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Willingness to communicate and self-presentation as chosen aspects of social activity in depressive patients

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Willingness to communicate and self-presentation in depressive patients and healthy individuals were compared. Significant differences were found.

Key words: depression, communication, self-presentation

Introduction

Clinical features of depression are usually associated with a variety of symptoms such as changes in behaviour and social functioning, which affect communication and self-presentation.

Willingness to communicate is described as a personality orientation (which means it is relatively constant and inter-situational), which decides on the frequency and willingness to initiate verbal contact [1]. Willingness to communicate depends on the mood, situation, and attitude towards the receiver and opinions about the expected consequences of the contact (e.g. profit or loss).

Self-presentation has different meanings in literature. Some authors understand self-presentation as a process of controlling the impression one makes on others [2, 3 and 4] or as creating a good impression of oneself in others [5]. Grzesiuk [6] and Argyle [7], who describe it as presenting information about oneself in the process of communication, present different understanding of the term. This article uses self-presentation as described by Stach [8], who says that "self-presentation is the image of one's own person taking form of a message sent to another person".

Previous investigation both into willingness to communicate and self-presentation refers to healthy persons. Therefore the evaluation of these variables in depressive patients seems to be especially interesting. So the aim of this study is to try to assess the level of two mentioned variables using McCroskey's and Stach's methods. As the author expects depressive patients will show the lower level of willingness to initiate verbal contacts when compared to healthy individuals. The way of presenting oneself is expected to differ the investigated groups: the self-presentation of depressive patients

will probably be focused on different aspects of living and will be more negative.

The results of this study can show important aspects of possible symptoms connected with depression and can be helpful in the process of therapy.

Material and methods

In the present study we examined 68 persons.

The experimental group consisted of 46 inpatients (41 women and 5 men, where the mean age was 42,5 years) with the diagnosis of endogenous or non-endogenous depression. Inclusion criteria for the control group were (according to experimental group): age between 30-60 years, at least 12 years of education and no past or present episode of depression. The control group consisted of 22 healthy persons (17 women and 5 men, mean age was 40,9 years) but only 19 patients' results were included in the analysis of self-presentation because three persons refused to write a note about themselves. It was difficult to gain healthy subjects for the study so the number of healthy controls is low. The opinion of a specialist in statistics allowed the author to analyse the data in spite of differences in number of the groups members. There were no significant differences in age and education level between two investigated groups.

In the study two methods were used. To evaluate the willingness to verbal contact J.C. McCroskey's "Willingness to Communicate Scale" (WTCS) was used, translated by W.Tłokiński. The WTCS is a 20-item scale designed to measure one's predisposition towards approaching or avoiding the initiation of communication. 12 items are diagnostic. As a result of quantitative analysis we obtain the general score (TOTAL), context related sub-scale scores (public, meeting, group, dyad) and receiver related sub-scale scores (stranger, acquaintance, friend) [9,10].

Self-presentation style was evaluated by Stach's method [8]. The subjects were asked to write a one-page letter to a stranger presenting him or herself in a completely free way (regarding both content and form). The following instruction was given to the subjects: "Please write a one-page letter to a strange person (woman or man). You can write whatever you want about yourself, your life, personality or opinions. The content of the letter depends only on your decision. The time of writing is not limited." After collecting all the letters the structural analysis of the notes' form was done. This analysis was based on reading each note, on distinguishing specific cognitive categories, which constitute the presented image of oneself, and on quantitative analysis of the material. In this study the analysis of the notes was also based on qualitative analysis, which covered evaluation of each note's mood and the optimistic or pessimistic message content as in case of depressive patients the quantitative analysis seems to be of no depth and insufficient. The quantitative as well as qualitative analyses were done by the author, additionally the evaluation of letters' mood was done by a psychiatrist. Each note had a number; none of persons analysing the letters knew to which group the author belonged.

Both tests used are short, easy and do not make the subjects feel tired. These qualities seem to be important especially for depressive patients.

SPSS/PC+ programme was used for statistical analysis.

Results

In order to confirm the homogeneity of the experimental group the results of WTCS in patients with endogenous and non-endogenous depression were compared.

Table 1

The comparison of the WTCS results between diagnostic groups

WTCS SUBSCALES	DEPRESSION				p Value (p ≤ 0,05)
	ENDOGENOUS		NON-ENDOGENOUS		
	MEAN	SD	MEAN	SD	
P - public	24,3	18,2	25,0	22,8	0,827
M - meeting	38,0	16,2	44,0	21,7	0,370
G - group	40,0	16,7	53,3	16,5	0,404
D - dyad	50,1	24,4	44,7	21,4	0,462
S - stranger	22,3	17,4	21,1	18,5	0,825
A - acquaintance	43,0	16,8	45,8	16,0	0,004
F - friend	50,1	24,0	50,0	21,5	0,823
TOTAL	40,4	17,0	42,3	16,3	0,732

"endogenous depression" and "non-endogenous depression" groups into one.

The next stage of the investigation was the comparison of WTCS results in experimental and control groups. The results are shown in table 2.

The significant differences were found in 6 out of 7 sub-scales of WTCS, and in the TOTAL score. Only in S sub-scale ("stranger") no significant differences were found. The highest level of willingness to communicate was observed in F ("friend") and G ("group") sub-scales, the lowest level was found in P ("public") and S ("stranger").

Table 2

WTCS results – comparison between depressive patients (experimental group) and healthy controls (control group)

Self-presentation analysis started with creating 10 cognitive categories of words or phrases used in the messages. Then the results of quantitative analysis were compared.

WTCS SUBSCALES	CONTROL GROUP		EXPERIMENTAL GROUP		p Value
	MEAN	SD	MEAN	SD	
P - public	40,6	26,8	25,4	21,3	0,013*
M - meeting	56,1	21,2	42,8	20,9	0,017*
G - group	72,3	19,9	52,0	19,4	0,000*
D - dyad	65,8	18,9	46,4	22,2	0,000*
S - stranger	21,8	20,8	21,4	16,0	0,202
A - acquaintance	68,7	19,3	44,9	19,7	0,000*
F - friend	79,7	15,0	56,5	22,2	0,000*
TOTAL	58,7	15,0	41,7	16,6	0,000*

* significant differences, p ≤ 0,05

Table 3

The percentage of people using each category – comparison of experimental and control group

Initially the percentage of people using a given category was compared. Significant differences were found only in two categories: A1 – "disease, mood" and A6 - "opinions, beliefs" (respectively p=0,002, p=0,018, where the level of significance

COGNITIVE CATEGORIES	EXP. GROUP	CONTROL GROUP	p Value
A1 disease, mood	52,20	0,00	0,002*
A2 biography	76,10	73,70	1,000
A3 self-esteem	71,70	73,70	1,000
A4 expectations, plans, desires	63,00	47,40	0,373
A5 interests, likes and dislikes, skills	50,00	76,90	0,060*
A6 opinions, beliefs	19,60	63,20	0,018*
A7 compliments	15,20	5,30	0,486
A8 assessment by others	4,30	0,00	0,893
A9 appearance	4,30	5,30	1,000
A10 explicit attitude towards oneself	2,20	0,00	1,000

* significant differences, $p \leq 0,05$

was $p \leq 0,05$).

Then the proportion of each category in all letters was compared. The results are shown in table 4.

Table 4

Proportion of each category in all letters. Comparison between experimental and control group

The significant differences were found in the following categories: A1 – "disease, mood" (p=0,001), A6 – "opinions, beliefs" (p=0,005) and A5 – "interests, likes and

COGNITIVE CATEGORIES	EXP. GROUP	CONTROL GROUP	p Value
A1 disease, mood	18,20	0,00	0,001*
A2 biography	22,63	21,68	0,953
A3 self-esteem	18,18	21,47	0,688
A4 expectations, plans, desires	16,45	11,45	0,271
A5 interests, likes and dislikes, skills	17,66	29,36	0,026*
A6 opinions, beliefs	3,68	14,65	0,005*
A7 compliments	2,66	0,81	0,277
A8 assessment by others	0,28	0,00	0,359
A9 appearance	0,21	0,35	0,482
A10 explicit attitude towards oneself	0,07	0,00	0,520

* significant differences, $p \leq 0,05$

dislikes, skills". A1 category did not appear in healthy controls' letters and the percentage of A5 and A6 was significantly lower than in the experimental group.

The next step was to investigate the proportion of each category only for the persons

who used this category in their letters. Due to the fact that A1, A8 and A10 categories were non-existent in the control group, these categories were excluded. No significant differences were found ($p \leq 0,05$).

The last stage of the comparison of the experimental and control group results was to compare the mean number of words and phrases used in each category (table 5).

Statistically significant differences were found in A1, A5 and A6 categories (respectively p=0,000, p=0,039 and p=0,000). The experimental group members used fewer expressions to describe interests and likes (A5), and opinions and beliefs (A6), but more in A1 category.

Table 5

Mean number of words and phrases used in each category. Comparison between experimental and control group

COGNITIVE CATEGORIES	EXP. GROUP	CONTROL GROUP	p Value
A1 disease, mood	2,80	0,00	0,000*
A2 biography	3,04	2,32	0,714
A3 self-esteem	2,67	1,74	0,444
A4 expectations, plans, desires	1,80	1,42	0,200
A5 interests, likes and dislikes, skills	2,37	3,95	0,039*
A6 opinions, beliefs	0,46	1,68	0,000*
A7 compliments	0,33	0,11	0,271
A8 assessment by others	0,07	0,00	0,359
A9 appearance	0,04	0,05	0,837
A10 explicite attitude towards oneself	0,02	0,00	0,520

* significant differences, $p \leq 0,05$

tive, pessimistic content.

Comments

The initial stage of the research was to compare the level of willingness to communicate in patients with diagnosed endogenous depression as opposed to non-endogenous syndromes. It has been established that members of these two subgroups did not show significant differences in terms of the examined variable. Therefore in the next researches all patients were treated as a homogenous group, named the experimental group.

The analysis started with comparing the results of the test measuring willingness to communicate in the control and experimental groups. It appeared that patients with depression show a significantly lower readiness to communicate.

Then the analysis of self-presentation style was done. The main differences that the analysis helped to find was rather unexpected big openness observed in depressive patients comparing with healthy controls especially taking into account the intimacy of the message content. Content and size analysis of the letters and the fact that 3

persons from the control group refused to write a note and the rest did it with great hesitation, indicate that healthy people demonstrate rather low openness. Messages written by healthy subjects consisted of mainly personal information and description of their interests, likes and opinions while patients didn't describe their interests, skills or beliefs in detail. They rather focused on their personal lives, illness and illness-related feelings. The quantitative analysis of the number of words and phrases used, showed the differences in 3 out of 10 categories (the number was lower in patients' letters in 2 categories, higher in 1 category). This fact and the fact that groups were matched for educational level seem to suggest that depression can be a cause of using a different number of words.

The other way of the data analysis was the evaluation of negative-positive outlook of the notes' content which helped to notice that depressive patients' letters were generally dominated by negative content related to current situation, emotions and feelings, image of oneself and future.

The obtained results seem to agree with McCroskey's [9] and Tłokiński's [11] opinions that lowered level of willingness to communicate and lack of willingness to maintain interpersonal contacts are connected with low self-esteem, higher level of communication fear and expectation of negative reaction from the external world. Lack of willingness to establish communication is explained by other authors by general decrease in motivation to act, low self-confidence and the feeling of being a burden for others [12, 13, 14, 15, 16, 17, 18]. Anxiety, blues, depressive mood, loss of interest in the surrounding world, diminished intellectual abilities and a change in cognitive functioning (stereotypical thinking, deformed processes of receiving and processing information [19]), and also the subjective feeling of one's clumsiness and imperfection, make patients dislike initiating and maintaining verbal communication.

Both investigated groups showed the highest willingness to communicate in the "friend" (F) sub-scale and the lowest in the "stranger" (S) sub-scale. This seems logical, as it is natural for both healthy and depressive patients to initiate conversation with the closest and hesitation in contacts with strangers [7, 20 15, 21].

Self-presentation analysis showed that only patients described their illness and illness-related feelings and only this group of patients used A8 and A10 categories (respectively "assessment by others" and "explicit attitude towards oneself"), but the percentage of subjects using them was insignificant. The observed correlation seems to be clear due to the fact that patients have very emotional attitude towards their illness and also because cognitive and emotional processes are dominated by the illness (illness-focus, negative image of oneself and the outside world). In connection with it depressive patients' letters were dominated by a negative content related to their situation, emotions, feelings, future and the negative image of oneself. The reason of this rather unexpected openness, especially concerning information that discredits the author, may be the patients' specific situation, that is their expectation of advice and help. Kępiński [15] and Niebrzydowski and Płaszczyński [21] point to the fact that patients are less inhibited to reveal information about themselves to their doctor or psychologist. Participation in therapeutic group activities also plays an important part.

The results of the presented study suggest that the methods used can be helpful

in assessment of the new aspects of social functioning, e.g.: interpersonal communication in depressive patients. The investigation showed one of the possible ways of using McCroskey's and Stach's methods. The possible influence of other variables such as personality traits (e.g.: locus of control, empathy) or cognitive functioning on willingness to communicate level and self-presentation style are going to be the aim of future studies.

Conclusions

1. Inpatients with diagnosed endogenous depression and non-endogenous depression syndromes show no differences in willingness to communicate.
2. Depression patients show a significantly lower level of willingness to communicate as compared with healthy persons.
3. Quantitative analysis of self-presentation style demonstrated significant differences in 3 out of 10 categories between depression patients and healthy persons. There are also qualitative differences in self-presentation between these two groups: in patients' letters pessimistic content and negative image of oneself is clearly visible and prevailing.

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