

**Commentary on “Shame and Community:
Social Components in Depression”**

**On Shame, Shame-Depression,
and Other Depressions**

LOUIS A. GOTTSCHALK

Professor Thomas Scheff has made here a valuable contribution to the social psychology of shame and shame-depression. In this time of enthusiasm over the scientific advances in the biological sciences, such as the discovery and description of the human genome, the successful reproduction of a sheep from its own cell lines, the likely cloning of a human being by the same method, the finding that stem cells residing in one's own body can be stimulated to repair and replace damaged tissues, and the successful transplanting of vital organs and tissues from one person to another, the effects of social and environmental events on the life course and personal behavior of individuals may tend to be obscured.

Professor Scheff's 5-month observation in 1965 of neuropsychiatric intake interviews of about 70 elderly, mostly over age 60, blue-collar, male, depressed patients being admitted to a mental hospital in England, gently reminds us of the effects of life experiences on human behavior. He noted a transient lifting of the depressed mood in those psychiatric interviews in which the patient was asked to share his activities during World War II, a phenomenon which at that time Dr. Scheff could not understand. On later reflection, he realized that chronic shame and the lack of a sense of belongingness to a social community was probably responsible for the depression

pervading these men. Being asked to report on their activities during the war evoked fleeting memories of social bonding and being engaged in a community enterprise, and such memories briefly lightened the disabling depression.

Dr. Scheff acknowledges the contributions of biological and genetic factors to the predisposition of major depression as well as the influence of such life experiences as quality of parenting, education, and the course of life events in the development and formation of this mental disorder. What he has accomplished in his article is to remind the reader, as the title of his article indicates, of the contribution of “social components in depression.”

The article nicely discriminates the emotions of shame and guilt. I have used these distinctions in my own research in the development of the Anxiety Scale, based on the content analysis of verbal behavior (Gottschalk and Gleser 1969), and I have credited Piers and Singer (1953) for being of assistance in this clarification. Scheff also cites the excellent book of Lewis (1971) and a number of other writers on the different psychodynamics of shame and guilt.

In my own long-term research on the development and validation of a methodology for measuring over a dozen neuropsychiatric and neuropsychological dimensions from the content analysis of speech and verbal texts—which uses as the smallest unit of verbal communication the grammatical clause and requires the human scorer of these content analysis scales to parse these clauses—I have reported on the psychological and neurobio-

Louis A. Gottschalk, MD, PhD, is Professor Emeritus, Psychiatry and Human Behavior, College of Medicine, University of California, Irvine, Medical Science 1, D437, Irvine, CA 92697-1675.

logical distinctions between shame and guilt (Gottschalk 1995). And beginning about 25 years ago, in trying to achieve objective scoring of such complex states and traits by computer, with the assistance of an expert programmer (Robert Bechtel), artificial intelligence software has been created that can do so. The software has a dictionary of over 300,000 words and idiomatic phrases. It can clause natural language, it can parse a sentence, it is able to compare scores derived from computerized verbal content analysis with norms and provides how many standard deviations the scores obtained vary from the norms. It will even, if requested to do so, suggest DSM-IV neuropsychiatric diagnoses the user of the computer software might consider on the basis of the verbal data given it (Gottschalk and Bechtel 2001).

With respect to social differences, it is interesting that cross-cultural studies using these Content Analysis scales have revealed no significant differences in anxiety (including Shame and Guilt subscales), hostility outward, and hostility inward scores between mentally and physically healthy people in the United States, Germany, Australia, and Chile (Gottschalk and Lolas 1989). On the other hand, German researchers using the Anxiety Scale reported a couple decades ago higher total anxiety from a group of subjects in East Germany as compared with a group from West Germany when these portions of Germany were still divided.

In this age great advances in neuropsychopharmacology and biological neuropsychiatry, clinical practitioners do not tend to concern themselves with the psychopathogenesis of depressions, whether labeled "dysthymia" or "major depression," or "bipolar disorder." Today antidepressant and/or tran-

quilizing drugs are often prescribed whether the patient is suffering from an acute grief reaction after the death of a loved one, a separation depression triggered by the divorce of parents, a lost limb or two from an auto accident, or feelings of guilt or shame. No sound research has been done to determine whether these drugs are capable of focusing on separation anxiety, shame or guilt depression, or depression from debilitating somatic diseases or bodily injury. Although there is good evidence that these psychoactive drugs can relieve depression and may stabilize mood swings, psychodynamic contributions are tending to be neglected. Many years ago, around the same time Dr. Scheff was collecting his data for this journal article, I pointed out the importance of evaluating the psychodynamics of every patient's depression (Gottschalk 1966). Like Dr. Scheff, I have not abandoned that perspective. The Depression Scale applicable to verbal samples I have developed (Gottschalk and Hoigaard-Martin 1986) has seven subscales: (I) Hopelessness; (II) Self-Accusation, A. Guilt Depression, B. Shame Depression; C. Hostility Directed Inward; (III) Psychomotor Retardation; (IV) Somatic Concerns; (V) Death and Mutilation Depression; (VI) Separation Depression; (VII) Hostility Outward (Overt and Covert).

To support Dr. Scheff's perspective and mine, recent research on the effectiveness of psychoactive drugs has indicated that the relapse rate with drug discontinuation is fairly high when a psychoactive drug is the only treatment procedure, and the relapse rate is significantly decreased when psychotherapy is combined with pharmacotherapy. Clearly, psychosocial factors have an influence on the causes, course, and treatment of mental disorders.

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