# Individual differences in fears of negative versus positive evaluation: Frequencies and clinical correlates

Melanie F. Lipton [a], Justin W. Weeks [b], Andres De Los Reyes [c],*

[a] University of Maryland at College Park, Department of Psychology, Comprehensive Assessment and Intervention Program, Biology-Psychology Building, Room 3144, College Park, MD 20742, United States
[b] Center for Evaluation and Treatment of Anxiety, Department of Psychology, Porter Hall 249, Ohio University, Athens, OH 45701, United States
[c] University of Maryland at College Park, Department of Psychology, Comprehensive Assessment and Intervention Program, Biology-Psychology Building, Room 3123H, College Park, MD 20742, United States

## ARTICLE INFO

## ABSTRACT

*Objective:* Examine individual differences in fears of evaluations (i.e., Fear of Negative Evaluation [FNE] vs. Fear of Positive Evaluation [FPE]) and their associated features (i.e., internalizing domains such as social anxiety [SA]).
*Method:* A sample of 375 undergraduates (77% female, age M = 19.63) completed self-reports of FNE, FPE, and multiple internalizing domains, including SA. We identified groups of individuals who were (a) low on FNE/FPE; (b) high on FNE, low on FPE; (c) low on FNE, high on FPE; and (d) high on FNE/FPE.
*Results:* LowFNE/FPE individuals displayed the lowest levels of internalizing symptoms across groups, and HighFNE–LowFPE and LowFNE–HighFPE showed significantly more internalizing symptoms than the LowFNE/FPE group, but were not significantly different from each other. HighFNE/FPE individuals displayed the highest levels of internalizing symptoms across the groups.
*Conclusions:* We identified individual differences in expressions of FNE and FPE, and both FNE and FPE share both unique and cumulative effects in relation to internalizing symptoms.

## 1. Introduction

Social Anxiety Disorder (SAD) is the third most prevalent mood/anxiety disorder, behind Specific Phobia and Major Depressive Disorder (Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012). SAD has lifetime and 12-month prevalence rates of 13% and 7%, respectively (Kessler et al., 2012), typically emerges in adolescence (i.e., around 13 years of age), and remains heightened throughout adolescence and into adulthood (Kessler et al., 2005).

Individuals suffering from SAD often experience enduring and debilitating fears of social situations, namely interactions with strangers (American Psychiatric Association, 2013). Further, individuals with SAD often fear situations where performance is required (e.g., public speaking, meetings at school/work; Bögels et al., 2010), and in particular they hold maladaptive beliefs that individuals with whom they will interact will critically evaluate their performance, resulting in avoidance (Clark & Wells, 1995). Consequently, heightened social anxiety [SA] symptoms often result in impaired relationships with peers, romantic partners, and coworkers (e.g., Beidel, Rao, Scharfstein, Wong, & Alfano, 2010).

The mechanisms underlying fears in SA stem from how those suffering from these fears process information from their environment (Leary, Kowalski, & Campbell, 1988). Those with SA exhibit hypervigilance towards a variety of social cues, and preconceived notions about their environment, resulting in cognitive biases and maladaptive decision-making (e.g., behavioral avoidance; Rapee & Heimberg, 1997; Leary et al., 1988). For instance, the Fear of Negative Evaluation (FNE; Clark & Wells, 1995) involves maladaptive beliefs that others are negatively evaluating one's behavior in performance-based situations (Watson & Friend, 1969). Traditionally, FNE involves beliefs that others have high performance standards (i.e., even without support for this belief), doubts about living up to these high standards, and thus the belief that negative evaluations will follow imminent "failure" (Weeks, Heimberg, & Rodebaugh, 2008). Thus, FNE may account for the fear and avoidance seen in those suffering from SAD.

Importantly, fear and avoidance may result from evaluative concerns beyond FNE (Weeks & Howell, 2012). Indeed, researchers find links between SA and Fears of Positive Evaluation (FPE; Heimberg, Brozovich, & Rapee, 2010). Similar to FNE, FPE involves fearing the consequences of positive evaluations (e.g., praise). These fears may manifest in multiple ways. First, those high in FPE may display a high concern with public displays of positive evaluations (e.g., boss praising an employee about her/his presentation in front of coworkers). Second, individuals experiencing FPE may anticipate that a positive evaluation in the present may lead to negative consequences in the future (e.g., after good performance, people raising expectations to unreasonable standards in subsequent encounters; Weeks & Howell, 2012).

* Corresponding author.
*E-mail addresses:* mlipton@umd.edu (M.F. Lipton), weeksj@ohio.edu (J.W. Weeks), adlr@umd.edu (A. De Los Reyes).

Third, those experiencing FPE may fear an inability to meet heightened expectations, thus disappointing those who previously evaluated them positively.

Concerns with FPE may stem from a fear that public praise results in the individual experiencing increased competition from observers who view the praise as threatening (e.g., coworkers; Weeks, Jakatdar, & Heimberg, 2010). Thus, among high-SA individuals, high levels of FPE may result in avoidance of circumstances in which they become the center of positive and/or negative attention. Consequently, relatively high levels of FPE have been robustly identified in studies of SAD patients (e.g., Weeks, Heimberg, Rodebaugh, Goldin, & Gross, 2012).

Overall, findings indicate that FNE and FPE represent related but distinct constructs, an idea that has recently been conceptualized within the Bivalent Fear of Evaluation (BFOE) model (Weeks & Howell, 2012). Specifically, individuals with SAD experience fears of evaluation that represent distinct valences of social experience (i.e., positive vs. negative). In fact, in recent work FPE was uniquely and more strongly related to various positively valenced impairment-related concerns (e.g., social reprisal concerns due to positive impressions), relative to FNE or SA symptoms (Weeks & Howell, 2012).

In line with the BFOE model, there may exist individual differences among people in terms of how saliently they perceive FNE and/or FPE. Some individuals may show heightened concerns with both FNE and FPE, whereas others may show heightened concerns with one and not the other. Further, two main domains underlie psychopathology (i.e., internalizing, externalizing; Krueger, McGue, & Iacono, 2001; Krueger & South, 2009). Internalizing symptoms such as SA significantly relate to other internalizing concerns. Given the clinical implications for the present study, we chose to examine depression, anxiety sensitivity, and maladaptive reactions to anxiety-provoking situations (i.e., safety behaviors), as these constructs frequently co-occur with elevated SA and SAD (Cuming et al., 2009; Zinbarg, Barlow, & Brown, 1997). Similarly, FNE and FPE may also relate to multiple displays of internalizing concerns. Therefore, individual differences in evaluative concerns and the associated features of these individual differences are important to examine.

### 1.1. Purpose and hypotheses

We examined individual differences in displays of evaluative concerns (FNE vs. FPE), and their correlates. We expected individuals low in both FNE and FPE to display the lowest levels of internalizing symptoms. We hypothesized that those relatively high in FNE but low in FPE, and relatively low in FNE but high in FPE, to evidence greater levels of internalizing concerns, relative to those low on both FNE and FPE. Lastly, we expected FNE and FPE to have a cumulative effect on SA symptoms and internalizing concerns, such that individuals high in *both* evaluative concerns would show the highest levels of internalizing symptoms, relative to all other groups.

## 2. Methods

### 2.1. Participants

We recruited 375 undergraduates enrolled at a large Mid-Atlantic university through an online recruitment system (SONA), where undergraduates could sign up for studies. Initially, we recruited 406 participants, and we only examined those who provided complete data (N = 375). The 31 participants who did not provide complete data did not differ significantly from the final sample on gender or age (both $ps > .05$). The sample had a mean age of 19.63 years (SD = 2.81) and 289 female participants (77.1%). Participants self-identified their race/ethnicity as White, Caucasian, American, or European (65.1%); Black/African American (12.8%); American Indian (0.5%); Asian American (16.3%); and Hispanic and/or Latina/o (8%).

### 2.2. Measures

All measures administered in the current study were self-report.

#### 2.2.1. Fear of Negative Evaluation

We measured FNE using the Brief Fear of Negative Evaluation Scale (BFNE; Leary, 1983). The BFNE is a 12-item self-report measure that utilizes a 5-point, Likert-type response scale. Greater BFNE scores relate to greater scores on measures of social avoidance and distress (Leary, 1983). Further, the BFNE reliably distinguishes non-anxious controls from SAD patients (Rodebaugh et al., 2011). Consistent with prior work, we utilized the straightforward scoring approach (i.e., omitted use of reverse-scored items; Rodebaugh et al., 2011). In our sample, we observed excellent internal consistency estimates ($\alpha = .93$).

#### 2.2.2. Fear of Positive Evaluation

We assessed FPE using the Fear of Positive Evaluation Scale (FPES; Weeks et al., 2008). The FPES is a 10-item self-report measure that uses a Likert-type response scale. Greater FPES scores relate to greater scores on the BFNE and SA symptom measures (Weeks et al., 2008). Further, scores on the FPES are sensitive to change among patients undergoing treatment for SAD (Weeks et al., 2012). In our sample, the FPES demonstrated good internal consistency ($\alpha = .83$).

#### 2.2.3. Social anxiety symptoms

We assessed SA symptoms using two well-validated self-report scales, namely the Social Interaction Anxiety Scale (SIAS; Mattick & Clarke, 1998) and Social Phobia Scale (SPS; Mattick & Clarke, 1998). The SIAS is a 20-item self-report measure on which respondents rate how true items are of them on a scale from "0 = not at all characteristic of me" to "4 = extremely characteristic of me." The SIAS specifically asks respondents to rate items about initiating and maintaining social interactions. The straightforward scoring of the SIAS shows superior psychometric properties, and thus we used this scoring in our study (Rodebaugh et al., 2011). Similarly, the SPS is a 20-item self-report scale that assesses fear and anxiety related to being judged by others when performing such tasks as speaking, writing, or eating in public. The SPS uses the same 5-point scale described above. These scales: (a) evidence relatively high internal consistency, (b) display strong convergent validity in relation to established SA measures, and (c) evidence strong discriminant validity when compared to measures of agoraphobia (Mattick & Clarke, 1998). In our sample, both measures displayed high internal consistency, both $\alpha s > .91$.

#### 2.2.4. Depressive symptoms

To measure depressive symptoms, we used a modified version of the Beck Depression Inventory-II (BDI-II; Dozois, Dobson, & Ahnberg, 1998), a widely used 21-item self-report measure. We modified the BDI-II in order to address concerns related to clinical risk and liability; we did not administer the item assessing suicidal thoughts. Thus, we calculated our total score based on the remaining 20 original BDI-II items (BDI-II-modified). The original BDI-II displays adequate validity with other measures of depressed mood as well as good internal consistency estimates (Dozois et al., 1998). The BDI-II-modified displayed excellent internal consistency in our sample, $\alpha = .92$.

#### 2.2.5. Anxiety sensitivity

To assess anxiety sensitivity, we used the third version of the Anxiety Sensitivity Index (ASI-3; Taylor et al., 2007). The ASI-3 measures the most common aspects of anxiety sensitivity; namely cognitive, physical, and social concerns; using 18 self-report items rated on a scale of how strongly the respondent agrees that various statements are characteristic of him/her from "0 = very little" to "4 = very much." Individuals meeting criteria for anxiety disorders (e.g., panic and generalized anxiety disorders) obtain significantly higher ASI-3