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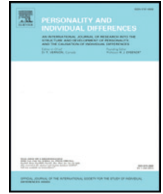

Depression, Neuroticism, and the Discrepancy Between Actual and Ideal Self-Perception

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ABSTRACT

Relationships between personality dimensions, depression, and self-perception were investigated in a sample of 95 subjects. Higher levels of neuroticism were significantly related to more negative self-perceptions, more stringent self-expectations, and greater discrepancy between actual and ideal self-perception across multiple domains of behaviour and feelings. Clinically depressed subjects also had more negative perceptions of Emotional Well-Being. No significant differences were found between depressed and normal controls concerning self-evaluation standards

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1. Introduction

The relationship between psychological distress and physical health has received a great deal of attention over the past decade. In particular, clinical depression has been found to be associated not only to illness, but also to premature death. Illustratively, in a 24-year longitudinal follow-up study of a cohort of clinically depressed patients and matched controls, significantly higher rates of premature death were found among depressed subjects (Thomson, 1996). While it is widely accepted that clinically depressed patients have a higher risk for death from suicide (Jamison, 1999), this study suggests that depressed patients are also at higher risk for premature death from physical illnesses, including cerebro-vascular disease and respiratory disease, as well as suicide and accidents. While this study suggests that there is a link between depression and mortality, further investigation is needed to elucidate the mediating factors that account for this relationship. One potentially important pathway through which depression may affect mortality is through its effect on self-criticism and self-derogatory ideation. Intense self-criticism and perfectionism has been identified as risk factors for suicide among clinically depressed individuals (Blatt, 1995). Excessively high self-criticism may have broader effects on health as well. Efforts to attain self-validation in the face of threats to self-worth may have deleterious effects on self-control, health maintenance habits, and physical health (Crocker & Park, 2004).

Numerous studies suggest that depression is closely linked with negative self-evaluation. Clinically depressed individuals tend to evaluate their competencies, behaviour, and self-worth more negatively than the general population (Blatt, 1995; Kovacs & Beck, 1978). Intense self-derogation in childhood and adolescence may be marker of increased risk for depression and other disorders in adulthood (Dubois & Tevendale, 1999). Negative self-evaluations are thought to stem both from negative self-perceptions and from unrealistically high self-expectations (Kovacs & Beck, 1978). Clinically depressed individuals may have negative self-perceptions due to distortions in information processing. For example, individuals who have suffered from clinical depression are more likely to recall experiences and events that are congruent with their negative mood (Haaga, Dyck, & Ernst, 1991). Threats to self-worth may also receive excessive attention (Mathews, Ridgeway, & Williamson, 1996). In addition to such cognitive distortions, negative self-perceptions may in part accurately reflect the diminished energy, cognitive skill, and coping capacity that characterize episodes of severe depression (Dobson & Franche, 1989). In addition, according to cognitive models of depression (e.g., Kovacs & Beck, 1978), a core element of clinically severe depression may be the rigid adherence to unrealistic self-expectations. Failure to fulfill unrealistic self-expectations, in turn, exacerbates depressive symptoms. Perfectionistic thinking, in particular, is thought to reduce flexibility and resourcefulness, and increase distress, in the face of stressful life events (Hewitt & Flett, 2002). However, while the association between clinical depression and negative self-perception has been well documented, the proposed link between depression and heightened self-expectations has not received consistent support from empirical research (Coyne & Gotlib, 1983).

The linkage between depression and self-derogation may arise, in part, from heightened levels of neuroticism among many clinically depressed patients. According to Eysenck's (1967) model of personality, physiological differences in the sympathetic nervous system give rise to individual differences in emotional stability versus neuroticism. Individuals who have a more neurotic temperament are more likely to experience negative affect, including depression. Individuals who are high on neuroticism are also more likely to engage in self-derogatory

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thinking, due in part to negative self-perception, as well as maintaining stringent and unrealistic self-expectations. Neuroticism can produce negative self-perception in part due to distortions in information processing. For example, anxiety can distort attentional processes, as perceived threats receive excessive amounts of attention (Mogg, Mathews, & Eysenck, 1992). Individuals who are high on neuroticism often have more stringent and demanding self-expectations. Maintaining unrealistically high self-expectations can increase levels of anxiety, and may account for the negative effects of neuroticism on coping with stressful life events and adjustment (Enns, Cox, & Clara, 2005; Laurenti, Bruch, & Haase, 2008).

The present research will investigate the following hypotheses concerning the relationships of neuroticism and depression with self-perception and self-evaluation:

1. Higher levels of Neuroticism will be associated with more negative perceptions of behaviours and feelings.
2. Higher levels of Neuroticism will be associated with more stringent standards for evaluating behaviour and feelings.
3. Higher levels of Neuroticism will be associated with higher levels of discrepancy between subjects' self-description and their ideal standards.
4. Clinically depressed subjects will exhibit more negative perceptions of behaviours and feelings.
5. Clinically depressed subjects will have more stringent standards for evaluating behaviour and feelings.
6. Clinically depressed subjects will exhibit higher levels of discrepancy between subjects' self-description and their ideal standards.

2. Methods

2.1. Sample

The present study utilized data from 159 participants. A substantial portion of the sample received psychiatric care for depression: 34.2% of the sample received treatment for depression, while the 65.8% of the sample did not receive psychiatric treatment for depression. Females comprised 64% of the sample, while 36% were male. The median age of the study participants was 39 years old. With respect to employment status, 40.9% of the sample was employed full-time, 30.8% were employed part-time, and 1.9% were self-employed. A further 6.3% were full-time students without employment, 10.1% were unemployed, 5.0% were disabled, 2.5% were retired, and 2.5% were homemakers. Preexisting medical conditions were present in 35.1% of the sample.

2.2. Procedures

The treated group consisted of patients referred to a psychiatrist and diagnosed as depressed in an outpatient department. The questionnaires were enclosed in a stamped addressed envelope and accompanied by an information sheet that explained the purposes of the study. Potential participants were informed that their involvement in the study was voluntary, that they could withdraw from the study at any time after they started, and that responses to the survey would be anonymous. Every patient who was referred as possibly depressed by their General Practitioner was invited to complete a questionnaire while they awaited the consultation with the psychiatrist. Control subjects were not being treated for mental illness.

2.3. Instruments

2.3.1. Eysenck personality inventory

The Eysenck Personality Questionnaire (EPQ; Eysenck & Eysenck, 1975) consists of 90 yes-no items that are designed to measure three dimensions of personality: Neuroticism, extraversion, and psychoticism. The measure also includes a Lie scale to screen out respondents who give distorted answers to appear socially desirable. The EPQ scales have shown high levels of reliability, both in terms of internal consistency and test-retest reliability coefficients (Eysenck & Eysenck, 1975). Alpha coefficients and test-retest correlations for the EPQ scales are higher than .8 across demographic sub samples. The dimensional structure of the EPQ has proved to be robust in numerous factor-analytic studies. Illustratively, a simple structure factor rotation yields three dimensions that are comprised, respectively, by the Neuroticism, Extraversion, and Psychoticism items (Barrett & Kline, 1980). Further, these three dimensions appear to underlie the factor structure of many other widely used personality inventories (Kline & Barrett, 1983). Considerable evidence for the external validity of the EPQ dimensions has been provided by numerous studies relating differential performance on experimental tasks, as well as behavioural patterns in real-world settings, to levels of Neuroticism, Extraversion, and Psychoticism (Eysenck, 1967).

2.3.2. Self defeating quotient

The self defeating quotient (SDQ) was developed by the author for the purposes of the present investigation. Items for the SDQ were piloted with patients who were undergoing treatment for depression, and were revised in consultation with treating psychiatrists. The SDQ consists of 33 statements describing elements of the respondents' behaviour and feelings, and is administered in two parallel forms: one describing the extent to which the statement describes the actual behaviour or feelings of the respondent (the Now form), and the other indicating the ideal level of each item (the Ideal form). Illustratively, the Control item asks participants to indicate how much control they have over "things that made them feel optimistic and content." Participants responded to this item by indicating whether they had Total Control or No Control (Appendix A shows the full set of SDQ Now and Ideal items). Subjects were asked to mark their response to each item on a scale that ranged from 0 to 100. At the one extreme, the preferential state or behaviour was represented by a score of 0, while a negative response was indicated by a score of 100. The SDQ Now Total is scored by computing the average SDQ Now rating items. The SDQ ideal total score is computed as the average Ideal rating of the items. The SDQ total discrepancy score is computed by subtracting the Ideal score from the Now score. Higher discrepancy scores indicate a greater difference between ideal and perceived behaviours and feelings, and are interpreted as an indicator of increased risk for self-harm. The factor structure of the SDQ will be examined in the present investigation.

3. Results

Preliminary analyses examined the mean response of subjects to the EPQ scales and SDQ items. The main analyses of the present study then proceeded in three stages. The first stage of the analyses sought to identify the underlying dimensional structure of the SDQ through factor analysis, and to develop factorially based scales for scoring the SDQ items. The second stage of the analyses examined the relationship of specific SDQ sub-scales with differential levels of psychoticism, neuroticism, and extraversion. The final stage of analysis focused on whether clinically depressed patients and normal controls could be differentiated using the SDQ scales.

3.1. Sample descriptives

3.1.1. Eysenck personality inventory

Of the 159 subjects who participated in the present study, 125 provided complete data on the EPI. Mean scores for the sample on the EPQ scales are shown in Table 1. Compared with the EPQ norms (Eysenck & Eysenck, 1975), scores on the Neuroticism scale are notably higher, as would be expected in a sample that is comprised predominantly of individuals with clinical depression.

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