

A Social-Emotional Theory of Depression

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Abstract: This paper outlines a theory of hidden shame as the cause of depression, and the rudiments of a treatment plan. It builds upon earlier studies of shame, especially the work of the psychoanalyst- psychologist Helen Block Lewis. The theory concerns the cybernetics of emotion: recursive shame-based spirals may be the basic mechanism of both minor and clinical depression. Shame/fear, shame/shame, and shame/anger spirals are described. **Hypothesis:** depression results from a shame/shame spiral or when the anger in shame/anger spirals is directed inwards, recursively, with little or no limit. Limitless spirals may occur when shame is completely, rather than partially hidden. These ideas lead to a proposal for treatment of depression focused on social bonds and hidden emotions. In this connection, possible effects of anti-depressants on emotion are also discussed.

James Gilligan (1997) served as a prison psychiatrist for many years. Based on his interviews with prisoners, he came to the conclusion that shame can be an awesomely powerful force:

The degree of shame that a man needs to be experiencing in order to become homicidal is so **intense and so painful that it threatens to overwhelm him and bring about the death of the self, cause him to lose his mind, his soul, or his sacred honor.**" (112).

Gilligan proposed that it is secret shame that has awesome power:

"Shame is probably the most carefully guarded secret held by violent men... (112)

This paper also proposes that secret shame is a powerful causal agent, as Gilligan did, but that it can also cause clinical depression. It will also take a step missing from Gilligan's study and most other work on shame by outlining a process through which shame might become an overwhelming force.

The psychologist Gershen Kaufman is one of several writers who have argued that shame is a secret in our whole society:

American society is a shame-based culture, but ...shame remains hidden. Since there is shame about shame, it remains under taboo.The taboo on shame is so strict ...that we behave as if shame does not exist (Kaufman 1989).

Kaufman's phrase "shame about shame" turns out to have a hidden importance, since it can be seen as implying the first step in a recursive sequence, as will be discussed below.

A Study of How Shame Became Unspeakable and Invisible

The idea that shame is kept secret in modern societies is supported by a monumental study by the sociologist Norbert Elias (1939, in German, 1978 in English). Over the last five hundreds of years of European history, Elias analyzed etiquette and education manuals in five different languages. There are two main themes; 1. As physical punishment decreased, shame became increasingly dominant as the main agent of social control. 2. As shame became more prevalent, it also became almost invisible because of taboo.

The following excerpt gives the flavor of Elias's study. It is from a nineteenth-century work (von Raumer 1857) that advises mothers how to answer the sexual questions their daughters ask:

Children should be left for as long as possible in the belief that an angel brings babies.... If girls should later ask how children come into the world, they should be told that the good Lord gives the mother her child..."You do not need to know nor could you understand how God gives children." It is the mother's task to occupy her daughters' thoughts so incessantly with the good and beautiful that they are left no time to brood on such matters.... A mother . . . ought only once to say seriously: "It would not be good for you to know such a thing, and you should take care not to listen to anything said about it." A truly well brought-up girl will from then on feel shame at hearing things of this kind spoken of. (1978:180)

Elias first interprets the repression of sexuality in terms of hidden shame:

An aura of embarrassment...surrounds this sphere of life. Even among adults it is referred to officially only with caution and circumlocutions. And with children, particularly girls, such things are, as far as possible, not referred to at all. Von Raumer gives no reason why one ought not to speak of it with children. He could have said it is desirable to preserve the spiritual purity of girls for as long as possible. But even this reason is only another expression of how far the gradual submergence of these impulses in shame and embarrassment has advanced by this time. (1978:180)

Elias raises a host of significant questions about this excerpt, concerning its motivation and its effects. His analysis goes to what may be a key causal chain in modern civilization: denial of shame and of the threatened social bonds that both cause and reflect that denial.

Considered rationally, the problem confronting him [von Raumer] seems unsolved, and what he says appears contradictory. He does not explain how and when the young girl should be made to understand what is happening and will happen to her. The primary concern is the necessity of instilling "modesty" (i.e., feelings of shame, fear, embarrassment, and guilt) or, more precisely, behavior conforming to the social standard. And one feels how infinitely difficult it is for the educator himself to overcome the resistance of the shame and embarrassment which surround this sphere for him. (1978:181)

Elias's study suggests a way of understanding the social transmission of taboo. The adult teacher, von Raumer, in this case, is not only ashamed of sex, he is ashamed of being ashamed. The nineteenth-century reader, in turn, probably reacted in a similar way: being ashamed, and being ashamed of being ashamed, and being ashamed of causing further shame in the daughter. Von Raumer's advice was part of a social system in which attempts at civilized delicacy resulted and continue to result in an endless chain reaction of hidden shame.

Elias understood the significance of the denial of shame to mean that shame goes underground, leading to behavior that is outside of awareness:

Neither rational motives nor practical reasons primarily determine this attitude, but rather the shame (scham) of adults themselves, which has become compulsive. It is the social prohibitions and resistances within themselves...that makes them keep silent. (1978:181; emphasis added)

Like many other passages, this one implies not only to a taboo on shame, but the actual mechanisms by which it is transmitted and maintained.

This study has been widely proclaimed as a masterpiece. However, those that praise and/or use it haven't noticed that the central thesis concerns shame. There are many citations, but only a few mention shame, and they do only in passing. Elias seems to have noticed this, since he avoided using the s-word in a later study (1996) that also involves shame in its central thesis. Instead, he used the word humiliation, and only once. Neither word appears in the index. Perhaps he wasn't surprised, since he had predicted the invisibility of shame in modern societies.

A Novel Approach to Shame

Elias's study and the other approaches to secret shame raise a question: if shame is a secret for everyone, under what circumstances does it lead to depression? The work of Helen Block Lewis on shame and anger provides a first step toward answering this question.

Lewis's conception of shame and other closely related emotions (such as guilt) was and is still radically different than that of most other shame experts. Her working conception of shame grew out the results of a study (1971) of the transcripts of many psychotherapy sessions conducted by other therapists. Using a systematic method based on long lists of indicators words for the major emotions (Gottschalk and Gleser 1969) she located and analyzed emotion episodes in the transcripts. She found that shame/embarrassment was by far the most frequent, with more occurrences than all the other emotions combined.

Lewis found that shame occurrences were not mentioned by patient or therapist. Other emotions, such as sadness or anger, were often referred to by either patient or therapist or both. But in the many instances of shame/embarrassment/humiliation, emotion names were never used, not even indirectly (see the discussion of indirection below). Lewis called these instances "unacknowledged shame." This finding supports, at the micro level, Elias's findings at the macro level on the invisibility of shame in modern societies.

Hiding Shame

Lewis found that shame goes unacknowledged in two different ways. The first way she called "overt, undifferentiated shame" (OU). The patient is in pain, but it is referred to indirectly, at best. There are hundreds of words and phrases in English that can be used to refer to shame without naming it. For example, one can say "I fear rejection," or "This is an awkward moment for me," and so on. Many of these cognates have been listed by Retzinger (1991; 1995. Her entire list of anger and shame cognates can be found in the Appendix of Scheff 1994).

OU shame is usually marked not only by pain, but often by confusion and bodily reactions: blushing, sweating, and/or rapid heartbeat. One may be at a loss for words, with fluster or disorganization of thought or behavior, as in states of embarrassment. Many of the common terms for painful feelings appear to refer to this type of shame, or combinations with anger:

feeling hurt, peculiar, shy, bashful, awkward, funny, bothered, or miserable; in adolescent vernacular, being freaked, bummed, or weirded out. The phrases “I feel like a fool,” or “a perfect idiot” are prototypic.

Even indirect reference may be avoided when shame is labeled erroneously. One error is to misname the feeling as a physical symptom: “I must be tired” (or hungry or sleepy, or pregnant, etc). Although Lewis found this kind of shame occurring with both women and men, it was predominantly used by women.

The usual style of men, she called “bypassed.” Bypassed shame is mostly manifested as a brief painful feeling, just a flicker, followed by obsessive and rapid thought or speech. A common example: one feels insulted or criticized. At that moment (or later in recalling it), one might experience a jab of painful feeling (even producing a groan or wince, although not necessarily), followed immediately by imagined replays of the offending scene.

Many of the replays are variations on a theme: how one might have behaved differently, avoiding the incident, or responding with better effect. The scene may be replayed involuntarily through meals and keep one awake at night. One is obsessed.

However, there is also a form of bypassed shame in which the indications are weaker. Apparently it is possible to further bypass bypassed shame to the point where it is noticeable only through extremely close examination. One may feel blank or empty in a context of embarrassment or shame.

Two further steps beyond Lewis’s approach is necessary if we are to understand how unacknowledged shame can lead to depression. Lewis uses a simple dichotomy: shame is either acknowledged or unacknowledged. Since Elias and others have suggested that virtually all shame is secret, we probably need to envision various DEGREES of hiding in order to understand why secret shame sometimes causes depression.

Suppose that hiding shame is usually not complete. When the shame is only partially hidden, at least some of it may be resolved, at least partially. It was James (1983) who first suggested that emotions are at core bodily tensions that can be resolved through physical expression. If this is the case, then limitless shame-based spirals occur only when shame is COMPLETELY unresolved. For our purposes, we therefore need at least a trichotomy: acknowledgement, partial hiding, and complete hiding.

Cultural Assumptions about Emotions

The discussion of Lewis’s treatment of shame brings up a delicate issue, because it implies an utterly different conception of emotion than the one held in modern societies, especially English-speaking ones. Most people believe that emotions are feelings. That is, like feeling fatigue or affection, emotions are always felt. Lewis’s work on unacknowledged shame suggests, however, that the emotion of shame is not mainly a feeling, but a bodily state, one that might not be felt.

In Lewis’s description of OU shame, it is clear that there is a feeling, but it is misnamed or misinterpreted. In the case of bypassed shame, there seems to be mostly no feeling of any kind. When Lewis first discovered this form of shame, she was very cautious about naming it. She

called it unacknowledged because she couldn't tell from the transcriptions if the emotion was being felt, but not referred to, or it wasn't referred to because it wasn't felt.

But she later questioned patients whose responses suggested bypassed shame, and also therapists. She usually found that the patients were not feeling shame, and that the therapists did not identify the responses as shame. After many such trials, it became clear that bypassed shame states were not felt. This finding, since it runs against a central cultural assumption, is a hard sell. Although widely praised, this aspect of Lewis's study has been little cited. Indeed, she once complained to me that her 1971 book was frequently praised but seldom read.

Another implication of Lewis's approach is that it widens the definition of shame to include a host of siblings and cousins (Sedgwick and Frank 1995 also point to shame siblings and cousins, even though their approach is based on the work of another shame pioneer, Sylvan Tomkins).

In English-speaking cultures, the conception of shame is extremely narrow: a crisis emotion involving disgrace. But in all other languages, there is also an everyday shame that is more or less present in ordinary social occasions, especially as an anticipation of the risk of shame. In French, for example, there is the idea of *pudeur*. In English, this kind of emotion would be called modesty or shyness, and not considered as a type of shame.

Another example is embarrassment, which in English seems to be a separate emotion because it is seen as inflicted by others and is brief and weaker than shame. But in other languages, embarrassment is considered to be a member of the shame family. For example, in Spanish, the same word, *verguenza*, is used for both emotions.

In Lewis's conception, guilt is also a member of the family, if only a cousin. That is, shame is a shame-anger sequence, with the anger directed at self. By the same token, resentment is the opposite cousin, being a shame-anger sequence, but with the anger directed at other.

Lewis goes on to take up another problem, the meaning of the opposite of shame, the word pride. Without inflection (genuine, justified, authentic, etc), pride is usually taken as negative: arrogant, self-centered, "pride goeth before the fall". I call this kind of "pride" false pride, because it can be seen as a defense against shame. People who protest too much about how great they are might be hiding shame.

These difficulties with emotion arise in all modern languages because they have evolved in societies that are individualistic and oriented toward the visible outer world of material things and behavior, and only recently shown any interest in the interior world of emotion. Since English was the language of the nation that modernized earliest, through industrialization and urbanization, the emotional/relational world in English speaking cultures has become the most hidden.

Emotion Spirals

Lewis' idea of emotion sequences can be expanded to include unending spirals of emotion. She noted that when shame occurs but is not acknowledged, it can lead to an intense response, a "feeling trap:" one becomes ashamed of one's feelings in such a way that leads to further emotion. Since normal emotions are extremely brief in duration, a few seconds, Lewis's idea of a

feeling trap opens up a whole new area of exploration. Emotions that persist over time have long been a puzzle for researchers, since normal emotions function only as brief signals.

The particular trap that Lewis described in detail involved shame/anger sequences. One becomes instantly angry when insulted, and ashamed that one is angry. One trap, when the anger is directed out, she called "humiliated fury." The other path she noted, when the anger is directed in, results in depression. This idea is hinted at in psychoanalytic approaches to depression. Busch et al (2004), for example, devote Chapter 7 to "Addressing Angry Reactions to Narcissistic Vulnerability." As is usually the case in modern societies, they avoid using the s-word by encoding it: "narcissistic vulnerability."

Lewis presented many word-by-word instances of episodes in which unacknowledged shame is followed by either hostility toward the therapist or withdrawal. In her examples of the latter, withdrawal takes the form of depression. She refers to the shame/anger/withdrawal sequence as shame and anger "short circuited into depression" (1971, p. 458-59 and passim):

[The patient] opened the hour by reproaching herself for being "too detached during intercourse." She had had a satisfactory orgasm, as had her husband, but she noticed that she was not totally absorbed in the experience and then reproached herself for having been detached enough to make this observation. She now observed that she was scolding herself and immediately located a source of humiliated anger at her husband. He had criticized her that same day for having been so "drained" by caring for the children that she had no energy left for him when he came home, and she had at the time thoroughly agreed with him. She had also agreed with his criticism over irritable behavior with the children. (She was normally in agreement with him about her faults.)

A careful analysis of her experience at the time her husband reproached her unearthed the fact that she had had a fleeting feeling something like resentment accompanied by thoughts which ran approximately: "I wonder how he can be so 'detached' that he has no feeling for me. You'd think he was lecturing in class." (Her husband is a teacher.) That night she readily agreed to intercourse, partly to placate her husband. A short time afterward she was scolding herself for being "too detached," and too observant.

Lewis's idea of emotions short-circuited into depression might be used as a first step toward a theory of the emotional origins of all depression. Since none of the therapy sessions she studied involved depression to the point of complete silence, she didn't consider that possibility. The aftermath of unacknowledged shame that she noted involved slight hostility toward the therapist or the kind of momentary withdrawal and/or self-blame that might be indicators of incipient depression.

The sequences Lewis referred to involve at most three steps, as in the case of the shame/anger sequence short-circuited into depression: shame-anger-withdrawal. A model of feeling traps that can go far beyond a few steps may be necessary. How could such a process lead to a doomsday machine of interpersonal and inter-group withdrawal?

Some emotion sequences may be recursive to the point that there is no natural limit to their length and intensity. People who blush easily become embarrassed when they know they are blushing, leading to more intense blushing, and so on. The actor Ian Holm reported that at one

point during a live performance, he became embarrassed about forgetting his lines, then realized he was blushing, which embarrassed him further, ending up paralyzed in the fetal position. This feeling trap would not be a shame/anger sequence, but rather shame/shame: being ashamed that you are ashamed, etc. Lewis did not note the possibility of shame/shame sequences.

Recursive shame-based sequences, whether shame about anger, shame about fear, or shame about shame, need not stop after a few steps. They can spiral out of control. Perhaps collective panics such as those that take place under the threat of fire or other emergencies are caused by shame/fear spirals, one's own fear is not acknowledged, the obvious fear of others cause still more fear in a recursive loop. Depression might be a result not only of a shame/anger spiral, but also shame/shame alone.

Judging from her transcriptions, withdrawal after unacknowledged shame seems to be much more frequent than hostility toward the therapist. A shame/shame spiral of unlimited duration would be a blockbuster of repression, covering over not only all shame and other emotions but also all of the evidence of its existence. This level might correspond to the blankness, emptiness and hollowness of complete depression or alexthymia (emotionlessness; Krystal 1988, Taylor et al, 1997).

Whether recursive shame-based loops lead to depression/withdrawal or to violent aggression seems to depend on whether the anger in the shame/anger sequences point inward (guilt) or outward (resentment). In intergroup process, a scapegoat group seems to provide cognitive help that directs the anger outward into violence. Scape-goating can occur at the interpersonal level also, in the case of rage directed toward a woman by a man or toward a black person by a white. If, as suggested here, the direction of anger in or out determines depressive or violent outcomes, it would be fair to say that violence serves as a defense against depression.

Suppose that if the bodily tensions of shame are only partially hidden, they will be mostly resolved over time. But if they are completely hidden, the laminas of tension can build up to the point that they feel utterly unbearable, leading to violence or depression.

In a review of the research literature (1987, pp. 29-49), Lewis reviewed studies by other authors using a variety of measures that showed strong correlations between shame and depression. This finding currently continues. Reporting on 25 years of quantitative research, Shohar (2001) found strong links between shame and depression. Future research might determine that shame/shame spirals are the basis of the withdrawn type of depression, and that shame/anger spirals might lead to other types, such as agitated depression.

Shame and Social Acceptance

My earlier (2001) article on shame and depression described a series of what seemed to be temporary recoveries from depression. As a visiting researcher at Schenley Hospital (UK) in 1965, I observed all intake interviews of male patients for 6 months: 83 patients in all. Of this number 70 patients were sixty or older. The comments that follow concern the older men. The 13 younger men were mostly not diagnosed; the older men were diagnosed as depressed. Contrary to my expectations, every one of the men presented as deeply depressed in their speech and manner. However, even more surprising, there were moments in some of the interviews that seemed to me like miracles of recovery.

The psychiatrists asked 41 of the seventy older patients about their activity during WWII. For 20 of those asked this question, their responses shocked and surprised me. As they begin to describe their activities during the war, their behavior and appearance in varying degrees underwent a transformation.

Those who changed in the greatest degree sat up, raised their voice to a normal level instead of whispering, 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 long pauses and speech static. Their facial expression became lively and showed more color. Each of them seemed like a different, younger, person. The self-blame that was frequent in their earlier speech disappeared.

The majority changed to a lesser extent, but in the same direction. I witnessed 20 awakenings, some very pronounced, however temporary. The psychiatrists told me that they had seen it happen many times. After witnessing the phenomenon many times, like the psychiatrists, I also lost interest.

But some 35 years later, because of my work on shame, I proposed an explanation (2001): depression involves the complete repression of painful emotions, such as shame, grief, fear, and anger, but with shame the major component, and lack of a single secure bond. Recalling the memory of the patients' earlier acceptance as valued members of a group during wartime, relived the feeling of a secure bond and generated pride that counteracted the shame part of their depression.

The memory of belonging to a community during WWII had been enough to temporarily remove the shame of being outcasts. Conveying to the psychiatrist that "once we were kings," had briefly relieved their shame and therefore their depressive mood.

Social/Emotional Elements in the Treatment of Depression

The four steps listed here follow from my discussion of Lewis's work above, and from my study of depressed men just mentioned.

1. Elicit memories of times where there was a secure bond with at least one other person, or a sense of community with a group. Explore each memory at length, to the point that patient feels genuine pride. Depression should lift at this time, if only temporarily. This step, when it works, provides a powerful incentive for patient involvement in treatment, and for the next step, empathic union with the therapist.
2. The therapist, from the first moment of contact, should try to form an empathic emotional union with the depressed patient, by hook or crook, no matter the content. Some find this goal fairly easy, but others might need coaching and practice. Get off of TOPICS, into RELATIONSHIP talk. Discussion of anything than that is not happening in the moment is topic talk. An example of relationship talk is "I didn't understand what you just said. Could you repeat it?" or "You seem sad," "I am proud of you," "You seem distracted," and so on. Relationship talk is about what is happening in the moment, either to the patient or therapist, or between them. For most people, it is very difficult to stay on track, avoiding topic talk. (The psychiatrist Melvin Lansky refers to topic talk as "Mother-in-law stories.") Empathic union in psychotherapy is the central idea in a recent volume on relational-cultural therapy (Walker and Rosen 2004).

3. When therapist and client are connected, encourage patient to discuss their shame episodes to the point of ACKNOWLEDGEMENT (Lewis 1971). Lewis indicated that a core goal of most psychotherapy is the acknowledgment of shame. The sub-title of one of her essays on psychotherapy (Chapter 7, 1980) was “The Problem of Abreacting Shame and Guilt.” However, she didn’t make clear what she meant by abreaction (catharsis). Chapter 13 of her earlier book (1971) is entirely about treatment, but the cases are presented concretely, for the most part. The concepts that are used are mostly conventional psychoanalytic ones. They don’t help to explain acknowledgment.

One explanation of the meaning of acknowledgment is that it is a verbal recognition of a shame state that is accompanied by the actual experience of shame. Most of the confessions of shame I observed when I studied AA meetings wouldn’t qualify, since they were merely verbal, without being backed by the requisite feelings. In seeking to explain a parallel situation, Goffman, Ian Miller and I have suggested that the expression of shame is the key to a sincere apology. A verbal apology, unless accompanied by the expression of shame or embarrassment usually doesn’t satisfy the recipient. Catharsis will be discussed further below.

Uncovering Hidden Shame

The problem that needs to be faced concerns what surely must be called repressed shame. The reason most shame states are not acknowledged is that they are covered over by layers of defenses, often many layers. Children learn to repress emotions very early, first by the example of their caretakers, later to avoid punishment, such as ridicule. Males, particularly, are taught to hide shame and other vulnerable emotions behind a façade of swagger, anger and/or aggression. After many repressions, one might have the sense that to feel the backload repressed emotions would be unbearably painful. How does one overcome such barriers to feeling?

Earlier, I used the concept of distancing, borrowed from the theatre, to explain a path into repressed emotions (1979; 2007). According to drama theory, audiences may experience a performance at three distances from their emotions: over-distanced (detached from feelings), under-distanced (so painfully close to feelings to be like a repetition of the unresolved situations) and aesthetic distance. The goal of classical drama, whether tragedy or comedy, was to encourage audiences to experience their emotions at an aesthetic (optimal) distance.

Unfortunately, the idea of catharsis is currently heretical. For many years experimental psychologists have been demonstrating that venting anger doesn’t help one feel better, a valuable finding. But psychologists have made the error of considering venting to be a type of catharsis, the classical use of dramatic theory being unknown to them. Audiences are not required to scream at the actors in anger, or for that matter, to panic in fear.

Optimal distance means that audience members are able to experience unresolved emotions safely. The events in the drama are not their own, as they can reassure themselves. In this setting, what seems to happen is that viewers of drama can move in and out of painful emotions in a way that lessens the pain. Indeed, a formerly painful emotion, such as fear, may be experienced as pleasurable, as is the case with young people with their horror movies and roller coaster rides. Using different language, “somatic therapy,” seems to be based to on the same idea: “pendulating” in and out of painful emotions (Levine 1997).

The application of this idea to psychotherapy suggests a way of finding the distance that is optimal for each patient. Patients who are too removed from their feelings can be asked to retell an incident more slowly and in more detail. Those who are too close can be encouraged to touch on the incident more quickly and in less detail, or to leave it entirely, at least for the nonce. Maneuvers of this kind could lead to the kind of catharsis that is needed. In my experience, the resolution of hidden shame takes considerable verbal acknowledgment, but often occurs in the form of finally finding humor and laughter in their own misfortunes.

4. Help find and/or rebuild at least one secure bond in the patient's social life, in addition to the one with the therapist. Using many case studies of persons who recovered from serious mental illness, Neugeboren (1999) shows that in every case there was at least one person who stuck with the patient through thick and thin. The biography *A Beautiful Mind* (1998) makes the same point about a famous case (Nobel Laureate John Nash) not included in the 1999 book. Contrary to the film version, the author of the biography states that Nash took none of the “newer psychiatric drugs” as claimed in the film. She gives credit for Nash’s recovery to the unfailing support of his wife and mother. Even with only a single secure bond, one is no longer alone in the universe (See Masserman 1953; Baumeister and Leary 1995).

Anti-depressants?

Since the treatment of choice for depression is currently anti-depressants, some discussion is warranted. On the one hand, it has been frequently claimed that a combination of anti-depressants with psychotherapy is the most effective treatment available (e.g. Coyne 2004). As far as I can tell, in this study and all the others that recommend anti-depressants + therapy strategies, the follow-up was only 4 to 6 weeks.

The brief follow-ups seem to be one way that RCTs (Random Clinical Trials) are organized so as to give misleadingly positive results (For 13 other ways, see Jackson 2005). Glasser’s brief review (2005, pp. 115-116) of the research literature on psychiatric drugs, including anti-depressants, suggests that the evidence supporting their effectiveness is close to zero.

There are a few studies that follow-up the effects of anti-depressants for a full year (e.g. Kirsch, et al 2002; 2010). These studies invariably report no significant difference between treatment and control groups. It seems likely that the positive effects of anti-depressants are at best short lived, or at worst, merely placebo.

In my 1965 study, almost half of the men who were asked about WWII did not show any change. It is therefore possible that they were suffering from endogenous depression, which opens up the possibility, at least, that anti-depressants might be indicated. On the other hand, there is also the possibility that the shame of the men who didn’t respond to the one intake question was repressed to the point that it would have required more psychotherapy than the few minutes inadvertently offered.

Then there is also a substantial amount of evidence that psychiatric drugs, and anti-depressants specifically, interfere with one’s emotional life, and with sensitivity to the emotions of others. For example, many studies have made it clear that the SSRI’s suppress crying. Some of the causes and ramifications are explored by Healy (2004). Karp (1996) analyze the medicalization

of sadness. Horwitz and Wakefield (2007), on the other hand, have a suggestive title (The Loss of Sadness), but vacillate over whether they really mean it.

As an outsider to the field of drug studies, I feel obliged to mention some impressions. First, I have been unable to find a broad treatment of the effect of drugs on the full spectrum of emotions. Virtually all the studies are extremely narrow, focusing on single drugs or classes of drugs, and one or two emotions or emotional expressions at most. If there are broad reviews that I have missed, I would very much appreciate hearing about them.

The second point is shocking: in virtually all the studies, emotions are the enemies. This orientation is understandable with respect to rage, but laughing and crying also are usually treated as pathological. There are many studies of a new pathology called emotional lability (EL), and a more extreme label, “emotional incontinence.” The very phrase is highly prejudicial and shaming.

It seems to have occurred to only a few drug researchers that the absence of emotional expression might be a far wider problem, and possibly a much more damaging one. I found one drug research article that touches indirectly on this issue. Scopetta et al (2005) showed that SSRIs suppress crying even in normal persons. They admit a doubt about the wisdom of the widespread use of these drugs:

SSRIs are among the most used drugs in the world, every day they are consumed by millions of people including politicians, businessmen, soldiers, army commanders, policemen and criminals. The idea is... worrying that the control of the emotions and behavior of these millions of people can be quickly modified by one SSRI for a few days....

The management of grief provides one example of over-, rather than under-control of emotions. The inability to mourn and unresolved grief (Mitscherlich 1975; Parkes 1988) particularly among men, is a social institution in modern societies. To the extent that the theory outlined here is true, then the use of drugs that further inhibit crying and other forms of emotional expression would be damaging rather than helpful (Cummings 2005, p. 102 makes this point also.)

I recently heard a comment in passing that is illustrative: a woman reported that she stays on anti-depressants because she gets “weepy” when she goes off them. There is a description of a situation like hers in Iris Dement’s song, No Time to Cry (1993):

My father died a year ago today,
the rooster started crowing when they carried Dad away
There beside my mother, in the living room, I stood
with my brothers and my sisters knowing Dad was gone for good
Well, I stayed at home just long enough to lay him in the ground
and then I caught a plane to do a show up north in Detroit town
because I'm older now and I've got no time to cry
I've got no time to look back, I've got no time to see
the pieces of my heart that have been ripped away from me
and if the feeling starts to coming, I've learned to stop 'em fast
'cause I don't know, if I let them go, they might not wanna pass

And there's just so many people trying to get me on the phone
and there's bills to pay, and songs to play, and a house to make a home
I guess I'm older now and I've got no time to cry...

When I questioned my colleague, the psychiatrist Melvin Lansky, about this matter, he said he would never prescribe anti-depressants for grief. But hospice workers tell me that they are continually facing bereavement clients who have been put on anti-depressants. Dr. Lansky went on to say that in his experience, anti-depressants not only don't suppress emotions, but help to uncover them. However, he knew of no published references to this effect, nor have I been able to find one. On the other hand, Healy (1994) reviews several studies that suggest that anti-depressants blunt emotion (pp. 174-75 and 182-184).

Under the circumstances, it may be best to avoid drugs in the treatment of depression, or at least use them no more than three months. In any case, a social/emotional therapy directed toward increasing pride by working through unresolved shame and building secure bonds might add a new technique to the treatment of depression.

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