

Teacher-Ratings and Self-Ratings of Social Competency in Adolescents with Low- and High-Depressive Symptoms

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A comparison of teacher-ratings and self-ratings of adolescents' social competency was investigated. One hundred five high school students completed the Reynolds Adolescent Depression Scale (RADS; Reynolds, 1987) and were divided according to their scores into three groups: the lowest quartile [low-depressive symptoms (LDS) group (n = 27)], the highest quartile [high-depressive symptoms (HDS) group (n = 28)], and the remainder. Students also rated themselves and were rated by their teachers on a social competency scale. A 2 (High- and Low-Depressive Groups) × 2 (Teacher-Ratings and Self-Ratings) ANOVA was conducted using social competency rating scores as the dependent variable. The two main effects were significant ($p < .01$). Adolescents with low-depressive symptoms rated themselves and were rated by their teachers as more socially competent than adolescents with high-depressive symptoms; additionally, self-ratings of social competency were higher than teacher-ratings. Results are discussed in the context of an adolescent optimistic bias or a teacher pessimistic bias.

The relationship between depression and social skills in adults was studied quite extensively in the 1970s (Coyne, 1976; Ferster, 1974; Lewinsohn, 1974, 1977; MacPhillany & Lewinsohn, 1974). As the role of social competency in depression became more acknowledged, the separation of actual competency deficits from those of encoding or the perception of those competencies occurred. Lewinsohn, Mischel, Chaplin, and Barton (1980)

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attempted to disentangle the role of two potentially relevant personal variables: social competencies (as perceived by others) and the individual's encoding, or self-perception, of their social competencies. Undergraduates were trained to code social competency (e.g., friendly, popular, assertive, attractive, etc.) in group interactions of depressed and nondepressed adults. It was found that the depressed adults saw themselves as others saw them, deficient in social skills. Unexpectedly, nondepressed adults saw themselves as more socially competent than did the observers, indicating an illusory or optimistic bias for the nondepressed adults, but not for the depressed individuals. An important question is whether this optimistic bias functions similarly for children and adolescents.

Although few studies originally related social competency to depression in children and adolescents, several have considered this population. Blechman, McEnroe, Carella, and Audette (1986) found that an academically and socially "competent" group of elementary school students had significantly lower peer-nominated and self-rated depression scores and higher peer-nominated happiness scores than an "incompetent" comparison group. Sacco and Graves (1984) found that depressed children performed significantly worse than nondepressed children on the Primary Means-Ends Problem Solving task, on social comparisons with their peers, and on self-satisfaction. The authors suggested that depressed children are less socially skillful than nondepressed children. Ehrenberg, Cox, and Koopman (1991) determined that self-efficacy was negatively correlated with level of adolescent depression; low perceived self-efficacy was associated with depression; high levels of self-efficacy related to lack of depression.

In studying the prevalence of depression in children, Lefkowitz and Tesiny (1985) correlated 38 variables with depression and found 25 significantly related to depression. Those that pertained to social skills were peer-nominated happiness, mother-rated happiness, popularity, locus of control, self-rated depression, mother-rated depression, and teacher-rated social behavior. Berenson (1987) found significant correlations between depression and loneliness, and depression and depressogenic attributional style in fifth- and sixth-grade school children. Dalley, Bolocofsky, Alcorn, and Baker (1992) showed that learning-disabled (LD) students evidenced more depressive symptoms than did nonspecial education students, and unsuccessful LD students evidenced a greater number of depressive symptomatology, and more dysfunctional attitudes and depressogenic attributional styles than did other adolescents.

It appears that depressed and nondepressed children differ on a number of variables that relate to social competency. However, the research is indistinct as to whether a difference exists between depressed and nonde-

pressed students' perceptions of their social competencies (encoding) and how others view them.

The present paper attempted to replicate some features of the Lewinsohn *et al.* (1980) adult study and employed nonspecial education adolescents in a school context. Three hypotheses were proposed: (a) Adolescents with low-depressive symptoms would self-report and be rated by their teachers as more socially competent than adolescents with high-depressive symptoms; (b) adolescents would self-report higher social competency levels than their teachers; and (c) an interaction effect would occur such that adolescents with high-depressive symptoms would self-report social competencies no differently than their teachers, but adolescents with low-depressive symptoms would self-report significantly higher competency levels than their teachers. Thus, an illusory or optimistic bias would be demonstrated.

METHOD

Subjects

Subjects were 105 high school students from three northern Colorado high schools with 500 to 800 students in each. The study took place in April. Students were recruited as part of a class assignment in five psychology and two American history classes; the student-teacher ratio for these classes was approximately 23:1. Because of small class sizes and the lateness in the school year, it was felt that teachers knew their students fairly well. Of the targeted 160 students, 69% returned consent forms, and 105 students participated. The mean age of the students was 17.3 ($SD = 0.89$). Most students were 11th graders, and more females (63%) participated than males (37%). The ethnic composition of the two gender-based groups was approximately equal: nearly 91% white, 8% Hispanic, and less than 1% other. The 105 students were ranked according to their scores obtained on the Reynolds Adolescent Depression Scale (RADS; Reynolds, 1987). Students scoring in the lowest 25th percentile on the RADS were designated as the low-depressive symptoms (LDS) group ($n = 27$); those scoring in the highest 25th percentile were designated as the high-depressive symptoms (HDS) group ($n = 28$). The remaining students were not used. The RADS mean score for the LDS group was 44.04 ($SD = 4.69$; range 34 to 50); the mean score for the HDS group was 74.96 ($SD = 6.36$; range 68 to 97).

Measures

Reynolds Adolescent Depression Scale. The RADS was designed, in part, to assess the presence of self-reported depressive symptomatology and to be used for research on depression and related constructs in adolescents age 13 through 18 (Reynolds, 1987). Scores of 77 and above were determined to delineate a level of symptom endorsement associated with clinical depression. This does not, however, constitute a diagnosis of depression, but, rather, indicates the depth or severity of depressive symptoms. The scale is a 30-item self-report inventory rated on a 4-point scale: almost never, hardly ever, sometimes, and most of the time. Examples of items include "I feel like hiding from people," "I have trouble sleeping," and "I feel like nothing I do helps anymore." Research by Reynolds (1987) indicated the RADS to be both a reliable and valid instrument for determining severity of depressive symptoms in adolescents. For the present study, the internal consistency was .91. Reported internal consistencies have been above .90 (Reynolds, 1987). In three separate studies using 6-week, 3-month, and 1-year intervals, test-retest reliabilities, r , were .80, .79, and .63. Content validity for the RADS has been established with the RADS items relating to specific symptoms of depression using clinical and research criteria for depression. Criterion-related and construct validity have also been demonstrated by the RADS strong correlation with the clinical interview scale, the Hamilton Depression Rating Scale (Hamilton, 1967), and other self-report depression measures and related constructs (Reynolds, 1987).

Social Competency Ratings. Social competency was measured using a scale adapted from Lewinsohn *et al.*, (1980), but modified for adolescent use. In the present study, adolescents self-rated 11 competencies on a 7-point scale (1 = not at all characteristic, 7 = extremely characteristic) on each of the following items: (1) "I am friendly"; (2) "I am assertive" ("I go after what I want, but I respect others"); (3) "I am attractive"; (4) "I am a warm person" ("caring"); (5) "I have clear communication" ("I get my point across well to others"); (6) "I am socially skillful" ("I work well with others"); (7) "I am interested in other people"; (8) "I have a sense of humor"; (9) "I am open and self-disclosing" ("I am honest, and I can tell others how I feel"); (10) "I am confident and self-assured" ("I know what I want, and know I can get it"); and (11) "I have a positive outlook on life." Student responses are referred to as self-reports (S-Rs). The teacher whose classrooms were used for this research also completed the same social competency ratings for each student, and these are referred to as teacher-ratings (T-Rs). Instructions to the teachers were to rate the specified student on the same social competency scale as the student rated

himself or herself. Teachers were not allowed to see S-Rs, and students were not allowed to see T-Rs. The internal consistencies determined from this study were .85 for S-Rs and .95 for T-Rs.

Procedure

Parents and students were required to sign consent forms for student participation. The RADS and the social competency scale were administered during the same class time in counter balanced order. Students were allowed to ask questions, and teachers gave assistance, when needed. Each of the seven classroom teachers completed a social competency rating for each participating student; thus, each student had a self-rating and a teacher-rating of his or her social competency, and a depression score. Each student was assigned a random number and instructed to use only that assigned number.

RESULTS

The 2 (High- and Low-Depressive Groups) \times 2 (Teacher-Ratings and Self-Ratings) ANOVA was conducted using social competency rating scores as the dependent variable. Table I presents the social competency mean ratings, standard deviations, and number of subjects for each of the cells in this design. Higher means indicate more adaptive-type social competency.

Results from the 2 \times 2 ANOVA showed significant differences for the two main effects, depressive groups, $F(1, 108) = 12.95, p < .0005$; type of rating, $F(1, 108) = 7.86, p < .006$. These results supported the first two hypotheses: (a) The LDS students rated themselves and were rated by their teachers as significantly more socially competent than the HDS students, and (b) S-Rs were significantly higher than T-Rs. The interaction effect was not significant, $F(1, 108) = 0.08, p = .77$. The third hypothesis was not supported.

Table I. Mean and Standard Deviations of the Self Rating and Teacher Rating by the High- and Low-Depressive Symptoms Groups

Group	Self-ratings			Teacher-ratings		
	<i>M</i>	<i>SD</i>	<i>n</i>	<i>M</i>	<i>SD</i>	<i>n</i>
High depressive	57.36	8.90	28	53.07	10.50	27
Low depressive	63.89	6.08	27	58.63	9.03	27

DISCUSSION

The premise that social competency plays an important role in adolescent depression was supported by this investigation. Consistent with Coyne's (1976) study of adults and Sacco and Graves (1984) and Blechman *et al.*'s (1986) research with children, the present study found that adolescents who self-reported more depressive symptoms rated themselves and were rated by their teachers as less socially competent than those who reported less depressive symptoms. The present research was unique in that teachers and adolescents both rated the adolescents' social competencies on the same instrument, enabling a teacher-student comparison. Lewinsohn *et al.* (1980) proposed an optimistic bias for nondepressed adults; the present study suggests that adolescents regardless of depressive status show an optimistic bias in relationship to their teachers' observations. What the present research intimates is partially consistent with Lewinsohn's study: the nondepressed may have a self-serving optimistic bias or illusion of performing better, which may serve as a defense against depression. Of course this bias could be a "pessimistic bias" on the part of teachers. It may be that teachers are generally more pessimistic than students, or perhaps they are less aware of students' social competencies, and therefore, rate students as less socially desirable. Whether optimistic or pessimistic, this bias occurred in this study because teachers rated the HDS students lower in social competency than they did the LDS students. In Lewinsohn's study, the observer rated the depressed and nondepressed similarly. In the present study, if teachers had rated the two adolescent groups equally, the hypothesized interaction effect, hypothesis (c), would have occurred; but it did not. In fact, teachers rated the LDS students similarly to the way HDS students rated themselves (cf. means of 58.63 and 57.36).

Reschly (1985) indicated that third-party respondents rating students create a number of problems such as respondents' lack of information, respondents' biases, and how well informed the respondents are concerning the clients' competencies. Reschly implied that teachers know little about what their students do outside of school. On the other hand, Elliott and Gresham (1989) found teacher-ratings accurately differentiate popular adolescents from rejected adolescents, thus substantiating the validity of teacher-ratings. Our results do not solve this dilemma, but it is mentioned to highlight the problem of using teacher-ratings. Lewinsohn *et al.* (1980) trained undergraduate students to rate their adult subjects interacting in the confines of therapy; in the present study, teachers responded only to a social competency rating scale regarding their students. This difference in methodology points to a future direction in this area—training observers to rate adolescents both within and outside the school context.

Much criticism of child and adolescent studies of depression has to do with the severity of the depression being observed. Lewinsohn's *et al.*'s (1980) study and many of the adult studies of depression involve the observation of adults diagnosed as depressed and treated as such. In many of the children and adolescent studies, students self-reported depressive symptoms, teachers reported depressive symptoms of children, and/or peer nominations acted to select depressed students. None of these methods qualify as indicating that a student is clinically depressed. It is worth mentioning the RADS scores from the two groups of adolescents used in the present study. The LDS group's mean score was 44.04 ($SD = 4.69$, range 34 to 50), indicative of students reporting minimal depressive symptoms—the lowest score on the RADS is 30. The HDS group's mean score was 74.96 ($SD = 6.36$, range 68 to 97), indicating a significant number of self-reported depressive symptoms. Out of the 28 students in the HDS group, 32% scored 77 or above on the RADS; none in the LDS group scored this high. A RADS score of 77 or above denotes a level of symptom endorsement associated with clinical depression. Thus, the two groups were representative of individuals with depressive and nondepressive symptomatology. However, the limitation of this approach in studying depression within the context of schools rather than clinics is acknowledged.

A further limitation of the present study regards the measure used. The RADS, as well as other types of self-report depression scales, are highly correlated with anxiety and other measures of negative affect such as low self-esteem, loneliness, learned helplessness, suicidal ideation, and negative life events. A question is raised as to whether the current results are specific to only depressed adolescents. Reynolds (1987) provided extensive validity data not only on the RADS' content and criterion-related validity, but also on convergent and discriminant construct validity which disclosed high correlations among various constructs. Reynolds argued that self-esteem and anxiety maintain some unique specific variance, but are also symptom components of depressive disorder and as such have strong relationships with depression. Gotlib (1984) contended that, because of commonalities of symptoms, a unitary factor such as general distress, dysphoria, or malaise might be a better description of students' emotionality than depression. It is uncertain whether results of the present study would generalize to other student groups, but based on Reynolds' (1987) psychometric analyses and Gotlib's argument, one would be inclined to answer yes. Future research will need to consider whether results of the response bias is only representative of depressed students or if other groups of students displaying negative affect demonstrate this bias as well.

A related limitation of this research regards the specificity of the results to the dependent variable. It is not known if the depressed students

in the current study showed a negative response bias only to social competency issues or if this bias was pervasive across other domains such as academic performance and athletic skills. Depressed youths have been shown to have academic difficulties (Reynolds & Coates, 1982), intellectual deficits (Kaslow, Tannenbaum, Abramson, Peterson, & Seligman, 1983), social/behavioral problems (Berenson, 1987; Blechman *et al.*, 1986), and low self-efficacy (Ehrenberg *et al.*, 1991), but whether they demonstrate a negative response bias across domains has not been determined. Future research is also needed to show whether proficiency in various domains would be perceived differently by depressed and nondepressed youths and by the observations of others such as trained observers, teachers, counselors, administrators, peers, and parents.

It should be kept in mind that the present study was completed in a school setting with an homogeneous ethnic grouping (91% Caucasian), limited to mostly 11th graders, and had a skewed distribution of 63% females. Future research should obviously employ more ethnic diversity, equal gender groupings, and other grade levels.

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