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The Glass is Always Half Empty: An Analysis of the Negative Worldviews for Those with Anxiety and Depression

by Bradley Marcy—Augsburg College

ABSTRACT: Since it was first proposed by Leon Festinger in the 1950s, cognitive dissonance theory has been the subject of many research papers. Explorations have expanded the theory to provide further insight into the conditions required for this phenomenon to occur, how it can be observed, and how it affects judgment. Cognitive dissonance has also proved useful in creating new ways to treat various mood disorders, such as depression and anxiety. The success of this type of therapy implies that there may be a stronger connection between these two topics that are often discussed apart from each other. This paper will outline the development of cognitive dissonance theory, its current applications in terms of psychotherapy, and the potential future studies that could further examine how cognitive dissonance relates to depression and anxiety.
Introduction

Instinctively, humans seek to create a consistent worldview, and to act in a way that properly demonstrates their beliefs. There is comfort involved in having one's image of the world line up with reality, as well as having beliefs line up with actions. When there is a disruption, such as a countering belief being raised or acting in a way that does not reflect their beliefs, people experience a sense of unease. This is not a pleasant experience, and there is a desire, a motivation, for a quick alleviation of this discomfort.

This feeling was described and referred to as cognitive dissonance by Leon Festinger. Festinger developed a theory that people seek to alleviate this discomfort in one of three ways: minimize the importance of one of the conflicting factors, ignore one of them completely, or introduce a third variable that will reconcile the two. In all cases, the objective is to reduce cognitive dissonance and restore the consistent worldview that was previously held.

Usually, this is done so that one can maintain a positive worldview or self-image, but for people with depression and social anxiety, research demonstrates that there may instead be a desire to perpetuate a negative perception. This paper will attempt to demonstrate that cognitive dissonance, and the alleviation of it, is really at the heart of depression and social anxiety, whose sufferers seek to instead maintain a negative image, and experience cognitive dissonance when their skewed worldview is disrupted. This desire to reduce cognitive dissonance in unhealthy ways maintains these biased interpretations and makes it much more difficult for individuals to reduce these cognitive disorders.

Development of the Theory of Cognitive Dissonance

Festinger first proposed the theory of cognitive dissonance in the 1950's. He conducted an experiment where students took a survey that was not very interesting. Then, the students were randomly assigned into two groups. The first group was requested to tell the incoming student that the survey was interesting, with a financial reward of one dollar if they did. The instructions were the same for the second group; yet their reward was twenty dollars. Despite knowing that the survey was boring, the students lied in order to receive financial gain.

Festinger then followed up with these students to analyze any residual effects of falsifying information. When asked questions about the survey a week later, many students reported that it was actually very interesting. Festinger theorized that there was an “uncomfortable feeling” attached with believing one thing and saying another, or having two conflicting beliefs, and the subjects reinterpreted the survey as more interesting to alleviate this discomfort. He argued that people
experiencing this feeling resolved it in one of three ways: reducing the importance of one variable, ignoring it completely, or introducing some new information that helped to reconcile the conflict (Festinger, 1957). Festinger also proposed Festinger that people will avoid situations or information that may create dissonance (Festinger, 1957).

Further studies have helped to refine the definition of cognitive dissonance. A more specific definition is that cognitive dissonance is an uneasy feeling created when people act in a way that conflicts with what they believe, or hold a belief that conflicts with other beliefs that they have (Meyers and Spencer, 2006). People inherently strive for consistency in their beliefs, attitudes and behaviors. Disequilibrium that occurs when there is not consistency among beliefs, attitudes, and behaviors results in a negative cognitive state, one that motivates people to restore equilibrium (Walton, 2011). This motivation is demonstrated in a study done in 2009 that tested if cognitive dissonance is only present in situations where there is a reward in place, such as Festinger's studies, or if it can be experienced more broadly. The results suggest that cognitive dissonance is more of an intrinsic property of the mind, as it was experienced and minimized by the participants despite having nothing to gain (Dias, Oda, Akiba, Arruda and Bruder, 2009). Thus, there was a motivation to reduce dissonance, not for a tangible reward, but instead to fulfill the inherent desire to establish equilibrium. By utilizing methods of reducing cognitive dissonance, the individual is able to modify their peripheral attitudes instead of changing their core values or beliefs (Walton, 2011).

Cognitive dissonance has already been shown to be a factor in the perpetual justification of people's smoking habits, despite them knowing that it is unhealthy. People instinctively perceive themselves as rational and capable of making good choices for their health, and smoking counters this innate perception (Kneer, Glock, and Rieger, 2012). Thus, when health concerns are brought to the attention of the smoker, the self is threatened, and the conflict between the attitude of the person and their behavior creates internal discomfort (Stone and Cooper, 2000). Smokers then resolve this dissonance either by quitting, denying the relationship between smoking and disease, or emphasizing different cognitions, such as the short-term benefits like relaxation that smoking provides (Kneer et al., 2012). An additional strategy the smoker uses is to think less about the conflicting information (Kneer et al., 2012). All of these methods are consistent with what Festinger proposed as methods employed by those seeking to reduce their cognitive dissonance.

**The Insulated Perpetuation of Social Anxiety and Depression**

The development of different techniques for therapy has allowed us to learn
more about how various psychological illnesses develop and are sustained, despite their maladaptive tendencies. A good example of this is social anxiety. Cognitive theories indicate that informational biases that focus on threats in the environment are key to sustaining this disorder (Bowler et al., 2012). Environmental cues that have potential for negative situations, such as angry faces, are attended to, and take up most of the attention of the socially anxious person (Bowler et al., 2012). Additionally, these individuals perceive situations that are ambiguous as inherently negative, a type of interpretation bias (Bowler et al., 2012).

Social anxiety can be sustained despite lack of reinforcement from the environment when these biases increase the frequency or intensity of negative thought, which affects the person's emotions and increases the symptoms of social anxiety (Hallion & Ruscio, 2011). As a result of these biases, socially anxious people will focus on negative aspects of their appearance and social threat cues (Hallion & Ruscio, 2011). These threats that the person fixates on are anything that have the potential to disrupt physical or psychological wellbeing (Hallion & Ruscio, 2011). This is supported by research that suggests that while everyone will be attentive to high-level threats, those with social anxiety also attend to low and medium level threats (Tobon, Ouimet & Dozois, 2011). Therefore, the key difference in people with social anxiety is what they attend to, and the frequency and intensity with which they attend to it.

The same thing can be observed for people with depression, although the biases that perpetuate depression differ from those experienced by people with social anxiety. As with social anxiety, these biases increase how often people with depression experience negative thoughts, which influences the frequency and intensity of their negative emotions (Hallion & Ruscio, 2011). As a result of these attention biases, those with depression experience negative self-evaluation, heightened arousal, and increased anxiety (Hallion & Ruscio, 2011). Depression differs from anxiety in the type of stimuli that the depressed person attends to, as well as in what they do not attend to. For those with depression, there is not a bias towards attending to threats, but rather a difficulty in separating themselves from mood-congruent self-relevant stimuli (Hallion & Ruscio, 2011).

The depressed person's perceptions that they experience while sad or in a negative state of mind have a tendency to remain, as the person is unable to remove their attention from the stimuli. Additionally, the depressed person will avoid attending to positive stimuli (Hallion & Ruscio, 2011). People with depression become fixed in cycles of thought that highlight their own shortcomings and fail to acknowledge that there may be environmental factors that determine the outcome of their actions (Tryon & Misurell, 2008). The depressed individual develops a set of core values and negative cognitions that center on the self, other people, and the future (Thomas & Ashraf, 2011). This creates a negative worldview that the indi-
individual organizes everything into; a perception that persists and affects how they perceive present experiences (Thomas & Ashraf, 2011).

**Applying Cognitive Dissonance in a Clinical Setting**

Cognitive therapy has become a popular and effective method of treating social anxiety and depression in the last forty years. Originating as a way of rectifying the conflict between the psychoanalytic and behaviorist schools of psychotherapy, cognitive therapy draws from ideas of both schools to treat mental disorders. Cognitive therapy focuses on the present cognitions of the person and their thoughts in the moment (Thomas & Ashraf, 2011). However, this is not to say that cognitive therapy only works to treat symptoms as they occur. Rather, by focusing on current cognitions, this school of therapy works to promote change by consciously building new operating principles and beliefs (Thomas & Ashraf, 2011). Essentially, the change is promoted by encouraging a reevaluation of cognitions, beliefs, and principles that work against the patient. The change of present cognitions is not the final solution, but works to move the patient towards cognitive change (Thomas & Ashraf, 2011).

One variation of cognitive therapy that has become popular in recent years is Cognitive Bias Modification (CBM), which has been applied successfully to treat social anxiety and depression. This type of psychoanalytic therapy focuses on the biases that serve to maintain social anxiety and depression, as they have been shown to have a causal relationship (Bowler et al., 2012). CBM challenges patients to identify their current negative cognitions, and to question whether their beliefs are valid or not. This method works by helping those with social anxiety expand their perceptions and take in both threats and positive factors (Bowler et al.). The results of CBM therapy in treating social anxiety are positive: CBM has been shown to reduce the symptoms of social anxiety, as well as the threat-based biases that perpetuate the disorder (Bowler et al.; Tobon, Ouimet & Dozois, 2011).

Techniques used in CBM therapy for treating depression, while still effective, differ from those implemented in treating social anxiety. This unique method of treating depression is referred to as dissonance induction and reduction. Essentially, dissonance is introduced by countering the patients preexisting negative bias about themselves. The reduction of this dissonance, either by positive reinforcement or by having the patient become more exposed to situations that support healthy attitudes, helps to alleviate the depression that they are experiencing (Tryon and Misurell, 2008). Treatment for depression, similar to treatment for social anxiety, aims to change the behaviors of the individual. Since it is a cognitive therapy, the current cognitions are targeted in an attempt to create dissonance that the patient must then reduce (Tryon & Misurell, 2008). Additionally, the passive
state of the depressed person is challenged by encouraging them to be more active in areas such as conflict resolution (Tryon & Misurell, 2008). This change in their behavior also generates dissonance that must be alleviated. Ultimately, the goal is to change the negative schemas that affect how the depressed person interprets the world. Research has demonstrated that this type of treatment is effective because the acknowledgement of the emotions that we protect ourselves from feeling alleviates the need to hide from them (Pyszczynski, Greenberg, Solomon, Sideris and Stubing, 1993).

Analysis of a Reverse Paradigm

Traditionally, the theory of cognitive dissonance has been understood to be crucial to the maintenance of a positive worldview, where the person is generally healthy and happy. Conflicting information must then be something that would challenge that mindset. As shown with smokers, the perception is that the person is capable of making healthy choices that benefit them, and the dissonance arises when the negative health risks are discussed. However, with people with depression and social anxiety, there is instead a desire to perpetuate a negative worldview.

For people with social anxiety, there is a desire to maintain the view that there are many stressors in the environment, and their attention should be focused on these (Hallion & Ruscio, 2011). For people with depression, the perception is that they are failures and everything about themselves and their environment is negative (Tyron & Misurell, 2008). These are two negative paradigms that are perpetuated internally and usually take some sort of treatment to change once they have developed far enough. People with depression and social anxiety seek to perpetuate their skewed interpretations of reality, and shield themselves from information that challenges this mindset. In cases of social anxiety, positive factors in the person's environment are ignored in favor of threats, and information that does not have a positive or negative connotation is viewed as negative (Bowler et al., 2012). Depressed people become withdrawn, preventing them from having positive experiences, and focus on their personal failures while also failing to acknowledge environmental factors that may have contributed to these failures (Tyron & Misurell, 2008). There is a desire to maintain congruency, a consistent worldview, albeit a negative one. This desire for consistency motivates people to reduce their cognitive dissonance, and perhaps perpetuates these unhealthy disorders.

As Festinger proposed in the original literature, one of the methods employed by people to avoid having their perceptions challenged is to avoid situations that may create dissonance (Festinger, 1957). The depressed person who is withdrawn and avoids going out may in fact be avoiding situations that would create dissonance by challenging their negative perceptions. Likewise, the socially anx-
ious person who only attends to threats may be avoiding having their worldview challenged and reinterpreted. This selective attentiveness could in fact result from a subconscious minimization of positive information, another technique that is employed to reduce cognitive dissonance. Positive factors that either demonstrate that the world is not all threats (for social anxiety) or highlight situations that went well (for depression) are not processed with the same importance as the negative factors (Bowler et al., 2012; Tyron & Misurell, 2008). Thus, it seems that their importance is being reduced so that cognitive dissonance is reduced.

The connection between cognitive dissonance and these two cognitive disorders is further implied by the use of cognitive dissonance as a method of therapy. As previously shown, once someone acknowledges the emotions and cognitions that reduction of cognitive dissonance is meant to protect them from, there is less of a need to avoid them (Pyszczynski et al., 1993). Once CBM is applied in therapy, the person with these disorders starts to acknowledge their negative cognitions, and this continuous process works well to reduce how often someone experiences symptoms, and the cognitions that influence the intensity (Bowler et al., 2012). This demonstrates that working on decreasing the motivation to reduce cognitive dissonance in the person with depression or social anxiety can result in less need for these symptoms to occur. As such, those with the disorder will experience less depression and social anxiety, with less intensity.

Setting up Future Studies

Far from just a conceptual theory, research into determining whether or not cognitive dissonance has a connection to cognitive disorders is a valid project. Various studies have shown that it is possible to tell when someone is experiencing cognitive dissonance. When health information about the risk of disease was presented to people who smoked, their processing and response time was longer than usual, and returned to normal as they were exposed to the information again and again (Kneer, Glock & Reiger, 2012). This implies that they had to expend cognitive capacity to alleviate their cognitive dissonance, slowing their response time when first introduced to the conflicting beliefs (Kneer et al., 2012). Afterwards, as they became more familiar with the conflicting beliefs, they were able to readily suppress their dissonance and generate a response that established their consistent beliefs. Studies that demonstrate an attitude change before and after introduction to a conflicting attitude have been conducted, and have shown that a change occurs (Pyszczynski et al., 1993).

The implications of this are that measuring the attitude changes of individuals can show whether or not they experienced cognitive dissonance when exposed to two conflicting beliefs, and even how the person chose to alleviate their disso-
nance. Developing a study that would measure a depressed or socially anxious patient's response time when introduced to dissonance, perhaps by highlighting some of their achievements or encouraging them to observe positive variables in their environment, would work to demonstrate that they experienced dissonance. The response times would have to be measured when they began therapy and during each session to determine if they became more adept at reducing their dissonance as they became better practiced.

Since therapy can change the attitudes of people with depression and social anxiety, it is worth determining if cognitive dissonance is actually what perpetuates the negative attitudes. If this can be demonstrated, the knowledge that psychoanalytic therapists have about these disorders would increase, allowing them to develop more effective methods to treat patients. Helping these patients understand that their disorder stems from a desire to maintain a negative rather than positive paradigm could help them evaluate their cognitions and understand how to help them reduce their symptoms and promote healthier emotions. While no studies have yet been conducted that would demonstrate a relationship between cognitive dissonance, depression, and social anxiety, an analysis of the potential connection could be beneficial for both patients and therapists.
References


