# Validation of the Self-Discrepancies Scale (S-DS)
# A tool to investigate the Self in clinical and research settings

Validation du questionnaire d'écarts des sois :

Un outil pour explorer le Soi en recherche et en clinique

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Authors' Note

Abstract

The present report investigates the validity, psychometric characteristics, and the clinical relevance of the Self-Discrepancy Scale, an instrument designed to assess discrepancies between mental representations of the self: the actual self, on the one hand, and ideal or socially-prescribed selves, on the other hand. The Self-Discrepancy Scale has been administered in a large community sample, together with measures of depression, anxiety, self-esteem, and self-efficacy. It was also applied to a clinical sample composed of clients with a diagnosis of mood or anxiety disorders seeking psychotherapeutic help. The data suggest that the Self-Discrepancy Scale is a valid measure of self-discrepancies and a valuable predictor of emotional vulnerability, especially with regards to abstract global judgments of discrepancies and of discrepancy-induced distress. It is concluded that the Self-Discrepancy Scale is a valuable tool in clinical settings.


Cet article explore la validité, les caractéristiques psychométriques et la pertinence clinique de l'Echelle d'Ecarts des Sois, un instrument conçu pour évaluer avec des indices multiples les écarts entre les représentations mentales du soi : le Soi actuel, d'une part, et le sois idéal et socialement prescrit, d'autre part. L'Echelle d'Ecarts des Sois a été administrée à un large échantillon tout-venant, en même temps que des mesures de dépression, d'anxiété, d'estime de soi et d'efficacité personnelle. Il a aussi été proposé à un échantillon clinique de patients répondant à un diagnostic de trouble de l'humeur ou d'anxiété. Les présentes données suggèrent que l'Echelle d'Ecarts des Soi est une mesure valide des écarts des Sois et un prédicteur de la vulnérabilité émotionnelle, spécialement en ce qui concerne les jugements globaux et abstrait des écarts et de la détresse qu'ils induisent. L'Echelle d'Ecarts des Sois constitue une aide précieuse en contexte clinique.

Validation of the Self-Discrepancies Scale (S-DS)

A tool to investigate the Self in clinical and research settings

Many people seeking psychotherapy complain of not being the person they would like to be, or of having the feeling that they disappoint significant others.  Rogers (1951; 1959) has pointed to the discrepancy between real and ideal selves as a source of emotional distress. The notion of self-discrepancy has been further theorized by Higgins (1987), who distinguished between two types of discrepancies.  He proposed that the discrepancy between the perceived actual self (who people believe they are) and the socially prescribed or "ought" self (who people believe others would want them to be) is uniquely related to anxiety, while the discrepancy between the actual self and the ideal self (who people ideally would want to be) is uniquely related to depression.  Despite these clinical roots and implications, the construct of self-discrepancy are rarely used in clinical psychology and psychotherapy, while it has been very successful in social and personality psychology research (for a review, see Hardin & Lakin, 2009).

The lack of interest for self-discrepancy in clinical settings might stem from uncertainty on how to best evaluate it.  Indeed, several measures of self-discrepancies have been proposed, but all have been criticized and no consensus has emerged around a standard and practical measure.  Higgins has proposed an idiographic method, the Selves Questionnaire, to measure self-discrepancies (Higgins, Klein, & Strauman, 1985). It requires participants to generate lists of up to 10 attributes each for their actual, ideal, and socially prescribed selves, from their own standpoint and from the standpoint of a significant other, hence generating six self-descriptions.  Discrepancies are evaluated by comparing the attributes listed for pairs of self-representations (actual – ideal; actual – socially prescribed, from both standpoints) and computing the difference between the number of matches (same or

synonymous words listed in each self-representation) and mismatches (opposite words listed in each self-representation). This questionnaire has been criticized for being long and tedious (e.g. Tangney, Niedenthal, Covert, & Barlow, 1998), as it requires participants to generate six lists of 10 characteristics, hence a total of 60 traits. Also, the scoring of the questionnaire is long and subject to interpretation, as it requires the coders to identify possible synonyms and antonyms in the lists generated by the participants. Furthermore, Boldero and Francis (2000) noted that the questionnaire underestimates self-discrepancies: Across four studies using the Selves Questionnaire, they observed that only between 4.3% and 26% of their participants actually obtained scores indicating the presence of self-discrepancies. All these characteristics make the Selves Questionnaire impractical in clinical settings.

In order to address some of these shortcomings, other measures of self-discrepancy have been proposed. For instance, Watson (2004, http://www.wm.edu/research/watson) developed three instruments that assess discrepancies between the actual self and the ideal or socially prescribed selves. In two of these instruments, the idiographic "Self-Concept Questionnaire – Personal Constructs" and the nonidiographic "Self-Concept Questionnaire – Conventional Constructs", participants are requested to describe their actual, ideal, and socially prescribed selves on either bipolar scales (first instrument) or unipolar scales (second instrument) anchored with traits related to the self. In the last instrument, which is content-free and abstract, participants indicate in general to which extent their actual self and their ideal self are alike, and the extent to which their actual self and their socially prescribed self are alike, by selecting a pair of intersecting squares or circles that pictorially represents degrees of similarity. In a series of comparison studies, Watson, Bryant and Thrash (2010) observed good psychometric validity for the first two measures, but weaker validity for the abstract instrument, especially with regards to indices related to the socially prescribed self.

Convergence with other measures was particularly strong for the first, idiographic questionnaire. The authors have consequently advised researchers to rely on the idiographic measures of self-discrepancies in clinical and personality research.

Another attempt to overcome the limits of Higgins's Self-discrepancy questionnaire has been formulated by Hardin and Lakin (2009): the Integrated Self-Discrepancy Index (ISDI). The ISDI assesses ideal and socially prescribed self-discrepancies from the participants' own standpoint and from the standpoint participants attribute to a significant other. It comprises two components. In the idiographic component, participants are requested to list up to five characteristics that best describe each of the four target selves (ideal and socially prescribed selves, from either their own standpoint or the standpoint of a significant other). After generating traits for each self, in the nomothetic component, participants are shown a list of 100 traits from which they can choose to complete (if fewer than five attributes were listed) or modify their lists. Finally, participants have to rate each trait on a 5-point scale, indicating the extent to which each of the traits listed actually describes their ideal or socially prescribed self. Self-discrepancy scores are the average of the ratings of the five attributes generated for each of the self-states. Hardin and Lakin reported two studies conducted on undergraduate samples showing good convergent validity of the ISDI. In addition, they observed that socially prescribed self-discrepancies were more specifically related to agitation but not to dejection (after partialling out other self-discrepancies), whereas ideal self-discrepancies were uniquely related to dejection but not to agitation (also after partialling out other self-discrepancies).

Given the qualities reported by Hardin and Lakin (2009), the ISDI seems very promising: It captures participants' idiographic self-discrepancies, it is accessible to a diverse sample of participants (as it does not require an extended vocabulary about personality traits),

and it can be objectively scored. Yet, it leaves unanswered at least two questions. First, it is unclear how the averaged discrepancy scores, stemming from the individual trait ratings, relate to the overall phenomenological feeling from the individual of that very discrepancy. In other words, how would the scores of the ISDI relate to an abstract measure such as that proposed by Watson, Bryant and Thrash (2010)? A second question is the relation between the perceived discrepancy and the psychological distress it may induce. Indeed, some individuals might perceive large self-discrepancies, but accept them and develop healthy self-compassion (Neff, 2009), while others might experience great distress to similar or even weaker self-discrepancies. One might suspect that the relation between self-discrepancy and depression or anxiety might be stronger for the distress elicited by the discrepancy than for the extent of the discrepancy itself. Carver and Scheier (1990) noted that self-discrepancies could lead to anxiety and depression under two conditions. One is that the rate of reduction of the discrepancy is perceived as too slow by the individual. The second is goal conflict. Goal conflict can occur between more than one ideal self-state, or between an ideal and a socially prescribed self-state. Kelly et al. (2015) has even proposed that it is this discrepancy between ideals, or between ideals and social prescriptions, that maintains actual-ideal discrepancies. The common point of these two conditions is that distress results from the discrepancies.

With these considerations in mind, we endeavor to develop a self-discrepancies questionnaire that would merge the qualities and advantages of those developed by Watson, Bryant and Thrash (2010) and by Hardin and Lakin (2009). In addition, we desired to have a questionnaire that would be practical and useful in clinical settings, i.e., informative about the idiosyncratic self-representations of the clients and easy (and short) to administer. We created the Self- Discrepancies Scale (S-DS), by simplifying the ISDI and by adding scales evaluating the overall feeling of discrepancy and the associated distress. In order to simplify the ISDI,

we deleted the assessment of the discrepancies from the perspective of another person, as it does not seem to add much predictive power in terms of emotional vulnerability, such as depression or anxiety. We also directly presented a non-restrictive list of possible traits directly at the start of the questionnaire (not at a second step, like in the ISDI), as previous clinical experience has shown that this order of presentation made the instructions clearer for the participants and reduced the completion time. Another way in which the S-DS is different from the ISDI is that each self in the S-DS is defined not only in terms of the desired traits that best characterize it, but also with the undesired traits that negatively define it (i.e., the traits in opposition to the self in question). Again, our clinical experience suggests that negative formulation might be particularly relevant for people experiencing self-dejection (Leary & Baumeister, 2000). Concretely, the S-DS consists of two parts, one that defines the ideal self and that estimates the discrepancy between the ideal self and the actual self, and one that defines the socially prescribed self and that estimates the discrepancy between the socially prescribed self and the actual self. The composition of the S-DS is fully described in the method section.

The aims of the present study are to establish the psychometric characteristics of the S-DS as well as to investigate the relations between average scores and global judgments of discrepancies and distress. In addition, we investigated whether the distress elicited by a discrepancy between two self-states is a better predictor of depression or anxiety than the extent of that discrepancy itself. Finally, we desired to examine the discriminant validity of the S-DS in a clinical sample. Therefore, we completed a validation study in a large community sample. We complemented that study with an additional data collection in a clinical sample composed of clients seeking psychotherapy help for diagnosed mood or anxiety disorders.

**Method**

**Participants**

**Community samples**

Participants were contacted by email via several channels: a pool of volunteers from the community organized by our research institute (10% of the final sample), a CNRS server for psychology experiments (RISK, www.risc.cnrs.fr) (16 % of the final sample), social networks (23% of the final sample), and acquaintances of the authors and their colleagues with a snowball procedure (51% of the final sample). Requirements to take part in the study were to be 18 years old or more and to be fluent in French. Two hundred and eighteen participants (170 women) completed the survey. They were between 18 and 70 years old ($M$ = 35.33, $SD$ = 14.32), most of them were married or living in a couple (52.3%) or single (39.4), and holding a university degree (71.1%) or a superior school diploma (15.1%) as their highest education qualification. A subsample of 82 participants (65 women) participated in a six-week test-retest assessment. The mean time between the two measurements was 44 days ($SD$ = 6.33). There were no differences in age, education, or marital status (all $p > .17$) between those who took part in the second survey and those who did not.

Another sample was recruited among the same pool of volunteers from the community and acquaintances for a shorter (one week) test-retest assessment. It comprised of 49 participants (13 women). Compared to the main control sample, this sample was younger (mean age = 28.64, $SD$= 9.64), $t(103) = 3.98$, $p < .001$, and comprised of more men, $\chi^2(1) = 49.12$, $p < .001$.

**Clinical sample**

Sixty patients seeking psychological treatment for mood and anxiety disorders (43 women) were administered an intake questionnaires protocol. They were asked whether they agreed to their questionnaire data being used for research purposes. It was explained that the researchers and the therapist would be different persons and that their data would remain anonymous. This protocol was approved by the ethics committee of the psychology department of the first author's university. All patients agreed. They were consulting psychotherapists working either in university psychological service centers, hospitals, or private practice. Based on their primary diagnosis ascertained by a licensed psychotherapist, patients were categorized as "depressive" (major depression, dysthymia; 5 men, 14 women; mean age = 36.10), "anxious" (phobias, panic disorder, agoraphobia, generalized anxiety disorder, obsessive compulsive disorder; 9 men, 21 women; mean age = 32.57), or "comorbid" if complying to the criteria of a disorder in both domains (3 men, 8 women; mean age = 31.10). These three groups did not differ among themselves, nor did they differ from the main control sample regarding gender distribution, $\chi^2(3) = 1.14$, $p > .77$, age, $F(3, 274) = .66$, $p > .57$, or marital status, $\chi^2(12) = 13.97$, $p > .30$. There was, however, a significant difference in education, $F(3, 270) = 5.73$, $p > .001$. Bonferroni post-hoc tests revealed that depressed patients ($M = 3.88$, $SD = .99$) were less educated than the control participants ($M = 4.53$, $SD = .83$), $p < .03$. No other differences were significant (anxious patients: $M = 4.07$, $SD = 1.18$; comorbid patients: $M = 3.91$, $SD = 1.22$).

**Questionnaires**

The **Self-Discrepancies Scale (S-DS)** evaluates self-discrepancies and more globally self-representations (See Annexe 1). It consists of two parts, one defining the ideal self and estimating the discrepancy between the ideal self and the actual self, and one defining the socially prescribed self and estimating the discrepancy between the socially prescribed self

and the actual self.  Participants were first requested to generate a list of characteristics (maximum 8) that they ideally wish to have (desired traits), then a list of characteristics (maximum 8) that they ideally wish not to have (undesired traits). For each trait, they estimated the extent to which they possess it on a scale from 0% to 100%. Next, participants were asked to estimate (a) the perceived gap between their ideal and actual selves (item example : "Overall, what is the gap between this ideal and the way you perceive yourself?"), and (b) the resulting distress on two Likert scales from 0 to 7 (item example: "What is the distress elicited by this gap?").  This procedure was then repeated for the socially prescribed self. Following the procedure adopted in the ISDI (Hardin & Lakin, 2009) to help participants identify their personal characteristics, a list of 105 traits was provided, encompassing the domains of competence, likability, and physical appearance.  Participants were instructed that they could select characteristics that were not presented in the list.  The English and French versions of the S-DS can be downloaded from http://uclep.be/s-ds/.

The S-DS is scored in the following way: Percentages reflecting the extent to which each trait is possessed are averaged for the desired and undesired ideal and socially prescribed traits, leading to four scores: Desired Ideal Trait Percentage (WIT%), Undesired Ideal Trait Percentage (UIT%), Desired Prescribed Trait Percentage (WPT%), and Undesired Prescribed Trait Percentage (UPT%).  Hence, the Self-Discrepancies questionnaire yields eight scores: the four aforementioned scores, and self-reported global distance between the actual and ideal self (Ideal Gap), self-reported distress elicited by that distance (Ideal Distress), self-reported global distance between the actual and socially prescribed self (Prescribed Gap), and self-reported distress elicited by that distance (Prescribed Distress).

The **Self-Efficacy Questionnaire (SE-Q)** was created by our team (Philippot, Dethier, Baeyens, & Bouvard, 2016) in accordance with the recommendations of Bandura (2006). It

comprises 10 items covering various life domains: relationships within the family, relationships within the couple, relationships with friends, professional relationships, parenthood, sex life, profession or studies, emotion regulation, free time and hobbies, daily chores. Participants are requested to evaluate the level of confidence in their ability to handle each domain on a scale from 0 (not at all) to 100 (perfectly). A total score is computed by averaging all items. Its internal consistency is very good (Cronbach's alpha = .82).

The **Beck Depression Inventory** (BDI-21; Beck, Steer, & Brown, 1996) is a 21-item self-report inventory that assesses depression. For each item evaluating a symptom of depression, four answers are proposed, scoring from 0 to 3. A total score greater than 11 is considered as denoting mild depression. The internal consistency is very good (Cronbach's alpha = .89).

The **Beck Anxiety Inventory** (BAI; Beck, Epstein, Brown, & Steer, 1990) is a 21-item self-report inventory that assesses anxiety. Each item evaluating a symptom of anxiety is rated on a four-point scale ranging from "not at all" to "very much – barely bearable". A total score greater than 9 is considered as denoting mild depression. The internal consistency is very good (Cronbach's alpha = .89).

The **Rosenberg Self-Esteem Questionnaire** (RSE-Q; Rosenberg, 1965) is a 10-item scale that measures global self-worth by measuring both positive and negative feelings about the self. All items are answered using a 4-point Likert scale format ranging from strongly agree to strongly disagree. The internal consistency is very good (Cronbach's alpha = .90).

**Procedure**

In the main community sample, the survey was completed online. Informed consent was obtained from all participants included in the study. They first filled in demographic

variables and were then proposed the Self-Discrepancies Questionnaire, the Self-Efficacy Questionnaire, the Beck Depression Inventory, the Beck Anxiety Inventory, and the Rosenberg Self-Esteem Questionnaire. Finally, they were asked whether they would agree to be re-contacted via email to fill in part of the questionnaires again. Those who agreed were re-contacted after six weeks, and again completed the S-DS.

The additional community sample completed the S-DS as a paper and pencil questionnaire. It was included in a package comprising questions about demographic variables and the Depression, Anxiety and Stress Scale (DASS-21; Lovibond & Lovibond, 1995), whose data are not reported here. The participants were directly approached by the experimenter who gave the instructions and delivered the questionnaires to the participants at home. One week later, the experimenter once again delivered the same questionnaire package to participants.

In the clinical sample, participants filled in the questionnaire protocol either online, or on paper. This protocol consisted of seven questionnaires, including the S-DS (for a full description of the protocol, see Philippot et al., 2016).

All the psychometric properties (internal consistency, test-retest, external validity and individual differences) were calculated on the main control sample and the test-retest characteristics were also computed on the additional control sample. The clinical sample was only involved in the computation of discriminant validity as applied to a clinical sample, in comparison to the main control sample.

## Results

### Data analysis strategy

First, the internal reliability of the S-DS was examined through the correlations among the different indices and a factor analysis. Then, the external reliability was investigated with the correlations between S-DS indices and the scores of the questionnaires measuring convergent concepts. This was followed by analyzing individual differences with *t*-tests or correlations between S-DS scores and individual characteristics. Next, test-retest reliability was examined by correlating S-DS scores measured at two times, in two samples differing in terms of the time lag between the two measures. Finally, the clinical discriminant validity was assessed by contrasting four samples differing in terms of clinical status on the S-DS scores.

The correlation coefficients were interpreted using the description of Cohen (1988).

**Internal reliability**

Correlations among the different indices of the Self Discrepancies Questionnaire are displayed in Table 1. As can be seen, the Ideal Gap is strongly negatively correlated to the Desired Ideal Trait Percentage. The correlation is very weak with the Undesired Ideal Trait Percentage. Correlations are weaker for Ideal Distress, and undifferentiated among ideal and prescribed indices. A similar pattern is observed for the Prescribed Gap. Prescribed distress is positively correlated with all the indices of self-reported discrepancies (Gap indices). Finally, distress indices are strongly correlated with themselves and significantly related to their respective self-reported discrepancy. It is also interesting to note that the large negative correlations within the two Desired and within the two Undesired Trait Percentage. The overall Cronbach's alpha for the 8 indices is .60, which is rather low and suggests that the construct is multidimensional.

Insert about here Table 1

To further explore the covariation pattern of the self-discrepancy indices, we factor analyzed them with a Varimax rotation. A three factor solution was selected explaining 70% of the total variance (44% explained by the first factor, 15% by the second factor, and 11% by the third). As can be seen in Table 2, the first factor sums all the Gap indices, except those denoting undesired traits that constitute the third factor. The distress indices gathered on the second factor. This covariation structure suggests that the representations for self-discrepancies are similar for the ideal and the socially prescribed selves. Also, the distress resulting from the self-discrepancies seems partly independent of the magnitude of the discrepancy gap. Finally, the endorsement of undesired traits seems to be determined by factors other than only the magnitude of the gap or the resulting distress.

Insert about here Table 2

**External validity**

The indices of the Self-Discrepancy scale were correlated with the scores of self-esteem (RSE-Q), self-efficacy (SE-Q), depression (BDI), and anxiety (BAI). Table 3 shows that all the correlations were significant and in the expected direction. It should be noted that the correlation with anxiety tended to be weaker than the one with depression, self-esteem, and self-efficacy. Also, the correlations with the indices related to the ideal self were systematically larger than those related to the prescribed self, with the exception of the undesired trait indices. Finally, the correlations with the indices related to the discrepancy gaps were similar in magnitude to those with the indices related to the distress induced by these discrepancies.

Insert about here Table 3

Linear regressions with the "enter" method were conducted with the scores of self-esteem (RSE-Q), self-efficacy (SE-Q), depression (BDI), and anxiety (BAI), as dependent variables, and with all eight indices of discrepancy and distress related to the selves as predictors. As can be seen in Table 4, the self-reported discrepancy for the ideal self and its related distress were significant predictors for all four dependent variables. The Undesired Prescribed Trait Percentage also added predictive power to the self-efficacy and depression scores. Finally, the Desired Ideal Trait and the Desired Prescribed Trait Percentages added predictive power to the self-efficacy score. No other predictors were revealed to be significant.

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Insert about here Table 4

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**Individual Differences**

Correlations were computed between the indices of discrepancy and distress related to the selves on the one hand, and age, educational level and socio-economic status, on the other hand. No correlation reached significance, except for correlations between age and some ideal-self indices: $r(218) = -.25$, $p < .001$, for Ideal Gap, $r(218) = -.20$, $p < .001$, for Ideal Distress, $r(218) = -.22$, $p < .001$, for the Undesired Ideal Traits Percentage. This suggests that the discrepancy between actual and ideal selves, as well as the associated distress, tends to diminish with age.

*T*-tests with gender as the independent variable, and the indices of discrepancy and distress related to the selves as the dependent variables revealed no differences. In contrast, a one-way ANOVA with marital status as the dependent variables revealed several significant differences. As can be seen in Table 5, singles, people living in couple, or those who are married report more discrepancies and distress related to the ideal self than divorced or

separated people, respectively, $F(2, 215) = 5.81$, $p < .003$, and $F(2, 215) = 5.39$, $p < .005$.

These effects were not significant with socially prescribed self-indices. It should noted,

however, that the present sample comprises of only 18 separated or divorced participants.

Insert about here Table 5

**Test-Retest**

Table 6 displays the test-retest correlations between Time 1 and Time 2 among the

differences indices of the S-DS in the main control sample. Correlations were all strong and

clearly significant, with the exception that the correlations of the self-reported indices related

to the socially prescribed self tended to be weaker, albeit still clearly significant. All the

correlations were near .70, except the socially prescribed self indices (discrepancy and

distress). Only the Ideal Distress test-retest correlation was above .70.

Insert about here Table 6

The same analysis was performed on the additional control sample with a shorter (one week)

test-retest delay. Correlations were clearly stronger in this case: $r(33) = .84$; .91; .72; .84, all

$ps < .001$, for respectively Ideal Gap, Ideal Distress, Prescribed Gap, and Prescribed Distress.

**Clinical discriminant validity**

A one-way ANOVA was conducted on the data merged between the main control

sample and the clinical sample, with "diagnosis" as a between-subjects factor and the self-

indices as dependent variables. The control sample was assigned a null diagnosis, while the

clinical sample received a diagnosis of either depression, anxiety, or comorbid mood and

anxiety disorder, as explained above. As can be seen in Table 7, both gap and distress self-

indices were higher in the clinical samples as compared to the control sample. The latter

shows the highest endorsement for desired traits and the lowest for undesired traits. Interesting differences also appear between diagnosis categories. It is remarkable that the Ideal Gap and the Ideal Distress are particularly high for those suffering from depression and, to a lesser extent, comorbid depression and anxiety. In contrast, levels of Prescribed Gap as well as Prescribed Distress were similar among depressed and anxious patients. However, they tended to be more elevated in those suffering from comorbid anxiety and depression. Finally, participants suffering from depression (whether uniquely or comorbid with anxiety) have the highest endorsement of undesired traits and the lowest for desired traits. Participants suffering from anxiety disorders only are no different from controls regarding the endorsement of desired and undesired traits.

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Insert about here Table 7

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Discussion

In the present study, the S-DS was administered to a large range of individuals, differing in age, socio-economic, or clinical status, and in a diversity of contexts (internet survey, therapy sessions in a private practice or public hospital, etc.). No participant from the clinical sample reported any major difficulty in completing the questionnaire during the extensive debriefing conducted with their therapist during the individual feedback session on the questionnaire. This attests to the practicality of the S-DS, including in clinical settings. While all indices were inter-correlated, their overall Cronbach's alpha was rather weak (.60), suggesting that the construct might be composed of different dimensions. The factor structure indeed revealed that the gap indices loaded on one dimension, while the distress and the undesired trait endorsement loaded each on their respective second and third dimensions. The

fact that indices related to the ideal and socially prescribed selves were indistinguishable in the factorial structure questions the relevance of this distinction (this point will be further discussed below). The different self-discrepancy indices showed good convergent validity with external indicators such as self-esteem, self-efficacy, depression or anxiety. Finally, test-retest analyses showed excellent stability at a one week follow-up, but which somewhat diminished, while remaining in the acceptable range, at a six-week follow up. This stability replicates previous findings, suggesting that self-discrepancy could be considered as a personality trait (Strauman, 1996).

One question examined in the present study pertains to the relation between the overall abstract judgements regarding self-discrepancies and their evaluation by the idiosyncratic mean endorsements of traits. It appears that both types of measures are highly correlated, especially regarding the ideal self-discrepancy. In addition, correlations tend to be larger within the same self-domain than across domains and types of indices. Both types of discrepancy estimates appear to be similarly related to external indicators. However, the regression analyses show that the abstract self-report discrepancy indices, especially those related to the ideal self, are better predictors of anxiety, depression, self-esteem, and self-efficacy than the idiosyncratic mean indices. Taken together, the present data suggests that the abstract indices are a valid and easily measured estimate of self-discrepancies. This is in contrast with the conclusions of Watson, Bryant and Thrash (2010), based on their observations of smaller correlations between their abstract measures and external validity indices (depression and anxiety), as well as smaller test-retest correlations, as compared to their idiographic indices. A possible explanation is that, while our measures were based on 8-point Likert scales, Watson et al.'s (2010) abstract measures consisted of selecting drawings of intersecting abstract figures representing different self-states (i.e. separate circles

represented different self-states, and the physical overlap between the two circles was varied to illustrate the extent to which the two representations conceptually overlap). It is possible that people are more familiar with the response format we used, and thus responded more reliably. Another factor is that participants of the present study filled in the idiosyncratic measures before the abstract measures. This might have helped them to anchor their judgment on more concrete reference points than if they had to directly answer to the abstract measures as in Watson et al. (2010).

The analyses conducted on the clinical sample confirm previous observations of larger self-discrepancies in clinical populations as compared to non-clinical populations (Fairbrother & Moretti, 1998; Parker, Boldero, & Bell, 2006; Roelofs et al., 2007; Scott & O'Hara, 1993; Strauman et al., 2001; Weilage & Hope, 1999). They also confirmed that depression is particularly characterized by a larger discrepancy with the ideal self as compared to the socially prescribed self. This is in line with previous studies showing that the ideal self-discrepancy is specifically related to sadness and dejected emotions (Higgins, 1987; for a review, see Moretti & Higgins, 1999) and to depression (Fairbrother & Moretti, 1998; Scott & O'Hara, 1993). In contrast, the social prescribed self-discrepancy did not differ between anxious and depressed patients, while it tended to be particularly large in patients with comorbid disorders. Hence, we did not replicate the specific link between agitated emotions and socially prescribed self-discrepancy, as predicted by Higgins (1987). It should be noted that this specific link has also not been observed by other studies (Bruch, et al., 2000; Bryan et al., 2008; Scott & O'Hara, 1993; Tangney et al., 1998; Weilage & Hope, 1999). The pattern of our data is congruent with the hypothesis proposed by Watson, Bryant and Thrash (2010). Based on Rogers's (1959) notion that emotionally vulnerable individuals would have introjected conditions of worth from significant others, Watson et al. (2010) inferred that large

socially prescribed self-discrepancies should lead to large ideal self-discrepancies. In this perspective, both anxiety and depression are criteria for both discrepancies, with ideal self-discrepancies being the more proximal predictor, which is supported by previous findings (Bryan, Watson, Babel, & Thrash, 2008).

The S-DS is also the only self-discrepancy instrument that comprises measures of distress elicited by each discrepancy. We hypothesized that such distress might be a better predictor of general emotional distress (depression and anxiety) than the extent of the discrepancy itself. Considering the proportions of variance explained by clinical status for each discrepancy index (Table 7), it appears that distress and the extent of the ideal self-discrepancy do not differ, while, for the social prescribed self-discrepancy, distress explains almost three time as much variance as does extent, hence partially confirming our hypothesis. Similarly, in the healthy main sample, the regression coefficients (Table 4) for the distress elicited by the discrepancy between the actual and ideal selves are larger than those of the gap for this discrepancy for both self-esteem and depression. In contrast, these coefficients are similar for anxiety and smaller for self-efficacy. It should also be noted (Table 1) that the correlation between distress and the extent of the gap is larger for ideal self-discrepancy ($r =$ .49) as compared to socially prescribed self-discrepancy ($r = .32$). This suggests that ideal self-discrepancy more directly affects the individual, while socially-prescribed self-discrepancy might less directly induce distress. However, when it does, it might be related to more acute emotional distress and vulnerability. Indeed, in the present clinical sample, the correlations between gap and distress are similar for ideal ($r(58) = .54$) and socially prescribed ($r(58) = .53$) self-discrepancies. The possibility that socially-prescribed self-discrpeancy might be positively related to emotional distress and vulnerability is also congruent with the report of a recent study examining self-discrepancies with the S-DS in

recently detoxified alcoholic patients (Poncin, Dethier, Philippot, Vermeulen, & de Timary, 2015). In this clinical population, it was observed that distress, but not gap, associated with self-discrepancies specifically predicted negative and positive affectivity, and importantly, the alcohol craving. Both distress and extent of the self-discrepancies predicted depression. Unfortunately, this study collapsed ideal and socially prescribed self-discrepancies, which do not allow possible differences between these self-states to be examined. Taken together, these data suggest that both distress and extent of the self-discrepancies are clinically important. This is also supported by our clinical experience of the S-DS that attests to the importance of considering both distress and extent in order to understand the impact of self-discrepancies on the functioning of individuals.

To conclude, the present data suggest that the S-DS is a valid measure of self-discrepancies and a valuable predictor of emotional vulnerability. It is easy to administer and to code, and is of practical use in clinical settings. Adding to an ongoing debate on this question (for a discussion, see Watson, Bryant and Thrash, 2010), we did not obtain a clear psychometric distinction between ideal and socially prescribed self-discrepancies. However, at the clinical level, this distinction is meaningful as it might discriminate among different diagnoses. Still future research has to further examine the relation between these two types of discrepancies; a possible avenue being to consider the interplay between the extent of the discrepancies and the distress elicited, as well as the developmental trajectory as initially suggested by Rogers (1959).

One limitation of the present study is that it did not examine whether the S-DS is sensitive to treatment (Strauman et al., 2001). A preliminary single case study (Dethier, Bouvard, Baeyens, & Philippot, 2015) suggests it is the case, but this need to be further investigated in large clinical samples. Another question pertains to the usefulness of

including undesired traits in the self-descriptions. The factorial analysis suggests that they

belong to a dimension other than the other self-discrepancy indices. In addition, the

regression analyses suggest that undesired traits have some specific predictive value. This

question needs to be further investigated. Another limitation of the S-DS is that it does not

explicitly investigate potential conflicts among ideal self-states or between ideal and socially

prescribed self-states. As stated in the introduction, several authors have hypothesized that

such conflicts were central in explaining how self-discrepancies could lead to distress (e.g.

Carver & Scheier, 1990; Kelly, Mansell & Wood, 2015). A Likert scale could be added to the

questionnaire, assessing the extent to which a respondent perceives conflict among his or her

ideals. In the clinical setting, the therapist should definitely enquire as to whether the client

perceives such conflicts in order to identify possible sources of distress.

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Table 1

*Correlations among the Different Indices of the Self Discrepancies Questionnaire (n = 218)*

| | Ideal Distress | Prescribed Gap | Prescribed Distress | WIT % | WPT% | UIT% | UPT% |
|---|---|---|---|---|---|---|---|
| Ideal Gap | .486** | .506** | .264** | -.646** | -.370** | .177** | .205** |
| Ideal Distress | | .371** | .590** | -.375** | -.353** | .283** | .293** |
| Prescribed Gap | | | .324** | -.447** | -.457** | .161* | .315** |
| Prescribed Distress | | | | -.315** | -.306** | .238** | .289** |
| WIT% | | | | | .514** | -.115 | -.240** |
| WPT% | | | | | | -.132 | -.287** |
| UIT% | | | | | | | .483** |

*Notes.* ** $p < .01$; * $p < .05$

WIT% = Desired Ideal Trait Percentage, WPT% = Desired Prescribed Trait Percentage,

UIT% = Undesired Ideal Trait Percentage, UPT% = Undesired Prescribed Trait Percentage.

Table 2

*Factor Structure of the Self-Discrepancy Indices after Varimax Rotation*

|  | Factor | | |
| --- | --- | --- | --- |
| Self-discrepancy Indice | 1 | 2 | 3 |
| Ideal Gap | **.800** | .203 | .033 |
| Ideal Distress | .340 | **.800** | .141 |
| Prescribed Gap | **.693** | .176 | .241 |
| Prescribed Distress | .165 | **.879** | .156 |
| Desired Ideal Trait Percentage | **-.841** | -.164 | .000 |
| Desired Prescribed Trait Percentage | **-.697** | -.165 | -.210 |
| Undesired Ideal Trait Percentage | .038 | .168 | **.839** |
| Undesired Prescribed Trait Percentage | .224 | .094 | **.823** |

Table 3

*Correlations between the indices of the Self Discrepancies and Self-efficacy, Depression,*

*Anxiety, and Self-Esteem (n = 206)*

| Self-discrepancy Indice | SE-Q | BDI | BAI | RSE-Q |
|---|---|---|---|---|
| Ideal Gap | -.492** | .467** | .331** | -.582** |
| Ideal Distress | -.453** | .525** | .350** | -.576** |
| Prescribed Gap | -.337** | .268** | .140* | -.360** |
| Prescribed Distress | -.379** | .251** | .193** | -.333** |
| Desired Ideal Trait Percentage | .482** | -.359** | -.245** | .461** |
| Desired Prescribed Trait Percentage | .383** | -.282** | -.225** | .320** |
| Undesired Ideal Trait Percentage | -.145* | .234** | .225** | -.231** |
| Undesired Prescribed Trait Percentage | -.300** | .337** | .246** | -.319** |

*Notes.* \*\**p* < .01; \**p* < .05

SE-Q = Self-Efficacy Questionnaire; BDI = Beck Depression Inventory ; BAI = Beck

Anxiety Questionnaire ; RSE-Q = Rosenberg self-esteem questionnaire.

Table 4.

*R² and Regression Coefficients for each Self-Discrepancy Indice while Predicting Self-*

*Esteem, Depression, Anxiety, and Self-Efficacy*

| Dependent Variable | $R^2$ | Standardized betas | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | Ideal Gap | Ideal Distress | Prescribed Gap | Prescribed Distress | WIT % | WPT% | UIT% | UPT% |
| Self-Esteem (RSE-Q) | .463** | -.317** | -.356** | -.006 | .040 | .093 | .016 | -.024 | -.104 |
| Depression (BDI) | .363** | .218* | .410** | -.040 | -.130† | -.071 | -.026 | .021 | .162* |
| Anxiety (BAI) | .174** | .213* | .217* | -.110 | -.031 | .000 | -.083 | .080 | .085 |
| Self-Efficacy (SE-Q) | .358** | -.207* | -.151† | .008 | -.109 | .167* | .127† | .076 | -.122† |

*Notes*. \*\*$p < .01$; \*$p < .05$; †$p < .10$

SE-Q = Self-Efficacy Questionnaire; BDI = Beck Depression Inventory ; BAI = Beck

Anxiety Questionnaire ; RSE-Q = Rosenberg self-esteem questionnaire.

WIT% = Desired Ideal Trait Percentage, WPT% = Desired Prescribed Trait Percentage,

UIT% = Undesired Ideal Trait Percentage, UPT% = Undesired Prescribed Trait Percentage.

Table 5

*Mean Self-Reported Discrepancy between Ideal and Actual Selves and Mean Distress as a*

*Function of Marital Status (SD in Parentheses)*

| Self-Discrepancy Index | Marital Status | | |
| --- | --- | --- | --- |
| | Single (n = 86) | Married / in Couple (n = 114) | Separated/divorced (n = 18) |
| Ideal Gap | 3.76[a] (1.471) | 3.35 [a] (1.297) | 2.61[b] (1.335) |
| Ideal Distress | 3.17 [a] (1.855) | 3.00 [a] (1.629) | 1.72 [b] (1.526) |

*Note*. Means with different subscripts differ at the .05 level according to the Bonferroni procedure; SD = Standard Deviation

Table 6

*Test-Retest Correlations in the Main Control Sample*

| Measures at Time 2 | Measures at Time 1 | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Ideal Gap | Ideal Distress | Prescribed Gap | Prescribed Distress | WIT % | WPT% | UIT% | UPT% |
| Ideal Gap | .696** | .624** | .378** | .336** | -.744** | -.371** | .506** | .389** |
| Ideal Distress | .509** | .783** | .407** | .496** | -.546** | -.392** | .525** | .421** |
| Prescribed Gap | .440** | .303** | .420** | .188 | -.463** | -.320** | .254* | .235* |
| Prescribed Distress | .318** | .432** | .277* | .346** | -.303** | -.221 | .153 | .323** |
| WIT % | -.484** | -.372** | -.307** | -.193 | .687** | .386** | -.340** | -.357** |
| WPT% | -.332** | -.296** | -.398** | -.219* | .451** | .615** | -.254* | -.331** |
| UIT% | .465** | .481** | .351** | .383** | -.414** | -.344** | .640** | .444** |
| UPT% | .431** | .389** | .350** | .269* | -.461** | -.381** | .507** | .619** |

*Notes*. \*\**p* < .01; \**p* < .05 WIT% = Desired Ideal Trait Percentage, WPT% = Desired

Prescribed Trait Percentage, UIT% = Undesired Ideal Trait Percentage, UPT% = Undesired

Prescribed Trait Percentage.

Table 7

*Mean self-indices as a function of diagnostic category (Standard Deviation in parentheses)*

| Self-Discrepancy Index | Diagnostic Status | | | | ANOVA |
| --- | --- | --- | --- | --- | --- |
| | Control (n = 218) | Depressed (n = 19) | Anxious (n = 30) | Comorbid (n = 11) | |
| Ideal Gap | 3.450 [c] (1.401) | 5.105 [a] (1.487) | 4.133 [b] (1.502) | 4.636 [a b] (1.286) | $F(3, 274) = 11.07$, $p < .0001$, partial $\eta^2 = .108$ |
| Ideal Distress | 2.963 [c] (1.749) | 4.895 [a] (.410) | 3.767 [b] (1.775) | 4.273 [a b] (1.618) | $F(3, 274) = 9.92$, $p < .0001$, partial $\eta^2 = .098$ |
| Prescribed Gap | 3.693 [b] (1.505) | 4.526 [ab] (1.744) | 4.179 [b] (1.611) | 5.182 [a] (1.079) | $F(3, 272) = 5,26$, $p < .0002$, partial $\eta^2 = .055$ |
| Prescribed Distress | 2.904 [c] (1.588) | 4.526 [ab] (1.680) | 4.143 [b] (1.799) | 5.273 [a] (1.737) | $F(3, 272) = 11.99$, $p < .0001$, partial $\eta^2 = .150$ |
| WIT % | 60.785 [a] (16.661) | 49.952 [b] (21.614) | 57.312 [ab] (19.891) | 52.205 [ab] (18.245) | $F(3, 272) = 3.07$ $p < .023$, partial $\eta^2 = .033$ |
| WPT% | 59.873 [a] (19.269) | 49.471 [b] (24.116) | 52.757 [ab] (22.991) | 47.273 [b] (17.911) | $F(3, 272) = 3.43$, $p < .017$, partial $\eta^2 = .037$ |
| UIT% | 28.233 [b] (20.685) | 38.885 [a] (28.778) | 33.171 [ab] (22.135) | 48.547 [a] (21.632) | $F(3, 272) = 4.49$, $p < .004$, partial $\eta^2 = .047$ |
| UPT% | 41.091 [b] (24.251) | 53.930 [a] (24.508) | 47.888 [ab] (23.525) | 61.326 [a] (22.482) | $F(3, 272) = 4.17$, $p < 007$, partial $\eta^2 = .045$ |

*Note*. Means with different subscripts differ at the .05 level according to the Bonferroni procedure.

Annexe 1. : Self-Discrepancy Scale

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## Questionnaire d'écart entre les sois

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Réfléchissez un instant et faites une liste des caractéristiques que vous aimeriez avoir ou non dans l'idéal (peu importe que vous estimiez ou non les posséder). Pour vous inspirer, si besoin est, voici quelques exemples de caractéristiques possibles :

| | | | |
|---|---|---|---|
| A la mode | Discret | Logique | Plein d'entrain |
| Agréable | Disgracieux | Lucide | Prudent |
| Agressif | Dominateur | Malveillant | Pudique |
| Aimable | Doux | Marrant | Puéril |
| Ambitieux | Drôle | Mauvaise langue | Radical |
| Artiste | Dur | Méchant | Raffiné |
| Astucieux | Efficace | Menteur | Raisonnable |
| Autoritaire | Egoïste | Méprisant | Reconnaissant |
| Avare | Energique | Mesquin | Rusé |
| Bienveillant | Enthousiaste | Méthodique | Sage |
| Brillant | Envieux | Modéré | Sensé |
| Brouillon | Equilibré | Moderne | Sentimental |
| Calculateur | Exubérant | Modeste | Sérieux |
| Calme | Fiable | Moral | Serviable |
| Clairvoyant | Frivole | Névrosé | Simple |
| Comique | Gentil | Nonchalant | Solitaire |
| Compulsif | Grande gueule | Normal | Soumis |
| Conformiste | Honnête | Obéissant | Spirituel |
| Cordial | Imitateur | Obstiné | Timide |
| Créatif | Imprévisible | Ouvert d'esprit | Tolérant |
| Crédule | Imprudent | Paresseux | Trompeur |
| Cultivé | Inculte | Pas fiable | Trop sûr de soi |

| Curieux | Indépendant | Pénible | Vaniteux |
|---|---|---|---|
| Délicat | Indiscret | Perspicace | Vif |
| Désagréable | Ingénieux | Pessimiste | |
| Désintéressé | Insensible | Peu sûr de soi | |
| Désordonné | Irrespectueux | Philosophe | |

| Soi idéal | | | |
|---|---|---|---|
| **Caractéristiques que j'aimerais avoir :** | **Pourcentage** | **Caractéristiques que je n'aimerais pas avoir :** | **Pourcentage** |
| -_____ | _____% | -_____ | _____% |
| -_____ | _____% | -_____ | _____% |
| -_____ | _____% | -_____ | _____% |
| -_____ | _____% | -_____ | _____% |
| -_____ | _____% | -_____ | _____% |
| -_____ | _____% | -_____ | _____% |
| *Pour chaque caractéristique désirable, indiquez dans la colonne à droite la mesure (en %) selon laquelle vous possédez cette caractéristique, l'idéal étant 100%. Par exemple, si vous avez un idéal de générosité et que vous pensez posséder cette caractéristique à 80% de votre idéal, indiquez « Généreux : 80% ».* | | *Pour chaque caractéristique indésirable, indiquez dans la colonne à droite la mesure (en %) selon laquelle vous possédez cette caractéristique, l'idéal étant 0%. Par exemple, si vous détestez l'avarice et que vous pensez posséder cette caractéristique à 20%, indiquez « Avare : 20% ».* | |

Entourez la bonne réponse.

*De manière globale, quel est l'écart entre cet idéal et la manière dont vous vous percevez vous-même ?*

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Je me sens très proche de cet idéal | | | Je me sens moyennement proche de cet idéal | | | Je me sens très éloigné de cet idéal |

*Quelle est la détresse provoquée par cet écart ?*

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Je ne ressens pas de détresse | | | Je ressens une détresse moyenne | | | Je ressens une détresse importante |

| par rapport à cet écart | | | par rapport à cet écart | | | par rapport à cet écart |
|---|---|---|---|---|---|---|

par rapport
à cet écart

Réfléchissez un instant et faites une liste des caractéristiques qui sont attendues de vous ou non par vos proches (peu importe que vous estimiez ou non les posséder).

| Soi socialement prescrit | | | |
|---|---|---|---|
| Caractéristiques que les personnes importantes pour moi pensent que je devrais avoir : | Pourcentage | Caractéristiques que les personnes importantes pour moi pensent que je ne devrais pas avoir : | Pourcentage |
| -_____ | _____% | -_____ | _____% |
| -_____ | _____% | -_____ | _____% |
| -_____ | _____% | -_____ | _____% |
| -_____ | _____% | -_____ | _____% |
| -_____ | _____% | -_____ | _____% |
| -_____ | _____% | -_____ | _____% |
| *Pour chaque caractéristique désirable, indiquez dans la colonne à droite la mesure (en %) selon laquelle vous possédez cette caractéristique, l'idéal étant 100%. Par exemple, si vous pensez que vos proches ont pour vous l'idéal de générosité et que vous pensez posséder cette caractéristique à 80% de cet idéal, indiquez « Généreux : 80% ».* | | *Pour chaque caractéristique indésirable, indiquez dans la colonne à droite la mesure (en %) selon laquelle vous possédez cette caractéristique, l'idéal étant 0%. Par exemple, si vos proches détestent l'avarice et que vous pensez posséder cette caractéristique à 20%, indiquez « Avare : 20% ».* | |

Entourez la bonne réponse.

*Quel est l'écart entre cet idéal et la manière dont vous vous percevez vous-même ?*

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Je me sens très proche de cet idéal | | | Je me sens moyennement proche de cet idéal | | | Je me sens très éloigné de cet idéal |

*Quelle est la détresse provoquée par cet écart ?*

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Je ne ressens pas de détresse par rapport à cet écart | | | Je ressens une détresse moyenne par rapport à cet écart | | | Je ressens une détresse importante par rapport à cet écart |