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Mood Disorders & Self Defeating Behaviors

DEPRESSIVE DISORDERS

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Mood disorders lead to a variety of symptomatic self-defeating behaviors, many of which contribute to perpetuation of negative affect. The present chapter will examine these behaviors, but will also attempt to delineate what is known about the self-defeating behaviors that make people more vulnerable to mood disorders. The chapter will first examine the cognitive style of depressed persons and persons vulnerable to depression and will then explore the consequences of cognitive styles for physical health and performance in academic, job, social, and general life situations. Next, experimental studies of the effects of cognitions and mood on behavior will be reviewed. Finally, consideration will be given to the possibility that a cluster or clusters of enduring behavioral patterns, which might qualify as depressogenic personality styles, make people vulnerable to depression. The chapter does not attempt to provide a comprehensive review of the extensive literature on this topic, but does try to highlight the major findings.

COGNITIVE STYLE AND SELF-DEFEATING BEHAVIORS

Considerable research and clinical data have clarified the cognitive styles of depressed persons in contrast to those of nondepressed persons. After Beck (1967) identified a depressive triad of negative feelings about the self, the world, and the future, many research investigations examined the cognitive processes of depressed individuals (Abramson, Seligman, & Teasdale, 1978; Alloy, 1982, 1988; Derry & Kuiper, 1981; Peterson & Seligman, 1984). Research on depressives' cognitive styles has focused primarily upon their negative self-schemata and their self-defeating attributional style. These aspects of depressives' cognitive styles will be discussed and the behaviors related to them will be examined subsequently.

Self-Views of the Depressed

Depressives rate themselves more poorly than nondepressed patients do on a variety of personality traits (Laxter, 1964; Lunghi, 1977). When evaluating themselves in comparison to others, they see themselves as inferior in such important areas as intelligence, attractiveness, and social status (Alloy & Ahrens, 1987). They have also been found to have low self-esteem (Beck, 1976; Nadich, Gargan, & Michael, 1975). Depressives engage in self-focusing after failure (Pyszczynski & Greenberg, 1985) and fail to exhibit the self-serving information search of nondepressed persons (Pinkley, LaPrelle, Pyszczynski, & Greenberg, 1988).

Experiments have also shown that normals show superior memory for positive rather than negative self-referential material, but depressives recall more negatively toned personal information about themselves (Lishman, 1972), or show equal recall for both types of material (Derry & Kuiper, 1981; Kuiper & Derry, 1982; Kuiper *&* MacDonald, 1982). Research demonstrates that normal, nondepressed people have self-schemata with positive content, which increases their efficiency in processing and recalling positive self-referent information (Alloy, Greenberg, Clements, & Kolden, 1983; Davis, 1979a, 1979b; Davis & Unruh, 1981; Derry & Kuiper, 1981; Greenberg, Vazquez, & Alloy, 1988; Hammen, Marks, Magol, & deMayo, 1985; Hammen, Miklowitz, & Dyck, 1986; Ingram, Smith, & Brehm, 1983; Kuiper *&* Derry, 1982; Kuiper & MacDonald, 1982; Kuiper, Olinger, MacDonald, & Shaw, 1985; Ross, Mueller, & de la Torre, 1986). In contrast, the self-schemata of depressives appear to be either negative (Derry & Kuiper, 1981) or unstable, containing both positive and negative content (Ingram et al., 1983; Kuiper et al., 1985; Kuiper & Derry, 1982; Kuiper & MacDonald, 1982). Recent work by Greenberg et al. (1988) showed that depressed persons endorse more depression-related negative adjectives as self-descriptive than do either normal or anxious subjects. Kuiper, MacDonald, and Derry (1983) and Greenberg et al. (1988) noted that whether depressed people possess strong negative self-schemata or mixed content schemata may depend on the severity of their symptoms (Kuiper & Derry, 1982) or the chronicity of their symptoms (Davis, 1979a, 1979b; Davis & Unruh, 1981). Kuiper et al. (1983) suggested that mild

depressives may have an “overload” of positive and negative information, which impairs efficient processing of all self-referent material.

The research on the negative self-schemata of depressives has frequently shown that, when their depression lists, their schemata resemble those of nondepressed persons (Hamilton & Abramson, 1983; Lewinsohn, Steinmetz, Larson, & Franklin, 1981). Some research, however, has demonstrated that negative life events that are congruent with the depressogenic self-schema are associated with depression whereas schema-irrelevant events are not.

Thus, the negative self-schema of depressed persons appears to be a concomitant of depression and not a marker of it. In an attempt to predict those persons who are vulnerable to depression, Kuiper and Olinger (1986) developed a “self-worth contingency model of depression.” They proposed that excessively rigid and inappropriate rules for guiding one’s life constitute a cognitive predisposition to depression. A number of such rules or dysfunctional attitudes were identified by Beck (Beck, Rush, Shaw, & Emery, 1979) and can be measured by the Dysfunctional Attitudes Scale (DAS) developed by Oliver and Baumgart (1985) and used by Dobson and Shaw (1986). Examples of such dysfunctional attitudes are: “If I do not do well all of the time, people will not respect me,” or “If someone disagrees with me, it probably indicates that he does not like me,” or “My value as a person depends upon what others think of me” (Kuiper, Olinger, & MacDonald, 1988, p. 296). According to their model, the self-worth of depressed

persons depends upon their self-worth contingencies being met. Support for this model was obtained by Olinger, Kuiper and Shaw (1987).

Kuiper et al. (1988) found that persons scoring high in vulnerability to depression as measured by the DAS, but low in depression as measured by the BDI, rated their Perceived Popularity as quite high, even higher than nonvulnerable depressed subjects rated theirs. As their depression level increased, however, vulnerable subjects showed a marked decrease in Perceived Popularity. For subjects scoring low on the DAS there was little difference in Perceived Popularity across differing levels of depression. Kuiper et al. interpreted these data as demonstrating that vulnerable individuals who are not depressed perceive themselves as currently meeting their self-worth contingencies. Vulnerable individuals who are depressed do not see themselves as meeting their criteria for self-worth and begin to focus upon negative aspects of the self.

Further support for the self-worth contingency model was obtained in a study of perception of similarity to others (Swallow & Kuiper, 1987). Vulnerable, nondepressed subjects perceived themselves as more similar to others than did nonvulnerable or depressed individuals. As the level of depression increased, vulnerable subjects displayed the largest decrease in similarity ratings. A large body of research in social psychology has demonstrated that when people perceive others as similar to themselves, they like them more (Byrne, 1971; Griffit, 1974; Kaplan, 1972) and are more cooperative (Krauss, 1966). Depressed

persons' views of others will be discussed at greater length in the section that follows.

Views of Reality and of Other People

The realism and the accurate perceptions of the depressed in many situations, in contrast to the illusions and inaccurate perceptions of the nondepressed, have now been well-documented (Abramson & Alloy, 1981; Alloy & Abramson, 1979, 1982; Alloy, Abramson, & Viscusi, 1981; Benassi & Mahler, 1985; Vazquez, 1987).

These findings have challenged the original assumptions of Beck's (1967) cognitive theory of depression and Seligman's (1975) learned helplessness theory, which said that depressed persons negatively distort reality. Alloy and Abramson (1988) recently reviewed the judgments and inferences of depressed and nondepressed persons in six areas: judgment of control, attribution, expectancy/prediction, recall of feedback, self-evaluation, and social comparison. These studies indicated that depressive realism and nondepressive illusions of control are robust phenomena, but that there are some exceptions. The realism of the depressed and their attributional evenhandedness occur only for themselves and not for others. For example, Golin, Terrell, and Johnson (1977) found that depressed students had inappropriately high expectancies of success when an experimenter rolled the dice, but accurate expectancies when they rolled the dice

themselves. In contrast, nondepressed students were accurate when the experimenter rolled the dice, but inappropriately high in their expectancies when they rolled the dice themselves. Golin, Terrell, Weitz, and Drost (1979) subsequently replicated these findings with psychiatric patients. The depressed also underestimated the amount of positive feedback they received (Buchwald, 1977; Wener & Rehm, 1975), whereas nondepressed students (Buchwald, 1977) and nondepressed psychiatric outpatients (DeMonbreun *&* Craighead, 1977) overestimated the amount of positive feedback they received.

The low self-esteem of the depressed and social comparison theories (Festinger, 1954; Morse &Gergen, 1970;Schachter, 1959) led Alloy and others to suggest that depressed people would see others in highly positive terms. Research has shown that depressed people do view "people in general" more favorably than do normal, nondepressed people (Alloy & Abramson, 1988; Martin, Abramson, & Alloy, 1984; Tabachnik, Crocker, & Alloy, 1983; Vazquez & Alloy, 1987). Nondepressed people evaluate "people in general" more negatively, but not their best friends (Vazquez *&* Alloy, 1987). Although research generally has indicated that depressed people evaluate others favorably, Beck's theory suggests that they expect others to treat them poorly. A recent study by Janoff-Bulman and Hecker (1988) supported this idea. These researchers found that depressed people see others as more malevolent and themselves as more vulnerable.

Depressed persons are more accurate in their perceptions of the degree to

which they are liked by others than are nondepressed persons, who overestimate the extent to which they are liked (Strack & Coyne, 1983). Experimental research suggests that the illusion of the nondepressed should facilitate their actually being liked and the perception of the depressed should lead to their being liked less (Curtis & Miller, 1986; Swann & Read, 1981b). The expectancy confirmation effects of these beliefs will be discussed later in this chapter.

EXPLANATORY STYLE

Many studies have examined the attributional styles of depressed people. In a review of these studies by Sweeney, Anderson, and Bailey (1986), the authors conclude that depressed persons are more likely to attribute negative life events to their own inadequacy and, to a lesser extent, to attribute positive life events to external, unstable, and specific causes (Abramson, Alloy, & Metalsky, 1988; Abramson, Metalsky, & Alloy, 1988).

Health

Although the evidence is inconsistent, it has been suggested that depressed people are at a greater risk for illness than nondepressed people (Schleifer, Keller, Siris, Davis, *&* Stein, 1985). Schleifer et al. found that decreased lymphocyte function is associated specifically with depression and not related to hospital effects or, nonspecifically, to other psychiatric disorders. Peterson and Seligman (1987) obtained data showing that explanatory style predicts illness. Controlling for depression and physical illness at the onset of the study, Peterson and Seligman measured self-reports of illness after one month and after one year, and reports of visits to physicians after one year. A negative explanatory style predicted illness at both of the later times, on measures of self-report and visits to physicians. In a replication and extension of that study, using the same variables, the variables that related to explanatory style were related to illness: unhealthy habits, low self-efficacy to change the habits, and the occurrence of stressful life

events. The authors noted that bad life events are likely to precede pessimism as well as to follow from it. In another correlational study of members of the Baseball Hall of Fame, Peterson and Seligman found that external, unstable, and specific explanations for good events in newspaper quotations from 1900-1950 were correlated with living a shorter life, for a sample of 24 men. Internal, stable, and global explanations of bad events were also correlated with living a shorter life, for a sample of 30 players. Peterson, Seligman, and Vaillant (1988) demonstrated that pessimistic explanatory style at age 25 predicted poor health at ages 45 through 60 for a sample of 99 university graduates, even when physical and mental health at age 25 were controlled. Scheier and Carver (1985), using the Life Orientation Test, discovered that optimistic college students reported fewer physical symptoms at two different assessment periods—the beginning of the last four weeks of the semester and the end of the semester.

Academic Achievement and Job Performance

Explanatory style has been linked with poor performance by university students. Habitual explanation of bad events as having internal, stable, and global causes predicted poor academic performance, even when Scholastic Aptitude Test scores were held constant in a study by Kamen and Seligman (cited in Peterson & Bossio, 1989). Peterson and Barrett (1987) reported that this explanatory style predicted lower grades for university freshmen, when initial ability, measured by the SAT, and initial depression, measured by the Beck Depression Inventory, were

held constant. Their research also showed that students with a negative explanatory style were less likely to hold specific academic goals or to make use of academic advising. Explanatory style was also found to be correlated with depression and school achievement in elementary school children and to predict changes in depression over time. This research demonstrated that explanatory style and bad life events interacted to make children vulnerable to depression. Depression had a significant negative correlation with California Achievement Test scores and a positive correlation with helpless behaviors in the classroom. Similarly, explanatory style was correlated with achievement test scores and teachers' ratings of helpless behaviors in the classroom. In a work environment, negative explanatory style predicted poor productivity and quitting among life insurance sales agents (Seligman & Schulman, 1986).

The attribution of failure to stable, global, internal factors is associated with decreased effort and decreased persistence on tasks. Changing the explanation for an outcome to unstable, specific causes, such as lack of effort, has proved beneficial, leading to improved performance in both adults and children (Andrews & Debus, 1978; Chapin & Dyck, 1976; Foersterling, 1985; LaNoue & Curtis, 1985).

COPING WITH STRESS

Optimism has been found to be positively related to active, problem-focused strategies of coping with stress and negatively related to disengagement (Scheier, Weintraub, & Carver, 1986). Optimists reported that they were more likely to seek out social support and less likely to rely on denial or distancing. Optimism is related to positive coping outcomes (Carver & Gaines, 1987; Reker & Wong, 1985; Scheier & Carver, 1985, Study 3; Strack, Blaney, Ganellen, & Coyne, 1985; Strack, Carver, & Blaney, 1987), and to the success with which treated alcoholics move from the treatment setting into mainstream society (Strack et al., 1987). Optimists are more likely to complete aftercare programs successfully than are more pessimistic persons.

Optimism is negatively related to the development of postpartum depression. Carver and Gaines (1987) assessed depression and dispositional optimism during the third trimester of pregnancy and again three weeks after childbirth. Not surprisingly, optimism was inversely related to depression at each assessment period. When the researchers controlled for initial level of depression, however, the relationship between optimism and depression still had a significantly negative correlation. Humphries (cited in Scheier & Carver, 1988) reported similar findings with office workers undergoing major changes in their work procedures.

PERFORMANCE ON COGNITIVE AND SOCIAL TASKS

Performance on Psychomotor and Cognitive Tasks

Depressed persons perform more poorly than normals on cognitive tasks involving short-term memory (Glass, Uhlenhuth, & Weihreb, 1978; Sternberg & Jarvik, 1976; Williams, Little, Scates, & Blockman, 1987) and reaction time (Friedman, 1964; Hall & Stride, 1954; Martin & Rees, 1966). Laboratory research has indicated that low expectations about performance lead to poor performance (see Feather, 1982, for a review). Kuhl (1982) suggested that expectations are the best predictor of achievement motivation. Curtis (1989b) and Andrews (in press) argued that low expectations and the self-confirming attributions of failure to a lack of ability lead to a self-perpetuating cycle of low effort and poor performance. That the lack of effort on the part of the depressed is not totally an unmodifiable consequence of the depressed mood state was demonstrated in recent research by Frankel and Snyder (1987). In a laboratory study, they divided college students at the median of their distribution of scores on the Beck Depression Inventory (Beck, 1967). The depressed group, but not the nondepressed group, persisted significantly longer at a task when told it was highly difficult than when told it was moderately difficult. With difficulty as an excuse for poor performance, the depressed exerted greater effort. Snyder and Frankel (1989) argued that the low effort of the depressed in some situations appears to protect their already fragile sense of self-esteem.

Social Interactions

Coyne (1976a, 1976b) proposed a social interaction model of depression. According to this model, depressed persons provide little reinforcement to others and receive little in return. Although little evidence has been provided that such behaviors lead to depression, research has clearly indicated that such behaviors are characteristic of people who are already depressed. Furthermore, the lack of an intimate social relationship is a vulnerability factor in depression (Brown & Harris, 1978).

Depressed people are seen by observers as performing more poorly in social interactions (Coyne, 1976a; Gotlib, 1982; Lewinsohn, Mischel, Chaplin, & Barton, 1980). They speak more slowly and softly, maintain less eye contact, are less pleasant, and show a less aroused facial expression than normals although they do not differ from control subjects who are not depressed but show some other form of psychological deviation (Youngren *&* Lewinsohn, 1980). Hautzinger, Linden, and Hoffman (1982), in an examination of distressed couples with and without a depressed partner, found many differences in the verbal interaction of the couples. The depressed partners were more likely to talk about their negative mood, cry, give expression of their negative somatic and psychological well-being, give a negative self-evaluation, offer help, demand help, and ask questions about the partner's well-being. The nondepressed partners in the depressed couples demonstrated a positive feeling, mood, and self-esteem, but gave more negative

partner evaluations and were more demanding. The nondepressed couples communicated more positive well-being, more positive partner evaluations, and more agreement with their partner's statements. Hinchliffe and his associates (Hinchliffe, Hooper, & Roberts, 1978; Hinchliffe, Hooper, Roberts, & Vaughan, 1975) demonstrated that, after successful inpatient drug treatment, the interaction differences between depressed and nondepressed couples disappeared, but Hautzinger et al. believed this improvement to be unstable and short-lived. For example, Paykel and Weismann (1973) noted that submissive dependency improved when depression was alleviated, but that interpersonal friction and inhibited communication showed little change and appeared to reflect enduring personality disturbances. Coyne (1976b) determined that depressed persons were more likely to be rejected by others and induced negative affect in others. Subsequent studies have consistently demonstrated that depressed people are rejected, but have failed to show consistent negative mood induction in others (see Gutman, 1986, for a review). For example, Howes and Hokanson (1979) had confederates act in a depressed role, a normal role, or a physically ill role. Subjects who interacted with a depressed confederate responded with a higher rate of silence and negative comments and a lower rate of responding. They expressed a level of direct support similar to that of subjects with the "physically ill" confederate and greater than that of subjects with the normal confederate. Hokanson, Sacco, Blumberg, and Landrum (1980), in an experimental study with college students who were depressed, nondepressed with other psychological

problems, or normal, found that depressed persons given a high-power role behaved in an exploitive and noncooperative manner and showed elevated communications of self-devaluation, sadness, and helplessness. These behaviors elicited noncooperativeness, extrapunitiveness, and expressions of helplessness in their normal partners. Depressives in the low-power role communicated self-devaluation and helpless messages and, additionally, blamed their partner for their situation.

According to Coates and Peterson (1982), nondepressed subjects tend to dislike others who talk about their problems. Others may react with general avoidance (Lewinsohn & Shaffer, 1971; Lewinsohn, Weinstein, & Shaw, 1969), or, if reluctant to express negative feelings verbally, may express them through nonverbal behaviors, such as fewer smiles and less eye contact (Davis, 1961; Hinchliffe et al., 1978; Kleck, Ono, & Hastorf, 1966).

Lack of Assertiveness

Several studies have shown that depressed people exhibit deficits in social skills and assertiveness (Barbaree & Davis, 1984), fail to express an opinion or do so in a whining and ineffective manner (Weissman & Paykel, 1974), and report a high level of discomfort when attempting to behave in an assertive manner (Youngren & Lewinsohn, 1980). Recently, Olinger et al. (1987; cited in Kuiper et al., 1988) found support for the co-occurrence of nonassertiveness and attitudinal

vulnerability to depression. Their work was based upon Ludwig and Lazarus' (1972) hypothesis (cited in Kuiper et al., 1988, p. 302) that nonassertive persons are characterized by "(1) the desire to be liked by everyone, (2) perfectionism and self-criticism, (3) unrealistic expectations and excessive criticism of others, and (4) the labeling of assertive behavior as inappropriate."

In a study by Olinger et al. (1987), vulnerable subjects failed to use appropriate strategies for dealing with interpersonal conflicts and felt greater discomfort when behaving assertively than did the normal controls. The vulnerable subjects who were not currently depressed displayed the same assertion deficits as depressed individuals. Kuiper et al. (cited in Kuiper et al., 1988) demonstrated that subjects who score high on the DAS (Oliver & Baumgart, 1985) display heightened levels of public self-consciousness and social anxiety even when they are not depressed.

Self-Disclosure of Depressed Persons

What differences exist between the self-disclosures of depressed and nondepressed persons and what are the effects of the depressed person's disclosures? Carpenter (1987) suggested that the excessive focus on the self in depressives made it difficult for them to attend adequately to social cues and to benefit from social interaction. He suggested that fatigue, loss of pleasure, and reduced concentration interfered with effective interpersonal behavior. Finally, he

suggested that the negative mood resulted in deficient disclosure.

Research on the self-disclosure of depressives has demonstrated an interaction with the degree of the person's self-monitoring. High self-monitors are more concerned, are more sensitive to cues others provide (Snyder, 1979), and make more accurate interpretations of others' nonverbal communications (Mill, 1984). At relatively high depression levels for college students, high self-monitors reported more satisfaction with the support they received from friends when disclosing their distress (Coates and Winston, 1987). A significant negative relationship between reported distress disclosure and depression was also obtained, showing that people who said they talked about their problems more were less distressed at the moment.

In another study, depressed subjects viewed negative self-disclosure topics concerning their work, financial status, personality, and so on, to be more appropriate for discussion by themselves and others than did normal subjects (Kuiper & McCabe, 1985). Vulnerable subjects who were currently not depressed displayed the same views of topic appropriateness as did depressed subjects.

Hostility and Conflict

Although no research was located indicating that depressed persons are able to express their anger in a forceful or effective manner, the self-reports of the depressed reveal that their feelings of aggression are conscious and not

inaccessible or warded off as Abraham (1927) and Fenichel (1945), respectively, had suggested. Hostility may be more obvious in males than in females (Gjerde, Block, & Block, 1988), but considerable hostility is expressed by women in close relationships even though it is not always apparent in interviews (Weissman, Klerman, & Paykel, 1971).

MASKED DEPRESSION, SUBSTANCE ABUSE, AND ANTISOCIAL BEHAVIORS

Experimental research has demonstrated that alcohol relieves anxiety for some people in certain situations (Levenson, Sher, Grossman, Newman, & Newlion, 1980). Alcoholism is believed to mask depression in the general population, especially in men. Clinical observations and research have shown that depression occurs as frequently in men as in women in cultures such as the Amish, where alcohol is not used (Egeland & Hostetter, 1983), yet depression is more common among women in the general population. Research has also shown that a gene associated with vulnerability to depression in women is associated with alcoholism in men (Robinson, Davis, Nies, Ravaris, & Sylvester, 1971; Winokur, 1972). Many researchers have noted that truancy, running away, and antisocial or delinquent behaviors, especially in adolescents, mask depressive experiences (Chwast, 1961; Glaser, 1967;Toolan, 1962, 1974; Weiner, 1975).

MANIC SELF-DEFEATING BEHAVIORS

Very little research has focused upon the behaviors of manic patients. Janowsky, El-Yousef, and Davis (1974) found that in-patient manic patients were more likely to test limits, try to make others feel responsible for plans gone awry, be sensitive to and exploit the "soft spots" of others, attempt to divide staff, flatter, and evoke anger than either schizoaffective or schizophrenic patients. This pattern of behavior had been previously identified by Janowsky, Leff, and Epstein (1970). Bipolar manic-depressives in remission, however, were found not to differ on measures of positive mental health and measures of external orientation, including the Personal Orientation Inventory, the Marlow-Crowne Social Desirability Scale, Levenson's Internal and Powerful Others Locus of Control Scale or the Embedded Figures Test (MacVane, Lange, Brown, & Zayat, 1978). Remitted bipolars' inferences about the causes of failures have been found to resemble those of depressives, however, although their scores on a traditional measure of self-esteem (the Self-Report Inventory-II) did not differ from the normals (Winters & Neale, 1985). These data suggest that bipolar patients have the negative self-schema and depressive attributional style found in depressives, although their negative feelings are not revealed on usual self-report inventories.

EXPERIMENTAL STUDIES OF THE RELATIONSHIP BETWEEN MOOD AND BEHAVIOR

Perhaps because of the ethical implications of inducing a negative affect in experimental research participants, considerably more laboratory and field studies have investigated the effects of a positive mood on behavior than the effects of a depressed mood. This research was reviewed recently by Isen (1987). The finding that positive affect produces certain effects does not necessarily imply that negative affect will give rise to its opposite. Certainly, however, depressed people should be less likely, in many cases, to exhibit the behaviors associated with positive affect. Isen reviewed research on positive affect and social behavior, memory, and problem-solving. Some of these findings will be reported here.

Isen cited twelve studies demonstrating that people induced to have happy feeling are more likely to help others than are people in control groups. This finding holds for both children and adults. Happy people are more likely to volunteer to help someone, but less likely to volunteer to annoy someone (Isen & Levin, 1972). Other limits to their willingness to help have also been reported. Isen and Simmonds (1978) found that subjects who found a dime in a telephone booth were more likely than controls to help someone by reading and evaluating statements they were told would put them in a good mood, but less likely to read statements they were told would put them in a bad mood. Furthermore, persons who felt good were more likely than persons in a control condition to help a cause they favored, but less likely to help a cause they did not like (Forest, Clark, Mills, &

Isen, 1979).

People who feel good tend to reward themselves more than control subjects (Mischel, Coates, & Raskoff, 1968) and to display greater preference for positive rather than negative self-relevant information. They are more willing to initiate conversations with others (Batson, Coke, Chard, Smith, & Taliaferro, 1979; Isen, 1970) and to express liking for others (Gouaux, 1971; Griffit, 1970; Veitch & Griffit, 1976); they are less aggressive (Baron, 1984; Baron & Ball, 1974) and more cooperative (Carnevale *&* Isen, 1986). People in a good mood are more cautious in threatening situations, and more willing to take a risk when the threat is of little consequence (Arkes, Herren, & Isen, 1988; Isen & Geva, 1987; Isen & Patrick, 1983).

Isen reviewed several studies showing that positive affect speeds up the recall of positive memories (Teasdale & Fogarty, 1979) and increases the recall of positive material (Laird, Wagenar, Halol, & Szegda, 1982; Nasby & Yando, 1982; Teasdale & Russell, 1983). Isen also showed that people in a good mood are more likely to give a positive evaluation than others (Isen, 1987; Isen, Daubman, & Nowicki, 1987). The affect at the time of learning appears to influence the material learned more than the affect at the time of retrieval influences the type of material recalled. For example, Bower, Gilligan, and Montiero (1981) showed that people induced to feel good at the time of learning, but not induced to feel good at the time of recall, remembered more facts about persons described as happy. Isen

suggested that positive affect may give rise to an enlarged cognitive context, that is, a wide range of associated thoughts. She found that people induced to feel positive affect give more unusual word associations (Isen, Johnson, Martz, & Robinson, 1985) and show improved creative problem-solving, both social and nonsocial. For example, Isen et al. (1987) found that positive affect improved performance on the Remote Associates Test, whereas negative affect and affectless arousal did not. Similarly, persons in whom happiness was induced were better able to recall words when an obscure theme was not provided, but showed no advantage when it was provided (Isen et al., 1987). In a bargaining task, persons with positive affect were more likely to reach agreement and to reach the optimal agreement possible (Carnevale & Isen, 1986). Whereas positive affect appears to broaden association and attention there is some earlier work showing that negative affect leads to a restriction of attention and categorization (Bruner, Matter, & Papanek, 1955; Easterbrook, 1959).

The implications of the work on positive affect are that such affect facilitates a broad range of behaviors enhancing social relationships and problem solving. In contrast to persons with positive affect, persons lacking it exhibit impaired helping, cooperation, and creative problem-solving.

EXPERIMENTAL STUDIES OF THE RELATIONSHIP BETWEEN NEGATIVE SELF-SCHEMATA AND SELF-DEFEATING BEHAVIORS

The low self-esteem of the depressed person was suggested by Freud (1917/1957) and other psychoanalytic writers (Arieti & Bemporad, 1978; Bibring, 1953; Fenichel, 1945; Gaylin, 1968; Jacobson, 1953; Rado, 1928) as well as Beck (1967). Research on expectancy confirmation and self-verification processes has shown that people act in ways that confirm their negative self-schemata. Andrews (in press) has drawn upon this research to propose a "self-confirmation model" of depression.

Swann and Read (198 la) found that subjects sought information that would confirm their self-conception, regardless of whether they held self-concepts that they were assertive or nonassertive. In their research the subjects chose to read answers to questions another individual had completed about them that either probed for assertiveness, such as, "What makes you think that this is the type of person who will complain in a restaurant if the service is bad?" or probed for evidence of unassertiveness, such as, "Why would this person not be likely to complain if someone cuts into line in front of him or her at a movie?" In a second experiment, subjects even paid money for each piece of feedback they wished to examine. Subjects who perceived themselves as unassertive purchased more "unassertive" than "assertive" feedback and subjects who perceived themselves as assertive purchased more "assertive" feedback. In other research (Swann & Read, 1981b), subjects rated themselves as relatively likable or dislikable to others.

They were then led to believe that a person with whom they would be interacting viewed them favorably or unfavorably. When allowed to examine statements on slides that their prospective partners had ostensibly selected to summarize their initial perceptions, subjects spent more time reading the statements when the partner's appraisal was expected to confirm their self-conceptions. Self-likables spent a longer time reading the statements in the favorable conditions whereas self-dislikables spent a longer time reading the statements in the unfavorable condition. In a subsequent study (Swann & Read, 1981b, Investigation II), participants elicited reactions from their partners that confirmed their self-conceptions, especially when they suspected their interaction partners' appraisals might disconfirm their self-conceptions. Participants also were found to preferentially recall feedback consistent with their self-conceptions. When people receive feedback that is inconsistent with their self-conceptions, their intimate partners, but not strangers, act to discredit the inconsistent information even when it is positive (Swann & Predmore, 1985). Curtis and Miller (1986) found that when people believe that another person dislikes them, even when the belief is erroneous, they act in ways that make the belief come true. People led experimentally to believe that they were disliked disagreed more with their partners, expressed less similarity, and had a more negative general attitude. When the interaction was over, they were actually liked less than persons who had been led experimentally to believe that they were liked (Curtis & Miller, 1986). People choose mates who see them as they see themselves (Swann &

Pelham, 1990). They also regard information consistent with their self-concepts, even when it is negative, as more accurate and as delivered by a more competent evaluator. Persons with a negative self-concept believe unfavorable feedback, even though they feel upset hearing it (Swann, Griffin, Predmore, & Gaines, 1987).

All of this research suggests that once a depressogenic self-schema is activated by loss, failure, or stress, people will act in ways to make reality confirm it. Although the experimental research has focused upon negative self-schemata and expectancies, it seems reasonable to assume that these "negative" views are similar to those held by depressed persons and, probably, by many persons with bipolar disorder.

DEPRESSION, SELF-DEFEATING BEHAVIOR, AND CHRONIC PERSONALITY DISPOSITIONS

Depressed persons may be diagnosed as suffering from a wide variety of personality disorders, each characterized by particular types of self-defeating behaviors. They are most commonly diagnosed, however, as either avoidant or dependent personality disorders (Frank, Kupfer, Jacob, & Jarren, 1987; Shea, Glass, Pilkonis, Watkins, & Doherty, 1987). Leary's (1957) account of the depressive personality stresses the self-effacing/masochistic style of this person, but Horowitz, Rosenberg, Baer, Ureno, and Villasenor (1987) and more recently Andrews (in press) consider the dependent depressive as a separate subtype. Blatt, Quinlan, Chevron, and McDonald (1982) have also differentiated the self-critical and dependent types of depressed personalities, similar to the masochistic and dependent subtypes described by Leary.

Recently, with the Self-Defeating Personality Disorder (SDPD; formerly called Masochistic Personality) given provisional status in DSM-III-R and considered for inclusion in DSM-IV, the question has arisen as to whether persons with this particular cluster of behaviors are suffering primarily from symptoms of depression. The behaviors listed as descriptive of persons with a self-defeating personality disorder are as follows:

A. A pervasive pattern of self-defeating behavior, beginning by early adulthood and present in a variety of contexts. The person may often avoid or undermine pleasurable experiences, be drawn to

situations or relationships in which he or she will suffer, and prevent others from helping him or her, as indicated by at least five of the following:

(1) chooses people and situations that lead to disappointment, failure, or mistreatment even when better options are clearly available

(2) rejects or renders ineffective the attempts of others to help him or her

(3) following positive personal events (e.g., new achievement), responds with depression, guilt, or a behavior that produces pain (e.g., an accident)

(4) incites angry or rejecting responses from others and then feels hurt, defeated, or humiliated (e.g., makes fun of spouse in public, provoking an angry retort, then feels devastated)

(5) rejects opportunities for pleasure, or is reluctant to acknowledge enjoying himself or herself (despite having adequate social skills and the capacity for pleasure)

(6) fails to accomplish tasks crucial to his or her personal objectives despite demonstrated ability to do so, e.g., helps fellow students write papers, but is unable to write his or her own

(7) is uninterested in or rejects people who consistently treat him or her well, e.g., is unattracted to caring sexual partners

(8) engages in excessive self-sacrifice that is unsolicited by the intended recipients of the sacrifice

B. The behaviors in A do not occur exclusively in response to, or in anticipation of, being physically, sexually, or psychologically abused.

C. The behaviors in A do not occur only when the person is depressed.

(American Psychiatric Association, 1987, pp. 373-374.)

Certain characteristics of persons with an SDPD, such as pessimism, rejection of opportunities for pleasure, rejection of efforts to help, self-criticism, guilt, disinterest in caring partners, and failure to complete tasks may all be seen in patients suffering from depression. Akiskal (1983), Liebowitz (1987), and Vaillant and Perry (1985) criticized inclusion of the SDPD in DSM-III-R on the grounds of its conceptual overlap with other diagnostic categories, primarily depression and passive-aggressive and dependent personality disorders.

Curtis (1988) suggested, on the other hand, that although persons with SDPD may become depressed, the behaviors associated with this personality style usually allow the person to maintain a sense of control and to avoid depression. The social psychological literature on choosing to suffer in nonclinical samples demonstrates that people making such a "choice" believe they are improving future outcomes (Curtis, 1989a). Levey (1983) found that men who engaged in self-handicapping behavior in a laboratory experiment were more likely to feel depressed as measured by the Beck Depression Inventory, but also to feel a higher sense of control.

SUMMARY

Many self-defeating behaviors of the depressed seem to be concomitants of the depressed mood state. Other behaviors, related to the preexisting view of the self, of the world, and of causality appear to make some people more vulnerable to depression after stressful life events than others. Although people with dependent and self-effacing personality styles may be particularly prone to depression, further investigations into the ways in which views of self and others and means of coping with failure and loss are learned would be useful in the prevention of the development of depressogenic behavior patterns. Particularly necessary is further research examining how induced self-sacrifice and induced dependence (Langer & Benevento, 1978) lead to depressogenic self-schemata and attributional styles.

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