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The Self-System in Depression: Conceptualization and Treatment

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The self has been associated with psychological adjustment and adaptive functioning by psychologists of many persuasions (Allport, 1955; Cooley, 1902; Erikson, 1950, 1968; Freud, 1952/1920; Horney, 1950; James, 1890; Rogers, 1965; Sullivan, 1953). Psychotherapists, particularly those from Neo-Freudian and non-Freudian schools, have consistently maintained that changes in the self-system are central to therapeutic improvement. For example, Seward (1962) interviewed a group of 65 analysts including Freudsians, Neo-Freudians, Horneyans, Jungians, Sullivanians, and Existentialists, and encouraged them to spontaneously discuss the general goals they set for therapy and the changes they anticipated occurring during therapy. He found that personal integrity and insight into self-dynamics were common goals of all therapeutic schools. In addition, most psychotherapists viewed self-realization and self-expression as common goals of therapy and anticipated that therapy produced changes in self-acceptance and self-expression. From a Horneyan perspective, the most important therapeutic changes occurred within the self-system, allowing the patient to achieve the “ability to accept himself as he is, together with the awareness that he now can grow further and utilize his potentials without having to beat himself down for not having achieved perfect goals” (Seward, 1962, p. 144).

Sullivan (1953) and Rogers (1965) have explicitly discussed the changes that are expected to occur in the self-system during therapy. Sullivan suggested that therapy needed to include “complexly organized, rather prolonged, therapeutic operations by which we gradually build up a series of situations which require the self-system to expand—that is, to take in experience which had previously, because of selective
attention or otherwise, had no material effect on the patient's susceptibility to anxiety..." (p. 192). Rogers noted that, in successful therapy, a movement from "symptoms to self," from "environment to self," and from "others to self" was expected to occur. Successful therapy produced a fundamental move toward greater acceptance of the self in which the individual's self-evaluative standards were self-selected rather than introjected from significant others or cultural pressures. More recently, Guidano and Liotti (1983) have suggested that the modification of one's attitude toward oneself and the restructuring of personal identity are central to changes that occur as a result of successful psychotherapy.

The self has also been implicated in the development and maintenance of many types of psychopathology (Guidano & Liotti, 1983), including depression (Beck, 1967, 1976; Freud, 1952/1920, 1957/1917). Current models of the role of the self in the etiology and treatment of depression have adopted a distinctly cognitive perspective (e.g., Beck, 1967, 1976; Derry & Kuiper, 1981; Kuiper & Derry, 1982; Teasdale, 1983). Other theorists and psychotherapists have emphasized the affective and motivational aspects of the self that are important in depression (e.g., Guidano & Liotti, 1983; Leventhal, 1980).

A theoretical model that integrates the cognitive, affective, and motivational aspects of the self that are central in the etiology of depression may provide a useful framework for directing therapeutic intervention. In the first section of the chapter we present a structural and developmental model of the self-system in depression that emphasizes the interactive role of cognitive, affective, and motivational factors. In subsequent sections we examine self-processes that contribute to the onset and maintenance of depression, and intervention strategies.

**SELF-DISCREPANCY AND DEPRESSION**

Several contemporary theories suggest that discrepancies between the actual-self and valued self-states are associated with psychological distress (e.g., Ogilvie, 1987; Pyszczynski & Greenberg, 1987). Self-discrepancy theory (Higgins, 1987) also proposes that discrepancies within the self-system are associated with psychological distress, and in addition identifies the types of self-system disorders that are specifically associated with vulnerability to depression. A fundamental assumption of self-discrepancy theory is that various self-state representations act as important guides or standards for self-evaluation and self-regulation. Individuals may evaluate their actual-self (i.e., the traits or characteristics they actually believe they possess) in relation to either their ideal-self representation (i.e., the traits or characteristics they wish or hope to possess), or their ought-self representation (i.e., the traits or characteristics they believe they have a duty or obligation to possess). Furthermore, the actual-self may be evaluated in relation to self-state representations that embody either one's own perspective (e.g., ideal-own, ought-own), or the inferred perspective of a significant other (e.g., ideal-other, ought-other).

When individuals perceive their actual-self as discrepant from a self-guide, they are likely to experience psychological distress. The type of distress they experience depends on the type of self-discrepancy they perceive. When the actual-self is perceived as discrepant from the hopes and wishes that individuals hold for them-
Shaw, and Higgins (1988), however, provides preliminary evidence of greater structural interconnectedness within the self-systems of clinically depressed individuals than within those of nondepressed individuals. Frequent activation over an extended period of time may produce chronically accessible discrepant self-attributes that are activated in the absence of triggering stimuli (i.e., environmental or contextual cues).

The findings of Higgins et al. (1988) and Segal et al. (1988) suggest that individuals who possess actual-ideal self-discrepancies are vulnerable to depression not only because they possess individual discrepant self-attributes, but also because the activation of one discrepant self-attribute results in the activation of other discrepant self-attributes. The greater the number of discrepant traits that individuals possess, the more frequently all discrepant traits will be activated and the more accessible (i.e., readily accessed during processing) they will be during the processing of self-relevant information.

How might the structural relatedness of self-discrepant attributes in memory contribute to the maintenance of depression? It is well established that the development of an organized representation of information in memory automatically directs information processing with little demand on limited attentional capacity (Bryan & Harter, 1989; James, 1890; Logan, 1980; Shiffrin & Schneider, 1977). Automatic information processing may be triggered without an individual's awareness and, once initiated, may be difficult to inhibit even when individuals are aware of the triggering stimuli. If we assume that the influence of discrepant self-attributes on information processing is similar to that of other cognitive representations, then it is likely that discrepant self-attributes will automatically influence self-relevant information processing without an individual's awareness. In addition, an individual may experience difficulty inhibiting the influence of discrepant self-constructs on information processing even when he or she is aware of triggering stimuli (Bargh & Pratto, 1986; Higgins & King, 1981; Strauman & Higgins, 1987; Strauman, 1989).

Self-relevant information processing in depression may be overly determined by automatic processes because discrepant self-attributes are related in memory. Because automatic processing is predominantly directed by internalized cognitive representations, encoding, identification, and interpretation of information may be biased. Therefore, automatic processing is likely to sustain stability within a cognitive representation rather than promote change. As a consequence, the self-system in depression may be highly negative, rigid, and unchanging. This view of depression is consistent with clinical observations offered by Beck and his colleagues (Beck, 1967, 1976; Beck et al., 1979; Moretti & Shaw, 1989).

If automatic processing in depression leads to psychological distress and maintains dysfunction within the self-system, why don't depressed individuals simply interrupt these processes? It may be that although depressed individuals are aware of the outcomes of automatic processing (e.g., negative self-evaluations, feelings of depression and disappointment), they are not aware of the operation of automatic processes. Moreover, the negative self-evaluations and negative feelings that occur as a consequence of automatic processes may go unquestioned because they are consistent with the negative view that depressed individuals hold of themselves. Finally, the highly negative emotional state that characterizes depression may re-
duce attentional resources that are necessary to interrupt dysfunctional automatic processes and engage in corrective controlled processes (Moretti & Shaw, 1989).

THE SELF-SYSTEM IN DEPRESSION: DEVELOPMENTAL CONSIDERATIONS

Up to this point, we have considered the types of self-system deficits that are associated with depression. To fully understand and treat depression it is important that we also consider the etiology of vulnerability within the self-system. The importance of early childhood experiences in the development of the self-system and vulnerability to depression has been emphasized by many theorists. Psychoanalytic approaches to depression have emphasized the role of early experiences of loss (Abramson, 1985; Freud, 1957; Feur), feelings of helplessness regarding discrepancies between aspirations and expectancies (Rapaport, 1985), and child-parent relationships and parental attitudes (Cohen, Baker, Cohen, Fromm-Reichmann & Weigent, 1985/1954). Sullivan (1953) believed that the self-system frequently exerted a negative impact on psychological functioning, but that the degree of negative impact depended on the type of socialization practices that individuals experienced as children. Once established, the self-system had "nothing less than stupendous importance in personality" (Sullivan, 1953, p. 169) because it was resistant to change even when experiences were incongruous with its organization and functional activity.

More recent cognitive theories (Beck, Rush, Shaw & Emery, 1979; Guidano, 1987; Rovacs & Beck, 1985) also suggest that early interpersonal experiences have an impact on vulnerability to depression. Early experiences become organized, integrated, and cognitively represented in schemas about the self, the world (including interpersonal relationships), and the future. Once established, these cognitive representations operate as a filter or guide for the interpretation of self-relevant experiences.

While many theories acknowledge the importance of childhood experience as a distal cause of depression (see Alloy, Abramson, Metalsky & Hartlage, 1988, for a discussion of the notion of distal versus proximal causes in psychopathology), most do not specify the mechanisms by which these early events influence later experience, particularly with respect to the role of the self-system. A model that specifies the conditions that give rise to the development of vulnerability within the self-system and the effects of the self-system on subsequent experiences would assist psychotherapists in effectively targeting aspects of the self for therapeutic intervention. Higgins and his colleagues (Higgins, 1989a; Moretti & Higgins, in press-a) have recently formulated a developmental model that traces the development of discrepancies between self-beliefs to the interaction between the development of relational thought in children and parental socialization practices.

The development of relational thought (Case, 1985; Fischer, 1980; Selman, 1980) is a fundamental precursor to the development of the self-system. In order for children to develop different perspectives on the self that can be used for self-evaluation, they must be capable of representing the relationship between their behavior and the responses of others to them (self-other contingencies). At the earliest level of development (sensorimotor level), infants have the capacity to experience the presence or absence of both positive and negative events. Even though infants at this level are able to anticipate positive or negative events, they lack the capacity to relate these events to their own behavior. However, to the extent that children anticipate either the absence of positive events or the presence of negative events, they may withdraw or respond negatively to the approaches of others. These responses may have a negative impact on the self at a later stage of development since withdrawal and/or rejection of others can increase the probability that negative interpersonal events will occur in the future and will be related to the self when infants have reached a level of cognitive maturity to be able to do so.

As early as two years of age, children develop the ability to represent events symbolically (Bruner, 1964; Case, 1985; Fischer, 1980; Piaget, 1951; Werner & Kaplan, 1963) and they begin to consider bidirectional relations between objects. At this age children can represent the relation between themselves, or their actions, and the responses of another individual to them (e.g., their mother or father). They are also able to represent the psychological impact of others' responses to them on their own psychological state (e.g., feelings of happiness, sadness, fear, contemptment).

The ability to understand and represent the impact of self-features or behaviors on the responses of others provides the basis for children to represent self-other contingencies—that is, representations of the types of self-aspects or behaviors that lead to acceptance or rejection by others. This has an important impact on the development of the self-system and the emergence of self-regulation. Because children at this level can represent the relation between their behavior and the responses of others, as well as the impact of others' responses on their own psychological state, they are motivated to monitor their behavior to ensure the presence of positive psychological events and to avoid the presence of negative psychological events.

During the period of development between the ages of 4-6 years (late interrelational and early dimensional development), children are capable of viewing their behavior from the perspective of others, and they are able to adopt these perspectives or viewpoints as standards for self-evaluation (for a discussion of the development of perspective taking, see Case, 1985; Feier, 1970; Fischer, 1980; Flavell, Flavell, Fry, Wright & Jarvis, 1968; Higgins, 1981; Piaget, 1965; Selman & Bryne, 1974; Werner, 1957). Because these children can simultaneously consider and compare their own behavior with the standards that they believe others hold for them, they can determine the extent to which they are discrepant. At this point of self-development, children become vulnerable to experiencing discrepancies between their self-features or behaviors, and the self-features or behaviors that they believe others would like them to possess. If they believe that they have not behaved as others would ideally wish them to behave (ideal-self; other-perspective), then they may feel sad and humiliated. If children believe that they have not behaved as others thought they should or ought to (ought-self; other perspective), then they may feel fearful and guilty.

Between the ages of 9 and 11 years (late dimensional development), children's inferences of how others view them become organized in terms of generalized traits rather than specific behaviors (Harter, 1983). These changes in self-representation are associated with changes in self-evaluations and self-regulation. Children at this
stage are more likely to make general self-evaluations when they compare themselves to the standards that they believe others hold for them. If children experience discrepancies during this comparison process, then they are confronted with the task of altering themselves to reduce the discrepancies. This may be problematic because the discrepancies now reflect dispositional characteristics rather than behaviors. It is no longer a question of children changing what they do in order to meet important self-standards, but rather altering who they are.

The final level of cognitive development (vectorial development) occurs during early adolescence (ages 13–16) and is marked by the ability to simultaneously consider and integrate information from multiple perspectives (Case, 1985; Fischer, 1980; Inhelder & Piaget, 1958; Selman & Byrne, 1974). The ability of adolescents to simultaneously consider themselves from many different perspectives may lead to a more complex and differentiated view of the self. This may have positive consequences (Linvill, 1985, 1987), but it may also carry risks for psychological distress. Adolescents may experience themselves as discrepant from several important self-evaluative standards and they may feel pulled between conflicting self-guides. As a result, adolescents may suffer from problems in self-regulation and from feelings of conflict, confusion, and rebelliousness (see Van Hook & Higgins, 1988).

Not all children develop vulnerable self-systems. Parental socialization practices are an important factor in the development of children's self-systems. These practices influence both the type and the strength of self-evaluative guides that are acquired by children. When parents are oriented toward identifying and responding to their children's features that match their hopes and wishes, their relationships with their children are likely to be dominated by the presence of positive outcomes—that is, they are likely to reinforce and praise their children's behaviors. Parental interactions that consistently, clearly, and significantly highlight matches of children's features with parental wishes and hopes are likely to result in children's acquisitions of strong ideal self-guides. When parents are oriented toward identifying and responding to their children's features that match the duties and obligations that they have prescribed for them, their relationships with their children are likely to be dominated by the absence of negative outcomes (i.e., an absence of the need to punish their children). Parental interactions that consistently, clearly, and significantly highlight matches of children's features with the duties and obligations that parents have prescribed for their children are likely to result in children's acquisitions of strong ought self-guides.

Children exposed to either of these parental interaction styles are likely to develop self-concepts characterized by congruence rather than by discrepancy between the actual-self and self-evaluative guides. The perception of congruence between the actual-self and self-evaluative guides is more likely to be associated with positive emotional states than is the perception of discrepancy. When parents are oriented toward identifying and responding to their children's features that are discrepant from their hopes and wishes for them, their relationships with their children are likely to be dominated by the absence of positive outcomes—that is, parents may feel disappointed or dissatisfied with their children and they may withdraw support and acceptance. When parents are oriented toward identifying and responding to their children's features that are discrepant from the duties and obligations that they have prescribed for them, their relationships with their children are likely to be dominated by the presence of negative outcomes—that is, parents may feel angry and resentful, and criticize, reprimand, or punish their children. Parental socialization practices that focus on mismatches between children's features and parental guides are likely to produce vulnerability and discrepancy within children's self-systems.

Of course, these descriptions are simplified prototypes of parental socialization orientations. For most parents, socialization practices may vary across time, circumstances, and types of behavior enacted by their children. Variability in socialization practices across and within parents is likely to produce significant individual differences in degree and type of self-discrepancy within the self-system.

### PSYCHOTHERAPY AND THE SELF-SYSTEM IN DEPRESSION: GENERAL ISSUES

We have suggested that depression is associated with discrepancy between the actual-self and ideal-self guides. Self-discrepancies develop as a result of parental socialization practices that emphasize the mismatch between parental ideals for a child and the child's self-attributes or behaviors. Once established, actual-ideal discrepancies form a cognitive structure that is automatically activated during self-referent information processing. There is evidence to suggest that when attention is directed toward one element of a discrepant cognitive structure (e.g., an actual-self attribute), the corresponding element of the structure is automatically activated (e.g., an ideal-self attribute). Moreover, preliminary findings suggest that when attention is directed toward one element of a discrepant cognitive structure (e.g., an actual-self attribute), the entire structure of discrepant self-attributes may be automatically activated (e.g., all discrepant actual-self and corresponding ideal-self attributes). The structural interconnectedness between discrepant self-attributes within the self-system may lead to frequent activation of the entire system and chronic accessibility of discrepant-self-constructs during information processing.

Despite the importance of the self-system in the onset and maintenance of depression, the process by which therapeutic interventions alter the self-system and lead to improvement is not well understood. Few studies have evaluated self-system changes as a function of psychotherapy, with the exception of the research of Rogers and his colleagues. According to Rogers (1954), psychotherapy produced a movement toward more realistic and achievable self-ideals, and greater congruence between the actual-self and the ideal-self. He believed that the role of the therapist is to provide the patient with a nonevaluative, accepting, and nondirective reflection of the self—"a genuine alter ego in an operational and technical sense" (p. 40). The reflection of the self by the therapist provided patients with the opportunity to fully understand their own feelings and attitudes, promoting acceptance and reorganization of the self.

Several studies were completed by Rogers and his colleagues to evaluate self-system changes that occurred as a function of psychotherapy. Although many of these studies suffer from methodological and statistical flaws (see Wylie, 1979, for a...
that therapeutic techniques were secondary to therapists adopting the general attitude that an "individual has a sufficient capacity to deal constructively with all those aspects of his life which can potentially come into conscious awareness" (p. 24). Furthermore, Rogers believed that therapists' interventions should be directed toward conveying an understanding of the client's attitudes and feelings rather than achieving direct changes within the self-system. Changes within the self were assumed to occur as a consequence of the patient's increased awareness and understanding of their feelings and attitudes. Thus, although Rogers did emphasize the self in psychopathology and psychotherapy, he neither provided a framework for understanding how specific interventions produce change in the self, nor advocated that the self should be the immediate target of therapeutic intervention.

The understanding and organization of existing therapeutic techniques according to the effects they may have on the self during therapy may be valuable for several reasons. A framework that organizes existing therapeutic techniques according to the effects that they may have on the self is unlikely to suffer from the limitations of any single therapeutic approach (e.g., behavioral, cognitive, interpersonal, and psychodynamic). By identifying the self as the target and integrating these techniques, a framework of self-system therapeutic interventions cuts across the rigid boundaries of major psychotherapeutic models and encourages therapists to determine the course of treatment as a function of the changing needs of patients. It may be that some patients are more likely to benefit from therapeutic techniques designed to alter the actual-self, while others are helped by therapeutic techniques designed to alter the ideal-self. In addition, the types of problems and therapeutic needs presented by a patient may change over the course of therapy: patients may work on changing their actual-self and their ideal-self at different points in therapy. A framework of self-system therapeutic interventions could guide the use of therapeutic techniques that alter specific aspects of vulnerability within the self-system and offer a wide range of treatment options to clinicians and their patients.

In the final section of this chapter we present a framework that organizes existing therapeutic interventions according to the effects that they may have on the self-system. This framework integrates therapeutic techniques from several major psychotherapy models (Beck, Rush, Shaw & Emery, 1979; Lewinsohn, Sullivan & Grosscup, 1982; Rounsaville, Klerman, Weissman & Chevran, 1985; Sacco & Beck, 1985; Strupp, Sandell, Waterhouse et al., 1982; Weiss & Sampson, 1986; Zaiden, 1982) in an attempt to achieve a "pragmatic blending" (Halgin, 1985) of therapeutic techniques with the goal of changing the self-system. In addition, we have included several innovative therapeutic techniques that are suggested from research in the area of social cognition. This review does not provide an exhaustive description of therapeutic techniques that may lead to self-system changes, but rather a selection of examples of therapeutic techniques that may be useful in changing specific self-related problems. It should also be noted that although some therapeutic interventions may be more effective in treating some types of self-related problems, there is probably not a one-to-one correspondence between specific types of therapeutic interventions and specific types of self-system problems: similar techniques may be used to alter a variety of self-system problems.
Before discussing specific self-system interventions, it is important to consider general therapeutic issues that may arise during the treatment of depression. Persistent negative thoughts about the self and intense feelings of sadness, despair, and hopelessness are common complaints of individuals who are depressed. Patients often feel immobilized by intrusive and uncontrollable thoughts of personal inadequacy, worthlessness, and self-reproach. Psychotherapists may adopt a variety of approaches in treating these symptoms. Regardless of the specific approach or technique adopted by clinicians, however, the effectiveness of many therapeutic interventions for depression may rest on the patient's awareness of dysfunctional processes, and on their capacity to temporarily inhibit these automatic processes in order to utilize the therapeutic process. Many depressed persons have difficulty developing an awareness of dysfunctional processes and inhibiting automatic processes because of their intense emotional distress. As we have noted, intense emotional arousal may limit attentional resources that are available for monitoring and inhibiting automatic processes. This may be most problematic during the early phases of psychotherapy when psychological distress is intense, and during periods in which patients are dealing with highly emotional issues. At these times, clinicians need to be sensitive to patients' difficulties in identifying and inhibiting dysfunctional automatic processes and to their reduced capacity to immediately benefit from therapeutic interventions. Even if patients are unable to identify and interrupt dysfunctional processes "on-line," they can often review their thoughts, feelings, and behaviors shortly thereafter. This often brings relief from negative feelings and thoughts, and provides patients with an opportunity to consider alternative perspectives on the self.

SELF-SYSTEM THERAPEUTIC INTERVENTIONS

Our model of the self-system in depression suggests that therapeutic interventions may be aimed at several targets within the self-system: the actual-self, the ideal-self, and the structural relations between the actual-self and ideal-self. For each target, interventions may produce changes by altering patterns of self-knowledge activation. Changes in patterns of self-knowledge activation include changing the availability of self-related constructs (i.e., creating new self-related constructs in memory) or the accessibility of self-related constructs (i.e., increasing or decreasing the readiness with which existing self-related constructs are activated). In the following sections we summarize the types of interventions that may be helpful in altering different targets within the self-system by changing patterns of self-knowledge activation.

Changing the Actual-Self

Several existing psychotherapeutic techniques are likely to alter the actual-self in depression. The techniques discussed below share the common goal of either increasing congruency (i.e., match) or decreasing discrepancy (i.e., mismatch) between the actual-self and the ideal-self.

Making New Information Available Within the Actual-Self Representation.

Considerable research suggests that positive attributes are less frequently represented in the actual-self representations of depressed than nondepressed individuals (see Moretti & Shaw, 1989). Rogers (1954) suggested that the structure of the self often precludes the intrusion of inconsistent information. This may occur because of conscious denial of feedback that is inconsistent with the actual-self, or because of the failure to symbolize and internalize experiences that are incongruent with beliefs about the self. For example, depressed patients may deny or fail to accept positive feedback from others, or they may fail to acknowledge and fully experience their successes. This observation is consistent with research indicating that individuals fail to attend to and encode information that is inconsistent with their structure of self-knowledge (Bargh, 1989; Fiske & Taylor, 1984; Higgins & Bargh, 1987).

Several therapeutic techniques may effectively introduce new information into the actual-self representation of depressed patients. These include behavioral techniques or group therapy processes that provide patients with new experiences. Patients may come to believe that they are assertive, friendly, or capable of tackling new challenges once they have engaged in behaviors that were previously avoided or were not experienced because of lack of opportunity. The therapists' knowledge of patients' ideal guides may be helpful in determining what types of behavioral experiences are most important to patients and most likely to lead to the creation of actual-self/ideal-self matches.

Cognitive techniques that actively encourage patients to attend to particular types of experiences may also successfully introduce new information into the actual-self. For example, therapists may encourage patients to identify and attend to experiences of mastery and pleasure to promote the development of a balanced rather than negative view of the self (Beck et al., 1979). Again, knowledge of patients' ideal-self guides may be helpful to therapists in determining which attributes and experiences patients should pay attention to, thus maximizing the likelihood of creating increased congruence between the actual-self and ideal-self.

Finally, patients may hold beliefs about the type of individual they actually are, or can be, based on their early experiences with significant others. Exploration of these beliefs and how they might lead to constriction of individuals' current views of the self may be beneficial in removing unconscious constraints on self-definition. As a consequence of this process, patients may begin to consider new definitions of their actual-self and try out behaviors that were previously viewed as inconsistent with the self.

Increasing or Decreasing the Accessibility of Specific Types of Information Within the Actual-Self Representation

Depression has also been associated with the heightened accessibility of negative information and the attenuated accessibility of positive information that is represented in the self-system (Gotlib & Cane, 1987; Gotlib & McCann, 1984; Higgins & King, 1981). Particular contexts may temporarily prime the accessibility of actual-self attributes that either match or are discrepant from the ideal-self. Indeed,
therapy in itself can act as a context that primes different types of actual-self information.

Several behavioral, cognitive, and psychodynamic techniques may alter patterns of self-knowledge accessibility. Therapists may encourage patients to make particular behavioral changes in their lives to increase the accessibility of actual-self attributes that match an ideal-self guide (e.g., changing jobs or pursuing long term goals they have put on hold). Other techniques, such as helping patients leave destructive relationships or living conditions by offering alternative living arrangements (e.g., homes for battered women) may also temporarily reduce the accessibility of actual-self attributes that do not match ideal-self standards (e.g., the perception of oneself as unloved and worthless). Similarly, helping patients to inhibit problematic behavioral patterns may temporarily reduce the accessibility of actual-self attributes that do not match ideal-self standards because of the consequent lack of contextual cues. From a cognitive perspective, identifying and drawing attention to patients' attributes that match ideal-self standards can temporarily increase the accessibility of those particular traits.

Therapeutic techniques that temporarily alter the accessibility of actual-self information may have limited effectiveness, because, outside therapy, patients can encounter cues that prime the accessibility of actual-self/ideal-self mismatches, and/or not encounter cues that prime the accessibility actual-self/ideal-self matches. The long-term effectiveness of interventions designed to alter the temporary accessibility of actual-self information may depend on the patients' ability to adopt self-regulatory strategies to help themselves provide their own source of contextual priming of actual-self attributes (e.g., keeping a diary of experiences associated with actual-self attributes that match ideal-self guides, making sure that they control their environment and avoid situations that are associated with actual-self attributes that mismatch ideal-self guides).

Interventions that alter the temporary accessibility of actual-self information may also be effective if they occur frequently over a long period of time and result in fundamental changes in chronic patterns of accessibility. As previously noted, chronic accessibility of actual-self knowledge develops when experiences frequently prime certain types of self-knowledge over an extended period of time. Depressed patients often report chronic negative self-perceptions that are resistant to change. Techniques that can be utilized to temporarily alter patterns of self-knowledge accessibility may also be used to change patterns of chronic accessibility of actual-self information if they are used repeatedly and over an extended period of time. Some therapeutic interventions, however, may be more effective than others in altering patterns of chronic self-knowledge accessibility. For example, if patients' memories of significant events in their lives act as chronic sources of self-knowledge activation, then psychodynamic interpretations may be used to alter patterns of self-knowledge accessibility by changing patients' understanding of early experiences and the meanings that they have attached to these experiences. By changing the meanings that are attached to significant memories, therapists can alter the types of self-knowledge that are primed by these memories.

Changing the Extent to which Actual-Self Attributes are Believed to Exist

Depressed individuals may believe that they do possess actual-self attributes that they value (i.e., attributes that are represented in their ideal-self guide), but they may also believe that the extent to which they possess such attributes falls short of their hopes and wishes (i.e., fails to meet their ideal-self guide). For example, depressed individuals may complain of not being well-liked by others despite the fact that they report having many close friends. When questioned further, they may claim to be "tolerated" and perhaps even "liked a little," but still maintain that they are not really well-liked. It may become clear that their standard for being well-liked entails being well-liked by everyone.

Therapists may adopt one of two strategies in dealing with patients' perceptions that they do not possess actual-self attributes to the extent that they desire. One strategy is to target the patients' ideal-self standards. We will explore this option when we discuss therapeutic interventions that may change the ideal-self. An alternative strategy is to target the actual-self and to work with patients to change the extent to which they believe that they actually do possess actual-self attributes.

Behavioral techniques designed to increase patients' desired behavior (e.g., assertiveness training, social skills training) may lead to changes in patients' actual-self perceptions. Cognitive therapy techniques such as encouraging patients to attend to the friendly behaviors of others toward them, and to reevaluate their negative interpretations of interpersonal events, may also lead to changes in patients' beliefs about the extent to which they possess desired actual-self attributes. Similarly, reviewing memories of significant events that have had a profound effect on their self-definitional may lead patients to reinterpret these events in such a way that the memories no longer suggest that they fail to possess adequate levels of desired actual-self attributes.

Altering the extent to which individuals believe that they possess actual-self attributes can lead to a more positive self-view. These interventions can be useful in cases of depression where patients underestimate their abilities and the attractiveness of their personality characteristics. However, therapists should carefully consider whether the goals that depressed patients' set for themselves (i.e., ideal-self guides) are realistic and attainable. Research suggests that depressed patients may evaluate their performance more negatively than is appropriate given the feedback that they receive (DeMonbreun & Craighead, 1977; Dobson & Shaw, 1981; Golin & Terrell, 1977; Hammen & Krantz, 1976). Negative self-evaluation may result when depressed patients compare their performance to extremely high ideal standards. If this is the case, attempting to reduce actual-ideal discrepancies by increasing the extent to which individuals believe they possess actual-self attributes may be impossible, and it may support patients' use of unrealistic ideal standards.

Changing the Certainty of Beliefs Regarding the Existence of Actual-Self Attributes

Depressed patients often believe that they possess unacceptable actual-self attributes. As Beck (1967, 1976) has pointed out, negative beliefs about the self can exist despite the lack of confirming evidence, and even in the presence of discon-
firming evidence. For example, depressed individuals may claim with absolute certainty that they are selfish despite their desire to be unselfish. They may support their beliefs with one or two ambiguous examples and discount counterevidence presented by therapists or other individuals.

Several therapeutic techniques may be helpful in altering the certainty with which patients' believe that they possess actual-self attributes. From a cognitive perspective, therapists can help patients to assess the validity of their beliefs in light of contradictory evidence. Tendencies toward 'black and white' thinking and selective attention to current or past experiences may also be pointed out to the patient. Psychodynamic interpretations may alter the meaning of previous experiences so that they no longer serve as evidence of undesirable actual-self attributes. Such interventions could be directed both to decreasing the certainty of patients' beliefs about actual-self attributes that are discrepant from the ideal-self, and increasing the certainty of their beliefs about actual-self attributes that are congruent with the ideal-self.

Changing the Perceived Importance and Consequences of Possessing Actual-Self Attributes

Individuals do not suffer from psychological distress simply because they possess actual-self attributes that are discrepant from their ideal-self; they suffer because they believe that the consequences of possessing such attributes are extremely negative (see Higgins, 1987). As previously noted, children learn that their parents respond differentially to their various behaviors and traits. Some of their behaviors and traits are responded to with praise and reward, while others elicit disappointment or punishment. The beliefs that individuals adopt regarding the probable consequences associated with possessing actual-self attributes that are discrepant from ideal-self guides (i.e., self-other or interpersonal contingency beliefs) exert a tremendous influence over their emotional well-being.

Depressed individuals often anticipate that extremely negative events will occur as a consequence of their possessing particular actual-self attributes. For example, they may be concerned that others will discover that they are sometimes envious, unfriendly, or irritable. They believe that they will be abandoned when these 'flaws' are discovered. When asked how they know this to be the case, it is often clear that they have worked diligently to avoid the possibility of others discovering their perceived flaws. Consequently, they have provided themselves with few opportunities to 'check out' their interpersonal contingency beliefs (see Beck, 1976; Beck et al., 1979).

Psychotherapists may utilize a variety of techniques, alone or in combination, to address this problem. Behavior therapists might encourage patients to engage in rather than avoid interpersonal interactions. These experiences may lead to changes in patients' beliefs about the self and the interpersonal consequences of their actual-self attributes. Cognitive interventions can also help patients identify the existence of catastrophic beliefs and understand the impact of beliefs on current interpersonal functioning. Patients are encouraged to evaluate the validity of their beliefs in light of available evidence and to check out their beliefs by experimenting with new interpersonal behaviors. Psychodynamic techniques that explore the early experiences that led to the development of dysfunctional interpersonal contingency beliefs can also be helpful in promoting patients' awareness of the unconscious beliefs that continue to influence interpersonal relationships. In both psychodynamic and interpersonal therapies, the therapeutic relationship becomes an important arena where patients play out their interpersonal beliefs. Interpretation and analysis of the therapeutic relationship can increase patients' awareness and understanding of their interpersonal beliefs and self-related attitudes. The therapeutic relationship may also provide a context for the patient to experience a "corrective interpersonal experience" that produces change in beliefs about the self in relation to others.

Changing the Ideal-Self

The actual-self is only one component of the self-system that may require therapeutic attention. As previously noted, depressed patients may hold unrealistic ideal-self standards that lead to negative self-perceptions. Several existing therapeutic techniques may be effective in changing the ideal-self standards of depressed patients. These interventions are similar to those utilized for altering the actual-self, but attempt to alter the ideal-self rather than the actual-self in order to achieve congruence between the actual-self and the ideal-self.

Making New Information Available Within the Ideal-Self Representation

Few therapeutic techniques have been developed to introduce new information into the ideal-self representation. If the ideal-self does not contain information about attributes that match the actual-self, depressed patients may fail to value their experiences and achievements. Encouraging patients to value their experiences and achievements (i.e., identifying these experiences and achievements as highly desirable and ideally wished for) may create new ideal-self attributes. Knowledge of patients' actual-self representations may be helpful to therapists in determining which attributes and experiences patients fail to value, and may maximize the likelihood of creating actual-self/ideal-self matches.

Behavioral techniques, such as encouraging individuals to participate in activities in which their undervalued actual-self attributes will be recognized and praised, may be effective in introducing new information into the ideal-self representation. For example, a patient who is artistically talented may not value his abilities because his ideal-self does not contain attributes related to these abilities. This patient could be encouraged to join an art class in which he may have the opportunity to receive praise and recognition for his undervalued artistic abilities. If artistic abilities come to be valued and represented in his ideal-self, the congruence between his actual-self and ideal-self would be increased as a function of the increased number of matches between the two self-state representations.

Cognitive techniques that actively encourage patients to attend to undervalued actual-self attributes may also be effective in altering ideal-self guides. Depressed patients often dwell on the standards that they have failed to achieve rather than the
goals they have attained. Cognitive therapy techniques such as recording experiences of mastery and pleasure may help patients become aware of their successes and encourage them to value these experiences. As a consequence, these interventions may introduce new information into the ideal-self representation. Finally, depressed patients may hold beliefs about the types of attributes that are valuable or worthless based on their early experiences with significant others. These experiences may lead to constriction of the ideal-self and to the reduced capacity of patients to derive enjoyment from their attributes or abilities. Psychodynamic exploration of the meanings that patients have attached to early experiences and the effects of these experiences on their current capacity to value themselves may help to remove unconscious constriction of the ideal-self.

Increasing or Decreasing the Accessibility of Particular Types of Information Within the Ideal-Self Representation

Particular contexts may prime the accessibility of ideal-self attributes that are either congruent with or discrepant from the actual-self. Therapy may act as a context that primes specific types of ideal-self knowledge in the same way that it may prime specific types of actual-self information. If therapy increases the accessibility of patients' ideal-self standards that match actual-self attributes it can temporarily increase actual-self/ideal-self congruency.

Behavioral techniques such as encouraging patients to include activities in their lives that are highly valued or pleasurable may increase the accessibility of ideal-self standards that are congruent with actual-self attributes. For example, a patient for whom creativity is both an actual-self attribute and an ideal-self standard might be encouraged to engage in activities where creativity is an important component.

As previously noted, therapeutic techniques that alter the temporary accessibility of self-related information may not produce enduring changes. The long-term effectiveness of these interventions depends on patients' abilities to adopt self-regulatory strategies to help themselves provide their own contextual priming of ideal-self attributes (e.g., making sure they are engaged in activities that are highly valued and consistent with actual-self attributes). Interventions that temporarily alter patterns of construct accessibility may also produce long-lasting effects if they are repeatedly introduced over an extended period of time and result in fundamental changes in the chronic accessibility of ideal-self standards.

Interventions may also focus on reducing the chronic accessibility of ideal-self standards that are discrepant from actual-self attributes. This may be difficult to achieve because the activation of chronically accessible ideal-self standards may automatically inhibit the activation of other less accessible ideal-self standards. Cognitive therapy techniques, such as encouraging patients to identify when ideal-self standards have been automatically activated (e.g., using negative feelings as a "cue" to examine whether or not they are evaluating themselves in relation to a chronically accessible ideal-self standard) and whether the application of ideal-self standards is reasonable, may help patients reduce the chronic accessibility of ideal-self standards (see Moretti, Feldman & Shaw, in press; Moretti & Shaw, 1989).

Memories of significant events may serve as a chronic source of activation for discrepant ideal-self standards in the same way that they serve as a chronic source of activation for discrepant actual-self attributes. Psychodynamic interpretations of significant experiences may be effective in altering the meanings that patients have attached to these experiences and reducing or eliminating the extent to which memories prime discrepant ideal-self standards.

Changing the Extent to which Ideal-Self Attributes are Desired

It is not uncommon to find that depressed individuals hold extremely high standards for themselves. Performance that falls anything short of these standards is seen as evidence of personal inadequacy and failure. As previously noted, therapists may attempt either to increase the degree to which patients actually possess significant attributes, or to modify patients' ideal-self standards. Attempts to modify actual-self attributes so that they are not discrepant from the extremely high ideal-self standards that some depressed individuals hold for themselves may be impossible and destructive. Identifying and altering unreasonable ideal-self standards is often more productive.

Unreasonably high ideal-self standards may be identified and altered by encouraging depressed patients to consider whether they would negatively evaluate a peer using the same standards that they apply to themselves. This intervention is suggested from research on self and other perception (e.g., Bargh & Tota, 1988; Kuiper & MacDonald, 1982; Moretti & Shaw, 1989; Tabachnik, Crocker & Alley, 1983) indicating that negative evaluations are restricted to the self in depression. Often patients realize that their ideal-self standards are quite unreasonable when they are asked to apply them to others. Patients may be encouraged to consider the types of standards that are reasonable to apply to others to generate alternative standards for the self.

The desire to achieve very high ideal-self standards is often based on beliefs about negative consequences that may occur if one fails to live up to these standards. Therefore, reducing ideal-self standards may involve altering the beliefs that individuals have associated with achieving or failing to achieve ideal-self standards. Therapeutic techniques that alter the perceived importance and consequences of achieving ideal-standards are considered in a section to follow.

Changing the Certainty with which Ideal-Self Attributes are Desired

Depressed patients may wish to possess a number of ideal-self attributes that they perceive as positive and socially desirable. This may arise from the tendency of depressed individuals to unfavorably compare themselves to others and to believe that others possess positive attributes that they themselves lack (Tabachnik, Crocker & Alley, 1983). It may be helpful for therapists to encourage depressed patients to evaluate the assumptions that underlie their beliefs that they need to achieve particular ideal-self standards. Cognitive therapy techniques may help patients to evaluate the validity of their beliefs that others possess many positive qualities that they themselves lack, and that others do not suffer from stress or concerns about self-worth. Patients might also be encouraged to explore the costs and benefits of striving to achieve extremely high standards. As they review the costs and benefits associated with achieving these standards they may become less certain that they desire to do so.
Changing the Perceived Importance and Consequences of Possessing Ideal-Self Attributes

Individuals do not suffer from psychological distress simply because they wish to achieve an ideal-self standard, but because of the negative consequences that they believe will occur if they fail to live up to these standards. We have suggested that some children learn that their failure to live up to parental standards leads to parental disappointment or disapproval. Once established, beliefs about the consequences of failing to live up to standards can strongly influence the motivation to reach self-evaluative standards and the emotional consequences of believing that one has failed to do so.

It is important for therapists to determine depressed patients' beliefs about the consequences of failing to live up to high ideal-self standards. Patients may report that they believe their failure to live up to these standards will result in catastrophic events (e.g., "everyone will reject me," "they will see that I'm no good"), yet they do not know that this actually is the case because they have worked hard to prevent such an event from occurring. Behavioral techniques that encourage patients to "try out" moderate levels of performance that fall short of their ideal-self standards may provide patients with the opportunity to learn that the catastrophic outcomes they have imagined do not actually occur. Psychodynamic techniques may also help patients to alter unrealistic ideal-self standards by exploring the meaning they have attached to past experiences that are associated with beliefs about the consequences of failing to meet ideal-self standards. Patients may come to realize that the standards that they hold for themselves are not their own standards, but the standards that they believe that their parents or significant others hold for them. The consequences that they believe will occur if they fail to meet these standards may be based on their childhood interpretations of early experiences. Working through these beliefs from an adult perspective may result in patients changing the nature and extent of their ideal-self standards.

Changing Actual-Self/Ideal-Self Relations

The most straightforward approach to intervening in the self-system in order to increase actual/ideal congruency or decrease actual/ideal discrepancy is to work directly on either the actual-self or the ideal-self as specific targets of intervention. This is the approach that we have discussed thus far. It should be noted that because actual/ideal congruency and discrepancy concern relations between the actual-self and the ideal-self, interventions that alter the availability and accessibility of actual-self attributes or of ideal-self guides also alter the availability and accessibility of actual-self/ideal-self relations. In this approach, however, the targets of intervention are the actual-self or ideal-self attributes per se. It is worth considering, if only briefly, how therapists might directly alter actual-self/ideal-self relations. For the purposes of illustration, consider the following two possibilities:

Changing the Relative Accessibility of Actual-Self/Ideal-Self Discrepancies

Consider the following case. A female patient is suffering from depression and is found to possess a highly discrepant relation between her actual-self and the ideals that she believes her parents hold for her. The therapist observes that the patient becomes especially distressed when she discusses the views she believes her parents have of her. On the other hand, when the patient discusses alternative viewpoints on herself (e.g., her spouse's, her children's, her best friends', her own) she does not become distressed, and, indeed, the relations between the patient's actual-self and ideal-self associated with these other viewpoints are found to be congruent.

When the patient evaluates herself, she can do so from any of these alternative self-guide viewpoints (see Higgins, Strauman & Klein, 1986). At the beginning of therapy, it is likely that the self-guide standpoint of the patient's parents predominates and thus determines her self-evaluative processes. Her preoccupation with ideals she believes her parents hold for her may have led the attributes represented in the patient's actual-self to become strongly interconnected with the attributes represented in the parents' ideal-self for her. Thus, the "actual-self/ideal-parents" structure is likely to predominate and determine how the patient feels about herself.

When an actual-self attribute is activated, it is this structure that is most likely to be activated. Given that this structure reflects an actual/ideal discrepancy, the patient is vulnerable to depression. How might one alter the likelihood that this structure will be activated?

The likelihood that any knowledge structure will be activated and used to process input decreases when the accessibility of an alternative structure that is equally applicable to input is increased. If the excitation level of the alternative structure is increased beyond the level of the discrepant structure, the alternative structure should begin to predominate and perhaps even inhibit activation of the discrepant structure (see Higgins, 1989b). Actual/ideal structures involving any self-guide standpoint are equally applicable for self-evaluation. Therefore, increasing the accessibility of an actual/ideal structure involving a self-guide standpoint that is an alternative to the standpoint of the patient's parents should decrease the likelihood that the "actual-self/ideal-parents" structure will be activated. This could be accomplished by having the patient frequently discuss and think about the viewpoint of some alternative person, such as the patient's own view of herself or the viewpoint of the patient's spouse. As a consequence of such frequent priming, the alternative actual/ideal structure might eventually predominate and even inhibit activation of the "actual-self/ideal-parent" structure. Given that the alternative structure reflects an actual/ideal congruency, the patient should then experience less psychological distress and greater self-satisfaction.

The critical feature of this intervention is to increase the accessibility of an alternative, competing self-guide standpoint that is known to involve an actual/ideal congruency (or, at least, a substantially smaller actual/ideal discrepancy). In this example, increased accessibility of the alternative self-guide standpoint was accomplished by frequent priming. But there are many sources of accessibility and activation other than frequent priming (see Higgins, 1989b; Higgins & King, 1981). For
example, a patient's living conditions or lifestyle might be altered so that the likelihood of contextual activation (i.e., recent priming) of an alternative self-guide standpoint is increased. Increasing the actual or perceived importance or applicability of an alternative self-guide standpoint might also increase its accessibility and the likelihood that it will be used. Thus, there are many specific techniques by which this type of intervention could be accomplished.

**Changing the Automatic Activation of Actual-Self/Ideal-Self Discrepancies**

A major characteristic of actual-self/ideal-self discrepancies as a vulnerability factor is the fact that they can be automatically activated outside of awareness and cause emotional suffering (see Higgins, 1989b). Indeed, as discussed earlier, when people possess an actual-self/ideal-self discrepancy, mere exposure to a positive attribute (even an attribute characterizing other people) that is contained in their ideal-self can be sufficient to produce depressive symptoms if there is a mismatch between the actual-self attribute and that ideal-self attribute (see Strauman & Higgins, 1987).

The likelihood that an accessible knowledge structure will automatically influence responses decreases when people are actively oriented or consciously directed toward an alternative structure (see Neely, 1977; Posner, 1978). According to Posner (1978), when conscious attention is directed toward one kind of knowledge, processing input related to that knowledge is facilitated, but processing input unrelated to that knowledge is inhibited. Higgins et al. (1982) found evidence suggesting that such inhibition can also occur in relation to chronically accessible constructs, such that an active orientation to evaluate a target person in a particular way can inhibit automatic effects of chronically accessible constructs on judgment.

Actual-self/ideal-self discrepancies are chronically accessible knowledge structures. Therefore, if patients actively orient themselves to self-evaluative processes that are incompatible with these knowledge structures, then the automatic effects of such structures should be inhibited, thereby reducing suffering. This could be accomplished by training the patient to focus on their strengths and pay attention to their successes. Indeed, it is possible that one source of the “power of positive thinking” is the inhibition of the depressing effects of chronically accessible actual-self/ideal-self discrepancies. An active orientation to positive self-evaluations may have two beneficial effects. First, it would momentarily inhibit the negative consequences of automatic activation of actual-self/ideal-self discrepancies. Second, if such momentary inhibition occurs repeatedly, the excitation level of the discrepant structure would be given a chance to decay. By thus decreasing the chronic accessibility of the actual-self/ideal-self discrepancy structure, this structure might lose its predominance in the self-evaluative process. This technique, then, could be combined with the previously described techniques to make alternative, actual-self/ideal-self congruency structures predominate as the automatic source of self-evaluation.

**The Need for a Holistic Approach to Self-System Intervention**

This section has described self-system interventions aimed at multiple targets within the self-system: the actual-self, the ideal-self, and actual-self/ideal-self relations. Although two of these targets—the actual-self and the ideal-self—are elements of actual-self/ideal-self discrepancies, it is important to recognize that self-system interventions are not conceptualized as altering one aspect of the self (e.g., actual-self) independently of other aspects of the self (e.g., ideal-self). In addition, these interventions are exclusively focused on attributes that are currently involved in actual-self/ideal-self discrepancies (i.e., mismatches), or attributes that are currently or potentially involved in actual-self/ideal-self congruencies (i.e., matches). Moreover, self-system interventions may not alter actual-self or ideal-self attributes in an absolute way, but rather increase the representation of actual-self/ideal-self matches and minimize the representation of actual-self/ideal-self mismatches within the self-system. That is, all interventions that have been discussed, regardless of the target of intervention, have actual-self/ideal-self relations in mind. Thus, they reflect a holistic rather than elementistic approach to treatment.

At this point, the reader might well ask why not treat targets within the self-system in an elementistic fashion? Is it just a matter of theoretical preference not to do so or are there disadvantages to taking an elementistic approach? Cognitive-behavioral approaches to therapeutic intervention have tended to emphasize the importance of changing people's negative or irrational beliefs, cognitions, and attitudes (Beck et al., 1979). Such beliefs, cognitions, and attitudes are typically treated, both conceptually and therapeutically, as independent units. This elementistic approach is certainly effective, but it may have its drawbacks.

First, focusing on the negativity of independent self-beliefs rather than on negative relations between self-beliefs may be insufficient. For example, not all negative actual-self attributes are psychologically significant. Moretti and Higgins (in press) found, for instance, that individuals' negative actual-self attributes predicted low self-esteem only when these attributes were also discrepant from the individuals' ideal-self. Thus, interventions may be more effective if they focus on self-beliefs involved in actual-self/ideal-self discrepancies rather than simply on negative self-beliefs. In addition, it would be reasonable to concentrate on self-beliefs involved in actual-self/ideal-self discrepancies when patients suffer primarily from depression-depression syndromes, and to concentrate on self-beliefs involved in actual-self/ought-self discrepancies when patients suffer primarily from agitation syndromes. By distinguishing between these and other specific types of self-belief relations (e.g., actual-self/ideal-own discrepancies versus actual-self/ideal-other discrepancies), interventions may be utilized with even greater precision and efficiency.

Second, identifying functional and dysfunctional self-beliefs is in terms of their positivity and negativity as independent elements could even lead to errors in intervention. Imagine, for example, a male patient who is depressed about his past accomplishments but has not yet lost confidence in his capabilities and potential. From a strict cognitive-behavioral perspective, this patient's positive view of his capabilities might be seen as a positive indicator that could be strengthened and
used to improve his condition. For example, the patient might be reminded of his own positive view of his high potential in order to provide evidence against his current claim that he is totally worthless and will never accomplish anything.

Such an approach would be reasonable when considering each of the patient's self-beliefs independently. But when the relations among his self-beliefs are considered, the pattern that emerges might suggest a very different therapeutic strategy should be implemented. It may be, for example, that this patient's beliefs about his capabilities or potential—his Can self—is part of a pattern in which his actual-self is discrepant from both his ideal-self and his can-self, but his can-self matches his ideal-self. He believes he can live up to the ideals he holds for himself, but he is actually failing to do so. Higgins, Tkocinsky, and Vookles (in press) have found that when the actual-self is discrepant from the ideal-self and the can-self, but the can-self matches the ideal-self, individuals are likely to report depressive symptoms. Moreover, they found that this self-belief pattern involving a belief in one's positive potential (i.e., the can-self is congruent with the ideal-self) was more predictive of later depressive symptoms than a self-belief pattern involving the belief that one's potential is limited (i.e., the can-self is discrepant from the ideal-self), even though both patterns involve an actual-self/ideal-self discrepancy.

The results of the Higgins et al. (in press) studies suggest that a self-belief pattern reflecting "chronic failure to meet one's positive potential" is more problematic than a self-belief pattern reflecting "fulfillment of limited potential." Thus, a patient's belief in his or her potential is not necessarily a positive sign. In the case of our male patient, it may be advantageous to focus interventions on how he might ensure that he actually carries through and fulfills the potential that he possesses (e.g., behavioral strategies), or on understanding the underlying reasons that may have impeded his fulfillment of his potential.

By considering how a particular self-belief is related to other self-beliefs, it is possible to determine its true psychological significance for a patient. The key question for intervention is whether the self-belief is an element in a pattern that as a whole has negative psychological significance, rather than whether the self-belief by itself is negative. Indeed, without considering the role of a particular self-belief within a patient's self-system as a whole, there is the risk of strengthening a positive self-belief element only to produce a more negative self-belief pattern that increases the patient's suffering. And given that patients can have multiple and conflicting self-guides (see Van Hoek & Higgins, 1988), one might intervene to change a patient's actual-self in order to reduce an actual-self/ideal-self discrepancy only to increase some other actual-self/ideal-self discrepancy. Thus, self-system interventions need to adopt a holistic rather than elementtistic approach precisely because the self is a system.

SUMMARY AND CONCLUDING REMARKS

If changes in the self-system are central to therapeutic improvement, as many psychotherapists believe, then the first step toward producing such changes is to understand the nature of the self-system. Surprisingly, more attention has been paid to developing therapeutic methods than to understanding the nature of the target of these interventions. The self has received more conceptual attention recently in social, personality, and developmental psychology. Even here, however, the attention has been mostly restricted to the self-concept. Before dramatic progress can be made in developing therapeutic methods, there is a need to understand more fully not just the self-concept, but the self-system as a whole.

There are, of course, many possible perspectives on the self-system that can contribute to this fuller understanding. The present chapter began by reviewing one such recent perspective—self-discrepancy theory. According to self-discrepancy theory (see Higgins, 1987; 1989a), the key element in the self-system is the self-guide rather than the self-concept. Self-guides are valued end-states, self-directive standards. Both self-regulation and self-evaluation occur in relation to self-guides. And self-regulation and self-evaluation, in turn, are a major determinant of the self-concept.

In the first section of this chapter, the relation between the self-system and vulnerability to depression was discussed in detail. According to self-discrepancy theory, the people who are especially likely to suffer from depression are those who self-regulate and self-evaluate in relation to the ideal-self, and who believe that their actual-self (i.e., their self-concept) is discrepant from the hopes, wishes, and aspirations that they or others hold for them. Research evidence was described that supports the theory's proposal that symptoms of depression increase as the magnitude of actual-self/ideal-self discrepancies increase and as the accessibility of discrepancies increase.

The second section discussed the development of the self-system in general and of self-guides in particular. According to self-discrepancy theory, the critical precurser of self-guides is children's representations of the relations between their attributes and significant others' responses to them. Two major factors that influence children's acquisition of such self-other contingency knowledge are developmental changes in children's representational capacity, and different modes of caretaker-child interaction. This section also discussed how children's acquisition of self-other contingency knowledge and self-guides could increase some children's vulnerability to depression.

The model of the self-system provided by self-discrepancy theory presents a framework for utilizing therapeutic interventions with the common goal of altering the self-system. The logic of the model suggests three basic self-system targets—the actual-self, the ideal-self, and actual-self/ideal-self structural relations. The logic of the model also suggests that the major goal of intervention for each target is to reduce the magnitude and accessibility of actual-self/ideal-self discrepancies. To illustrate the application of this logic, possible therapeutic interventions for each target were discussed.

The purpose of this chapter was to examine the relation between the self-system and depression, and, by examining this relation, to identify therapeutic techniques that may be effective in treating depression. Self-discrepancy theory was used to fulfill this purpose. But self-discrepancy theory is not restricted to providing a model of the relation between the self-system and depression. The theory has also proposed relations between the self-system and both agitation-related symptoms (e.g., social anxiety) and confusion-related symptoms, and these proposed relations
have received empirical support (see Higgins, 1987). Indeed, one of the distinct advantages of applying self-discrepancy theory to the treatment of depression is its ability to differentiate self-system vulnerability to depression from self-system vulnerability to other types of emotional/motivational problems, and its ability to suggest interventions that may be particularly effective for the treatment of depression.

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References


Experiential Processes in the Psychotherapeutic Treatment of Depression

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There are several existing theories of depression, each particularly concerned with specific types of depressogenic processes—biological, psychodynamic, cognitive, interpersonal, and behavioral. Despite their different emphases, these theories have in common that they give little consideration to the adaptive role of affect (Greenberg & Safran, 1987) in therapeutic change or to the organismic tendency toward survival and growth (Rogers, 1959; Perls, Hefferline & Goodman, 1951). The omission of these processes in theorizing about depression is not far from the truth of how we, the human being, function and what we experience. Experiential therapies therefore should have something important to contribute in discussing this disorder.

Drawing on observations of the psychotherapeutic treatment of depression, we identify certain recurrent features of depressive information processing and discuss these as patterns of self-organization which leave people vulnerable to depression. Based on these observations we suggest that knowledge, in addition to dealing with negative cognition (Beck, Rush, Shaw & Emery, 1979), requires accessing biologically adaptive primary emotional responses and associated self-organizations in order to reorganize the growth tendency and increase the person's ability to attend to and process new information (Greenberg & Safran, 1987, 1989).

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Organism is used here to represent the whole functioning person combining physiological and psychological functioning into an integrated view of the human system.