = .37, .47; failsafe *n* = 7,279), contextual-legitimate (*k* = 36; *r* = .06; 95% CI = .02, .10; failsafe *n* = 233), and contextual-maladaptive (*k* = 12; *r* = .39; 95% CI = .32, .45; failsafe *n* = 1,024) guilt scales, *Q_B*(2) = 141.44, *p* < .001. Post hoc pairwise comparisons showed that contextual-legitimate guilt exhibited a smaller mean weighted effect size than both generalized and contextual-maladaptive guilt, *Q_B*s(1) > 64.70, *ps* < .001, which did not significantly differ from each other, *Q_B*(1) = .75, *p* > .05. Critically, associations of generalized and contextual-maladaptive guilt with depressive symptoms were statistically indistinguishable from associations of shame and depressive symptoms reported previously, *Q_B*s(1) < 1.76, *ps* > .05.

The partial correlation data showed that the mean weighted effect size across studies using generalized guilt scales (*k* = 15; *r* = .16; 95% CI = .09, .23; failsafe *n* = 321) was significantly larger than the mean weighted effect size across studies using contextual-legitimate guilt scales (*k* = 34; *r* = –.10; 95% CI = –.14, –.06; failsafe *n* = 0), *Q_B*(1) = 38.01, *p* < .001. Because only one study measuring contextual-maladaptive guilt reported partial correlation data, these data were not included in the moderator analysis.

Depressive symptom scales with versus without the term guilt (shame–depressive symptoms). Associations of shame and depressive symptoms were not significantly different across studies using depressive symptom scales with the term *guilt* (*k* = 41; *r* = .45; 95% CI = .40, .49; failsafe *n* = 21,114) versus without the term *guilt* (*k* = 48; *r* = .42; 95% CI = .39, .45; failsafe *n* = 32,898), *Q_B*(1) = .94, *p* > .05. This pattern remained unchanged when only partial correlation data were analyzed. Associations of “guilt-free” shame and depressive symptoms were not significantly different across studies using depressive symptom scales with the term *guilt* (*k* = 22; *r* = .35; 95% CI = .31, .39;

failsafe *n* = 4,656) versus without the term *guilt* (*k* = 25; *r* = .37; 95% CI = .32, .41; failsafe *n* = 8,465), *Q_B*(1) = .34, *p* > .05.

Depressive symptom scales with versus without the term guilt (guilt–depressive symptoms). Associations of guilt and depressive symptoms were significantly larger across studies using depressive symptom scales with the term *guilt* (*k* = 49; *r* = .33; 95% CI = .27, .38; failsafe *n* = 10,331) versus without the term *guilt* (*k* = 30; *r* = .21; 95% CI = .13, .29; failsafe *n* = 2,151), *Q_B*(1) = 5.02, *p* < .05. A different pattern emerged when only partial correlation data were analyzed. Associations of “shame-free” guilt and depressive symptoms were not significantly different across studies using depressive symptom scales with the term *guilt* (*k* = 22; *r* = –.01; 95% CI = –.08, .07; failsafe *n* = 0) versus without the term *guilt* (*k* = 25; *r* = –.04; 95% CI = –.10, .03; failsafe *n* = 0), *Q_B*(1) = .39, *p* > .05.

Publishing Bias

The funnel plot (see Figure 3) is helpful in assessing the degree to which the “file drawer problem” (Rosenthal, 1979), or a systematic bias in favor of publishing significant results, might have inflated effect size estimates. In short, small samples should yield substantially variable effects, whereas large samples should yield effect sizes that more closely approximate the “true” effect. In the absence of publication bias, plotting effect sizes as a function of their respective sample sizes should yield a funnel-shaped figure with a broad base (i.e., substantial variability for small samples) and a tall peak, resulting from convergence of effect sizes on the “true” effect as sample sizes increase. For associations of shame and depressive symptoms, close inspection of the funnel plot suggests that this general pattern was borne out. Effect sizes appear to converge at around *r* = .40, which closely approximates the mean weighted effect size (*r* = .43) that we obtained in our primary analyses. Moreover, a fairly discernable broad base suggests that the publication of large effects is at least roughly proportional to the publication of small effects. Effect sizes capturing associations of guilt and depressive symptoms tell a similar story. Although clear convergence on a “true” effect is less apparent, effect sizes are substantially variable and roughly equally

Table 4
Results Summary for Categorical Moderator Analyses

Categorical moderator	<i>k</i>	<i>r</i>	95% CI	Failsafe <i>n</i>	<i>Q_B</i>
Internal vs. external shame					
Bivariate					31.74***
Internal shame	63	.42	.39, .45	58,416	
External shame	11	.56	.52, .60	1,716	
Generalized vs. contextual shame					
Bivariate					11.42**
Generalized shame	23	.49	.44, .54	7,047	
Contextual shame	64	.39	.36, .42	46,578	
Partial ^a					0.03
Generalized shame	15	.36	.28, .44	1,668	
Contextual shame	37	.36	.32, .39	16,570	
Generalized vs. contextual-legitimate vs. contextual-maladaptive guilt					
Bivariate ^b					141.44***
Generalized guilt	30	.42	.37, .47	7,279	
Contextual-legitimate guilt	36	.06	.02, .10	233	
Contextual-maladaptive guilt	12	.39	.32, .45	1,024	
Partial ^a					38.01***
Generalized guilt	15	.16	.09, .23	321	
Contextual-legitimate guilt	34	-.10	-.14, -.06	0 ^c	
Depressive symptom scales with vs. without the term <i>guilt</i> (shame–depressive symptoms)					
Bivariate					0.94
With <i>guilt</i>	41	.45	.40, .49	21,114	
Without <i>guilt</i>	48	.42	.39, .45	32,898	
Partial ^a					0.34
With <i>guilt</i>	22	.35	.31, .39	4,656	
Without <i>guilt</i>	25	.37	.32, .41	8,465	
Depressive symptom scales with vs. without the term <i>guilt</i> (guilt–depressive symptoms)					
Bivariate					5.02*
With <i>guilt</i>	49	.33	.27, .38	10,331	
Without <i>guilt</i>	30	.21	.13, .29	2,151	
Partial ^a					0.39
With <i>guilt</i>	22	-.01	-.08, .07	0 ^c	
Without <i>guilt</i>	25	-.04	-.10, .03	0 ^c	

Note. *k* = the number of independent effect sizes upon which the analysis was based; *r* = the mean effect size, expressed as a correlation coefficient; CI = confidence interval; failsafe *n* = the number of additional studies averaging null results that would be required to bring the significance level of the specified combination of effect sizes down to *p* = .05; *Q_B* = a statistical test of differences between the specified categories of effect sizes. 95% CIs were constructed using random effects models.

^a For the partial analyses, guilt variance was removed from shame and shame variance was removed from guilt. ^b Contextual-legitimate guilt exhibited a smaller effect than both generalized and contextual-maladaptive guilt, which did not significantly differ. ^c The failsafe number is zero because the combined significance level of these effect sizes already exceeded *p* = .05.

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

distributed across the range of values included in the plot. In sum, the funnel plot suggests that the research literature under review does not evidence a systematic bias in favor of the disproportionate publication of significant results.

Discussion

The current study represents a major meta-analytic integration of a large volume of published and unpublished research exploring associations of shame and guilt with depressive symptoms. The results reported here are based upon an accumulation of over 20 years of data generated by over 20,000 research participants reflecting a range of depressive symptoms. This study was uniquely well equipped to evaluate our hypothesis that shame is more

strongly associated with depressive symptoms compared to guilt. We obtained support for this prediction, but only at the broadest level of analysis. Our initial analyses treated shame and guilt as monolithic constructs by collapsing across specific subtypes shown in subsequent analyses to exhibit variable links to depressive symptoms. In these analyses, shame exhibited a significantly stronger association with depressive symptoms compared to guilt. Also revealing were results of partial correlation analyses. In the subset of studies for which partial correlation analyses were possible, shame continued to show robust links to depressive symptoms after partialling guilt. Such was not the case for guilt, as results showed that “shame-free” guilt was essentially uncorrelated with depressive symptoms. Moreover,

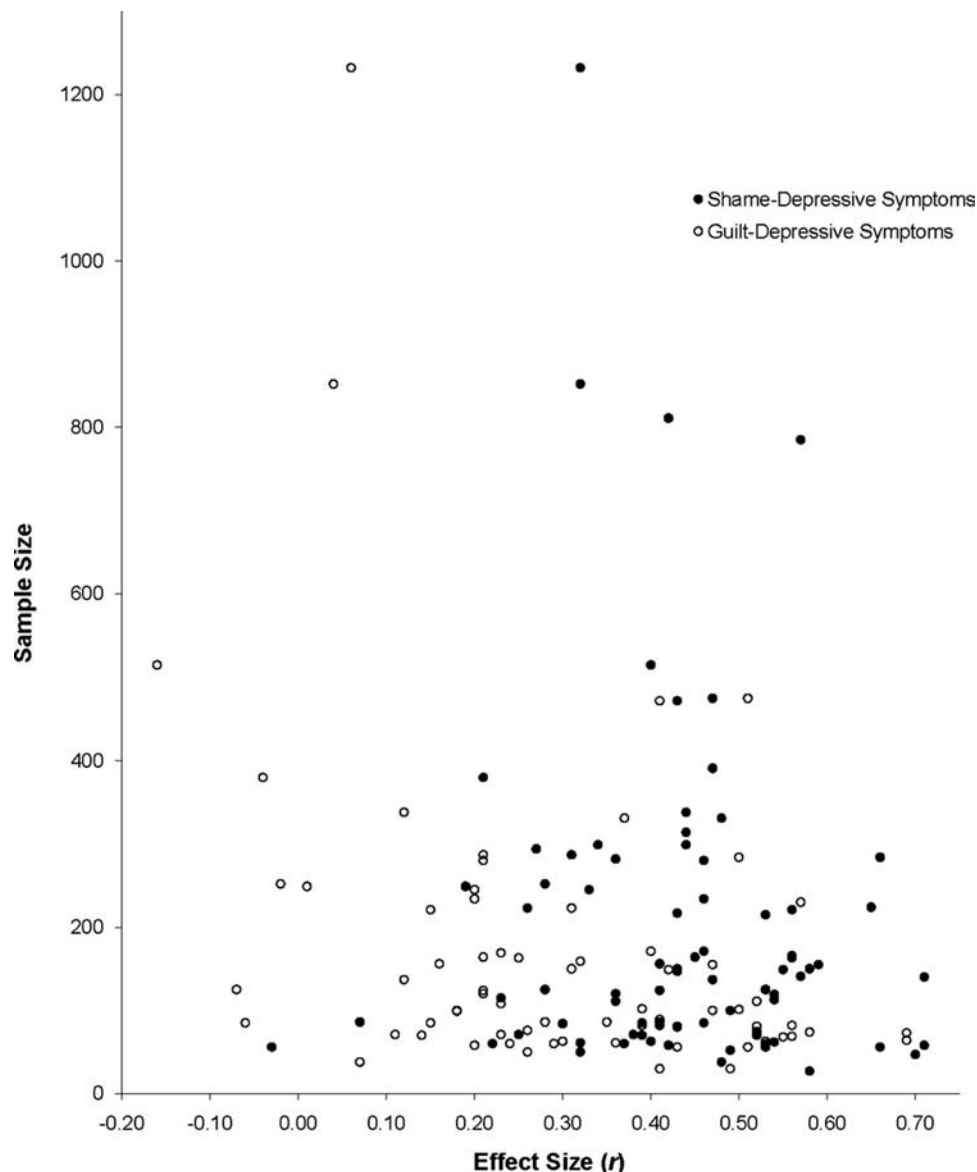


Figure 3. Funnel plot depicting effect size (r) as a function of sample size. In the absence of publication bias, plotting effect sizes as a function of their sample sizes should yield a funnel-shaped figure with a broad base, reflecting substantial variability in effect sizes for small samples, and a tall peak, reflecting convergence of effect sizes on the “true” effect as sample sizes increase. For both sets of effect sizes, fairly discernable broad bases suggest that the publication of large effects is at least roughly proportional to the publication of small effects.

we feel confident that the average effect sizes reported here represent relatively unbiased estimates of the “true” effects. Examination of the funnel plot (see Figure 3) reveals a trend toward publication of large effects that is roughly proportional to the publication of smaller effects, a pattern that minimizes concerns related to the so-called “file drawer problem” (Rosenthal, 1979). Failsafe numbers also demonstrate that our findings boast a great deal of tolerance to null results.

The overall analyses of monolithic shame and guilt notwithstanding, perhaps the most noteworthy results emerged from moderator analyses that separated the shame and guilt constructs into specific subtypes. Of particular importance was the finding that, in

terms of their associations with depressive symptoms, shame was statistically indistinguishable from two specific types of guilt that are especially likely to assume the focus of clinical attention: contextual-maladaptive guilt, which involves feelings of exaggerated responsibility for uncontrollable events, and generalized guilt, which involves a sort of “free-floating” guilt divorced from specific contexts. These findings render inappropriate the conclusion that shame is more important to depressive symptoms than guilt. Instead, the current results should encourage the more circumspect conclusion that shame and pathological guilt (see, e.g., O’Connor et al., 1997; O’Connor et al., 1999) are *both* important to depressive symptomatology, and to a roughly equal extent. In any event,

that shame has been traditionally obscured by an emphasis on guilt in scholarship on the emotional foundations of depressed mood is unjustified by the large volume of data integrated here. Our findings suggest that shame warrants much greater prominence in understandings of the emotional underpinnings of depressive symptoms.

Effects of generalized versus contextual measurement approaches on associations of shame and depressive symptoms were less straightforward. Analyses based on the full bivariate correlations showed that generalized shame exhibited significantly stronger associations with depressive symptoms compared to contextual shame. However, partialling guilt from shame in these analyses rendered this difference nonsignificant. We can appeal to a statistical argument to explain these results. The partialling of contextual guilt did little to change the link between contextual shame and depressive symptoms ($r = .39$ to $r = .36$). This is because contextual guilt is only modestly correlated with both contextual shame (see, e.g., Fontaine, Luyten, De Boeck, & Corveleyn, 2001; Tangney & Dearing, 2002) and depressive symptoms. In contrast, the partialling of generalized guilt substantially diminished the link between generalized shame and depressive symptoms ($r = .49$ to $r = .36$). This is because generalized guilt is highly correlated with both generalized shame (see, e.g., Averill, Diefenbach, Stanley, Breckenridge, & Lusby, 2002; Gilbert & Miles, 2000) and depressive symptoms. In short, removal of this meaningful variance was sufficient to render generalized shame equivalent to contextual shame with respect to its association with depressive symptoms.

Our results also support the validity of the distinction between internal shame, which involves negative views of self through one's own eyes, and external shame, which involves negative views of self as seen through the eyes of others. Most notably, our results provide evidence in favor of our hypothesis that external shame shows stronger links to depressive symptoms compared with internal shame. External shame theoretically reflects a dire state of rejection threat that, in an earlier evolutionary context, could have compromised physical survival. And although physical survival is generally less tenuous in the current evolutionary context, we speculate that the affective apparatus that facilitated smooth navigation of the social landscape among our ancestors persists largely unchanged in its sensitivity to rejection threats. The evolutionarily serious nature of these threats appears to be mirrored by profound negative implications for psychological adjustment, including depressive symptoms. We should acknowledge, however, that our conclusions are based on a small number of studies ($k = 11$) that utilized only one scale (the Other as Shamer scale; Goss, Gilbert, & Allan, 1994) that could be unambiguously categorized as measuring external shame. We cannot rule out the possibility that other properties of this scale help account for robust links to depressive symptoms.

Other variables that we speculated might moderate associations of shame and guilt with depressive symptoms did not. When age, sex, and ethnicity were entered simultaneously into a multiple regression model, none of these variables uniquely accounted for variation in effect sizes across studies. On the one hand, these results may attest to the robustness of the effect sizes to the variables we identified and tested. Indeed, associations of shame and guilt with depressive symptoms may represent fairly hardy effects that are relatively uninfluenced by plausible moderating variables. On the other hand, we must acknowledge that the

operationalization of one or more of these variables may have biased our analyses against the emergence of significant effects. For instance, ethnicity was operationalized as the proportion of Whites to Asians in study samples. This proportion was overwhelmingly high in a large number of the studies we reviewed, and such low variability is not amenable to the uncovering of significant moderating effects. In fact, there is evidence that large, ethnically heterogeneous samples do yield significant moderating effects of ethnicity at the level of individual studies. For example, in one study that employed a sample comprised of over one-third Asian participants (Kim et al., 2010), the association of "guilt-free" shame with depressive symptoms was significantly stronger among White compared with Asian participants. These findings are consistent with the pattern we predicted would emerge in the meta-analysis. Researchers should prioritize the recruitment of more ethnically and demographically diverse samples in order to both increase the external validity of their conclusions and to more effectively examine key moderating effects on associations of shame and guilt with depressive symptoms.

On a related note, almost all of the studies in the meta-analysis used unselected samples of participants whose depressive symptoms generally reflected, at worst, a modest level of mood disturbance. The few studies that did recruit clinically depressed participants found that these individuals reported significantly higher levels of shame and guilt compared to healthy controls (Ghatavi, Nicolson, MacDonald, Osher, & Levitt, 2002; Jarrett & Weissenburger, 1990; O'Connor, Berry, Weiss, & Gilbert, 2002). Recruitment of more psychiatrically impaired samples holds promise of illuminating the extent to which shame and guilt figure in the emotional lives of clinically depressed individuals. It would be especially worthwhile to explore whether the current study's chief finding (that shame is more strongly related to depressive symptoms compared to guilt) is generalizable to more profound levels of depressive disturbance.

Diagnostic Considerations

Our findings are most directly relevant to self-reported depressive symptoms in the subclinical range, but we nevertheless believe that the current results have clear implications for diagnostic assessment of mood disorders. In the *DSM* diagnostic system, guilt has long been seen as part and parcel of mood disturbance at the expense of shame. In the first edition of the *DSM* (American Psychiatric Association, 1952), guilt was seen as diagnostic of both psychotic and neurotic variants of depression. In the second edition (American Psychiatric Association, 1968), the diagnostic categories of involuntional melancholia and manic depressive illness (both types of psychotic depression) emphasized guilt that assumes delusional proportions and loses contact with reality. The purported link between guilt and mood disturbance persisted in the third edition of the *DSM* (American Psychiatric Association, 1980). In *DSM-III*, one of nine diagnostic criteria for major depressive episode reads as follows: "Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)" (p. 222). With respect to this "excessive," "inappropriate," and "delusional" guilt, the accompanying description specifically cited guilt marked by exaggerated responsibility for events over which the individual had little or no control. *DSM-IV-TR* (American

Psychiatric Association, 2000) and the draft criteria for *DSM-5* (American Psychiatric Association, 2010) use language that is identical to the *DSM-III* language. There is no mention of shame in any of the previous or current diagnostic criteria for mood disorders.

We believe that our findings should be used to inform future revisions of the diagnostic criteria for depression. First, our data unambiguously support the inclusion of guilt in diagnostic criteria for depressive disorders, given that maladaptive variants (i.e., “excessive,” “inappropriate,” “delusional”) are emphasized. Our findings with respect to contextual-maladaptive guilt, in particular, support the inclusion of such subtypes in the diagnostic criteria. Second, and most notably, our findings justify the recommendation that shame be afforded prominence alongside guilt in the revised diagnostic criteria. The empirical evidence clearly points to the substantial involvement of shame in depressive symptoms, and we believe that the revised criteria should reflect the large body of evidence in favor of shame’s inclusion. One might contend that this recommendation amounts to a splitting of hairs over relatively trivial semantic matters. Indeed, one might argue that shame and guilt are so similar that invoking one in the diagnostic criteria (“inappropriate” guilt) implies the presence of the other (shame). This view is not supported by the evidence. The theoretical and empirical literatures clearly demonstrate that shame and guilt are different with respect to numerous dimensions, including the focus of negative evaluation, subjective experience, action tendencies, hypothesized functions, and many others (see Table 1). Moreover, our meta-analytic data demonstrate that the mean correlation between shame and guilt is positive but fairly modest in size ($r = .40$). Simply put, shame and guilt are distinct emotions, and the presence of one does not imply the presence of the other.

Limitations and Future Directions

The current study was limited in several ways, and we believe that some of the more critical directions for future research should involve the rectification of these limitations. First, the correlational, cross-sectional nature of the data we integrated permits no inferences regarding causality and its direction. Given this limitation of the studies we reviewed, we were unable to determine which variables assume temporal precedence in the causal chain. It is possible that high levels of shame or guilt occur first and effect subsequent changes in depressive symptoms. Alternatively, people may come to experience shame or guilt as a consequence of their depressed mood. Indeed, it seems plausible to speculate that some people could interpret the onset of a depressive episode as evidence of a flawed self, in which case shame would arise in the aftermath of depressive symptoms. Of course, a bidirectional model may best reflect the causal processes in question. For example, feelings of shame may lead to increases in depressed mood, which may in turn lead to further increases in shame. The result of such a process would be a self-perpetuating cycle in which shame and/or guilt and depressive symptoms mutually fuel one another. It is also possible that some third variable that is not routinely measured in studies of shame, guilt, and depressive symptoms may yield concomitant increases in both. The resolution of this causal ambiguity represents an important avenue for future research. It is possible that experimental studies that manipulate shame and guilt could illuminate their causal effects on time-

limited changes in dysphoric mood. However, this work would require potent laboratory manipulations of shame and guilt that are probably unfeasible and ethically questionable. Milder manipulations (e.g., imagining previously experienced shame and guilt episodes; see Roseman, Wiest, & Swartz, 1994) would circumvent these concerns, but the psychological processes invoked by such manipulations may bear little resemblance to the experience of shame and guilt in the real world. Prospective, longitudinal studies that evaluate the extent to which naturally occurring individual differences in proneness to shame and guilt predict later depressed mood seem more likely to bear fruit.

Second, the current findings have documented the strength of associations of shame and guilt with depressive symptoms, but they shed no light on the mechanisms that link them. There is no shortage of theory related to such mechanisms, but there is a paucity of empirical research aimed at evaluating the theoretical predictions. Shame, especially, may be linked to depressive symptoms via some combination of mechanisms related to social conflict (Gruenewald et al., 2007), decreased social support (Joiner et al., 1999), behavioral withdrawal and its accompanying decreases in reinforcing environmental contingencies (Lewinsohn et al., 1998), self-focused rumination (Orth et al., 2006), and depressogenic patterns of attributions for events (Abramson et al., 1978; Peterson & Seligman, 1984). In addition, the presumed evolutionary functions of shame and guilt mentioned previously may offer clues as to potential mechanisms. Shame theoretically reflects concerns about decrements in social rank or occupation of low status in the social hierarchy (e.g., Gilbert & McGuire, 1998). An emerging body of theory and research suggests that such concerns are, in turn, especially potent predictors of depressed mood (Fournier, 2009; Sloman, 2008; Sloman, Gilbert, & Hasey, 2003). Guilt, which theoretically concerns motivations to avoid harming others (Crook, 1980; Gilbert, 1992), may show particularly robust links to depressive symptoms or other psychological distress among individuals highest in interpersonal sensitivity (see Snodgrass, 1985). Future research should transition from a focus on the mere documentation of associations of shame and guilt with depressive symptoms to an interrogation of the mechanisms that account for these effects.

Third, contributors to the research literature we have reviewed have sometimes relied upon vague or poorly articulated conceptual definitions of shame and guilt. In such instances, the measures used to tap shame and guilt reflect this conceptual ambiguity. Indeed, as noted previously, some measures rely upon respondents’ implicit understandings of shame and guilt in the absence of clear, theoretically informed conceptual definitions of the two emotions (e.g., Harder & Zalma, 1990; Hoblitzelle, 1987). It is worth noting, however, that conceptual ambiguity with respect to shame and guilt would likely facilitate a blurring of the distinctions between the two emotions, rendering discovery of differential links to other variables (e.g., depressive symptoms) less likely, not more likely. Our finding that shame exhibited a significantly stronger association with depressive symptoms compared with guilt may be especially remarkable in light of this logic. Nevertheless, we strongly encourage investigators in this area to prioritize the adoption of sharp conceptual definitions of shame, guilt, or their various subtypes and to select or construct measurement tools that clearly map onto these definitions.

Fourth, we have demonstrated empirically that links between guilt and depressive symptoms are inflated when depressive symptom scales contain items that explicitly tap guilt. This represents a rather obvious conflation of the two constructs. Less obvious, but nonetheless significant, conflation may occur when depressive symptom measures tap self-evaluative processes without invoking shame or guilt by name. For instance, numerous measures contain items that tap worthlessness (Beck et al., 1996; Hamilton, 1960), which shares a negative self-evaluative component with shame, in particular. As another illustration, the CES-D (Radloff, 1977) contains an item that reads: "I felt that I was just as good as other people." This item, too, appears to share conceptual overlap with the negative social comparison that some writers regard as characteristic of shame (Gilbert, 2000). However, we do not believe that these measurement issues were sufficiently serious to call our findings into question. This is primarily because the very small proportion of self-evaluative items in depressive symptom scales is insufficient to markedly inflate effect sizes. Moreover, our results showed that removal of shame variance eliminated the significant association of guilt with depressive symptoms, and this was true regardless of whether depressive symptom scales invoked the term *guilt*. Nevertheless, we encourage researchers to address these concerns by employing depressive symptom scales that eliminate overlap with self-evaluative processes characteristic of shame and guilt. An alternative solution is to simply remove self-evaluative items from measures that include them. It should be noted, however, that such a strategy might substantially alter the psychometric properties of the scales in undesirable ways.

Finally, we believe that the time is right for basic research on shame, guilt, and depressive symptoms to inform clinical assessment and intervention. Shame and guilt are clinically significant in their own right and thus merit therapeutic attention aimed at reducing the often considerable distress associated with each. Intervention at the level of shame and guilt might also be useful in preventing or forestalling some of the untoward effects with which both have been associated (including, but not limited to, depressive symptoms). Of course, the formulation of differential treatment strategies for shame and guilt requires keen clinical sensitivity to the distinctions between them. As such, clinicians who seek to develop competence in addressing shame and guilt in the therapeutic context should carefully examine the basic science that justifies their distinction.

Study Quality

The meta-analytic enterprise has long been subject to concerns related to the quality of studies integrated in the review. Eysenck (1978), in criticizing the quality of studies included in M. L. Smith and Glass's (1977) well-known meta-analysis of psychotherapy outcome studies, invoked the phrase "garbage in, garbage out" (p. 517) to argue that poor study quality results in dubious meta-analytic conclusions. One approach that meta-analysts have used to address this problem is to carefully code methodological characteristics that might serve as suitable proxies for study quality and to determine the extent to which these proxies predict variation in effect sizes. However, most of the methodological characteristics deemed important among meta-analysts are relevant to experimental studies but not to correlational studies of the sort reviewed here

(see, e.g., H. M. Cooper, 1984). For example, a study may be considered "high quality" to the extent that it (a) boasts high internal validity (i.e., changes in the dependent variable can be attributed to manipulation of the independent variable), (b) employs manipulation checks, (c) employs double-blind manipulation of the independent variable, (d) minimizes participant attrition, and so on. None of these frequently cited methodological characteristics of experimental studies are relevant to the correlational research that served as the basis of the current meta-analytic review. Indeed, most paper-and-pencil correlational research employs straightforward designs and simple procedures that are not generally subject to serious concerns about study quality. However, two methodological characteristics of correlational research are likely to be highly relevant to the quality issue as it relates to our meta-analysis: the psychometric properties of measurement scales and external validity.

First, correlational research may be threatened to the extent that measurements are unreliable, invalid, or both. There is substantial evidence of satisfactory internal consistency for the measures of shame and guilt that served as the foundation of our meta-analysis (see Robins, Nofhle, & Tracy, 2007). Moreover, test-retest reliabilities for the TOSCA and PFQ, the two shame and guilt measures most commonly utilized in the studies reviewed here, are very high (Harder & Lewis, 1987; Tangney et al., 1992). The construct validity issue is a bit more challenging. On the one hand, several shame and guilt measures show strong discriminant validity (i.e., modest correlations with other measures of conceptually unrelated constructs; see Tangney, Burckgraf, & Wagner, 1995). However, evidence of convergent validity (i.e., high intercorrelations of different measures of the same construct) is somewhat weaker. In the present meta-analysis, 19 studies employed multiple measures of shame, and 16 reported intercorrelations among these measures. In these studies, the mean correlation between separate shame measures was $r = .51$. Thirteen studies employed multiple measures of guilt, and 11 reported intercorrelations among these measures. In these studies, the mean correlation between separate guilt measures was $r = .19$. We believe that the modest size of these correlations, particularly for the guilt measures, reflects the multifaceted nature of the constructs, not poor construct validity. Indeed, we have empirically demonstrated that shame and guilt are not monolithic constructs, but are instead "umbrella" constructs that subsume a variety of different subtypes that may not share a great deal of conceptual overlap. Modest intercorrelations are not surprising in light of this observation.

Second, we acknowledge that quality may be compromised to the extent that the studies reviewed were limited in their ability to generalize beyond the typically young, predominantly White populations from which participants were sampled. We should note, however, that this threat to study quality is characteristic of a large volume of research conducted in psychological science. We reiterate our view that this research area will be valuably served by recruiting more diverse samples of participants more capable of informing whether demographic characteristics (e.g., ethnicity, sex) moderate associations of shame and guilt with depressive symptoms.

Summary and Conclusions

The self-conscious emotions of shame and guilt have been conflated throughout much of the history of psychological science. More recent theoretical and empirical work has drawn sharp conceptual distinctions between these two emotions, rendering possible an examination of their differential links to a variety of psychosocial variables. In the current study, we outlined a detailed rationale for the prediction that shame should exhibit stronger associations with depressive symptoms compared to guilt. The current meta-analytic review supported this prediction, but it also underscored the prominence of maladaptive variants of guilt in the emotional foundations of depressed mood. Overall, our results suggest that shame should figure more prominently in understandings of the emotional underpinnings of depressive symptoms.

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