Social Competence and Depression:
The Role of Illusory Self-Perceptions

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This article attempts to disentangle the role in clinical depression of two potentially relevant personal variables: social competencies (as perceived by others) and their encoding, or self-perception by the individual. Both self-ratings and ratings from observers were obtained for depressed, psychiatric control, and normal control individuals following a group interaction at different times in the course of treatment. As expected, the depressed individuals initially rated themselves and were rated by others as less socially competent than the two control groups, and their self-perceptions improved with treatment. Surprisingly, the depressed were more realistic in their self-perceptions than the controls. Specifically, the controls perceived themselves more positively than others saw them, whereas the depressed saw themselves as they were seen. This realism of the depressed tended to decrease in the course of treatment. The theoretical implications of a possibly illusory glow for appropriate affect and self-regulation are discussed.

Competence is an important personal variable in the cognitive social learning approach (Mischel, 1973) and the self-perception of competence or self-efficacy has been shown to substantially influence how well people can overcome clinical problems such as fears (Bandura, 1977). Competence deficits also have been postulated as important antecedents to the occurrence of depression, and some data suggest that depressed individuals may be less interpersonally or socially skillful than nondepressed persons (Libet & Lewinsohn, 1973; Libet, Lewinsohn, & Javorek, Note 1; Youngren & Lewinsohn, Note 2).

An adequate analysis of the role of competence in depression must separate the effects of actual competence deficits from those of a second potentially relevant personal variable—the individual's encoding, or perception of those competencies (Mischel, 1973). Specifically, the depressed person may be deficient in particular competencies, skills, or social attributes and/or may be misperceiving them. For example, on the one hand, Beck (1967) postulates an unrealistically negative view of self as part of the cause of depression, and he and Rehm (1977) have suggested that the depressed are characterized by a general tendency to evaluate themselves less positively. According to this hypothesis, depressives' negative social skill self-attributions would be viewed as a specific instance of this more general cognitive set. On the other hand, it is also possible that a negative self-image partly reflects a realistic recognition of one's own lack of positive interpersonal characteristics and competence. Thus, Lewinsohn (1974) and others have suggested that the depressed are indeed less socially skillful and therefore are perceived more negatively by those who observe them (Coyne, 1976a, 1976b).

To disentangle unrealistically negative
self-perceptions from actual social deficits (as perceived by others), it is necessary to obtain both self-ratings and behavior ratings by observers and to examine their degree of congruence in depressed and non-depressed persons. In the present study, we attempted to obtain such data. A finding that the depressed perceive themselves less positively than control subjects might imply that they in fact possess fewer positive social characteristics and their negative self-perception simply reflects this reality. On the other hand, the depressed might suffer from negative self-perceptions unjustified by their actual social characteristics as perceived by others. To distinguish these two possibilities, it was important that we compare the self-ratings of depressed people and appropriate control groups to ratings of the same individuals made by independent observers. We hypothesized that (a) the depressed will perceive their social competencies and characteristics less positively than nondepressed individuals, and (b) the discrepancy between the self-ratings and ratings by others will be greater (in the negative direction) for depressed than for nondepressed individuals. That is, depressed people will show more distorted self-perceptions—rating their competencies much less positively than others rate them, whereas nondepressed people will see themselves more as they are seen by objective observers. Our main interest was in the self-perceptions and observer perceptions of the three groups without any clinical interventions. However, the fact that after the initial assessments the depressed began to receive treatment and reassessments also provided an opportunity to examine the patterns of self-perceptions and observer perceptions over time and after treatment.

Method

Participants

Seventy-one depressed patients receiving treatment at the University of Oregon Psychology Clinic, 59 psychiatric controls, and 73 normal controls participated in this study. Potential depressed subjects were recruited by announcing, through both public media and community agencies, the availability of a depression treatment program. Potential psychiatric and normal controls were recruited by advertising an opportunity to earn a minimum of $20 for participating in a psychological research project.

A two-stage screening process, using cutoff scores on selected Minnesota Multiphasic Personality Inventory (MMPI) scales and interviewers' ratings on the depression factors identified by Grinker, Miller, Sabshin, Nana, and Nunnally (1961), was employed to select three subject groups, depressed, psychiatric control, and normal control. The criteria for selection are shown in Table 1. Mean MMPI D scale values (T scores) for the three groups were 89.0, 57.5, and 50.5, respectively.

The second stage of screening involved interviews conducted by members of the project staff. On the basis of these semistructured interviews, subjects were rated on 25 items of the Feelings and Concerns Checklist developed by Grinker et al. (1961). The items represent the most common symptoms of depression, and each was rated on a 4-point scale (0 = not present; 3 = present to a marked extent). Satis-

Table 1
Classification Procedures for Selecting Depressed and Nondepressed Subjects

<table>
<thead>
<tr>
<th>Group</th>
<th>Step 1: MMPI</th>
<th>Step 2: Grinker interview rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressed</td>
<td>( D \geq 70T ) and ( D &gt; ) all other clinical scales* or ( D &gt; 80T )</td>
<td>One or more factor scores &gt; 1.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mean factor score &gt; .70</td>
</tr>
<tr>
<td>Psychiatric control</td>
<td>( D &lt; 70T )</td>
<td>Factor 1 (dysphoria) &lt; .70</td>
</tr>
<tr>
<td></td>
<td>At least one clinical scale* ( \geq 70T )</td>
<td>Subject rated as having no current or major past problems with depression</td>
</tr>
<tr>
<td>Normal control</td>
<td>( L &lt; 60T )</td>
<td>Mean factor score \leq .35</td>
</tr>
<tr>
<td></td>
<td>All clinical scales* &lt; .70T</td>
<td>No factor score &gt; .70</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Subject rated as having no current or major past problems with depression</td>
</tr>
</tbody>
</table>

Note. MMPI = Minnesota Multiphasic Personality Inventory.

* Clinical scales did not include \( L, K, Mf, Ma \), and \( Si \).
factory interrater reliability for individual items (average $r = .59$) was reported for 30 subjects in a previous study (MacPhailamy & Lewinsohn, 1974). On the basis of these ratings, scores were computed on four of the depression factors identified by Grinker et al. (1961): (1) dysphoria; (2) material burden; (3) guilt; and (4) loneliness/unloved. Mean scores on Factor 1 (dysphoria) for the three groups were 1.56, 1.0, and .04, respectively.

Previous experience has indicated that the two-stage depression criteria identify persons in whom depression is present to a clinically significant degree and for whom being depressed constitutes the major presenting psychopathology (Lewinsohn, Biglan, & Zeiss, 1976). The present sample of depressives may be considered predominantly neurotic and unipolar, with severity level ranging from moderate to severe. The depressives were assigned randomly to one of three treatments: (a) interpersonal treatment (Zeiss, Note 3), (b) cognitive treatment (Muñoz, Note 4), and (c) pleasant activities treatment (Lewinsohn, Note 5). All assessments were conducted at three monthly assessment periods (T2, T3, T4) following the initial assessment (T1). Mean $D$ scale scores on the MMPI changed from 58.8 (T1) to 62.3 (T4) for the depressives.

The two major hypotheses of this study were tested using all of the subjects available at T1 (71 depresseds, 59 psychiatric controls, 73 normal controls). However, in the hope of gaining additional insight into the self-perceptions of the depressed, we also compared differences between their self-ratings and ratings by others with those of the control subjects at T1 and T4. The number of individuals for whom data were available for these secondary analyses was 45, 46, and 38 for the depressed, psychiatric controls, and normal controls, respectively. Of the 26 depressed subjects who were unavailable at T4, 7 decided against entering therapy after being accepted, 8 dropped out of treatment after being accepted, and 11 did not complete assessment at T4 for scheduling and other administrative reasons (e.g., they had moved). Attrition in the nondepressed control groups resulted from scheduling problems. The reader should note that this loss of subjects does not affect the major findings of this study, since those findings are based only on the T1 assessments, for which all subjects were available. It is only the secondary analyses at T4 that could have been biased by a loss of subjects.

The mean ages and age ranges (in parentheses) for the three diagnostic groups were: depressed, 33.9 years (21–70); psychiatric control, 25.7 years (17–77); and normal control, 29.9 years (18–64). The percentage of females in each group was 68.0, 38.0, and 51.3, respectively.

**Group Procedure**

Subjects participated in four 45-minute group interactions at each of the four monthly assessment periods (T1, T2, T3, T4). The original design called for six-person groups, including two from each diagnostic group. However, because of scheduling problems, the actual mean group size was 5.2. At least one male and at least one subject from each diagnostic group was included in each group session. The participants were selected so as to ensure that they had not met one another in earlier group or dyadic interactions. The seating arrangement was circular. Each subject was asked to give a 3-minute self-introduction monologue. Following the monologues, the experimenter left the room and the group continued conversing for approximately 20 minutes.

**Instructional Set.** Psychiatric and normal controls were not made aware that some of the subjects were patients in depression treatment programs. All participants were told that, as part of the study, the investigators were interested in learning more about how people who are strangers relate to one another. Subjects were instructed that they could talk about anything they wished except the research project and their particular roles in the project.

**Coders**

Fifty-eight undergraduates were selected and carefully trained to serve as observers and coders for the group interaction. The coders were not paid for their services but instead received course credit through a research class sponsored by the Psychology Department. Regular class sessions were held to train the coders for their role in this study. The training began with lectures on observation and coding. This was followed by further instruction and practice with both videotaped and live interactions. In addition, the observers were provided with a coders' manual that briefly described the rating form and that emphasized the importance of reliability. However, no specific instruction on how to rate the individuals on the social skill attributes was provided.

The coders were blind to the diagnostic categorization of the subjects. They were aware of the general goals of the research: (a) that it was concerned with depression, (b) that it was intended to evaluate the effectiveness of treatment on a wide range of outcome measures, and (c) that we were interested in exploring the functional relationship between depression and interpersonal behavior. However, an explanation of the experimental design (i.e., the existence of specific groups and treatments) and of the hypotheses was not provided until all the data were collected.

**Measures**

**Coder Ratings.** Two to four coders, stationed behind each of the two one-way observation windows, were responsible for rating the behavior of the subjects facing them in each group session. Immediately following each group session, the coders rated the behavior of the subjects whom they had directly observed on the following 17 desirable attributes:

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1 The authors wish to thank Allan Albert, Brian Breijling, Janet Flaherty, Rick Gaber, Jim Hatch, Randy Hughes, John Larson, Ricardo Muñoz, Tone Ristorcelli, Margareta Seb-Olsson, Sandy Smith, and Toni Zeiss for serving as experimenters.

2 The subjects also were rated, and rated then-
important to establish the reliability of the observer ratings and the internal consistency of the items contributing to those ratings. The use of 58 observers who rated small subsets of the more than 200 subjects should enhance the generalizability of any findings but also complicates the reliability analysis by preventing us from simply correlating pairs of observer ratings across all the subjects. Instead, it was necessary to first identify pairs of observers who saw the same subset of common subjects and then compute separate reliability coefficients for those pairs. In addition, many observers saw fewer than 10 common subjects, and reliability correlations computed across such a small set of observations could not be interpreted meaningfully. We therefore computed separate reliability coefficients for all pairs of observers who rated 10 or more subjects in common and then took the average of those correlations as the estimate of observer reliability. At the pretreatment assessment, 11 pairs of observers rated 10 or more subjects. Their mean number of common subjects was 17, and the 11 reliability coefficients had a mean (computed using the $r$-to-$z$ transformation) reliability of .65. Most subjects were rated by three observers, and the estimate of observer reliability was corrected using the Spearman-Brown prophecy formula, which yielded a reliability at the pretreatment assessment of .74. A similar analysis was performed on the observer ratings made at the posttreatment assessment, at which 9 pairs of observers rated 10 or more common subjects ($M = 12$) with a mean reliability coefficient of .59. The Spearman-Brown corrected estimate of observer reliability at the posttreatment assessment was .68. In sum, though the reliability of the observers varied, in general it was high enough to allow a test of the major hypotheses.

The primary data in the analyses reported here are the mean self and observer ratings computed across the 17 items. To determine if combining these 17 items into a single measure, which we have labeled social competence, is justified, the internal consistency of our aggregate measure was assessed using the Kuder-Richardson Formula 20 (coefficient alpha) (KR-20). For the observer ratings, the KR-20 values are
.95 and .97 at the pre- and posttreatment assessments, respectively. For the self-ratings, the values are .89 and .91. These high KR-20 values indicate that the items used in this study all reflect aspects of the same construct.

Pretreatment Perceptions

The basic design of this study is a 3 x 2 (Diagnostic Category [Depressed, Psychiatric Control, Normal] x Rater [Self, Observer]) analysis of variance with repeated measures on the latter factor. Table 2 shows the mean ratings for each of the cells in this design. Higher means indicate that the attributes were more generally descriptive of the individuals. Table 3 summarizes the results of this analysis.

The main effect for diagnostic category is important for the first hypothesis, that the depressed perceive themselves as less socially competent than the control groups perceive themselves. However, because observer ratings are included in this main effect, and because there is a significant Rater x Diagnostic Category interaction, an analysis of the simple main effects of diagnostic category was undertaken separately for the self-ratings. Further, to control the "experimentwise" error rate in these analyses, the conservative Newman-Keuls test for unequal sample sizes (Keppel, 1973, p. 354) was used to compare the means of the three diagnostic groups. For an α level of .05, this test indicates that the critical difference between two means is .34. The differences between the mean of the depressed group and the means of the psychiatric control and normal control groups (.60 and .80, respectively) exceed this critical difference, whereas the difference between the means of the two control groups (.20) does not. Likewise, two orthogonal comparisons indicated no differences between the two control groups, F(1, 200) = 1.81, ns, but a highly significant difference between these two groups and the depressed, F(1, 200) = 29.54, p < .001. The data then clearly show that as predicted, the depressed persons perceived themselves as less socially skillful.

The second hypothesis is that the least desirable perceptions of the depressed reflect, to some extent, negative distortions rather than actual social skill deficit. Specifically, the second hypothesis predicted a greater discrepancy between the self-ratings and observer ratings for the depressed (with self-ratings in a less desirable direction) than for the control groups. As with the self-ratings, the Newman-Keuls test revealed that the differences between the mean observer ratings of the depressed and the means of the psychiatric control and normal control groups (.4 > .34) were significant. The difference between the means of the observer ratings for the two control groups was .00, and thus not significant. Similarly, orthogonal comparisons showed that the two control groups did not differ from each other, but did differ from the depressed group, F(1, 200) = 12.01, p < .001.

More crucial to the second hypothesis is the Rater x Diagnostic Category interaction. As can be seen in Table 3, this interaction was obtained, F(2, 200) = 3.60, p < .03. Note that contrary to expectation, this

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic category (DC)</td>
<td>2</td>
<td>12.9</td>
<td>17.97**</td>
</tr>
<tr>
<td>Error</td>
<td>200</td>
<td>.7</td>
<td></td>
</tr>
<tr>
<td>Rater (R)</td>
<td>1</td>
<td>17.9</td>
<td>40.59**</td>
</tr>
<tr>
<td>R x DC</td>
<td>2</td>
<td>1.6</td>
<td>3.60*</td>
</tr>
<tr>
<td>Error</td>
<td>200</td>
<td>.4</td>
<td></td>
</tr>
</tbody>
</table>

* p < .05. ** p < .001.

Table 2
Means and Standard Deviations of the Ratings Received by the Three Groups (Pretreatment Assessment)

<table>
<thead>
<tr>
<th>Group</th>
<th>Self-ratings</th>
<th>Observer ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Depressed</td>
<td>3.4</td>
<td>1.0</td>
</tr>
<tr>
<td>Psychiatric control</td>
<td>4.0</td>
<td>.7</td>
</tr>
<tr>
<td>Normal</td>
<td>4.2</td>
<td>.8</td>
</tr>
</tbody>
</table>

Note. n = 71, 59, 73 for the depressed, psychiatric control, and normal groups, respectively. Ratings are on a 7-point scale, where higher scores reflect that the adjectives were seen as being more descriptive of the individuals.
The discrepancy scores (observer ratings subtracted from self-ratings) over time (T1 to T4).

The Individual Items

The foregoing tests of the major hypotheses of this study were performed on measures collapsed over a set of 17 desirable (positive) attributes. These aggregate measures were used because the primary purpose of this study was to examine the desirability of self-perceptions as a function of clinical depression. However, it was of interest to examine the extent to which the major findings of this study were consistent across the individual items. Hence, the means and standard deviations of the individual items were computed separately for the differing diagnostic groups.

In general, the findings were consistent at the item level, although there were differences between the items in terms of their discriminability between the depressed and the controls. With the exceptions of the attributes reasonable and understands what others say, the depressed rated themselves as substantially less desirable than did the controls. Also, the observers rated the depressed as being less positive on all the items. Finally, the discrepancies between the self and observer scores for each item are generally consistent with the findings reported above. In contrast to the controls, who rated themselves as being more desirable than did the observers on all items, the depressed rated themselves as being less desirable on has a positive outlook, confident, socially skillful, popular, attractive, and communicates clearly. However, for most items the absolute discrepancy between the self and observer scores is less

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* All $t$ tests are two-tailed.
* Means and standard deviations computed separately for the control groups and for the depressed subgroups are available from the authors.
Table 4
Means and Standard Deviations of the Ratings Received by the Groups at the Pretreatment (T1) and the Posttreatment (T4) Assessments

<table>
<thead>
<tr>
<th>Group</th>
<th>Self-ratings</th>
<th></th>
<th>Observer ratings</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T1</td>
<td>SD</td>
<td>T4</td>
<td>SD</td>
</tr>
<tr>
<td>Depressed</td>
<td>3.4</td>
<td>1.0</td>
<td>3.9</td>
<td>1.0</td>
</tr>
<tr>
<td>Psychiatric controls</td>
<td>4.1</td>
<td>.6</td>
<td>4.0</td>
<td>.8</td>
</tr>
<tr>
<td>Normal controls</td>
<td>4.2</td>
<td>.9</td>
<td>4.3</td>
<td>.7</td>
</tr>
</tbody>
</table>

Note. Only data for subjects who remained to T4 are included. n = 45, 46, and 58 for the depressed, psychiatric control, and normal control subjects, respectively. Ratings are on a 7-point scale, with higher scores indicating that the adjectives were more generally descriptive.

for the depressed than for the control groups.

Relationships With Time and Treatment

The foregoing analyses suggest that (a) the depressed see themselves as being less socially skilled than do normals, (b) these less desirable self-perceptions are paralleled by the perceptions of others, and (c) the depressed tend to distort (relative to the observers) their self-perceptions less than do controls; the nondepressed (controls) distort more, rating themselves more positively than they are seen.

Table 4 presents the means and standard deviations of the self and observer ratings at the initial (pretreatment) assessment (T1) and at the final (posttreatment) assessment (T4) for subjects who participated at both T1 and T4. In evaluating these data, note that the depressed as a group showed considerable clinical improvement following treatment (Zeiss et al., 1979).

The changes in self-perceptions were evaluated through a $2 \times 2$ (Time: Pretreatment [T1], Posttreatment [T4] $\times$ Diagnostic Category: Depressed, Control) analysis of variance. The results showed main effects for diagnostic category, $F(1, 141) = 16.96, p < .001$, and time, $F(1, 141) = 8.50, p < .005$. In addition, the Time $\times$ Diagnostic Category interaction was significant, $F(1, 141) = 8.70, p < .005$. Inspection of the self-ratings in Table 4 suggests that (a) there was virtually no change in the self-perceptions of the control groups between T1 and T4, (b) the depressed were more benign in their self-perceptions at the end of treatment than they were at the pre-treatment assessment, but (c) the depressed continued to view themselves as less desirable than the controls viewed themselves.

The results for the observer ratings, also shown in Table 4, were submitted to a similar analysis. Main effects for diagnostic category, $F(1, 141) = 6.88, p < .01$, and time, $F(1, 141) = 10.43, p < .01$, were obtained, and the interaction was significant, $F(1, 141) = 6.24, p < .02$. As can be seen in Table 4, at T4 the observer ratings of the depressed and of the nondepressed are quite comparable. Taken in their totality, the results indicate that there was a clear trend for the depressed group to become, during the course of treatment, more benign in their self-evaluations, and this change was corroborated by the evaluations of the observers. Further, this tendency was not observed over the same time for the control group.

The posttreatment assessments allowed us to re-examine the patterns of discrepancies between self and observer ratings found at T1 for the depressed compared to the controls. Inspection of Figure 1 suggests some interesting changes in these patterns of discrepancies. Specifically, for the de-

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1 The control groups were combined, since no significant differences between the psychiatric control and normal groups were obtained on any of the measures at either T1 or T4.
pressed, the relatively small discrepancy found before treatment between self and observer ratings increased after treatment; for the controls, the relatively larger discrepancies between self and observer perceptions found at T1 persisted in the reassessment at T4. Indeed, the mean self-ratings of the control group continued to be much more desirable than the mean observer ratings of them, \( t(100) = 6.13, p < .001 \). Although the self-ratings of the depressed also became more desirable after treatment, the difference between their self-ratings and the observer ratings still did not quite reach statistical significance, \( t(42) = 1.73, p > .09 \), although the tendency was in that direction.

Discussion

Observer Ratings

Before evaluating our findings, we will consider the observer ratings. To some extent, social reality has been defined in this study in terms of these observer ratings. Yet, it would clearly be naïve to assume that such reality is adequately assessed by a single or simple criterion, and it is certainly possible, for example, that observers who knew the subjects more intimately would have provided a different pattern of ratings. Fortunately, some evidence bearing on the validity of the observer ratings was provided by another set of data obtained from the group interactions. In addition to rating themselves on each of the attributes, all the group participants also had been asked to rank order the other group members on those attributes. Although the observer ratings used in the present study were absolute ratings, whereas the peer ratings were relative rankings and hence not directly comparable, it was possible to correlate, across all subjects, the observer ratings and the peer rankings. A correlation of .40 between the two measures on the 17 positive attributes was obtained and is significant beyond the .01 level. For the individual items, the correlations ranged from .15 to .61. Thus, the observer ratings, based on direct observation of the participants’ behavior in group interaction, do seem to provide one reasonable measure of how the subjects were perceived by others. Obviously, however, studies using additional sources and settings (e.g., group vs. dyadic interaction) will be necessary to assess the generality of the findings reported here.

Original Perceptions

As expected, in the initial assessment the depressed rated themselves less positively on social competencies than did either psychiatric control or normal groups, suggesting that they have less positive self-perceptions of their social efficacy. The question remains why such an unfavorable view occurs in depressed individuals. As noted earlier, the depressed may have an unrealistically negative self-perception or may actually possess fewer positive attributes. Partial support for the second alternative came from the finding that observers do indeed judge the depressed to be less positive on social skill attributes.

Depression: Loss of the Illusory Warm Glow?

The major and most unexpected pattern of results, however, involved the nature of the discrepancies between the original self-ratings and the initial ratings made by the observers (Figure 1). These discrepancies were significantly larger for the normal and psychiatric control subjects than for the depressed individuals. Specifically, the initial self-perceptions of the depressed subjects were less discrepant with observer ratings than were the self-perceptions of both the psychiatric and normal controls. The self-ratings of the depressed on positive attributes did not differ significantly from the observers’ ratings of them, and in that sense the depressed were the most realistic. In contrast, the control subjects saw themselves significantly more positively than the raters judged them to be. Nondepressed people may thus be characterized with a halo or glow that involves an illusory self-enhancement in which one sees oneself more positively than others see one. Clearly if social reality is defined by the extent of agreement with objective observers, the depressed at the initial assessment were the
most realistic in their self-perceptions, whereas the controls were engaged in self-enhancing distortions.

The finding that both normal and psychiatric control subjects may generate a perhaps illusory glow in their self-perceptions (compared to the realism of the depressed) may have important theoretical implications for understanding basic mechanisms in emotion generally and depression in particular. Although our finding at first may seem highly surprising, on closer analysis it appears consistent with results from several other lines of research. The importance of the "warm glow" of perceived or expected success and competence for a variety of self-regulatory mechanisms is documented in a considerable body of literature. For example, such a positive glow may lead to greater attention to, and memory for, one's own positive as opposed to negative personal attributes (Mischel, Ebbesen, & Zeiss, 1973, 1976), thereby perpetuating positive self-perceptions. The warm glow may make one generally more benign not just toward oneself but also toward others (e.g., Isen, Shalkfer, Clark, & Karp, 1978; Rosenhan, Underwood, & Boore, 1974). And in the clinical context it has been found that although the depressed may recall less positive and more negative feedback than control subjects, most interestingly (and consistent with the our interpretations here), they proved to be more accurate in their recall of low-frequency negative feedback, whereas the nondepressed underestimated the amount of punishment they had actually received (DeMontreun & Craighead, 1977; Nelson & Craighead, 1977). In other recent experiments, depressed and nondepressed students were confronted with a series of problems that varied in the actual degree of objective contingency between the performer's responses and the outcomes obtained (Alloy & Abramson, 1979). Surprisingly (and consistent with the present results) the depressed students appeared to be "sadder but wiser": their judgments of contingency were remarkably accurate (Alloy & Abramson, 1979, p. 441). The nondepressed students, in contrast, tended to overestimate the degree of contingency for frequent and/or desired outcomes but to underestimate the degree of contingency between their responses and outcomes when the contingent outcomes were undesired. Taken together with our present results, and based on widely divergent methods, an intriguing, unexpected, but seemingly coherent picture of realism is beginning to characterize the depressed.

Changes in Perceptions

As expected, in the course of treatment the depressed became more similar to the controls in their self-perceptions, improving their own perception of their positive social competence. The observer ratings largely paralleled the self-perceptions: They viewed the depressed as becoming more socially competent.

Obviously, at least some of the changes in the depressed individuals after treatment might reflect such factors as their own expectations for posttreatment improvement, the rater's expectations, regression effects from extreme initial scores, and selective attrition in the sample of depressed people who remained in treatment. These factors, though serious for assessing treatment efficacy, are not of central interest for the present work. Our focus here is on the relations between the self-perception of social competence and the attribution of such competence by observers to depressed versus nondepressed individuals regardless of any real therapeutic effects and indeed before any clinical intervention at all. The posttreatment data simply provide us with an additional opportunity to assess the relationships found at the initial testing.

Note that even after treatment the depressed still saw themselves somewhat less positively than the controls saw themselves. Of most interest to us, again, were the comparisons between self-ratings and observer ratings at the terminal assessment. These comparisons (Table 4 and Figure 1) still showed that the depressed rated themselves somewhat more realistically, that is, in ways that more closely matched how others saw them, than did the controls, but this difference between the groups had diminished. In the course of treatment the depressed not only rated themselves more
positively, but, more interesting to us, began to increase the discrepancy between how they rated themselves and how they were rated. Indeed, during treatment their self-perceptions became more unrealistic in the sense that they began to see themselves more positively than the observers rated them. They thus became more like the controls, who continued to judge their own qualities more benignly than did those who observed them. It is tempting to conjecture that a key to avoiding depression is to see oneself less stringently and more favorably than others see one. If so, the beliefs that unrealistic self-appraisals are a basic ingredient of depression and that realism is the crux of appropriate affect may have to be seriously questioned. To feel good about ourselves we may have to judge ourselves more kindly than we are judged.

Reference Notes


References


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