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THE STIGMA OF BEING PESSIMISTICALLY BIASED

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People are stigmatized and socially rejected for a range of deviant appearances and behaviors. This includes the social rejection of people who are depressed or have a pessimistic outlook on life. We examined whether being pessimistically biased (i.e., thinking one's risk for negative events is greater than that of one's peers) also leads to social rejection. Two experiments showed that pessimistically biased individuals were less socially accepted and that this lack of acceptance originated in the presumption that pessimistically biased people are also hopeless, sad, and depressed. In general, people are overwhelmingly optimistically biased. This research suggests one potential reason why pessimistically biased people are stigmatized and socially rejected.

Many people have some feature that stigmatizes them in interactions with others. Race, ethnicity, religion, sexual orientation, physical disabilities, obesity, unattractive appearance, and health problems represent a few of the many aspects of an individual that may be stigmatizing. In general, "stigmatized individuals possess (or are believed to possess) some attribute, or characteristic, that conveys a social identity that is devalued in a particular social context" (Crocker, Major, & Steele, 1998, p. 505). Stigmatized people are often viewed as having intrinsic moral faults. Moreover, those responsible for their stigmas are more harshly judged and devalued. In fact, if a stigma is perceived to be controllable, people are more disliked and rejected than are people with uncontrolla-

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ble stigmas (Crocker et al., 1998). For example, obesity might be more stigmatizing than a physical disability in part because obesity may be viewed as individually controllable. Even after stigmas are overcome, they can carry a social deficit (Rodin & Price, 1995).

Affective states can also be stigmatizing. Research consistently shows that we do not like depressed individuals and reject them interpersonally (for a review, see Segrin & Dillard, 1992). In addition, we do not like non-clinically depressed individuals if they exhibit negative affect in the form of dysphoria, low self-esteem, or pessimism. Furr and Funder (1998) investigated personal negativity, which was operationalized as a composite of scores on depression, happiness, satisfaction with life, and self-esteem measures. People who ranked high in personal negativity were rated by both a personal acquaintance and their parents as being fearful, hostile, distrustful, critical, vulnerable, etc. In actual interactions with opposite-sex strangers, the people who ranked high in personal negativity demonstrated social discomfort, difficulty communicating, poor social skills, and appeared socially awkward. It is not surprising that the strangers were viewed by independent coders as being detached from the interaction, acting irritated, trying to control and dominate the interaction, and keeping the personally negative person at a distance. Thus, the results generally show that people who are unsatisfied with life and themselves are (a) negatively viewed by both strangers, friends, and family; and (b) are socially rejected in interpersonal situations.

People do not only reject those who are personally negative. Research shows that people tend to show low levels of social acceptance of people who are pessimistic. Carver, Kus, and Scheier (1994) used scenarios to examine the effect that a person's mood and outlook (i.e., pessimistic, neutral, or optimistic) had on being accepted or rejected by others. They found that mood was a powerful factor. Regardless of the person's outlook, people were more likely to reject unhappy than happy targets. More relevant to the present study, they found that when the mood was neutral, people rejected pessimists and accepted optimists (Carver et al., 1994). It appears that pessimism, like depression and personal negativity, carries a social stigma.

In general, it appears that depression and pessimism are stigmatizing and that people exhibiting these qualities are socially rejected. Does this social rejection also extend to negativity in risk estimations? Whereas pessimism is a broad dispositional characteristic, pessimism in risk estimations is specific to a given risk. In addition, pessimism measures do not include estimations of specific risks and dispositional optimism is typically not correlated with risk estimations (Helweg-Larsen, 1999). Are people who exhibit a pessimistic bias, who think that their risk of

negative events is greater than that of other people, also socially rejected? An extensive literature exists on the optimistic bias, which is the tendency for people to think they are less likely to experience negative events than others (Weinstein, 1989). This literature demonstrates convincingly that people are overwhelmingly optimistically biased. People tend to believe that they will not be victims of auto accidents (Robertson, 1977) or crimes (Perloff & Fetzer, 1986) and that they will not fall prey to illness (Perloff & Fetzer, 1986), depression (Kuiper, MacDonald, & Derry, 1983), unwanted pregnancy (Burger & Burns, 1988), or a host of other negative health events (van der Pligt, Otten, Richard, & van der Velde, 1993). Very few studies find any evidence of pessimistic bias (Dolinski, Gromski, & Zawisza, 1987) or find it only under very specific circumstances (Shepperd, Ouellette, & Fernandez, 1996).

Researchers have proposed several explanations for why people are optimistically biased including the notion that optimistic predictions stem from (a) a desire for personal control; (b) egocentric thinking; (c) selective comparisons with others who are less fortunate or more at risk than oneself; (d) positive illusions; (e) the availability of personal examples; (f) a desire to enhance or protect self-esteem; and (g) a desire to make downward social comparisons (Klein & Weinstein, 1997; Perloff, 1987; van der Pligt, et al, 1993; Weinstein, 1989). No single cause is a consistent and clear factor in explaining the optimistic bias, although negative affect, perceived control and features of the comparison situation appear to consistently influence the optimistic bias (Helweg-Larsen & Shepperd, 2001). No one has examined the possibility that the optimistic bias might stem from the dislike and social rejection of pessimistically biased people. It is possible that an optimistic bias is reinforced by friends, family, and strangers who treat optimistically biased people positively and socially reject pessimistically biased people. Although we did not test this hypothesis directly, we hypothesized that there is a stigma associated with being pessimistically biased, in that people who have pessimistically biased risk perceptions are more likely to be socially rejected than are people who have optimistically biased or neutral risk perceptions. Furthermore, we investigated why exhibiting a pessimistic bias might lead to social rejection by others.

PILOT STUDY

A pilot study was performed in which 36 predominantly Caucasian volunteers (11 males and 25 females) enrolled in social psychology courses at the University of Florida (M age = 20 years, $SD = 1.84$) participated. In this within-subjects design, participants read an excerpt from a hypothetical interview in which three male college students discussed their

health risks for getting into a car accident, contracting a sexually transmitted disease (STD), or developing heart disease. In their discussion, the three students consistently revealed the same health behaviors, but one student was pessimistically biased, one was optimistically biased, and one was not biased in any one direction (i.e., neutral). Five dependent variables were summed to measure the extent of social rejection (Cronbach's $\alpha = .51$). The pessimistically biased person ($M = 4.55$, $SD = 1.09$) was less likely to be socially accepted, compared with the optimistically biased person ($M = 3.53$, $SD = 1.19$), $F(1,32) = 11.74$, $p < .002$, $\eta^2 = .27$ and compared with the neutral person ($M = 3.01$, $SD = 0.88$), $F(1, 32) = 38.93$, $p < .001$, $\eta^2 = .35$. The optimistically biased person and the neutral person differed marginally, $F(1, 32) = 3.06$, $p = .09$, $\eta^2 = .09$. As predicted, the pessimistically biased target was less socially accepted than the optimistically biased target or the neutral target. In Study 1 we decided to use a between-subjects design so that the manipulation was not apparent to participants. In addition, we added two more questions to the social rejection index to increase the α value.

STUDY 1

METHODS

Overview. Study 1 used a between-subjects design in which participants were randomly assigned to read one of three scenarios. In one scenario, the person was always pessimistically biased about his chances of getting into a car accident, contracting an STD, or developing heart disease. In another scenario, the person was optimistically biased about his chances. In the last scenario, he was neutral (neither optimistically or pessimistically biased). The primary dependent variable was social rejection.

Participants. Participants were 54 Caucasian volunteers (10 males and 44 females) enrolled in a social psychology course at the University of Florida (M age = 21 years, $SD = 2.64$). The participants did not participate in the pilot study.

Procedure. Students were informed that participation in the study was voluntary and anonymous. Informed consent was obtained. Upon completion, the questionnaires were returned to the instructor and the participants were debriefed and thanked.

Materials. Participants read an excerpt from an interview that had either an optimistically biased person, a neutral person, or a pessimistically biased person. In these scenarios, a 20-year-old student named Jason was interviewed about various health risks, specifically his risk of getting injured in a car accident, contracting a STD, and developing

heart disease. All three scenarios, contained exactly the same background information about Jason. In one of the scenarios he answered optimistically biased for all the questions; in another, he showed no bias in his answer to the questions; and in the final scenario, he was pessimistically biased in his answers. An open-ended question asked participants to report the single factor that had the biggest influence on them in forming their impression of Jason.

After reading the scenario and indicating their gender and age, a manipulation check asked how optimistic or pessimistic the participants thought that the target was about his risk judgments. Responses were scored on a 7-point scale, ranging from 1 (*very pessimistic*) to 7 (*very optimistic*). The next three questions assessed the extent to which the target seemed (a) happy, with scores ranging from 1 (*very sad*) to 7 (*very happy*); (b) depressed, with scores ranging from 1 (*definitely depressed*) to 7 (*definitely not depressed*); and (c) hopeless, with scores ranging from 1 (*definitely hopeless*) to 7 (*definitely not hopeless*). These three questions tapped into the same construct (target dysphoria) and were therefore combined into a single index (Cronbach's $\alpha = .82$). The items were scored so that higher scores indicated greater target dysphoria.

The questionnaire asked seven questions that measured social rejection. Participants were asked to rate the target on a 7-point scale, with scores ranging from 1 (*definitely fun*) to 7 (*definitely not fun*), indicating if they thought it would be fun to "hang out" with the person. The remaining questions asked

- (a) if they would like to meet the person;
- (b) if they would work with the person on a class group project;
- (c) if they would like to have the person as a friend;
- (d) if they would like to go to a campus party with this person;
- (e) if they would like to talk to the person; and
- (f) if they would like to have the person on their sport team.

These six questions were scaled with scores ranging from 1 (*definitely would not*) to 7 (*definitely would*). Because the seven questions were tapping into the same construct, they were combined into a single social rejection index (Cronbach's $\alpha = .73$). Items were scored so that greater scores indicated greater social rejection.

Three questions asked whether the participants thought that the target took risks to increase his chance of getting into a car accident, contracting an STD, or developing a heart disease. All questions were scaled with scores ranging from 1 (*would take risks*) to 7 (*would not take risks*). Participants were also asked if reading the interview made them think about

their own health risks and behaviors and if reading the interview put the participant in a bad mood. Both were answered on a scale with scores ranging from 1 (*not at all*) to 7 (*a great deal*).

RESULTS

Manipulation Check. As expected, the optimistically biased target was perceived as most optimistic ($M = 5.63, SD = 1.12$), the neutral target was perceived as less optimistic ($M = 4.53, SD = 1.01$), and the pessimistically biased target was perceived as least optimistic ($M = 2.33, SD = 0.59$), $F(2, 51) = 59.10, p < .001, \eta^2 = .70$, Tukey's HSD procedure, $ps < .05$.

Social Rejection. The primary dependent variable concerned the extent to which the target person was socially rejected. A 1×3 (target person: optimistically biased, neutral, or pessimistically biased) between-subjects analysis of variance (ANOVA) revealed a marginally significant effect of social rejection, $F(2, 51) = 2.73, p = .075, \eta^2 = .10$, such that the pessimistically biased target tended to be less socially accepted ($M = 4.26, SD = 0.52$) than the optimistically biased target ($M = 3.76, SD = 0.79$), Tukey's HSD procedure, $p < .05$. Neither of these means differed from the neutral condition, $M = 3.92, SD = 0.79$.

Reasons for Social Rejection. We tested four explanations for why the pessimistically biased person was less socially accepted. First, social rejection might occur because the pessimistically biased target is perceived as sad, hopeless, and depressed. Second, social rejection might occur because a pessimistically biased person is also thought to engage in risky behaviors, and risk takers are evaluated negatively. Third, the pessimistically biased target might be rejected because the contact with the pessimistically biased person generates a bad mood. Because we are generally motivated to avoid negative moods, we might avoid people who could potentially ruin our moods. Fourth, people might reject a pessimistically biased target because their own health risks are made salient. By interacting or even reading about a person who thinks he or she is at risk for a given problem, he or she may remind us that we might have that same problem. Given the extent of the literature on the optimistic bias and the general failure to make people less optimistically biased (Weinstein, & Klein, 1995), this did not seem a likely explanation but is worth testing. The last two hypotheses were tested with single-item measures, thus providing a relatively weak test of the hypotheses.

First, we examined the perceived affective state of the target. We found an overall effect, $F(2, 51) = 19.34, p < .001, \eta^2 = .43$, such that the pessimistically biased target was rated as having greater dysphoria ($M = 4.11, SD = 0.76$) than the neutral target ($M = 3.17, SD = 0.95$), who was

rated as having greater dysphoria than the optimistically biased target ($M = 2.39, SD = 0.82$), Tukey's HSD procedure, $ps < .01$. Clearly, pessimistically biased targets were viewed as most depressed or disphoric.

Second, the three risk items were highly correlated ($rs > .62, ps < .001$) and these three items were also combined into a single risk index (Cronbach's $\alpha = .85$). Results of a 1×3 ANOVA, showed that participants thought the pessimistically biased target would take fewer risks ($M = 4.67, SD = 1.20$), than the neutral target ($M = 4.25, SD = 0.92$), who would take fewer risks than the optimistically biased target ($M = 3.40, SD = 0.94$), $F(2, 51) = 7.30, p < .002, \eta^2 = .22$, Tukey's HSD procedure, $ps < .05$. Thus, the optimistically biased target (who was most socially accepted) was judged as taking the most risks. This risk-taking perception apparently did not lead to a negative attitude toward the optimistically biased target.

Third, participants were asked if they felt that reading the interview put them in a bad mood. The 1×3 between-subjects ANOVA revealed a marginally significant effect, $F(2, 51) = 2.98, p = .06, \eta^2 = .10$, revealing a trend for the optimistically biased scenario to leave participants in a better mood ($M = 1.42, SD = 0.84$) than the pessimistically biased ($M = 2.22, SD = 1.35$) or the neutral ($M = 2.18, SD = 1.13$) scenarios. However, a Tukey's HSD procedure revealed no significant differences among the three means.

Fourth, a single-item measure of whether participants themselves thought that reading the interview made them question their own risks and health behaviors revealed no significant effects across the three scenarios, $F(2, 51) = 1.67, p = .20, \eta^2 = .06$.

We found support for the notion that the pessimistically biased target was perceived as having greater dysphoria and as being less of a risk taker. Could one of these two findings account for the social rejection effect? A 1×3 (target person: optimistically biased, neutral, or pessimistically biased) analysis of covariance (ANCOVA) was conducted for the social rejection measure covarying out target dysphoria. The results revealed that when target dysphoria was held constant, the difference in social rejection disappeared, $F(1, 50) = .07, p > .05, \eta^2 = .003$. It appears that the presumed dysphoria of a pessimistically biased target can explain why people socially reject pessimistically biased individuals. Is it possible that presumption of risk-taking behavior also makes a difference? A 1×3 ANCOVA was repeated, this time covarying out risk-taking behavior. Results showed that social rejection differences remained marginally significant when perceptions of risk-taking behavior was removed, $F(1, 50) = 2.67, p = .08, \eta^2 = .10$. We can tentatively conclude that the most likely reason for the social rejection of pessimistically biased people lies in the assumption that a pessimistically biased person is also

hopeless, sad, and depressed and not because we think poorly of risk takers. Based on these data, it appears that we like risk takers.

DISCUSSION

As expected, the pessimistically biased target was less socially accepted than the optimistically biased target. We examined several possible explanations for this rejection. A presumption of target dysphoria seemed to best explain the lower social acceptance of the pessimistically biased target. In addition, the pessimistically biased target was judged to take the least amount of risks. However, risk-taking behavior did not appear to influence the amount of social acceptance that resulted. We also found that reviewing the risk-taking behavior of others had little influence on how much the participants reported thinking of their own risk behaviors. Finally, the participants reported no difference in mood as a result of reading the scenarios.

This study suggests that social rejection of pessimistically biased targets stems from the perception that pessimistically biased targets are dysphoric. Examining this issue experimentally would provide a stronger test of the possibility that a presumption of target dysphoria is the driving factor behind the social rejection. In Study 2, we manipulated the information participants received about the target in the scenario, such that in one condition no information was provided, whereas in another condition participants were told explicitly that the target showed no evidence of dysphoria. In addition, we used recorded interviews rather than written scenarios to make the scenarios more impactful and realistic.

STUDY 2

METHOD

Overview. Study 2 was a 2 (Information: none or not depressed) \times 3 (Target person: optimistically biased, pessimistically biased, or neutral) between-subjects experiment in which participants listened to one of six recorded interviews and were then asked to complete a questionnaire. In three of the interviews no information was provided about the mental status, mood, and affect of the interviewee, but the target always answered optimistically biased in one scenario, neutral in another, and pessimistically biased in the third. In the other three interviews, participants were told that the interviewee had excellent mental health, was not depressed or hopeless, and was in a good mood most of the time.

Again, in one of the scenarios the target was optimistically biased, in another he was neutral, and in the final one he was pessimistically biased.

Participants. Participants included 87 predominantly Caucasian Transylvania University students (30 males and 57 females) who received course credit for participating (M age = 20 years, SD = 1.65).

Procedure. Once participants arrived for the study, they were informed that their responses were anonymous and informed consent was obtained. Participants were randomly assigned to one of six listening stations. Participants were informed that they were about to listen to an interview of a student participating in a "Health Awareness Week" at Northwestern University. They were asked to listen carefully and to try to form an impression of the person. After the participants listened to the interview, they received a questionnaire assessing their impressions. After completing the questionnaire, participants were thanked and debriefed.

Manipulated Variables. In all six recorded interviews, a female interviewer thanked a male student (the target) for his participation in the survey and then asked the student what his chances were of getting into a car accident, contracting an STD, or developing heart disease, in comparison with other students at the university. In all interviews, the student gave the exact same response as to why he felt his chances were what he stated. However, in one interview he concluded that his risks were below that of other students (optimistically biased), in another interview he concluded that his risks were above that of other students (pessimistically biased), and in the last interview he concluded that his risks were the same as that of other students (neutral).

Information was manipulated by either providing no information or by specifically telling participants that the person in the interview was in good mental health. Participants in this last group were told twice that the person was happy and neither depressed nor hopeless; this was relayed first in the handout given to participants before listening to the interview and then again at the beginning of the tape.

Dependent Measures. The measures in this study were identical to those used in Study 1. The seven items measuring social rejection were combined into a single social rejection index (Cronbach's α = .84) and the three items measuring target dysphoria were combined (Cronbach's α = .83). Items were scored so that higher scores indicated greater social rejection and greater target dysphoria. Participants also completed the life orientation test (LOT). The LOT is an 8-item measure of dispositional optimism (Scheier & Carver, 1985), which is scaled with scores ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Dispositional optimism was not correlated with any of the dependent measures, so it will not be discussed any further.

RESULTS

Manipulation Check. First, we wanted to make sure that participants perceived the target as either optimistically biased, pessimistically biased, or neutral in correspondence with the manipulation. As expected, a 2 (Information: none or not depressed) \times 3 (Target: optimistically biased, pessimistically biased, or neutral) between-subjects ANOVA showed a significant effect of target, such that the optimistically biased target was seen as more optimistic ($M = 5.72, SD = 1.13$) than the neutral target ($M = 4.90, SD = 1.11$), who in turn was seen as more optimistic than the pessimistically biased target ($M = 2.76, SD = 1.15$), $F(2, 81) = 50.99, \eta^2 = .56, p < .001$, Tukey's HSD procedure, $p < .05$. There were no other significant effects of this measure.

Second, we examined the effect of Information and Target on perceived dysphoria. Analyses revealed a significant effect of target, $F(2, 81) = 14.18, p < .001, \eta^2 = .26$, qualified by the predicted interaction of information and target, $F(2, 81) = 4.18, p < .05, \eta^2 = .09$. As seen in Table 1, when participants received no information about the target's mood, they assumed that the pessimistically biased target had greater dysphoria ($M = 4.36, SD = 1.26$) than the neutral target ($M = 2.89, SD = 1.15$), who had greater dysphoria than did the optimistically biased target ($M = 2.24, SD = 0.98$), Tukey's HSD procedure, $p < .05$. However, when participants were informed that the target person was not depressed, there were no differences across the three conditions, $F(2, 39) = 2.14, p = .13, \eta^2 = .10$. In this case, participants made equal rating of target dysphoria in the optimistically biased ($M = 2.62, SD = 1.00$), neutral ($M = 2.67, SD = 0.73$), and pessimistically biased ($M = 3.21, SD = 0.78$) conditions.

Social Rejection. We expected that participants in the no information condition would be less socially accepting of the pessimistically biased target. A 1 \times 3 (Target person: optimistically biased, neutral or pessimistically biased) between-subjects ANOVA revealed a marginally significant effect for the social rejection variable, $F(2, 42) = 2.68, p = .08, \eta^2 = .11$, such that pessimistically biased target tended to be less socially accepted ($M = 4.78, SD = 0.88$) than the optimistically biased target ($M = 4.02, SD = 0.74$), Tukey's HSD procedures, $p < .05$, with neither of these means differing from the neutral condition ($M = 4.26, SD = 1.11$). This finding is identical to the primary findings in Study 1. The critical question in Study 2 was what happens to social rejection when target dysphoria is constant across the three conditions. A 1 \times 3 ANOVA revealed no differences in social rejection across conditions. When target dysphoria did not vary across conditions, social rejection was similar when the target person was optimistically biased ($M = 4.27, SD = 1.16$), neutral ($M = 4.45$,

$SD = 0.55$), and pessimistically biased ($M = 4.41$, $SD = 0.97$), $F(2, 42) = .15$, $p > .05$, $\eta^2 = .008$ (see Table 1).

Other Dependent Measures. We also assessed how risky the participants thought the target person might be. We combined these three items into a single risk index (Cronbach's $\alpha = .82$) and performed a 2×3 between-subjects ANOVA. There were no significant effects. Similarly, 2×3 ANOVAs revealed no significant results with respect to participants' judgments of their own risk or their own mood as a result of the experimental manipulations.

DISCUSSION

As we found in Study 1, without information about target dysphoria, the pessimistically biased target was assumed to be depressed and was less socially accepted than the optimistically biased target. However, when the experimental manipulation precluded an assumption of target dysphoria, there were no differences in the social acceptance of the pessimistically biased target in comparison with the optimistically biased target. Our results suggest that it is a presumption of target dysphoria that leads to less social acceptance.

It is notable that several participants disclosed during debriefing that they thought they had been "tricked" by having to evaluate a pessimistically biased person who was not depressed, sad, or hopeless. Apparently this combination is quite unexpected as part of people's naive theories about which traits co-occur (Schneider, 1973).

GENERAL DISCUSSION

In two studies, we found that it is stigmatizing to be pessimistically biased and that people are less socially accepting of those who are. The driving factor in the lower levels of social acceptance appears to be that pessimistically biased people are presumed to be sad, hopeless, and depressed. In other words, people react to a presumption of target dysphoria in the pessimistically biased target rather than the pessimistic bias per se. These findings are consistent with previous literature on depression and the social rejection faced by depressed people. Research shows that the downward spiral in depression is propelled by the negative reactions that people have in response to depressed individuals (Coyne, Burchill, & Stiles, 1991). People who are in a bad mood are also rejected more than are those who are in a good mood; when mood is neutral, those who are pessimistic are rejected more than those who are optimistic (Carver, et al., 1994). We might want to avoid associating with

TABLE 1. Perceived Target Dysphoria and Social Rejection of Target as a Function of Information Provided and Target Bias

Information Provided	Pessimistically Biased Target		Neutral Target		Optimistically Biased Target	
	M	SD	M	SD	M	SD
Target Dysphoria						
No information about target dysphoria	4.36 ^a	1.26	2.89 ^b	1.15	2.24 ^c	0.98
Target not disphoric	3.21 ^a	0.78	2.67 ^a	0.73	2.62 ^a	1.00
Social Rejection of Target						
No information about target dysphoria	4.78 ^a	0.88	4.26 ^b	1.11	4.02 ^a	0.74
Target not disphoric	4.41 ^a	0.97	4.45 ^a	0.55	4.27 ^a	1.16

Note. Within rows, cells with different subscripts are significantly different, $p < .05$.

people who are sad, depressed and hopeless either because contact with such individuals is unpleasant or because they create a generally negative environment that most people prefer to avoid.

The majority of people demonstrate an optimistic bias rather than a pessimistic bias (Weinstein, 1989). This research suggests one plausible reason, namely that there is a social stigma associated with a pessimistic bias and that it is driven by the presumption of target dysphoria. Is the assumption that perceived dysphoria and pessimistic bias co-occur based on people's accurate observations of the world around them? Several studies show that target dysphoria is related to lower levels of optimistic bias. People who are depressed (Alloy & Ahrens, 1987; Pietromonaco & Markus, 1985; Pyszczynski, Holt, & Greenberg, 1987), in a bad mood (Abele & Hermer, 1993; Salovey & Birnbaum, 1989), or anxious (Butler & Mathews, 1987; Dewberry, Ing, James, & Nixon, 1990; Dewberry & Richardson, 1990) show less optimistic bias, although they are not necessarily realistic and usually not pessimistic. We can infer that people's implicit personality theory about the relationship between pessimistic bias and perceived dysphoria is indeed based on a grain of truth about the actual relationship between these variables.

In these experiments, the effects of social rejection were consistent but not very powerful. One possible reason is that social desirability prevented the participants from strongly indicating that they would not want to associate with a pessimistically biased person. Other researchers have used an indirect method to combat this problem of social desirability. For example, Rodin and Price (1995) asked participants not what they personally thought of the person in the scenario but rather what they thought another person might think. In our study, using this type of indirect method might have led to stronger effects of social rejection.

Another weakness of the present study was that the scenarios were relatively artificial, consisting of a short written description or an audio tape of an interview. In a more realistic setting, in which the participant either viewed a video tape or interacted with people who were pessimistically biased, would the results change? It is possible that in a more realistic situation the lack of target dysphoria would be more evident, thus letting participants know that the target is only pessimistically biased, but not depressed, sad, and hopeless. Conversely, it is possible that people's expectations of a pessimistically biased target would lead to even less acceptance. That is, confirmatory hypothesis testing (Snyder & Swann, 1978) and the self-fulfilling prophecy (Sibicky & Dovidio, 1986) might lead the perceiver to see even greater dysphoria if they actually had the opportunity to interact with the pessimistically biased target. Despite the artificiality of the situation, perceivers consistently rejected the pessimistically biased target.

Finally, in both studies, the manipulation check (measuring affect) appeared before the primary dependent variables (measuring social rejection). It is possible that the affect questions biased participants' perceptions of the target by drawing attention to his affective state. It is not clear if any such bias would equally or differentially influence the social rejection responses across the experimental conditions. In addition, no participants reported any accurate hunches about our hypotheses during debriefing. Nevertheless, this caveat is worth keeping in mind when interpreting these data.

This research shows that we may socially reject pessimistically biased people because we think they are depressed. Cross-cultural research shows that mental illness is generally stigmatizing (Link, Cullen, Mirotnik, & Stuenkel, 1992) as is depression (Kleinman & Good, 1985). In cultures where depression is not as deviating from the cultural norms, we would expect depressed people to suffer less stigmatization. For example, it is expected among the Kaluli of New Guinea to openly express feelings of rage and grief. Depressive symptoms are expressed as minor somatic complaints and there are no words for depression in the language or cultural recognition of such a disorder (Schieffelin, 1985). Different cultures portray and understand feelings of sadness and grieving differently. What may be an aberration of the norm in one culture may be acceptable in another. Because affective states are viewed differently in different cultures, it could be that it is only in some cultures that people associate a pessimistic bias with depression, sadness, and hopelessness. Similarly, we might expect that in cultures where a pessimistic bias does not deviate from the cultural norms, thinking one is at greater risk than others has no stigmatizing consequences.

Little cross-cultural research exists with respect to the optimistic bias. We know that some cultures (both Western and Eastern) show less optimistic bias than North American culture (Helweg-Larsen, 1994; Heine & Lehman, 1995). It is possible that in cultures where people are less optimistically biased, social rejection is not associated with a pessimistic bias. This is an intriguing area for further exploration.

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