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# SELF-FOCUSED ATTENTION: COMMONALITIES ACROSS PSYCHOPATHOLOGIES AND PREDICTORS

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**Abstract.** Self-focused attention, also thought of a self-absorption, has been linked to a variety of affective states and clinical syndromes, including depression, panic disorder, social anxiety, schizophrenia, and alcoholism. Ingram (1990b) has suggested that self-focus may be a ''nonspecific process'' that is common across psychopathologies. Studies with nonclinical samples have supported this contention, and the current study assessed whether self-focus was common across various clinically diagnosed groups. A second issue, given this commonality, was to examine the factors across diagnostic conditions to which self-focus was related. One hundred and thirty-eight outpatients were included, and were divided into three groups based on primary diagnosis: ''depression'', ''panic'', and ''other anxiety''. They were assessed with the ADIS-R/IV and completed measures assessing self-focus, affective states, global psychopathology, and problem-solving. Self-focus was common across groups, with minor valence variations. Severity of primary diagnosis predicted total self-focus, with level of depression and trait anxiety predicting negative self-focus. Correlational analyses suggested that self-focused attention is related to general measures of psychopathology and severity, and negatively related to problem-solving. The pattern with negative self-focus was even more pronounced, with significant relationships to all measures of psychopathology, clinician-rated severity, and a negative relationship with problem-solving. Results are discussed in terms of differences between ''normal'' and problematic self-focus, the causal direction in the relationship between self-focus and negative affect, and the link between self-focus and problem-solving.

*Keywords:* Self-focused attention, affect, problem-solving.

## Introduction

Self-focused attention has been defined as ''an awareness of self-referent, internally generated information'' (Ingram, 1990b, p. 156). Also thought of as self-absorption or egocentricity, the tendency to attend more often to the self or self-referent material than to external stimuli has been linked in analog samples to the experience of a variety of negative affects. For example, Wood, Saltzberg, Neale, Stone and Rachmiel (1990) investigated the association of negative affect and self-focused attention in a community based sample in an

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attempt to examine the specificity of affect associated with self-focused thought. Results suggested that self-focusing is associated with global negative affect, rather than with specific mood states such as sadness. Wood, Saltzberg and Goldsamt (1990) hypothesized that affective experiences induce self-focused cognition. Based upon mood induction paradigms, their results indicated that sad mood induces self-focus, whereas a happy mood does not.

The role of self-focused attention has been assessed within the context of a wide variety of pathological conditions. Foremost among such efforts has been the study of how self-focused attention might be related to depression. Significant relationships between self-focused attention and depressive symptomatology have been reported by numerous researchers in the psychological literature (Ingram, 1990b; Smith & Greenberg, 1981), and these results lend credence to the notion that these two constructs are related in an important way. Recent formulations suggest that self-focused attention may be linked to depression through the activation of negative self-conceptions. Such notions are based in a cognitive model that assumes that a rigid direction of one's attention to negative self-evaluations might lead to the experience of depressed states. Sedikides (1992a) provided evidence for such a relationship by demonstrating that self-focused attention induces negative mood only when self-focusing occurs within the context of a negative self-conception valence. These findings were taken as evidence that ''self-conception valence moderates the effects of attention on mood'' (Sedikides, 1992a, p. 582). In other words, if the content of one's thoughts are characterized by negative evaluations of the self, then these are the thoughts that will be salient and readily available to someone with a tendency to self-focus. When attention is directed to this information in a rigid way, it seems logical that a person might come to feel an exacerbation of depressed affect.

Interestingly, there is also some evidence that depressed moods, once present, may serve to induce and exacerbate states of self-focused attention. For example, several studies in which mood induction procedures were employed yielded results that indicate that depressed subjects score higher on measures of self-reported, self-focused states (Sedikides, 1992b) and produce more negatively self-focused statements than subjects in a happy mood (Carr, Teasdale, & Broadbent, 1991). Thus, it seems that self-focus might be critical to the formation of depression through a rigid focus on negatively valenced self-referent information, and elevated states of depression might then serve to exacerbate and maintain levels of self-focused attention. Such a process might constitute a ruminative cycle through which distressed states are maintained by a mutual causality between self-focused attention and depressed affect.

While potential relationships between self-focused attention and depression have been explored rather extensively, research aimed towards discovering associations between self-focus and other pathological conditions has received far less attention. However, a review of the literature by Ingram (1990b) indicates that there is sufficient evidence to support the notion that self-focused attention plays an important role in a variety of pathological conditions including experiences of anxiety, alcohol abuse, and schizophrenia. In particular, there has been a recent trend towards examining the presence of self-focused attention within the context of clinical anxiety. For example, Borden, Lowenbraun, Wolff and Jones (1993) found that subjects with panic disorder were characterized by a tendency to respond to distress and physiological arousal with heightened levels of self-focused attention relative to normal subjects who experienced similar states. More recently, Woody (1996) investigated the possibility that self-focused attention might play a crucial role in the exacerbation

of social anxiety. She found that when focus of attention was manipulated in generalized social phobics performing a speech task, increases in anticipated anxiety and anxious appearance were observed (Woody, 1996), supporting the earlier findings of Hope and Heimberg (1985).

Such findings indicate that the same mechanisms hypothesized to exist between self-focused attention and depression may also operate within the context of clinical anxiety. For example, just as someone who focuses excessively on negative cognitions concerning the self might become depressed, someone who focuses excessively on the catastrophic implications of physiological sensations might begin to panic. Similarly, someone exerting a rigid focus on negative thoughts concerning his or her social performance might be expected to show evidence of increases in symptoms of social anxiety. With regard to the latter formulations, Daly, Vangelisti and Lawrence (1989) found that subjects exhibiting high levels of public speaking anxiety showed elevated levels of self-focused attention and poorer self-presentations in public. It was suggested that highly anxious speakers are characterized by negatively self-focused thoughts concerning their performances, and this is related to less effective self-presentations. Thus, there appears to be sufficient evidence to surmise that self-focused attention plays a critical role in the formation and exacerbation of clinical anxiety, and it appears that the nature of one's thoughts plays a crucial role in determining what type of affective experience is produced and maintained.

After reviewing the self-focus literature, Ingram (1990b) suggested that self-focused attention may be a ''nonspecific process in psychopathology'' (p. 173). That is, the process of inwardly directing thoughts that become rigid and ''automatic'' may be the salient dimension for understanding thought processes associated with various pathologies. Further, Ingram (1990b) hypothesized that while the process of self-focusing in a rigid and excessive manner for extended periods may be a common process among different forms of psychopathology, perhaps what differentiates these conditions is the cognitive content to which one's focus is directed. Thus, the depressed person might focus upon thought content reflecting the belief that he or she is effectively inadequate, while the anxious person might focus upon the sense that feelings, physiological sensations, and life events are out of control. In essence, the process of self-focusing is similar among such conditions, while the contents of thoughts to which focus is directed are quite different in character. Support for such a formulation has been provided by Ingram (1990a), as he found that elevated levels of self-focused attention were similar in groups of college students experiencing ''pure'' depression, ''pure'' anxiety, and a mixture of heightened depression and anxiety relative to a comparison group who was neither anxious nor depressed. Ingram (1990a) concluded that ''self-focused attention appears to be problematic regardless of whether the person is depressed or anxious'' (p. 32), and cited evidence that ''cognitive content dimensions differentiate depressed and anxious affective states and may therefore be critical in shaping the determinants of these specific states'' (p. 33).

Overall, then, it appears that the process of self-focusing characterizes psychopathological states in general, and not individual affective states per se. However, to date, research that has examined the relationship of self-focused attention to different forms of psychopathology within the same study has been limited to subclinical samples. The goal of this study was to examine empirically the extent of self-focused attention across several clinically diagnosed groups. Further, if self-focus characterizes clinical psychopathology in general, rather than any particular pathological condition, it is important to ascertain to

which variables across pathologies self-focus is related. The second goal of this study was to examine predictors and correlates of self-focused attention.

## Method

### *Participants*

Participants were 138 clinical patients consecutively presenting over a 3-year period to an outpatient clinic specializing in the treatment of panic and other anxiety disorders. There were 90 women and 47 men (with one participant not providing this information). Their age ranged from 19–64 years with a mean of 37.05 (*SD* = 11.87). Participants had completed an average of one year of college education. All were assessed with the ADIS-R/ADIS-IV (Brown, DiNardo, & Barlow, 1994; DiNardo & Barlow, 1988) for Axis I disorders. Those receiving a primary diagnosis of an anxiety or depressive disorder were included. There were no exclusionary criteria. Participants were divided into three groups, Panic (*N* = 63), Depression (*N* = 37; including Major Depression, Dysthymic Disorder, and Depression NOS), and Other Anxiety Disorders (*N* = 38; social phobia, GAD, and PTSD). Panic was separated from other anxiety disorders as a means to replicate findings of increased self-focus in panic disorder samples. This effect has also been found for other anxiety disorders as detailed above, but there were insufficient numbers to warrant other individual diagnostic comparisons.

### *Procedure*

All interviews were videotaped, and one-third rated by a second interviewer to determine interrater reliability of primary diagnosis (Kappa = .90). Differences were resolved through consensus. Following completion of the ADIS, participants completed the Self-Focused Sentence Completion (SFSC; Exner, 1973), a standardized measure of self-focused attention. The SFSC contains 30 sentence completion stems, many of which begin with I, me, or my (e.g., I think; I wish; It's fun to daydream about). Participants are instructed to complete each stem as they choose. The SFSC is a commonly used measure of self-focus as response style in social cognitive research, and has been used in both clinical (Ingram, Lumry, Cruet, & Sieber, 1987) and nonclinical (Edison & Adams, 1992; Ingram & Smith, 1984) samples of depressed subjects. Validation studies are presented in Exner (1973). Responses on the SFSC were coded into 8 categories by content (self, external, ambivalent, and other) and valence (positive, negative, and neutral) and then converted into percentages to control for number of responses. Two coders were trained to a criterion of 80% agreement. Overall interrater reliability for coding was 86.42%, with acceptable levels of agreement for all but the ''other'' category, which was excluded. As a means to assess correlates and predictors of self-focus, participants completed the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988), Spielberger State-Trait Anxiety Inventory (STAI; Spielberger, Gorsuch, & Lushene, 1970), SCL-90-R (Derogatis, 1983), and Social Problem Solving Inventory (SPSI; D'Zurilla & Nezu, 1990).

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## Results

### *Preliminary group comparisons*

Groups were compared on demographic features, as well as diagnostic severity. There were no differences on age, educational level, gender, or severity of primary diagnosis. Groups did differ with regard to marital status, with proportionally fewer married individuals in the depressed group and fewer divorced individuals in the other anxiety group.

**Table 1.** Group demographics

| Measure | Panic | Depressed | Other anxiety | $F/\chi 2$ |
|---|---|---|---|---|
| Age | 37.88 (11.44) | 38.49 (12.45) | 34.29 (11.97) | 1.45 |
| Education (years) | 13.25 (1.95) | 13.51 (1.87) | 13.66 (2.36) | 0.51 |
| Sex | | | | |
| Women | 37 | 25 | 28 | 3.05 |
| Men | 26 | 12 | 9 | |
| Marital status | | | | |
| Married | 38 | 12 | 23 | 22.67* |
| Single | 12 | 8 | 10 | |
| Divorced | 9 | 14 | 2 | |
| Other | 4 | 3 | 3 | |
| Clinician rated severity (1–8) | 4.68 (1.46) | 4.65 (1.26) | 4.97 (1.65) | 0.55 |

* $p < .05$

### *Prevalence of self-focused attention*

The percent of self-focus across groups was analyzed with a MANOVA using total self-focus, and positive, negative, and neutral self-focus as dependent variables. The overall MANOVA was significant, Wilks' Lambda = 0.84, $p < .01$. Univariate ANOVAs were conducted on each self-focus dimension, with follow-up tukey tests for significant effects. The groups did not differ in the extent of their total self-focus, although the difference approached significance with anxious groups reporting slightly higher levels of total self-focus. Self-focused attention appeared quite common across the three groups, with approximately 60% of total cognitions coded as self-focused. There were some minor variations based upon valence of self-focus, with the panic group presenting more positive self-focus than the depressed group; and the depressed group displaying significantly less neutral self-focus than either of the other two groups. The groups did not differ with regard to negative self-focus, although this difference approached significance.

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**Table 2.** Univariate analyses of percent self-focused attention by diagnostic group

| Category | Panic | Depressed | Other anxiety | *F* |
|---|---|---|---|---|
| Total | 64.18 | 58.92 | 64.21 | 2.63 |
| self-focus | (10.71) | (13.54) | (12.29) | |
| Positive | $16.98_a$ | $12.25_b$ | 15.00 | 3.35* |
| self-focus | (9.67) | (6.48) | (9.36) | |
| Negative | 26.77 | 32.16 | 28.95 | 2.69 |
| self-focus | (10.61) | (10.28) | (12.95) | |
| Neutral | $19.89_a$ | $13.96_b$ | $20.09_a$ | 6.66** |
| self-focus | (9.23) | (6.47) | (9.15) | |

Note: standard deviations are in parentheses; numbers with different subscripts differ significantly ($p < .05$).
*$p < .05$; **$p < .01$

### *Predictors of self-focused attention*

To examine predictors of self-focus, two stepwise multiple regressions, one for total self-focus and one for negative self-focus, were conducted using severity of pathology (from the ADIS-R), SCL-90-R general symptom index, BDI, BAI, and STAI scores as predictors.

For the Total Self-Focus regression, severity of pathology was the only significant predictor ($R^2 = .07$). In predicting Negative Self-Focus, the BDI entered on the first step ($R^2 = .29$) and the trait STAI score on the second step ($R^2 = .31$). No other variables entered into the equation.

### *Correlates of self-focus*

A series of Pearson correlations was computed between total self-focus and external-focus, the negatively valenced categories, self-report measures, and severity measures from the ADIS-R. Together with the negative self-focus multiple regression, the results suggest that self-focused attention, regardless of valence, is significantly correlated with general measures of pathology and severity, and negatively correlated with problem-solving abilities. When negatively valenced self-focused attention is isolated, the pattern of correlations remains and becomes somewhat more pronounced. Negative self-focus is significantly related to all self-report measures of psychopathology and to clinician-rated severity, and negatively correlated with problem-solving. The pattern reverses for external focus. Use of percentages necessitates that as self-focus increases external focus decreases. In general, the more externally-focused, the less pathology reported by subjects and rated by clinicians. The relationship appears specific to negative self-focus and not negative responses per se as negative external focus showed no significant relationship to any variable assessed.

## Discussion

The current study examined whether self-focused attention is common across differing conditions in a clinical sample. The results of this study support Ingram's (1990b) conclusion that self-focus seems to be a common feature across the anxious and depressive disorders

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**Table 3.** Pearson correlations of self- and external-focused attention and self-report and severity measures

| | GSI | BDI | BAI | STAIT | SPSS | Sev |
|---|---|---|---|---|---|---|
| Total self-focus | .18* | .13 | .25** | .05 | –.16* | .25** |
| Negative self-focus | .41** | .50** | .22* | .43** | –.37** | .34** |
| Positive self-focus | –.17 | –.34** | –.13 | –.31** | .24* | –.10 |
| Total external focus | –.29** | –.20* | –.29** | –.20* | .07 | –.22* |
| Negative external focus | –.09 | –.04 | –.16 | –.05 | .14 | –.15 |

*$p < .05$; **$p < .01$
GSI = SCL-90-R General Symptom Index
BDI = Beck Depression Inventory
BAI = Beck Anxiety Inventory
STAIT = Spielberger STAI-trait
SPSS = Social Problem Solving Inventory
Sev = Clinician rated severity

assessed. The most meaningful differences between groups involved the valence of self-focus, not the presence or absence of self-focus. As might be expected, depressed subjects reported less positively valenced self-focused cognitions, as well as less neutral cognitions. Consistent with the results from subclinical samples (Ingram, 1990a), the process of focusing inwardly to self-referent material appeared common across all groups with the specific nature (and likely the content) of those self-focused thoughts differing somewhat by diagnostic grouping. Secondary diagnoses and the issue of comorbidity was not addressed in this study. Results may differ when comorbid diagnoses are controlled. However, the findings of valence differences, but no meaningful differences in the presence or absence of self-focus are consistent with prior findings.

Given the general consistency of self-focused attention across diagnostic groups, we next examined a series of correlates hypothesized to be related to the extent of self-focus. Collapsed across diagnostic categories, the regression and correlational data would suggest that self-focus (especially negative self-focus) is related to severity, global pathology, negative affect, and poorer problem-solving. In particular, dysphoria and trait anxiety predict negative self-focus. These data imply a continuum such that the more severe the pathology, the greater the extent of self-focused attention. One might assume from these findings that some degree of self-focus is thus normal and that this normal process is somehow altered as pathology becomes more severe.

The causal relationship among self-focus and these variables is of considerable theoretical and clinical significance. Based upon the presence of self-focus in normal samples (e.g., Borden et al., 1993; Ingram, 1990a; Sedikides, 1992a, b; Wood et al., 1990), it appears that self-focusing is a normal cognitive process. The correlational results of this study suggest an increasing level of self-focus with increased levels of distress. The transition then from ''normal'' self-focusing to that associated with psychopathology becomes a critical issue to explore.

Two interrelated issues that need to be explored are the nature of the ''alteration'' from normal to problematic self-focus and the causal directions among self-focused attention and

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measures of affect and psychopathology. Of importance is whether there are qualitative or quantitative differences between cognitive processing of ''normal'' and ''pathological'' self-focused attention. Ingram (1990b) has suggested that self-focused attention becomes pathological when it is directed internally to an ''excessive'' degree, is ''situated'' for extended periods of time, and thought processes are typified by inflexibility or ''cognitive intransigence'' (Ingram, 1990b, p. 169). This is sensible, particularly if the information being focused upon reflects cognitive content characterized by a negative valence. Thus, if one ruminates about the implications of negative expectations for the self in a given situation, and one experiences difficulty in shifting away from such negative expectations for extended periods of time, then it seems likely that such an individual will experience some form of negative affect (e.g., dysphoria or anxiety). The results of this study indicate that an overall tendency to self-focus is common to broad diagnostic groupings and similarly related to level of psychopathology. However, self-focusing on negatively valenced cognitive content is more strongly related to clinician rated severity of diagnostic status, global severity of symptoms, depression, state anxiety, trait anxiety, and decrements in problem solving abilities (see Table 3). Thus, the continuum from ''normal'' to ''pathological'' self-focusing might be influenced by the degree, duration, and inflexibility of the self-focusing tendency as Ingram (1990b) suggested, but the results here suggest that the valence of the cognitive content that is focused upon is also related to levels of psychopathology. That is, as the negativity of cognitive content increases with increasing levels of self-focus, the more severe the psychopathology. Given the correlational nature of this study, the causal direction of these relationships is not clear.

Future research directed towards determining the threshold at which self-focusing becomes pathological might be aimed at delineating several critical parameters. Concerning Ingram's (1990b) formulation, it seems crucial that future studies examine at what point the degree, duration, and cognitive inflexibility of one's self-focusing style becomes potentially pathological with regard to mental health. The results of the current study suggest that it is also important to consider the conditions under which these parameters exist. That is, it may be that an excessive and rigid focus on the self is particularly problematic when the focus is directed to cognitive information with a negative value for the individual. If this is the case, future research designed to examine when self-focusing crosses the threshold from ''normal'' to ''pathological'' should attempt to delineate how negatively valenced cognitive content contributes to this phenomenon.

Another area that requires further exploration involves the nature of the causal directions among self-focused attention and measures of affect and psychopathology. While there has been research to suggest that self-focusing might have the effect of inducing negative affective states in participants exhibiting negative self-conceptions (e.g., Sedikides, 1992a), other data suggest that negative mood states can induce or at least heighten self-focus (e.g., Wood et al., 1990). Clarifications of the directions of causality would allow a more complete understanding of the process and consequences of self-absorption or chronic self-focus. Rigid and excessive focus on negatively valenced cognitions may induce negative affect, with the content of the cognition influencing the nature of the affective response. Thus, focusing on thoughts regarding catastrophic expectancies might lead to anxious states, and thoughts reflecting beliefs of low self-efficacy might lead to dysphoria or depression. This formulation is consistent with the findings of Sedikides (1990a), which suggest that the effect of self-focus on mood are moderated by the valence of cognitions concerning the self,

and also with the current results that reinforce Ingram's (1990a) findings that self-focusing is a common process across pathological conditions. Once negative mood states are experienced by the individual, their presence might constitute salient information when one is already attuned to inner states, and the presence of such affective states could then heighten one's state of self-focus. What results may be analogous to a ruminative cycle in which focusing on negative beliefs and expectancies leads to negative affect, which in turn leads to an increase in self-focused attention, which then exacerbates the affect.

The results of this study also indicate that self-focused attention is negatively related to problem solving abilities. Other researchers have reported similar findings with regard to self-focused attention and coping (e.g., Brockner, 1979; Strack, Blaney, Ganellen, & Coyne, 1985; Wood et al., 1990). Focusing on the self may limit an individual's ability to formulate plans of action regarding a problem so that effective coping might take place (Kuhl & Helle, 1986). Consequent deficits in divergent thinking may become increasingly rigid and familiar, such that flexible allocation of attention becomes progressively more difficult. Interestingly, this deficit in problem-solving may also be linked to the recursive cycle of affect and self-focus in that deficits in problem-solving perpetuate distress yielding more self-focus.

In sum, the current study examined the extent and predictors of self-focused attention across several clinical diagnostic groups. Examination of other diagnostic groups would further underscore the results obtained in this study. Relationships between self-focus and measures of severity, distress, and problem solving point to important conceptual issues in the self-focus literature to further clarify the direction of causality and thus impact of this cognitive process.

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