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How awkward! Social anxiety and the perceived consequences of social blunders

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ABSTRACT

Seventy high socially anxious (HSA) and 74 low socially anxious (LSA) participants rated perceived interpersonal and emotional consequences of both (a) autobiographical social blunders recalled from their own lives and (b) imagined blunders presented in standardized hypothetical social scenarios. Ratings of participants' autobiographical blunders were also provided by research assistants who were blind to hypotheses. Results indicated that HSA participants overestimated the negative consequences of their own autobiographical blunders. These negative perceptions among HSA participants extended to imagined blunders, even when participants were instructed to imagine a third party other than themselves as the person committing the blunder. This pattern of results suggests the conclusion that the perceived consequences of social blunders among HSA individuals are driven by the belief that social standards are high, inflexible, or both.

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Social blunders are, unfortunately, a part of life. To the best of our knowledge, everyone has regrettable experiences of unexpectedly and unintentionally behaving in ways that violate culturally-accepted rules of social etiquette or conduct. But even if such experiences are universal, the *way* they are experienced is probably not. We expect that people are likely to differ from one another in their level of concern about the perceived risks or consequences of committing a social blunder, and that social anxiety plays an important role in helping to account for such differences.

Theoretical models suggest that high socially anxious (HSA) individuals are particularly attuned to the risk of social mishaps and to the negative evaluation that they imagine may occur as a result (Clark & Wells, 1995; Hofmann, 2007; Moscovitch, 2009; Rapee & Heimberg, 1997). Social anxiety is expected to confer stronger beliefs that committing a social blunder will publicly expose social incompetence or unacceptability (e.g., Moscovitch & Huyder, 2011), leading to criticism or rejection (e.g., Rodebaugh, 2009). In accordance with such models, researchers have increasingly focused their work on the tendency of HSA individuals to overestimate the likelihood and costs of negative social outcomes (Foa, Franklin, Perry, & Herbert, 1996) and the extent to which decreases in social cost estimates among individuals with social anxiety disorder (SAD) may mediate the anxiolytic effects of cognitive behavioral therapy (CBT; Hofmann, 2004; Foa et al., 1996; McManus, Clark, & Hackmann, 2000; Smits, Rosenfield, McDonald, & Telch, 2006; Taylor & Alden, 2008).

Encouraged by the possibility that social cost overestimation may represent a core cognitive process underlying the persistence of social anxiety symptoms, some clinical researchers have advocated for the integration of *intentional social mishap exposures* into CBT protocols for SAD (e.g., Hofmann, 2007). In such exercises, patients are instructed to commit purposeful social blunders during treatment in the service of correcting inflated cost estimates as they are confronted with objective evidence concerning the discrepancy between predicted social costs, which are imagined to be catastrophic, and observed (or felt) costs, which are typically quite minimal and short-lived.

Although social mishap exposures are based on sound theoretical premises and are associated with promising preliminary clinical outcomes (Hofmann & Scepkowski, 2006), there are very few studies that have investigated the impact of social anxiety on perceived risks and consequences of social blunders (see Arkin & Appelman, 1983; Edelmann, 1985a). It seems essential to elaborate the empirical justification for these clinical applications. In particular, studies are needed to establish how HSA individuals misinterpret social blunders. A better understanding of these misinterpretations would, in turn, benefit CBT clinicians who wish to implement social mishap exposures in their treatment of socially anxious patients.

The present study, therefore, was designed to examine the nature of perceived interpersonal and emotional consequences associated with committing both recalled (actual) and imagined social blunders in HSA and low socially anxious (LSA) individuals. Participants were

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selected based on a validated screening measure for SAD; the two groups, therefore, represent analogues of patient and normal control groups. We hypothesized, first, that HSA participants would perceive their own past blunders as being more emotionally[2] and interpersonally costly than would LSA participants and objective raters. Second, we predicted that relative to their LSA counterparts, HSA participants would overestimate the costs of blunders described in hypothetical scenarios in which they imagined themselves as the central character. Third, on the basis of research suggesting that socially anxious individuals may apply a double standard in their judgments of social behavior by applying more stringent rules to evaluations of their own behaviors than evaluations of the behavior of others (e.g., Amir, Foa, & Coles, 1998; Voncken, Alden, & Bögels, 2006), we predicted that HSA and LSA participants would not differ in their perception of the consequences associated with blunders committed by an imagined third person. Finally, given the well-documented overlap between symptoms of social anxiety and depression in their relation to negative self-relevant cognitions within social and interpersonal contexts (e.g., Dozois & Frewen, 2006), we were interested in the extent to which the perceived consequences of social blunders may be driven by symptoms of social anxiety, symptoms of depression, or both. In this regard, because of evidence that changes in perceived cost of negative social outcomes mediates treatment outcome in social anxiety disorder (Hofmann, 2004), we were particularly interested in whether social anxiety was uniquely related to perceived costs of social blunders. Thus, we hypothesized that although both symptoms of social anxiety and depression would each likely account for some of the variance in perceived costs of autobiographical and imagined social blunders, symptoms of social anxiety would maintain a unique relationship with cost, above and beyond depression.

Method

Participants

Undergraduate psychology students at a large, urban Canadian university were prescreened with the Social Phobia Inventory (SPIN; Connor et al., 2000), a well-validated measure of social anxiety symptoms (see description in Measures, below). Individuals who scored 30 or above (HSA) and 12 or below (LSA) on the SPIN were invited to participate in the current study. One hundred forty four (70 HSA) individuals comprised the final sample, all of whom received partial course credit in exchange for their participation. One additional participant failed to complete measures for more than one of the imagined scenarios and was thus excluded. The study was completed online through a secure webpage hosted by the university and all procedures were approved by the university's Research Ethics Board. Descriptive sample characteristics are listed in Table 1.

Measures

Social Phobia Inventory (SPIN; Connor et al., 2000)

This 17-item questionnaire was originally constructed to serve as a screening tool for SAD. Respondents indicate the extent to which each of the 17 SPIN items (e.g., *I am afraid of people in authority*) has bothered them over the past week on a five-point Likert-type scale, ranging from 0 (not at all bothersome) to 4 (extremely bothersome), with possible scores ranging from 0 to 68. The SPIN has been shown to be an excellent measure of social anxiety, with good test-retest reliability, strong convergent and divergent validity, good construct validity and high levels of internal consistency (Antony, Coons, McCabe, Ashbaugh, & Swinson, 2006; Connor et al., 2000). Although Connor et al. (2000) proposed a cut-off score of 19 and higher to select participants likely to have SAD, others (e.g., Moser, Hajcak, Huppert, Foa, & Simons, 2008) have expressed a preference for using a more stringent cut-off score of 30, which we also used in the present study. We selected a cut-off score of 12 or below for controls because Connor et al. (2000) reported that their nonpsychiatric control group had a mean SPIN total score of 12.1. This cut-off score resembles the score of 10 or below that has been used by Moser et al. (2008) to identify low anxious controls. The SPIN was administered prior to the current study to screen participants; the resulting screening score was also used for the analyses in the current study.

Beck Depression Inventory II (BDI-II; Beck, Steer, & Brown, 1996)

This measure, which assesses depressive symptoms in both the psychiatric and healthy population, consists of 21 groups of statements (i.e. Sadness: 0 – I do not feel sad, 1 – I feel sad much of the time, 2 – I am sad all the time, 3 – I am so sad or unhappy that I can't stand it), for which participants select the corresponding option that best describes their emotional state. Scores on the measure can range from 0 to 63 and cut-offs have been determined to reflect minimal (0–13), mild (14–19), moderate (20–28), and severe (29–63) levels of depression. The scale's Cronbach's alpha has been reported at .89 for a student population (Whisman, Perez, & Ramel, 2000). The BDI-II has demonstrated good reliability, validity (e.g., convergent), and high internal consistency (Beck, Steer, & Garbin, 1988; Steer, Rissmiller, & Beck, 2000). The BDI-II was administered during screening, along with the SPIN and other measures (not used here).

Assessment of autobiographical blunders

Participants were instructed to recall and describe a specific event in their lives in which they committed what they would call a *social blunder*. First, participants were asked to describe the blunder (see Appendix A for some specific examples of participants' responses). Next, they were asked to rate on a 5-point scale from 0 (not at all) to 4 (extremely) the extent to which

Table 1
Characteristics of participant groups.

	High SA	Low SA	Statistical test
SPIN	38.73 (7.59)	6.92 (3.34)	$t(142) = 32.86$, $p < .001$
BDI-II	15.75 (11.35)	5.99 (5.78)	$t(140) = 6.52$, $p < .001$
Age in years (SD)	20.9 (4.69)	21.48 (5.63)	$t(138) = .51$, *ns*
Gender (% female)	65.7%	66.2%	$\chi^2(1) = .004$, *ns*
Ethnicity			$\chi^2(2) = 12.71$, $p = .002$
Caucasian	36.2%	59.7%	
Asian	43.5%	16.7%	
Other	20.3%	23.6%	

Note. Differences in degrees of freedom across *t*-tests reflect differences in numbers of missing data points across measures; SPIN = Social Phobia Inventory; BDI-II = Beck Depression Inventory II.

[2] Normative responses to social blunders may include several potentially distinct emotional reactions, including shame and embarrassment. Edelmann (1985b, p. 196) proposed differences between these two affective states, defining embarrassment as "a feeling of concern with one's public image and with reactions from real or imagined others to inappropriate behavior" and shame as "a feeling of self-blame or self-disgust." Tangney, Miller, Flicker, and Barlow (1996) concluded that shame is a much more negative, intense, and enduring feeling than embarrassment, which is less negative overall and tends to be associated with a rapid recovery to baseline and with less need for reparative actions in psychologically healthy individuals. Complimentary research by Sabini, Garvey, and Hall (2001) concluded that a revelation of some characterological flaw incited both embarrassment and shame, but if a situation did not involve revelation of a characterological flaw, people felt embarrassment to a much greater degree than shame. Given these theoretical assumptions and associated research findings, it seems plausible that HSA individuals, who are more likely to believe that they are inept or otherwise characterologically flawed (Clark & Wells, 1995; Hofmann, 2007; Moscovitch, 2009; Rapee & Heimberg, 1997; Rodebaugh, 2009), should also be more likely to experience shame as a result of social blunders.

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