Brit. J. Psychiat. (1972), **120**, 259–64

Conscience and Depressive Disorders

By MILLARD J. AMDUR and MARTIN HARROW

The present research represents an attempt to study the construct of 'conscience' in quantitative fashion and to investigate its relation to various types of psychiatric disorders. The psychoanalytic literature deals extensively with aspects of functioning or behaviour which are related to the inner rules which influence man's conduct. In his early writing, Freud described conscience as 'one part of the ego' which judged it critically (6), but by 1921 (5) he referred to this self-critical agency as the ego ideal. In 1923, Freud included in the new construct superego the functions of ego ideal as well as conscience (7). Current emphasis continues to be on the censuring aspects of superego (12, 15) and its similarity to conscience (11).

In addition to the psychoanalytic literature, other reports have appeared on the relationship of conscience to formal psychiatric disorders. Strict conscience has been imputed to be a feature of certain specific conditions, such as depression and obsessive character traits and obsessional neuroses. Lax conscience has been described as one of the basic features of sociopathic disorders. Most of the literature in this area has been theoretical or impressionistic, without empirical investigation of conscience in various mental disorders.

A working definition of the term conscience is important to facilitate empirical work, because of the wide variety of meanings which have been given to it. We define conscience as *a construct referring to a person's standards about how he should live or behave which may act as an inward monitor of his conduct.* This is clearly related to the term superego, although more of the functions of the superego are usually considered to be unconscious. The definition of guilt used in the overall project is '. . . a painful, negative, psychological feeling directed towards oneself, with an accompanying belief that one has not lived up to or has violated one's own internal values or standards about how one should live or behave' (8). This definition of guilt as used in the present research refers more to feeling tone and less to principles or standards of behaviour.

The present investigation is part of a larger project studying guilt and conscience in behaviour disorders in general, and depression in particular (8). The current research report focuses on the presence of a strict or lax conscience in psychiatric patients, with an emphasis on depression. The specific questions we attempt to answer are: (1) What is the status of conscience in mental disorders? (2) Is a severe conscience more typical of depressive than of other disorders? (3) Is a lax conscience more typical of sociopathic than of other disorders? and (4) Do other factors such as age influence severity of conscience in mental disorders?

Method

Setting and subjects

The research was conducted with recent admissions to the acute psychiatric in-patient division of the Yale-New Haven Hospital (2, 4). The sample consisted of 134 consecutively admitted acute psychiatric patients who had been utilized in our research on guilt. The median age of the sample was 25·2 years, the median educational level 14·5 years, and the sample was composed of 65 per cent females. Diagnostically, there were 25 neurotic depressives, 25 psychotic depressives, 38 schizophrenics, 30 cases of personality disorder and 16 with varied other diagnosis.

Data collection instruments

Assessments of conscience: Three instruments were administered to obtain indices of 'conscience' (see Table I).

The first index was a scale designed to assess 'severe superego', consisting of seven personalized statements relating to conscience or superego. This seven-item scale is embedded in a larger 200-item personality inventory designed

https://doi.org/10.1192/bjp.120.556.259 Published online by Cambridge University Press

TABLE I

Representative items from the three measures of conscience

Lazare-Klerman 'Severe Superego' scale
I think that I have a more rigorous standard of right and wrong than most people.
I am guided in my conduct by certain principles which I have accepted.
I am conscientious about telling the truth.
I have a strong sense of responsibility about my duties.
Buss-Durkee scale
The few times I have cheated I have suffered unbearable feelings of remorse.
People who shirk on the job must feel very guilty.
When I do wrong, my conscience punishes me severely.
Mosher scale
Sex:
When I have sexual desires, I usually try to curb them.
Hostility:
After an outburst of anger, I realize that I have done wrong.
Morality-Conscience:
When I tell a lie, I'm angry with myself.
I hate sin.

by Lazare, Klerman and Armor to assess oral, obsessive and hysterical personality patterns (10).

The second index of 'conscience' used represented a modification of the guilt scale of the Buss-Durkee (B-D) Hostility Inventory (3), taken routinely at week 3 of hospitalization. The overall guilt scale consists of nine statements dealing with guilt-related themes and general standards of behaviour related to 'conscience' or 'superego'. The conscience subscale consists of three of the nine items which deal with specific standards of behaviour or which designate types of 'undesirable' behaviour which should be avoided, without necessarily implying frequent guilt on the part of the testee (see Table I).

The third instrument utilized to assess conscience was the Mosher True-False Inventory (13) designed to assess guilt. The items, however, relate more to standards of behaviour (e.g. 'Prostitution is a sign of moral decay in our society', 'I hate sin'), and seem to assess a construct fitting the usual definition of conscience more closely than they do guilt. The definition given by Mosher to the construct assessed by the scale (14) and the scale items seem to fit more closely to the typical definitions of conscience than to those of guilt. On an empirical level the Mosher scale scores correlate more highly with the other scales for conscience than with the scale used in the present research for guilt (see Table II). The test is administered at week 2 of hospitalization and then re-administered a second time at week 5.

The Mosher Inventory is composed of 103 items controlled for social desirability. In addition to an overall score obtained, the test provides separate scores from three subscales of this inventory which measure attitudes or standards concerning (1) 'sex', (2) 'hostility', and (3) 'morality-conscience' (see Table I). Sample items from these three subscales are presented in Table I.

RESULTS

Interrelation of conscience and guilt, and changes over time

The correlations between the six indices of conscience based on three different measures are presented in Table II. The results suggest high correlations between these measures which may be interpreted as one indication that they are assessing a common construct.

In addition, a five-item measure of guilt, used in our previous research, was included to help determine whether the measures of conscience correlated more highly with each other than with an index of the related construct of guilt (Table II, Scale 7). The pattern of correlations indicates high agreement between the various conscience measures. Thus, 14 of the 15 comparisons between any two measures of conscience have higher correlations than any of the 6 comparisons between the guilt scale and each of the conscience measures.

The data on the relationship between guilt and conscience are presented in Table II. The overall positive correlations suggest that the two constructs (guilt and conscience) are positively related though not identical.

Table II also reports the correlation between measures which were used to assess conscience at two different time periods (the Mosher scales), weeks 2 and 5 in hospital. Most patients on this acute treatment service show rapid changes in psychopathology during the first five weeks of hospitalization (1, 9, 16). During this

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three-week period of acute change, the pattern of scores for the Mosher Scale remained relatively stable ($r = \cdot 85$ and $r = \cdot 87$ for the two sets of scales) and the means of the overall Mosher Scale did not differ significantly. The relatively high intercorrelations of the different conscience measures given as far as six weeks apart also suggest relative stability of conscience during varying levels of psychopathology.

Relation of conscience to diagnosis, sociopathic trends, age and sex

The major results, the comparison of different diagnostic groups on the conscience scales, are reported in Table III. Overall, on the various measures of conscience, the depressives (both psychotic and neurotic) had significantly stricter consciences than the non-depressed patients.

The tests also were given at various time periods during the first eight weeks of hospitalization, with the results showing a uniform trend toward stricter consciences among diagnosed depressives on all scales. This suggests that the pattern of differences between diagnostic groups remained constant as the extent of psychopathology changed during the course of acute treatment.

Ratings by two senior staff members of sociopathic trends and of hysterical features were also assessed in terms of the conscience measures. The patients without sociopathic tendencies had significantly stricter consciences using the Klerman and Mosher Scales ($p < \cdot 01$). In addition, the group of personality disorders, the largest sample of patients without schizophrenic or major depressive trends, was analysed separately for the presence of sociopathic features. The results indicated that the group of personality disorders without sociopathic trends had significantly stricter consciences than those with sociopathy. In contrast to the results on sociopathic trends, the presence of hysterical features was not strongly related to strictness of conscience ($p > \cdot 20$).

TABLE II

Relationship between measures of conscience

Test and week administered	2 Mosh M-C (wk. 5)	3 Mosh total (wk. 2)	4 Mosh total (wk. 5)	5 L-K superego (wk. 8)	6 B-D conscience (wk. 3)	7† B-D guilt (wk. 3)
1. Mosher morality consc. (wk. 2) ..	·85	·87	·78	·45	·58	·36
2. Mosher morality consc. (wk. 5) ..		·78	·86	·52	·62	·26
3. Mosher total (wk. 2)			·87	·43	·49	·25
4. Mosher total (wk. 5)				·47	·51	·15
5. Lazare-Klerman severe superego (wk. 8)					·33	—·01
6. Buss-Durkee conscience subsc. (wk. 3)						·39

† Index 7, derived from the Buss-Durkee Scale, assesses *guilt* (see reference 8).

TABLE III

Mean conscience scores for depressive and non-depressive patients

Diagnostic group	Mosher scale (Total)		Mosher scale (Moral consc.)		Buss-Durkee		Lazare-Klerman scale	
	M	*t*†	M	*t*†	M	*t*†	M	*t*†
Psychotic depressives	119·57	—	36·81	—	1·84	—	5·38	—
Neurotic depressives	115·12	—	35·12	—	2·08	—	5·08	—
Schizophrenics	99·45	3·72***	30·62	3·00**	1·44	2·33*	3·83	3·25**
Personality disorders	108·62	1·78	30·69	2·43*	1·47	2·12*	3·50	3·25**
Others	118·73	0·29	36·93	0·69	2·13	0·60	5·15	0·17
All depressives	117·11	—	35·87	—	1·98	—	5·24	—
All non-depressives	105·97	2·60*	31·71	2·50*	1·57	2·49*	4·02	3·01**

† The respective *t* scores represent comparisons of each diagnostic group with the combined group of neurotic and psychotic depressives.

* $p < \cdot 05$. ** $p < \cdot 01$. *** $p < \cdot 001$.

https://doi.org/10.1192/bjp.120.556.259 Published online by Cambridge University Press

The data on the relationship of age to strictness of conscience are presented in Table IV. These results indicate that older patients had significantly more strict consciences than younger patients ($p < \cdot 05$). The trend toward more lax consciences among younger patients also held when the male and female patient groups were considered separately. Thus, the younger males had laxer consciences than older males and (to a lesser extent) the younger females had laxer consciences than older females.

Age and the presence of depressive diagnosis were also examined in combination with each other to control for each of these variables while analysing the other one. The results suggested that the trend for depressives to have stricter consciences than non-depressives was greatest at the younger age ranges because of a tendency for all older patients (both depressive and non-depressive) to have relatively strict consciences. Similarly, the trend for older patients to have stricter consciences held to a much greater extent for non-depressives, since depressives at all age ranges had relatively strict consciences.

The data on sex were more mixed. In the younger age range, male patients tended to have laxer consciences than female patients. This trend did not hold at the older age ranges, however, suggesting that the interaction between sex and strictness of conscience is a complex one which needs further analysis.

Discussion

A. *Conscience and diagnosis*

The present findings fit the formulation that a strict conscience is found more frequently in depression than in other major psychiatric disorders, such as schizophrenia or personality disorders. The related, but not identical, term 'punitive superego' which is used by some authors synonymously with strict conscience may be applicable to these findings as well. Thus, if one attempts to define operationally the concept of a strict superego, the questions comprising each of the major scales used come close to approximating this construct. In fact, one of the scales derived from a test utilizing psychoanalytic principles (the Lazare-Klerman Scale) has been labelled a scale to assess 'severe superego' (10).

Explicit emphasis on the importance of conscience or moral functions of personality in formulations about depression vary widely; many dynamic formulations emphasize guilt and postulate factors related to punitive superego as responsible for it. Thus it has usually been assumed that guilt is a striking feature of depressive disorders. On the basis of our findings on guilt in a previous report (8) and on a strict conscience in the present investigation, it is suggested that a strict conscience may be a more persistent and pervasive feature of patients whose primary disorder consists of a syndrome with depressive affect (with this syndrome being the *reason* for their admission to hospital). In contrast, guilt, although significantly more frequent in the neurotic depressives (8), was not as prominent a feature of these primarily depressed patients as was a strict conscience. Guilt, however, along with other symptoms often present in the depressive 'syndrome' was found as a frequent characteristic of a wide variety of patients with some depressive or cyclothymic features. These 'guilty' patients with cyclothymic and depressive trends (probably chronic and

Table IV

Relationship between age and conscience

Age	Mosher scale (wk. 2)		Buss-Durkee scale (wk. 3)		Lazare-Klerman 'severe superego' (wk. 8)	
	Mean	*N*	Mean	*N*†	Mean	*N*†
Under 25 years	104·06	46	1·55	46	3·66	34
25–40 years	105·47	50	1·72	49	4·37	29
41 years and older	121·55	38	1·92	36	5·54	26

† Due to the gradual discharge of patients from the hospital, tests administered later during the course of hospitalization have smaller sample sizes (e.g. Lazare-Klerman Scale) than tests administered earlier during hospitalization.

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long standing in nature) cut across the usual diagnostic categories and were admitted to hospital for a variety of reasons, including thought disorders (schizophrenics), primary depressive disorders (neurotic and psychotic depressives), and long-standing characterological difficulties (personality disorders).

The current findings raise a key question of importance for theory. Is a more severe conscience the result or concomitant of the depressive disorder, or does depression affect persons who already have stricter consciences? The latter alternative suggests that the stricter consciences in these patients may have been partly responsible for or influenced the form of their subsequent disorder (i.e. their depression). Our tentative evidence indicates that there may be a severe *premorbid* conscience in those patients whose test results reveal strict consciences during their stay in hospital for depression. Thus, some of the test instruments used (e.g. Lazare-Klerman Superego Scale) were administered at times late in the hospitalization when other measures of illness had returned to the normal or premorbid state, and these instruments also indicated that depressives had stricter consciences. In addition, the Mosher Scale was administered at two time periods, and the relation to depression was found to be equal or slightly greater at the second time period (week 5 in hospital) when the patient's acute illness had subsided considerably.

Perhaps particular personality styles and/or sets of beliefs and attitudes related to conscience may predispose patients to certain types of disorders such as depression. However, most previous investigators have not found uniform personality types associated with depressions as a whole. Thus our tentative results suggesting that depressed patients have stricter consciences before the onset of their illness may be most applicable to a subgroup of depressives, and in this subgroup it may be that conscience is a strong predisposing factor.

B. *Conscience and guilt*

Conscience and guilt are closely linked in theory, although there has been little in the way of formal research on this relationship. Our results suggest a strong (significant) relationship between guilt and conscience. However, even though these two variables (conscience and guilt) are highly correlated in the sample as a whole, many patients are high on one variable and low on the other variable. The small manic subgroup was reasonably high on conscience but quite low on guilt (8).

C. *Conscience and sociopathic trends*

The fact that individuals with sociopathic tendencies had lax consciences also fits the theoretical formulation of superego lacunae. The present sample did not include hard core sociopaths. However, patients with personality disorders who were rated high on rule breaking behaviour had consciences which were laxer than those rated lower on rule breaking behaviour.

D. *Conscience and age*

The data indicating a significant relation between age and strictness of conscience are of theoretical interest. At least part of the mechanism involved in the development of conscience or moral functions of personality is understood (identification and introjection of values from parental or authority figures). In the extreme, this has led to the belief by some that 'conscience' is determined at a fixed age, subsequent life events having minimal influence in changing it. Some, however, have noted a decrease in severity of moral functions as age increases (17). Neither of these formulations was confirmed with the results indicating a strong trend ($p < \cdot 01$) for older patients to have stricter consciences than younger patients.

While we understand some of the early mechanisms involved in the development of conscience, and while childhood may be more crucial, the current data suggest that other factors also exert an influence. Some of these variables are related to living in the world over time, the various types of life events people experience, and possibly factors related to the ageing process. In relation to ageing many have observed (and at times complained) that as adults get older they tend to accept social values and prohibitions more readily. This may be linked to such factors as decreased negativism, decreased rebelliousness and to increased rigidity with advancing age.

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The influence of various life events people experience as they grow older may include psychosocial factors such as increased stability and regularity of life style with greater maturity. They may also include changes from being a recipient of the rules as a child to a giver of rules (to one's own children) as an adult, losses in health, status and object relations.

Summary

Severity of conscience was studied in 50 depressive and 84 non-depressive psychiatric in-patients. The subjects were administered three different scales assessing strictness of 'conscience' and a guilt scale. High correlations were found between the various conscience measures, indicating that the three indices utilized are assessing a common construct. Results suggested that the two constructs, guilt and conscience, are positively related but not identical. The total scores on all three conscience scales indicated significantly stricter conscience in depressive disorders. The trend toward stricter consciences among diagnosed depressives was true at various time periods during the first eight weeks in hospital, even as severity of depression was changing. Patients without sociopathic trends had significantly stricter consciences than those with sociopathic trends. The presence of hysterical features was not related to strictness of conscience. Age was related to strictness of conscience, older patients having more severe consciences than younger patients.

References

1. Amdur, M. J., Tucker, G. J., Detre, T. *et al.* (1969). 'Anorexia nervosa: an interactional study.' *J. nerv. ment. Dis.*, **148**, 559–66.
2. Astrachan, B. M., Harrow, M., and Flynn, H. R. (1968). 'Influence of the value system of a psychiatric setting on behaviour in group therapy meetings.' *Soc. Psychiat.*, **3**, 165–72.
3. Buss, A. H., and Durkee, A. (1957). 'An inventory for assessing different kinds of hostility.' *J. consult. Psychol.*, **21**, 343–9.
4. Detre, T., Sayres, J., Norton, N. M. *et al.* (1961). 'An experimental approach to the treatment of the acutely ill psychiatric patient in the general hospital.' *Conn. Med.*, **25**, 613–9.
5. Freud, S. 'A differentiating grade in the ego.' In: *Standard Edition of the Complete Psychological Works of Sigmund Freud*, vol. XVIII, pp. 129–34. London: Hogarth Press.
6. —— (1917). 'Mourning and Melancholia.' In: *Collected Papers*, vol. IV. London: The Hogarth Press and the Institute of Psychoanalysis.
7. —— (1962). *The Ego and The Id.* Translated by Joan Riviere (ed. Strachey, James). New York: W. W. Norton.
8. Harrow, M., and Amdur, M. J. (1971). 'Guilt and depressive disorders.' *Arch. gen. Psychiat.*, **25**, 240–6.
9. —— Fox, D. A., Markhus, K. L. *et al.* (1968). 'Changes in adolescents' self-concepts and their parents' perceptions during psychiatric hospitalization.' *J. nerv. ment. Dis.*, **147**, 252–9.
10. Lazare, A., Klerman, G. L., and Armor, D. J. (1966). 'Oral, obsessive and hysterical personality patterns.' *Arch. gen. Psychiat.*, **14**, 624–30.
11. Lidz, T. (1968). *The Person*, p. 242. New York: Basic Books.
12. Lynd, H. M. (1961). *On Shame and the Search for Identity*, p. 230. Science Editions, Inc.
13. Mosher, D. L. (1966). 'The development and multitrait-multimethod matrix analysis of three measures of three aspects of guilt.' *J. consult. Psychol.*, **30**, 25–9.
14. —— (1968). 'Measurement of guilt in females by self-report inventories.' *J. consult. & clin. Psychol.*, **32**, 690–5.
15. Noyes, A. P., and Kolb, L. C. (1958). *Modern Clinical Psychiatry*, p. 33. Philadelphia: W. B. Saunders.
16. Shanfield, S., Tucker, G. J., Harrow, M. *et al.* (1970). 'The schizophrenic patient and depressive symptomatology.' *J. nerv. ment. Dis.*, **151**, 203–10.
17. Zinberg, N. E., and Kaufman, I. (1963). 'Cultural and personality factors associated with aging: An introduction.' In: *Normal Psychology of the Aging Process* (eds. Zinberg, N. E., and Kaufman, I.), pp. 17–71. New York: International Universities Press.

A synopsis of this paper was published in the January 1972 *Journal*

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(*Received 3 May 1971*)

https://doi.org/10.1192/bjp.120.556.259 Published online by Cambridge University Press