

Social performance deficits in social anxiety disorder: Reality during conversation and biased perception during speech

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Abstract

Cognitive models emphasize that patients with social anxiety disorder (SAD) are mainly characterized by biased perception of their social performance. In addition, there is a growing body of evidence showing that SAD patients suffer from actual deficits in social interaction. To unravel what characterizes SAD patients the most, underestimation of social performance (defined as the discrepancy between self-perceived and observer-perceived social performance), or actual (observer-perceived) social performance, 48 patients with SAD and 27 normal control participants were observed during a speech and conversation. Consistent with the cognitive model of SAD, patients with SAD underestimated their social performance relative to control participants during the two interactions, but primarily during the speech. Actual social performance deficits were clearly apparent in the conversation but not in the speech. In conclusion, interactions that pull for more interpersonal skills, like a conversation, elicit more actual social performance deficits whereas, situations with a performance character, like a speech, bring about more cognitive distortions in patients with SAD.

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1. Introduction

Patients with social anxiety disorder (SAD) are concerned about flaws in their social performance, for instance, an anxious appearance (e.g., appearing nervous) and awkward social behavior (e.g., not knowing what to say). Cognitive models (Clark, 2001; Clark & Wells, 1995; Rapee & Heimberg, 1997) predict that patients with SAD overestimate their anxious appearance and social mishaps and underestimate quality of their social behavior. Indeed, research showed that socially anxious individuals suffer

from biased perception of their social performance (Rapee & Lim, 1992; Stopa & Clark, 1993). That is, observers evaluated socially anxious individuals' social performance as more positive than the socially anxious participants evaluated themselves. Yet, there might still be a core of truth in SAD patients' concern about their social performance. In fact, a body of studies shows patients with SAD to perform worse in social tasks compared to control participants. This is found in both analogue (e.g., Beidel, Turner, & Dancu, 1985; Bögels, Rijsemus, & De Jong, 2002; Daly, Twentyman, & McFall, 1978; Lewin, McNeil, & Lipson, 1996; Thompson & Rapee, 2002; Twentyman & McFall, 1975) and patient samples (Baker & Edelman, 2002; Fydrich, Chambless, Perry, Buergener, & Beazley, 1998; Stopa & Clark, 1993). Even though studies in this

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area are accumulating, it is still unresolved whether patients with SAD are mainly characterized with: (1) biased perception of their social performance, or by (2) actual performance deficits¹.

It is noteworthy that for most studies that evidenced social performance deficits in socially anxious participants, it remained unclear whether these deficits were due to social behavior, anxious appearance, or both. That is, many “social performance” rating scales possess items concerning visible anxious appearance, such as blushing, sweating, trembling, or appearing nervous. It could be argued that showing such physiologic responses is a deficit in social behavior. On the other hand, physiologic reactions are automatic responses that are not under voluntary control, whereas social behaviors such as smiling, nodding, asking questions are. In line, Bögels et al. (2002) found that anxious appearance and social behavior were two separate factors in observations of individuals that perform a social conversation. Accordingly, some studies found different outcomes for each of the two factors. That is, both Clark and Arkowitz (1975) and Bögels et al. (2002) found that high and low socially anxious individuals could be discriminated by an anxious appearance but not social behavior whereas Halford et al. (1982) found exactly the opposite pattern.

In the last decades both conversation-like tasks (e.g., role plays, job interviews or getting acquainted) as well as speech tasks were subject to investigation in the social anxiety literature. When investigating biased perception and actual performance deficits in social tasks, it might be of value to discriminate between a conversation and a speech task. To illustrate, Rapee and Lim (1992) found no difference in actual social performance of SAD patients and controls during a speech, whereas other studies, which measured social performance (also) during conversation-like tasks, did find actual performance deficits in SAD patients (Alden & Wallace, 1995; Baker & Edelman, 2002; Stopa & Clark, 1993). It seems plausible that a conversation calls upon more complex interpersonal social behaviors than a speech. For instance, during a conversation one needs to listen, ask questions, and respond to what others say,

whereas during a speech one does not require interaction with the audience to such extent. Therefore, patients with SAD might show particularly deficits in social tasks that require these more difficult interpersonal social behaviors.

Prior studies assessed biased perception of own social performance by calculating the discrepancy between observer ratings and ratings of participants' own experience. However, instead of using participants' rating of their own experience during the social task it would be more valuable to have participants estimate *how they expect to be judged by their observers*. That is, it is assumed that distorted self-perception is not specific for SAD but, for instance, also characterizes depression. Instead, SAD patients would specifically suffer from distorted perceptions of how *others* view them. The study of Strauman (1989) illustrates this nicely. Social anxiety was characterized by a discrepancy between how patients perceive themselves and what they believe others want them to be. In contrast, depression was marked by a discrepancy between how patients perceive themselves and how they ideally want to be. In other words, not living up to perceived standards of *other* people is related to social anxiety. Therefore, a more precise assessment of cognitive discrepancies in SAD appears participants' ratings of how they believe observers will evaluate them, relative to observers' actual evaluations.

For the study reported here, we were interested whether patients with SAD were mostly characterized by biased perception or by actual performance deficits compared to control participants. We aimed to investigate these variables in both a speech and a conversation task and for both anxious appearance and social behavior. Therefore, we recruited patients with SAD ($n = 48$), and control participants ($n = 27$). They were asked to give an impromptu speech in front of two confederates (male and female) and to get acquainted with two other confederates (male and female). In order to assess biased perception regarding ones social performance, we let confederates rate participants' social performance and simultaneously, let participants estimate these ratings of the confederates. Anxious appearance and social behavior were assessed separately for both biased and actual deficits.

¹ In this paper, it was chosen to use the term 'performance deficits' instead of 'skills deficits'. Hopko, McNeil, Zvolensky, and Eifert (2001) argue that the term skill deficit is misused as a skill deficit implies the reason why the individual is not showing proper behavior, that is, (s)he is not *able* to show the behavior. However, in observation studies we are not able to distinguish between a lack of ability and deficits in performance due to anxiety or other stressors. Therefore, the term 'performance deficits' is more adequate in studies in which behavior is observed.

2. Method

2.1. Participants

Patients with SAD were recruited from the ambulant community mental health centre of Maastricht, the Netherlands. Patients treated in this centre are referred

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