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DEPRESSION, SELF-CONCEPT, AND PERSONAL CONSTRUCTS

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DEPRESSION, SELF-CONCEPT, AND PERSONAL CONSTRUCTS

BY

Martin V. Ross

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TITLE

DEPRESSION, SELF-CONCEPT,

AND PERSONAL CONSTRUCTS

BY

Martin Vincent Ross

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CHAPTER I

Introduction

Depression is one of the oldest, most persistent, and most incapacitating forms of human suffering (Knoff, 1975). It has been approached from many diverse perspectives without a clear theoretical understanding. One of the central problems discussed in the literature is that there are numerous uses of the term "depression." It may be conceptualized as a normal and transient affect, a mood, a symptom, a syndrome, or as a pathological entity. Depression is the "common cold" of psychopathology. An analogy can be drawn to the medical concept of fever which is not designated as a disease but as a symptom of a host of diseases. Depression may occur as a distinct disorder or it may be a secondary component of other pathology such as anxiety or schizophrenia. Another problem is the lack of adequate base rates. To consider anything "abnormal" one must be able to detect a gross departure from normal. Hence, a critical question to ask in this area is: "What are we to regard as depression?" In order to effectively understand depression, it is necessary to develop an explanation of the nature of depression which allows for appropriate diagnosis and treatment.

The Definition of Depression

Many researchers have highlighted the myriad approaches which have been taken in the description, classification, and diagnosis of depression (Akiskal & McKinney, 1975; Andreasen & Winokur, 1979; Beck, 1967; Feighner, Robins, Guze, Woodruff, Winokur, & Monoz, 1972; Spitzer, Endicott, & Robins, 1978; Winokur, 1979; Zung, 1973). No single definition of depression could possibly encompass all the varying findings and theoretical formulations which appear in the literature. Indeed, heterogeneity appears to be a hallmark of the depressive phenomena itself. However, a number of common features of depression are repeatedly acknowledged in the literature. Beck (1967, p. 6), in agreement with other researchers in the area, defines depression in terms of five attributes: sad, apathetic mood; negative self-concept (self-reproach, self-blame); desire to hide, to stay away from others; loss of sleep, appetite, and sexual desire; change in activity level, becoming either lethargic or agitated. The present study views depression as a pathological condition which impacts on the individual in the overlapping realms of emotional, cognitive, motivational, physical (somatic or vegetative) and behavioral functioning. The emotional manifestations of depression consist of the changes in the patient's feelings or the changes in his overt behavior which are attributable to his feeling states. Dejected mood, negative feelings toward the self, reduction in gratification, loss of

emotional attachments, crying spells, and a loss of mirth response are symptoms which appear more frequently in depressives than in nondepressives. The cognitive manifestations of depression consist of the depressive's distorted attitude toward himself, his experience, and his future. The cognitive aspect of depression also includes low self-evaluation, distortions of the body image, negative expectations, self-blame, and indecisiveness. Motivational manifestations include the strivings, desires, and impulses that frequently occur in depressions. Impulses tend to be passive. The manifestations include paralysis of will, wishes to escape and withdraw, suicidal wishes, and increased dependency. Vegetative and physical manifestations consist of bodily symptoms frequently complained about by depressives, such as loss of appetite, loss of sleep, loss of libido, and fatigue. The behavioral manifestations of depression include a reduced frequency of many different kinds of activities which result in positive reinforcement, particularly interpersonal behavior. Withdrawal and avoidance responses are more frequent among depressives, as are crying and complaining.

No one symptom is diagnostic of depression; the individual is considered depressed if a sufficient number of symptoms occur at a pathological intensity for a sufficient duration. Thus, whether subjective self-report scales, observer ratings, social histories, or clinical interviews

are used in the classification and diagnosis of depression, the level of depression is based on the presence or absence of certain symptoms, and the intensity and duration of these symptoms. Each technique of assessment has its drawbacks. Self-report is limited by the willingness and ability of the individual to acknowledge symptoms, and clinical observations require judgments which are not always accurate. There is no universally agreed upon external criterion with which to validate scales. The definition of depression is not consensually agreed upon at present and theorists differ on the aspects of depression emphasized and the dimensions applied to the classification of depression. Andreasen and Winokur (1979) commented that the multiplicity in systems for classifying affective disorders "leads not to an embarrassment of riches but rather to a hodgepodge of competing and overlapping systems: psychotic vs neurotic, endogenous vs retarded, manic-depressive vs involutional," p. 447. It is interesting, however, that Miller (1975) in a comprehensive review of studies concerning cognitive, motor, perceptual, and communication deficits found in depression concluded that depressives of all subtypes generally exhibit deficits in each of these areas. The deficit is usually more related to the severity of the depression than to the type.

The General Relevance of Personal Construct Theory to Depression

In order to define and understand depression an appeal must be made to some conceptual framework. The diversity of theoretical formulations which attempt to conceptualize depression mirrors the diversity of philosophies present in psychology which endeavor to make sense of man. Virtually every system of psychotherapy and personality has made some attempt to account for the psychopathology of depression. However, despite the abundance of theoretical and research studies, the phenomenon of depression remains an enigma. Clinicians talk knowledgeably about depression, yet their comprehension of this problem is questionable. Typically, theories present the depressive as someone markedly different from the rest of us. Perhaps one of the greatest barriers to the adequate conceptualization of depression has been the external vantage point emphasized by some investigators. That is, in their pursuit of "objectivity," investigators have paid insufficient attention to the personal experience of depression. One must not forget that depression is experienced by the person as a very personal, even private, occurrence. Furthermore, depression, as a mood or affect, is experienced at some time by almost everyone. In studying depression, there is always the danger that we may impose our professional constructs on those we study. Regardless of theoretical framework, clinicians working with

the depressive will need some understanding of the subjective, personal features of depression. The present study used a Personal Construct Theory (PCT) approach in order to help us understand the personal experience of depression.

PCT places the emphasis on exploring the individual in terms of the way personal meanings are derived, ordered, and applied. The meaning ascribed to experiences is viewed as a central component in the depressive syndrome, as will be explained in the section on cognitive theories. The ongoing phenomenal world of the individual is viewed as being relevant to the presence or absence of depression. The PCT approach places a focus on the experiential level. The person is seen as experiencing a lack of hope, a constriction, a feeling that not much is manageable. Part or all of the construct system is at stake. That is, depression involves an invalidation of important constructs relevant to self-esteem, hope, an enjoyable present, and an optimistic future. In studying depression from a PCT stance, we attempt to construe the construction processes of the depressives in the hope that we will be able to "see" the situation in their eyes. The purpose of the present study is to provide a way the subjects can articulate some important aspects of their life situation very much as they see it. Along these lines, Bannister and Fransella (1971) note George Kelly's first principle: "If you don't know what is wrong with the patient, ask him, he may tell you." The

present study used a PCT methodology for asking the depressive what is wrong.

The phenomenon of depression seems to be well within the range of convenience of PCT. The fundamental postulate implies that man reaches out for the future (Kelly, 1955). In the "normal" or "well-adjusted" person, the reach toward the future is, over time, a positive, hopeful, exploratory gesture. Constructs will be validated and invalidated, revised and traded in for new ones. Yet, an underlying sense of well-being is preserved. The state of well-being fluctuates, but the individual does not feel out of tune with himself for lengthy periods of time. The intact person, while insecure at particular times, looks to the future for the renewal of his or her feelings of well-being. For the depressive, in contrast, the future is bleak, constricted, limited. For those who are depressed, the reach toward the future is darkened by forbidding negative anticipations. The depressive not only lacks a sense of well-being in the present, he also does not see much relief in store for himself. From the perspective of Beck's cognitive theory (Beck, 1967), the depressive could be described as having a negative view of the future. In PCT terms, it is the obstruction of the usual positive, exploratory reach toward the future that makes depression so debilitating. The depressive can be seen as <u>constricted</u> in the sense that his present construct system does not allow for the

restoration of feelings of well-being. For example, the individual may construe in such a way that successful experiences are devalued and failures are exaggerated. Such an interpretation of life's events makes it extremely difficult for the person to alleviate his suffering. A further discussion of constriction and negativity, in relation to depression and suicide, is provided in Neimeyer (Note 2, pp. 11-14, and 18-24, respectively).

According to the PCT model, man is regarded as a form of motion (Kelly, 1955). Construct systems are in transitional states. The issues of how one becomes depressed must be faced, along with the issue of how depression is alleviated. It is conjectured that in moving from nondepressed to depressed or vice versa there must be some characteristic changes in one's thinking, valuing, and behaving. This may involve alteration of the deepest recesses of the individual's construct system. The contribution of transitions and movement to our understanding of depression has largely been neglected. One of the major deficiencies with the depression literature is the paucity of studies examining the experience of depression over time. Typically, studies consist of a single period of observation which does not reveal the ongoing processes of the individual. The point of transition from one state to another may be very crucial to our understanding of what happens in the mind of the depressive. Along these lines, Landfield (1976, pp. 106-107) noted:

> Clinical observation suggests that the manic-depressive is more prone to suicide at the point of transition from a more disturbed state to one of greater normality. Perhaps it is in this point of transition from one emotional state to its opposite that the patient experiences his greatest sense of uncertainty and his personal construct system is most vulnerable to invalidation.

The present study investigated the individual over a period of approximately two weeks, so that a better understanding of change within the construct system could be gleaned. Repeated observations may offer a more valid theoretical conceptualization.

Movement is related to anticipation. Anticipation is the essential nature of construing for constructs help to provide an understanding of future events which renders life predictable and meaningful (see Landfield & Leitner, 1980, p. 5). An individual's personal construct system provides the ability to anticipate life's experiences. The personal construct system consists of an interrelated structure by which each person seeks to organize and to control his world. The past is interpreted and reinterpreted so that the present and future can be made sense of. According to Kelly (1955), one may become enslaved by adhering to an unalterable view of what one's past means, thereby fixating the present. Within the PCT framework, depression may be

viewed as a form of this type of constriction. The depressed person is enclosed by certain of his propositions (Rowe, 1978). Painful memories of the past may obscure pleasurable experiences of the present. As burdensome as these memories may appear, they are memories which the individual ought not to forget (e.g., not to forget a loss, not to forget an injury). To climb from the pit of depression to a more hopeful world entails some important reconstruction. For example, a woman whose depression is lifting may be seeing her husband in a different light. However, in "reality" the husband may actually be very hurtful and rejecting. The woman's reconstruction of her husband's behavior may allow her to value, think and behave in new ways, ways which contain the seeds of hope instead of despair.

The constriction and contradiction in the types of personal meaning employed by depressives serves to maintain depression. The depressed usually have no friend in their conscience. The person's notion of what a "good person" is, of the person they would like to be, is often filled with contradiction (Rowe, 1978). Hence, it is impossible for them to approach; their conscience can never be satisfied. Space and Cromwell (1980), in a PCT study of depression, found that depressed patients had more mixed (positive and negative) self-description than nondepressed patients. The depressive is in a bind for it becomes very difficult to

obtain validation related to constructs of self-esteem, and, hence, to establish or maintain a basic sense of well-being. This bind has inspired much theorizing. Some psychoanalysts, for example, conceive of depression as a punishment inflicted on the ego by the conscience or super-ego (Jacobson, 1971). Arieti (1976), writing on the psychoanalysis of severe depression, noted that the process of cognitive reorganization which protectively occurs in normal sadness is doomed to fail in the case of depression for "the (depressed) patient cannot replace the collapsing constructs with new ones" (p. 331). In recounting the successful treatment of a severely depressed patient, Arieti observed that "the patient was able to reassess old meanings in a non-pathological frame of reference and came to accept new meanings" (p. 342). He further stated that:

> When we successfully treat a patient who is depressed, we do not ask him, of course, to give up his identity, but, rather, whatever lie or impossible value had become connected with that identity....(N)o matter how unusual, drastic, or unpleasant the external circumstances happen to be, we ourselves are the great contributors to our own sorrow because of the strange ways in which we mix and give meaning to our ideas and feelings. The study of the circumstances of life is important; but even more important is the study of our ideas about these circumstances, of our ideals and what