Shame and Community: Social Components in Depression

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ALTHOUGH there are many theories of the causes of depression, they all assume that some cases are primarily endogenous; that is, they are largely independent of situational influences. This article proposes that most cases of depression have a social component that is closely tied to the immediate situation. During 5 months in 1965 I observed nearly all intake interviews of male patients in a mental hospital near London. Most of them were over age 60, and all but one were diagnosed as depressed. However, there was usually a temporary lifting of depression in those interviews in which the psychiatrists asked the patients about their activities during World War II. At the time I didn't understand the significance of these episodes. I now offer an interpretation in the light of current studies of shame and the social bond: Recounting memories of belonging to a community temporarily resolved shame and depression. These episodes suggest a modification of existing theories of depression, that shame and lack of community, in addition to biology and individual psychology, could be a component of major depression.

Each of the many theories of depression proposes a different and usually disparate explanation and recommendation for treatment. These theories involve biological, psychological, or social causes. As diverse as these theories are, there is one issue on which they seem to be in agreement—that there is one type of depression in which the current situation is not highly significant. In psychiatric language, this type is called nonsituational or *endogenous*, as against *reactive* depression (Joffre, Levitt, Bagby, and Regan 1993). By definition, endogenous depression is not primarily a response to the immediate situation.

Although researchers of life events propose environmental causes, their empirical results also suggest the existence of endogamous depression. Virtually all of the more systematic studies at least report only a minority of cases in which a traumatic life event preceded the onset of clinical depression.[1] These results are taken by the proponents of biological and psychological theories to uphold their approach. If the immediate social situation does not contribute to the onset, then the cause of endogenous depression must be either biological or psychological.

However, it is possible that the life event studies have not yet found all of the kinds of situational elements that lead to depression. In existing studies the life events sought have been obvious traumas reported

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[1]This is my reading of the most recent reviews of systematic studies of depression. An example is provided by the volume edited by Dohrenwend (1998). Although he proposes that there is strong evidence of an environmental link to the onset of depression, the systematic studies in the volume suggest that this is true of only a minority of cases. However, I have found one more recent study (Mazure, Bruce, Maciejewski, and Jacobs 2000) in which life events predict a majority of the depressive cases.

by patients. This article proposes that the precipitating cause may be subtle or insidious enough that most patients would be unable to include it in their self-report: the absence of a stable community as a support for the individual (Karp 1996; Seligman 1990). Mokros's (1993) study suggests another possibility, that the methods of study may result in a constant bias that eliminates situational elements. I will return to these three studies in the Discussion section below.

I interpret the episodes that I observed to imply a social component for depression. My theory of depression does not eliminate the biological and psychological in favor of social causation. Instead, it concedes that all three are components of a complex process. In particular, this study implies that the theories and methods of sociology, psychology, and biology will probably need to be included in a single framework. Assuming that the phenomenon of depression is as complex as most other human behavior, it now appears that a complex multidisciplinary approach will be needed to understand it.[2]

INTAKE INTERVIEWS AT SCHENLEY HOSPITAL

I spent a year in Europe 1964 to 1965 with a research fellowship from the Social Science Research council. My plan was to compare intake interviews in Rome and London to those I had already observed in the United States. However, I was unable to gain sufficient access in Rome. In England I was given complete access. After visiting six mental hospitals, I chose Schenley just north of London. I was given an office and freedom to observe in any site I wished. For 7 months, I visited all of the units and talked to patients and staff.[3] In a hospital divided into separate men's and women's units, I spent most of my time on the male units.

For the last 5 months of my stay I sat in on virtually all intake interviews of male patients, 85 cases.[4] Most of these interviews were conducted by one psychiatrist, Peter Conran. The remaining interviews were held by three others: Drs. Kennedy, Cregar, and John. Though all of the interviewers followed a similar format, there was some variation in the questions. Occasionally one or more of the usual questions were omitted or new ones added. The interviews were usually between 35 and 45 minutes long.

At the time of the interviews, my main purpose was to compare intake procedures between England and the United States. My book on labeling (Scheff 1966) was in press; my research focus still concerned issues such as the precision and reliability of diagnosis. For this reason, my notes on depression in the older men, and their relationship network, which form the basis for the present article, are incomplete. In a few instances, I have supplemented the notes from memory, but because these events took place 35 years ago, I have had to rely mainly on my notes.

The majority of the new patients were 60 or older, but there were also 12 young males. None of them seemed depressed, and none were diagnosed as depressed. I mention them to show the sharp contrast with the uniformity of the cases of the older men. The most common diagnosis among the younger men was no diagnosis. The psychiatrists were unable to find mental illness in almost half of these cases. Here is a typical interview of a young male: Dr. Kennedy interviewed a 17-year-old and his mother, who was informally referred by a mental health officer (MHO). The boy has been sent by the MHO to a general practitioner (GP), apparently because he wore his hair long ("Like the Rolling Stones," the boy said). The mother said she

[2]For a reexamination of Freud's cases that shows how social science and psychology can be integrated, see Billig 1999.

[3]In these visits, I met David Cooper, then doctor of one of the units. Through him, I met R. D. Laing and participated in his weekly seminar for 5 months.

[4]Because of scheduling difficulties, I was unable to attend four interviews during the 5-month period. For the interviews I did attend, I have been unable to find my notes for three of them, all of older men.

had taken the boy to the GP because he had "thrown over his job and was running loose." But at the end of the interview, the mother said she didn't want the boy hospitalized, so Dr. Kennedy released him. As far as I could understand the boy's dialect (Cockney), he was angry at his mother, but showed no obvious symptoms.[5]

Of all the young men, there was only one who displayed obvious symptoms of mental illness. He was a slight 19-year-old accompanied by his father. Many of his utterances were garbled. For example, when asked by the psychiatrist how he was doing in school, the boy replied: "A is for up, B is for sideways. A plus B equals coordination." The psychiatrist called his language "word salads" and diagnosed him as schizophrenic.[6] However, at the end of the interview, when the psychiatrist asked him if he wanted to spend some time in the hospital, he answered with a clear and unequivocal negative. With the father's consent, he was released. Although the psychiatrist expected to see him again shortly, he didn't returned during the subsequent 3 months of my stay. There was no sign of depression in any of these young men. Unlike the patients who will be described below, these men, although all working class, had not yet experienced a lifetime of rejection, disrespect, and defeat. As yet they had no reason for depression.

DEPRESSED MEN

Of the 70 older males for whom I have notes, all but one was diagnosed as depressed and showed clear signs of depression in the interview. Even the one exception, diagnosed as paranoid, presented a clear picture of depression in the interview. All of these men also had English working-class accents, some very strong. The obvious difference between the social class of the patient and that of the psychiatrist (and also that of myself, the observer) influenced the mood of the interviews, as I will note below.

A 60-year-old man, whom I will call Harold Sanders, had a diagnosis of paranoia. He lived in his father-in-law's house, with his wife and his father-in-law all his married life. "Trouble started with a dog bite." He wanted the dog dead. His attitude interfered with his relationship to his wife, who loved the dog. (I noticed that he spoke somewhat louder and more clearly after his wife left the room). He imagined, he said, that his wife was having an affair with their clergyman. This is the third time Dr. Conran had seen him; he comes to the hospital when he is depressed.

The patient said he was being treated as a child by his father-in-law and as a lodger by his wife, and she despised him for it. He said he had delusions about her whole family. (But it seemed to me from the way she acted toward him, and from what they both said about their home life, that her family did gang up on him.) This was the only one of the older men asked about the cause of their mental illness who didn't put the blame for his problems entirely on himself. The psychiatrist admitted him to treatment, saying that he would probably get electroconvulsive therapy. Although both he and the psychiatrist mentioned delusions, none were in evidence in the interview. What was obvious, as in the other older men, was his depressed affect.

The rest of the older men also looked depressed, and were diagnosed as depressed. One 61-year-old patient, "William Kelly," diagnosed as suffering from agitated depression, was typical, except for his heavy drinking. He was admitted from a general hospital because he had collapsed several times. He said he had been drinking a half quart of whiskey a day as an escape from marital difficulties and house payments. The patient was a little oblique and

[5]The cases in which the psychiatrist could not find a diagnosis are somewhat reminiscent of those described in Laing and Esterson (1964). However, the families and psychiatrists I observed at Schenley were much more benign.

[6]The father's attitude toward his son's speech seemed naive. After the patient left the room, the psychiatrist asked the father what he made of the son's behavior. The father answered: "I don't know where he learned to talk like that, but it wasn't at home."

tremulous, but everything he said was relevant to the interview questions. Some of his responses were so soft that they were almost whispers. His gaze rested continually on the floor in front of him.

He said that he would like to go back to his job but would put himself in the doctor's hands. He also said he was worried about the rent due on Wednesday. The doctor summarized the patient's case to him: a history of chest pain, has two sons and a daughter, all working, good relations with his boss at fruit stand, but mental impairment. Patient replied that he was not mentally impaired, that he had to keep sums in his head at the fruit stand. Patient then showed, on his own volition, that he knew the time, date, and location. Like all but one of the older men, this patient blamed himself saying, "I brought it all on myself."

Although the diagnosis was different in these two cases, both patients presented themselves in the interview in a way that was remarkably similar to the other older men. For the most part, they spoke so softly that it was difficult to hear much of what they said. I noticed that the psychiatrists, like me, were often leaning forward attempting to hear. They also spoke quite slowly, with many pauses and much speech static (stammers, throat clearing, "*ah*-ing and *uh*-ing," etc). The older men also looked at the floor most of the time, rather than at the psychiatrist. Most looked pale or sallow. Finally, they all blamed themselves.

There were two questions that usually aroused the patients from their lethargy. The first question, asked in about a quarter of the interviews (22), had the form "Do you know what is causing your problem?" About half of these men responded that they didn't know; the other half (10) responded to the effect that their problem was caused by "self-abuse" (i. e., masturbation, although this term was never used). In this latter group, the psychiatrist deviated from his question schedule, attempting to dissuade the patient from the belief that "self-abuse" could cause depression. In most of these instances, the patient responded somewhat testily, accurately picking up, I think, the condescending or impatient tone of the psychiatrist.

In these episodes the patients also deviated from their usual manner; several argued to the effect that the psychiatrist was just a young fellow and that there were some things he hadn't learned yet. During this brief moment, the patient's voice would gain volume, and he would take a quick look at the psychiatrist. This change in demeanor was slight and very brief, however; the patient reverted quickly to his depressive manner. In the discussion that follows I relate the patients' attitudes toward masturbation to the emotional dynamics of depression.

TEMPORARY RELEASE FROM DEPRESSION

There was another question often (41 interviews) asked, however, which almost invariably had an obvious effect: "What did you do doing during the war?" (i.e., World War II, which had ended 20 years earlier). Only a few of the men said that they had served in the military service (9). Slightly more were members of organized groups, such as the Home Guard or firemen (10). The majority of these men had not been directly involved in the war effort. Yet, whatever their involvement, the question had a strong effect on their manner. In slightly more than half of the cases (21), they showed more aliveness but still not at a normal level. However, in the remainder of cases (20), their manner was transformed.

In this latter group, as they begin to describe their activities during the war, their behavior and appearance gradually changed. They sat up in their chair, raised their voice to a normal level or close to it, held their head up, and looked directly at the psychiatrist, usually for the first time in the interview. The speed of their speech picked up, often to a normal rate, and became clear and coherent, virtually free of pauses and speech static. Their facial expression changed and usually took on more color. Each of them seemed like a different, younger, person. What I witnessed were awakenings.

If memory serves, the transformation usually lasted only as long as they were an-

swering this particular question. I think that most of the men reverted to their former manner in response to the next question. However, with a few of these men, perhaps six, the change may have lingered longer. I am uncertain because I took no notes on this important issue.

In response to my questions, all four the interviewing psychiatrist told me that they had often seen this effect. Dr. Conran said it was the reason he asked the question, to help him gauge the depth of depression. None of the psychiatrists had any explanation, however; nor did I at the time.

SHAME AND DEPRESSION

In terms of recent work in the sociology of emotions (Karp 1996; Mokros 1991; Scheff 1990, 1997, 2000; Retzinger 1991; Scheff and Retzinger 1991), the episodes of the temporary lifting of depression are now meaningful to me. To discuss this meaning, however, it is necessary to explore the emotional/relational world of depression.

It is a commonplace among clinicians that depression is not a feeling but an absence of feeling. That is, depression is different than feeling sadness, loneliness, or disappointment. Rather, it is the experience blankness, hollowness, or nullity. But there is also near consensus that the blankness results from the *suppression* of feeling. That is, depression is a defense against emotional pain that seems so continuous as to be unbearable. Rather than feel the constant pain, one numbs the senses.

Clinical consensus breaks down, however, when it comes to identifying the emotional pain that is being suppressed. The two most frequently named emotions are grief and anger. Both Freud and Bowlby, for example, thought that depression occurs when there is loss of the person's most significant relationship through death or abandonment. Grief or sadness is directly caused by the loss, and anger or rage indirectly by it. Bowlby suggested that loss almost always lead to angry protest in an attempt to restore the bond, either the original bond or a replacement for it.

In terms of the depressed men that are the subject of this article, the idea that they were suffering from loss fits very well with my thesis: The basic cause of these men's depression was that they lacked secure bonds; all their bonds were either severed or insecure. By an insecure adult bond I mean a relationship that lacks a history containing moments of mutual understanding (both cognitive and emotional) or one that does not maintain at least a rough level of equality. A relationship may be stable, but unless it contains one or both of these characteristics, it is still insecure (Scheff 1990, 1994, 1997).

Given this definition of an insecure bond, to what emotions does it give rise? Most of the cases described here do not support the idea that the emotions they were suppressing were grief or rage. There were a very small minority of them whose faces showed sadness. None of them, except in their brief responses to the issue of self-abuse, showed any anger. Overwhelmingly, their facial expression was one of blankness.

However, their bodily expression, excepting the face, uniformly were suggestive of another primary emotion, shame. Indeed, their bodies positively radiated shame. The manner of each of the older men in the interview can be interpreted as an expression of continuing shame. Overly soft speech, lack of eye contact, slowness, fluster, and self-blame all are elemental shame indicators (Retzinger 1991, 1995). The behavior and appearance of these men suggested that they were deeply ashamed for most of the interview. These observations support Lewis's (1981) theory of depression: Although suppressed grief and anger may also be involved, the primary emotion is unacknowledged (unconscious) shame.

Lewis used shame as a technical term, a concept that is much broader than vernacular usage. In everyday usage, shame is used narrowly, usually meaning only an intense emotion of crisis and disgrace. But most shame scholars, like Lewis, consider shame to a family of emotions that include lesser manifestations, such as embarrassment, modesty, and shyness, as well as more intense ones, such as humiliation. What these and other affects

have in common, according to Lewis and others, is they are all reactions to threats to the social bond (Kaufman 1989; Lewis 1971; Morrison 1989; Retzinger 1991; Scheff and Retzinger 1991). Given this source, shame is seen as not only negative but also positive, a signal reminding actors to try to deal with bond threat.

In this technical usage, the concept of shame is also represented in a wide variety of vernacular terms such as lack of self-respect, low self-esteem, lack of self-confidence, heightened self-consciousness, and many other terms. In addition, many affects often thought to be elemental are also seen as shame based, such as resentment, guilt, and envy. Resentment, for example, is seen as a shame/anger sequence with the anger component directed outward. Guilt, similarly, is also a shame/anger sequence, but with the anger directed toward self. What unifies all these varied manifestations is threat to the bond. Misbehavior that invokes guilt, for example, is also likely to threaten the misbehaving person's bonds.

Apparently in Western societies there are a great many code words that are shame cognates or are at least linked to shame. The emotion of shame, in the broad sense, is a constant reminder of the crucial significance of social bonds. Western societies, because they emphasize the self-reliant individual, mask bonds and shame by having few relational terms and by ignoring or disguising shame. In less individualistic groups, such as Eastern and traditional societies, members are much freer to use relational and shame-oriented terms.

Given the technical definition of shame, we can now ask the question of why the old men described in this study were ashamed. In these cases, there were several possibilities. There is probably an element of shame for anyone in the role of a psychiatric patient, because of the implication that one's life is out of control, that one is inadequate or incompetent. This implication is probably emphasized by many patients who compare their own state with that of the psychiatrist, whom they assume has his or her life under control and is competent. Furthermore, the most private aspects of the patient's life may be discussed, even his or her secrets or aspects of the patient' s experience that are outside the patient's awareness. The psychiatrist's authority, and in the case of these patient's, his or her higher social class, also put the patient in an inferior position, one that could give rise to shame or embarrassment.

Another source of shame for some of the patients was their idea that their depression was caused by "self-abuse." Most of these patients would have been ashamed of their history of masturbation, which in the working class is often considered a sin or at least unnatural. Furthermore, this idea makes them responsible for their illness, another way of generating shame. Probably the dominant source of shame, however, was one that may have been characteristic of all of these men: None of them seemed to have a single secure bond with another human being. Masturbation, which signals the absence of a sexual partner, symbolizes the outcast condition. Referring to the two case histories above, it was clear at the time that Harold Sanders had no secure bonds. His conflict-ridden relationship with his wife and her family was one of the causes of his hospitalization. The case of William Kelly is not as clear, since I don't have notes on his relationship with his children. But his relationship with his wife was clearly dysfunctional. In only a few (7) of the interviews with older men was a relative of the patient present. In these cases there was clearly a conflictual relationship with the relative. Furthermore, during my own visits to the men's units, there were never any visitors.

However, these old men had felt that they belonged to a community during World War II.[7] But now they were outside the fold. As far as I could tell, none of them had even one secure bond. The married men were uniformly at odds with their wives, and the rest

[7]"Life during the war is always described in terms of the sense of comaraderie, of people pulling together and a sense of social cohesion. . . . there was the sense of psychological unity in the face of a common enemy." (Wilkinson 1996, p. 71).

were widowed, divorced, or never married. Very few lived with their children or other relatives. Although some had jobs, they didn't find them fulfilling. Nor was a bond formed during the intake interviews. Except for the two questions mentioned above, the patients were impassive during the interview, giving minimal answers. The psychiatrists, in turn, made little effort to connect; for the most part, they merely proceeded through their lists of questions. They probably felt it would be useless to try to penetrate the impassivity and silence of the older men.

There was a sense of distance from the moment that the psychiatrist spoke. All of the psychiatrists were middle class. None quite spoke BBC, but according to my American ear, all four had only slight accents. The patients, on the other hand, were all working class; they spoke with strong accents, including Yorkshire and Cockney. There was even one patient that I now think must have been from Glasgow; both the psychiatrist and I felt that we needed a translator. Even if the psychiatrists had been interested in forming a bond with any one of these men, the chance would have been slim because of the situation and because of the immense social distance in England at that time between the classes. They were usually kind, especially Dr. Conran, but they went through the interview pro forma, for the most part. As in all of their other relationships, the men had little chance of forming a bond in the interviews.

SHAME, SOCIAL BONDS, AND COMMUNITY

It has been proposed that shame is a social emotion, a response to threatened or severed bonds (Lewis 1971, 1976, 1981, 1987; Retzinger 1991; Scheff 1990, 1994, 1997, 2000). These men were in a state of chronic shame before and during the interview, predominately because all of their social bonds were insecure or had been severed. However, telling the psychiatrist their memory of belonging to a community during World War II had been enough to temporarily decrease their shame at being outcasts.[8] Conveying to the psychiatrist that "once we were kings" had briefly relieved their shame and therefore their depressive mood.

The historian Lucy Dawidowitcz (1989) has reported a parallel response to severed social bond by survivors of the Holocaust:

> The survivors liked best of all to talk about their former lives, . . . the houses they lived in, the family businesses, their place in the community. By defining themselves in their previous existence, they were confirming their identity as individuals entitled to a place in an ordered society. They had not always been outcasts. (p. 303)

It appears that one's identity as a worthy person depends both on the level of respect one is currently commanding, and also on memories of being treated respectfully. Social psychological theories of the self touch on this issue in the distinction that is made between the *self-image*, which is heavily dependent on the immediate situation, and the more enduring *self-concept*. But the way in which the self endures current situations is little discussed in social psychology.

Because Virginia Woolf's writing, even her novels, was largely based on her memories of her own, she devoted some attention to the role of memory in sustaining the self. This passage, by the editor, occurs in the preface of a volume of autobiographical writings by Virginia Woolf: "Memory is the means by which the individual builds up patterns of personal significance to which to anchor his or her life and secure it against the 'lash of random unheeding flail'" (Jeanne Shulkind, quoted in Woolf 1985, p. 21). Woolf herself made the point forcefully: "The present when backed by the past is a thousand times deeper than the present when it [the present] presses so close that you can feel nothing else" (Woolf 1985, p. 98). If Woolf

[8]Wilkinson (1999) and James (1997) make similar arguments about the way that social cohesion lifted shame during World War II. I am indebted to Bengt Starrin for calling the Wilkinson article to my attention and to Paul Stokes for the James book.

is right, then profound depression arises not only out of being an outcast, but also from not having had, or being cut off from, memories of experiencing community.

One possible source of depression therefore is having no experience, as an adult, of being an accepted member of a community. Of course every one who lives to be adult, depressed and not depressed, has had the experience as an infant of being emotionally connected to at least one caretaker, a little community of two or three. But for virtually everyone, this experience is beyond recall and cannot serve as a source of comfort and sustenance of the self. The task for the therapist in the case of those with no adult experience of community would be to develop a bond for the first time in the adult life of the patient, which might take considerable time, patience, and skill.

On the other hand, the therapist's task with those patients who have had the experience of community as adults, but are cut off from it, would seem to be much simpler. These patients, like the old men described in this study, need only be asked the right question and listened to respectfully. It would appear that the deficit in these cases is not inside the patient but in his social environment. The old men in this study lived in a milieu in which they were not likely to be asked about their experiences of any kind, much less those of 20 years earlier. If, in the unlikely event that such memories were retold, given the quality of their relationships, their hearers would likely have reacted with exasperation rather than respect.

I have asked many experienced mental health practitioners about the temporary lifting of depression. Most of them responded that they knew of highly skilled practitioners who seemed to have the ability to bring patients out of depression, at least temporarily. Some of my respondents cited names of persons, such as Norman Brill. But none could cite published instances and none made interpretations in terms of bonding with the patient or positive memory recall.

But there is a vast amount of evidence that "lack of attachments is linked to a variety of ill effects on health, adjustment and well-being" (Baumeister and Leary 1995). In this article, I want to take this idea a step further: I propose the hypothesis that lack of attachments is an immediate situational component of depression, perhaps including even depression that is primarily endogenous. As Baumeister and Leary point out, lack of attachments can give rise to many different kinds of pathologies. Depression is only one of many possible outcomes, depending on the particulars of the life course, and the biology and psychology of the individual.

If it turns out to be true that alienation is an immediate cause of depression, how could virtually all of the earlier studies have missed the cues? One possibility is that the human sciences are just as rooted in the institution of *individualism* as the lay public. Elias (1998) pointed toward this institution as "the myth of homo clausus" (the self-contained individual). In Western societies, social relationships are all but invisible because our perceptions are dominated by the concept of individuality.

Support for this idea can be found in an unexpected source—social psychological experiments that required subjects to choose between the person and the situation as causal (Ross and Nisbett 1991). The support is unexpected because experimental social psychology, like other human sciences, is dominated by the concept of the individual. Citing many studies, Ross and Nisbett reported that subjects showed a strong and consistent bias for attributing causes to individuals rather than to situations (pp. 125–33). For example, in one study, when asked to explain why some persons volunteered for work with a corporation and others didn't, they usually ignored the amount of financial incentive, attributing the cause to be a predisposition to volunteer. Ross and Nisbett call this bias the "Fundamental Attribution Error": They show that it occurs even under experimental condition in which the individualistic choice is absurd. And they concede, apparently, that this bias is cultural, because they note a study using Hindu subjects that found them much more likely than Western subjects to choose situational explanations (p. 185). It is possible that the

rarity of social explanations of depression is due to the fundamental attribution error by the researchers.

DISCUSSION

First I review three earlier studies that link depression to the social world. The first is by Christopher Peter, Steven Maier, and Martin Seligman (1993). Seligman, a psychologist, is well known for his theory of depression as learned helplessness. In a 1990 article, he reviewed a substantial number of studies suggesting that in recent years there has been a startling increase in the prevalence of depression. According to these studies, the rate of depression has increased for those born later rather than earlier in the 20th century. Seligman saw this increase as a virtual epidemic and sought to explain the rising rate of depression in terms of increasing emphasis on the individual, as against participation in a community. He used the phrase *the closing of the commons* to refer to this change, which is social as well as psychological. He seems to be referring to the idea of alienation, although he uses different words. He proposed that overemphasis on individuals leads to depression, because the individual is unprepared to manage his or her life alone.

Seligman's proposal is suggestive, but it is not sufficiently spelled out to be useful as a guide for further research. His idea of the closing of the commons and the shift to individualism, in particular, is only a metaphor. Karp's (1996) study of the phenomenology of depression is more specific. On the basis of interviews with 50 persons suffering from depression (29 of whom had been hospitalized), he proposed a social process of reciprocal causation. Depressive affect, he proposed, leads to "disconnection, isolation, and withdrawal" from others, which leads to further depression, and so on around the loop, amplifying the original depression. As Karp noted, this thesis connects his study to one of the core issues in sociology, alienation and its consequences (pp. 26–7).

Karp's (1996) theory, in conjunction with one of his findings, may be relevant to the treatment of depression. The finding concerned the use of antidepressant drugs. The experience of most of his subjects was that the drugs seemed initially to be effective, in some cases, even liberating. But apparently in most cases, the drugs proved to be a disappointment; they were not useful in the long run. For cases in which antidepressants are not effective, Karp's theory that alienation may form a feedback loop could be the basis for social and psychotherapeutic interventions, which is discussed below.

As in labeling theory, Karp (1996) did not seek to explain the initial causes of depression; he focused only on the interplay between social disconnection and major depression. His explanation parallels Lemert's (1992) explanation of paranoia. Lemert argued that suspiciousness can lead to social exclusion, which leads to further suspiciousness, and so on, intensifying the original symptoms, whatever their source.

Like Lemert's (1992) treatment of paranoia, Karp's (1996) insight on reciprocal causation and amplification of depression is important, because it could combine biological and/or psychological causation of the original depression with social causation. This three-way causal chain, because it is a feedback loop, might explain the extreme intensity of chronic depression. Indeed, Karp himself is a strong proponent of viewing depression in all its complexity, and has noted that it probably has biological and psychological roots as well as social ones. Reiterating his insistence on the complexity of depression, Karp cautions against approaches that seek a simple explanation. He is particularly critical of the biomedical model and even of labeling theory for this reason.[9]

I am in complete agreement with Karp (1996) on the complexity of depression and his insistence that no single framework is likely to explain it. Indeed, I will take this point somewhat further than he does, arguing that

[9]Karp errs in thinking that labeling theory proposes a unitary solution; it does not seek to explain the origins of primary deviance.

multiple frameworks and approaches will be needed because of the pervasive bias that a single theory or approach carries with it. To underscore this idea, because his social approach parallels mine, I seek to show some of the bias in Karp's own study, which it seems to arise from his approach. Like many studies based on extended interviews, it sometimes seems to imply that the subject's subjective awareness is a basic truth that transcends all others.

One of the reasons that Karp undertook his study was the absence of the patient's voice from virtually all the many empirical studies of depression. He is justifiably indignant that so little was heard of the patient's point of view. However, Karp valorizes the subjective point of view, as if it were the ultimate truth of the matter.

In one passage (p. 35) he notes that there have been a large number of studies which demonstrate linkage between early family arrangements, basic trust or distrust, chronic feelings of disconnection, and the eventual onset of depression. But Karp goes on to say that "the linkage between family dysfunction and depression is neither simple nor invariable. A number of [Karp's subjects] *insistently made the point that it would be impossible in their cases to trace the evolution of depression to an unhappy childhood or poor parenting*" (p. 35, italics added).

This passage seems to assume that subjects' reports of their childhood are reliable. Scattered through the book are other similar passages. But these passages ignore the many studies that suggest that the reliability of adult recollection of childhood is controversial at best. The clinical literature, indeed, suggests that recollections of childhood by adults may be highly distorted. One example would be what clinicians call "the myth of the happy childhood," which is to say that there are persons who manage memories of suffering from their childhood through repression: denial, forgetting, and reaction formation.

My purpose at this point is not to rebut Karp's (1996) argument. As indicated, the case is not open and shut. There is a vast literature in psychiatry, psychoanalysis, and the psychology of child development that suggests that some such reports are grossly unreliable. But this contention also has its critics; as indicated, the issue is controversial. The point I wish to make is a much broader one concerning disciplinary bias. Karp is a sociologist by discipline and a participant in the subdiscipline known as symbolic interaction. Like most sociologists, members of this subdiscipline try to avoid psychological issues. Following Blumer, they believe that their job is the accurate unearthing of the point of view of the subjects they study and that this point of view is the end of the line. They have developed a conceptual framework and a method that allows them to ignore psychology, no matter how relevant.

One debilitating result of the bias that Karp (1996) inherited from his discipline and subdiscipline is that he makes no effort to develop a coherent theory of even the social component of depression, let alone an interdisciplinary one that would trace interactions among the social, the psychological, and the biological. There is a vast amount of information in the discourse of his subjects that he quotes, but most of it goes unanalyzed. His use of the testimonies is primarily to make the point that his subjects experience depression in different ways, but because he has no theory and method to help find patterns in their discourse, this result is not surprising. Karp at times seems to argue that depression is so complex that it may not be possible to understand its causes. But this conclusion may be a result of his conceptual framework.

It would be unfair of me to single out Karp's (1996) study for criticism of this kind if I didn't mention that his limitation of focus is characteristic of most studies of depression, whatever the discipline. Just as Karp limits his focus to the subject's point of view, ignoring biological and psychological dimensions, so the biological and the psychological studies usually ignore their subjects' point of view and all other dimensions that are outside their discipline. In studies of depression, as in most other research on human conduct, the method may be determining the findings, the tail wagging the dog.

This idea is supported by a study re-

ported in Mokros (1993). He and his colleague studied two groups of adolescents diagnosed as clinically depressed. But rather than evaluate the children's mood only once, as the psychiatrists did, the Mokros and Merrick study sampled their behavior eight times a day for 8 consecutive days. Contrary to the responses of the subjects themselves, some of whom reported that they were sad all the time, it was found that there was a great deal of variation in mood and that it was strongly related to the particular social environment in which each sample was taken. The seemingly endogenous nature of depression may be in part a product of the method that is used to evaluate it, since the Mokros and Merrick study, by using a different method of evaluation, found a strong social component.

FURTHER ELABORATION OF A SOCIAL THEORY OF DEPRESSION

The psychoanalyst/research psychologist Helen Lewis (1981, pp. 179–193) has proposed a social-psychological theory of depression:

1. The principle emotional component of depression is not anger or grief but unacknowledged shame.
2. A key source of shame in depression is threatened or severed social bonds.

My discussion so far is in accord with this theory. But Lewis did not make the distinction, suggested by the case material reviewed here, between current states of the bond and memories of these states.

I suggest there may be two social components to depression. The first and more powerful would be the patient's current social milieu, the lack of secure bonds in his or her immediate social network. The old men described here seemed to have no secure bonds. In sociological terms, they were alienated from their society rather than integrated into it. As Karp (1996) has suggested, alienation of this extreme kind may be a result of a biosocial-psychological feedback loop: depressed affect, whatever the source, leads to alienation from others, which leads to more intense depression, and so on around the loop.

On the basis of the cases described here, however, there appears to be a second component also, one that is both social and psychological. The episodes I have reported here imply that recalling moments of solidarity within a community, especially when these memories are recounted to a respectful other, may lift depressive mood. If that is the case, then a proximate cause of depression would be the lack of such memories, or, if there are such memories, failure to recall them.

These ideas may have implications for the treatment of depression, if the hypothesized link among depression, unacknowledged shame, and the state of the patient's social bonds currently and in memory is confirmed in further research. Such confirmation would suggest that analysis of the patient's bond network, attempts to strengthen it, and having the patient attempt to recall memories of belonging to a community, would become mandatory in the treatment of depression. The idea of a feedback loop could be of major important both in explaining and treating all types of depression. A social-psychological loop, in which depressed affect leads to isolation, which in turn creates more depression, might be an explanation of the intensity of major depression. And in treatment, having the patient recount memories of secure bonds, as well as helping her establish current secure bonds (especially with the therapist), if only momentarily, might be a way of interrupting the loop.

According to the theory outlined here, any type of interruption of the loop, whether social, psychological, or biological, should help lift depression, at least temporarily. I have known of cases in which no treatment worked until the use of psychoactive drugs put the patient in touch with elemental emotions. But unless the respite, however generated, is used for individual and social development, a relapse may occur. During the respite, the patient should be encouraged to change his or her life and social network to avoid relapse.

FUTURE RESEARCH ON THE SOCIAL PSYCHOLOGY OF DEPRESSION

This article has proposed that alienation may be an immediate cause of depression, no matter what its distal causes. Because the data were not gathered with this hypothesis in mind and are also somewhat crude and unsystematic, this study only illustrates, rather than tests it. Actually testing this hypothesis would face an immediate difficulty. In the social sciences there is at present no approach that could be used to trace the link to depression that I propose here. I take alienation to mean lack of connectedness (intersubjectivity), that is, failure to understand and be understood by the other and failure to accept that which is understood about the other. [For a parallel neurophysiological approach to connectedness, see the studies cited by Lewis, Amini, and Lannon 2000, on limbic (mamalian) communication].

In this conception, alienation is a complex state: Measuring it would require understanding the degree of intersubjective accord. At the present time, the only approach that might recognize this elusive quality would be the analysis of the actual discourse in a social relationship in the context in which it occurs (Scheff 1990, 1997). Although counting the "I" and "we" pronouns would provide a very crude index of the state of the bond, the correlation would be slight (Scheff 1994). Understanding the quality of a social relationship seems to require understanding discourse in context.

In social theory the idea of alienation is largely a vernacular one. There are few precise conceptual definitions and no definitions that link alienation to empirical instances. The other approach is the use of psychological scales. Although there are plentiful studies of alienation using these scales, it is difficult to connect them to a theory of depression because the scales do not use conceptual definitions. Just as theories of alienation are entirely conceptual, scales that purportedly measure alienation are entirely empirical, with no theoretical underpinning.

For example, one might think that the highly developed studies of attachment in developmental psychology would provide a way of measuring alienation. Surprisingly, the attachment literature is ruled by studies using scales. But these scales cannot be used to analyze the kind of interview data that Karp (1996) collected, because they require forced choice questions. The tail wags the dog.

There is one approach in the study of mental disorder that appears to have promise of tapping the complexity of free talk. It is called the study of emotional expression (EE). Initially developed by the sociologist George Brown (1978), this method analyzes speech of the next of kin of the patient describing the patient. Many subsequent studies have replicated Brown's original findings: the next of kin of an ex-mental patient is more hostile and emotionally overinvolved with the ex-patient than the next-of-kin of nonpatients. There are many problems connected with this methodology, however. The interview is long and cumbersome, as is the analysis of the interview. In a modification, Gottschalk (1995) has shown that analysis of a 5-minute speech sample of a description of the ex-patient's next of kin is effective in predicting relapse of ex-patients. Using a counting method such as Gottschalk's, in conjunction with analysis of mechanically recorded discourse, might lead to reliable and valid studies of alienation in depression.

CONCLUSION

I have proposed that there is an immediate situational component in depression—the lack of a secure bond with another human being, a state of alienation. Given their lack of voluntary access to an actual community or their memories of community, the old men described in this study had no protection against conflict with their family members, the mechanical way in which they were treated in hospital, or the "lash of random unheeding flail" (Jeanne Shulkind, quoted in Woolf

1985, p. 21). Psychotherapy technique based on this idea might be able to treat depression by utilizing patients' memories of belonging to a community and /or by building a secure bond with the therapist and other significant persons in their lives. For research purposes, alienation is subtle enough that it may not be found in subjects' self-reports or in studies which employ psychological scales. It is proposed that analysis of discourse, even in a 5-minute sample of dialogue between a subject and the person that subject is closest to, might test the hypothesized link between alienation and depression.

REFERENCES

BAUMEISTER, R., AND LEARY, M. The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin* (1995) 117:497–529.

BILLIG, M. *Freudian Repression: Conversation Creating the Unconscious.* Cambridge University Press, 1999.

BROWN, G., AND HARRIS, T. *Social Origins of Depression.* Free Press, 1978.

DAWIDOWITCZ, L. *From That Place and Time: A Memoir 1938–1947.* Norton, 1989.

DOHRENWEND, B. 1998. *Adversity, Stress, and Psychopathology.* Oxford University Press, 1998.

ELIAS, N. Homo clausus: The thinking statues. In N. Norbert, ed., *Civilization, Power, and Knowledge.* (pp. 269–90) University of Chicago Press, 1998.

GOTTSCHALK, L. *Content Analysis of Verbal Behavior.* Erlbaum, 1995.

JAMES, O. *Britain on the Couch: Why We're Unhappier Compared with 1950 Despite Being Richer.* Century, 1997.

JOFFRE, R., LEVITT, A., BAGBY, R., AND REGAN, J. Clinical features of situational and non-situational major depression. *Psychopathology* (1993) 26:138–44.

KARP, D. *Speaking of Sadness.* Oxford University Press, 1996.

KAUFMAN, G. *The Psychology of Shame.* Springer, 1989.

LAING, R. D., AND ESTERSON, A. *Sanity, Madness, and the Family.* Tavistock, 1964.

LEMERT, E. Paranoia and the dynamics of exclusion. *Sociometry* (1992) 25:220–34.

LEWIS, H. B. *Shame and Guilt in Neurosis.* International Universities Press, 1971.

LEWIS, H. B. *Psychic War in Men and Women.* New York: New York University Press.

LEWIS, H. B. *Freud and Modern Psychology: Volume 1. The Emotional Basis of Mental Illness.* Plenum, 1981.

LEWIS, H. B. *The Role of Shame in Symptom Formation.* Erlbaum, 1987.

LEWIS, T., AMINI, F., AND LANNON, R. *A General Theory of Love.* Random House, 2000.

MAZURE, C., BRUCE, M., MACIEJEWSKI, P., AND JACOBS, S. Adverse life events in major depression. *American Journal of Psychiatry.* (2000) 157:896–903.

MOKROS, H. Communication and psychiatric diagnosis: Tales of depressive moods from two contexts. *Health Communications* (1993) 5(2): 113–27.

MORRISON, A. *Shame, the Underside of Narcissism.* Analytic Press, 1989.

PETERSON, C., MAIER, S., AND SELIGMAN, M. *Learned Helplessness.* Oxford University Press, 1993.

RETZINGER, S. *Violent Emotions: Shame and Rage in Marital Quarrels.* Sage, 1991.

RETZINGER, S. Identifying shame and anger in discourse. *American Behavioral Scientist* (1995) 38:104–13.

ROSS, L., AND NISBETT, R. *The Person and the Situation.* Temple University Press, 1991.

SCHEFF, T. J. *Being Mentally Ill.* Aldine, 1966.

SCHEFF, T. J. *Microsociology: Emotion, Discourse, and Social Structure.* University of Chicago Press, 1990.

SCHEFF, T. J. *Bloody Revenge.* Westview Press, 1994.

SCHEFF, T. J. *Emotions, the Social Bond, and Human Reality: Part/Whole Analysis.* Cambridge University Press, 1997.

SCHEFF, T. J. Shame and the social bond: A sociological theory. *Sociological Theory* (2000) 18: 84–99.

SCHEFF, T. AND RETZINGER, S. *Emotion and Violence: Shame and Rage in Destructive Conflicts.* Lexington Books, 1991.

SELIGMAN, M. Why is there so much depression today? The waxing of the individual and the waning of the commons. In R. Ingram, ed., *Contemporary Psychological Approaches to Depression* (pp. 1–9). Plenum, 1990.

WILKINSON, R. G. *Unhealthy Societies.* Routledge, 1996.

WILKINSON, R. G. Income inequality, social cohesion, and health: Clarifying the theory. *International Journal of Health Services* (1999) 29: 525–43.

WOOLF, V. *Moments of Being.* Harcourt Brace, 1985.