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Shame and Anger in Chronic Shyness
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SHAME AND ANGER IN CHRONIC SHYNESS

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ABSTRACT

Clinical observation of shy patients suggests that chronically shy people blame themselves for perceived inadequacy, but blame others for indifference or a predatory orientation. Other-blaming tendencies suggest the presence of anger as well as shame in chronic shyness. To test this hypothesis in a sample of our shyness clinic patients, other-blame was measured by the Paranoia Scale (*Pa*) of the MMPI. The presence of anger was assessed using three MMPI scales: Psychopathic Deviance (*Pd*) for resentment, Anger (ANGER) and Overcontrolled Hostility (O-H). These were correlated with scores on two shame scales, the Personal Feelings Questionnaire (PFQ) and the Test of Self-Conscious Affect (TOSCA). Scores on blame, shame and anger were then used to predict the degree of elevation on four MCMI Scales: Social Avoidance, Self-abasement, Self-defeating Behavior and Passive-aggressiveness. Shame was a significant predictor of social avoidance, self-abasement, self-defeating behavior and passive aggression. Resentment was a significant predictor of self-abasement, and anger was a significant predictor of passive aggression. Suppressed hostility was a significant negative predictor of self-abasement. Those diagnosed with Avoidant Personality Disorder scored significantly higher than the rest of the sample in other-blaming and shame.

INTRODUCTION

The association of shyness, shame and internal attributions for negative social outcomes has been reported frequently in the clinical and research literature (Arkin, 1980, Buss, 1980, Girodo, 1981, Henderson, 1992b, Teglasi, 1982). Specific self-blaming attributions have been reported by adults and adolescents (Henderson, 1992a; Henderson, 1994; Zimbardo, 1977, 1996). In addition, clinical observation and psychometric testing suggest that chronically shy individuals blame others as well as themselves, seeing others as dangerous, rejecting and unreliable (Henderson, 1992b; Henderson, 1997).

Blaming others has negative interpersonal and intrapersonal consequences (Tennen & Affleck, 1990) and is associated with hostility and resentment: in fact, many shy people seem to assume a hostile attitude toward both the self and others (Bartholomew & Horowitz, 1991). Beyond the interpersonal consequences of hostility are health problems such as high blood pressure and increased risk for hypertension (Gentry, Chesney, Gary, Hall & Harburg, 1982).

Recent research has shown that shame-prone individuals in general experience more frequent anger, externalize blame and report more maladaptive responses to anger, ranging from seething resentment and self-directed hostility to more open aggression (Tangney, Wagner, Fletcher & Gramzow, 1992). Furthermore, shame has been found to be negatively correlated with some measures of empathy (Feshbach & Lipian, 1987; Tangney, 1991), suggesting that empathy may not mitigate against anger and maladaptive responses to it in shame-prone individuals.

These findings are consistent with the observations of both Lewis and Scheff who described rage reactions in shame-prone patients (Lewis, 1971; Scheff, 1987). Because shame is a painful emotion, externalizing blame is thought to lessen the pain of self-blame in the short run and to protect one's self-esteem (Lewis, 1971). It seems likely that those who are self-blaming and shame-prone use other-blame to reduce negative emotion.

Buss (Buss, 1980) asserts that one of the precursors of social anxiety is parents' tendencies to place undue importance on the opinions of others, and socially phobic individuals report shaming as a means of discipline in their families (Bruch & Heimberg, 1994). These findings suggest that parents may blame shy children for negative social outcomes. Children may learn to blame themselves, but experience painful states of shame, which can then be alleviated

by "blaming back," so what is learned is that blame needs to be assigned somewhere.

In fact, a personality variable that contributes to a propensity toward aggression is emotional instability, according to a recent study of Italian adults (Caprara, Barbaranelli & Zimbardo, 1996), which corresponds to the traits of neuroticism and negative affect (McCrae & Costa, 1987); Caprara, 1996 #2436; (Watson & Tellegen, 1985) Those higher in emotional instability, or reactivity, are higher in trait anger and hostile rumination.

Interpersonal sensitivity and a sense of threat from others has been documented in a Minnesota Multiphasic Personality Inventory (MMPI) study of a shyness clinic sample (Henderson, 1997), as well as in studies of social anxiety and social phobia (Cloitre, Heimberg, Liebowitz & Gitow, 1992; Leary & Atherton, 1986), and probably plays a role in emotional reactivity. This hypersensitivity does not necessarily imply difficulty with impulse control, nor does it imply anger that is expressed verbally or behaviorally. It is probable that only a very small percentage of painfully shy and socially alienated individuals, such as those described in the study of Shy Murderers (Lee, Zimbardo & Bertholf, 1977, November), experience enough environmental provocation to resort to aggressive acts.

Direct behavioral aggression appears rare in shyness, and even extremely shy individuals who come to our clinic report little overt aggression. Instead, they report frustration, resentment and inhibition, and display more indirect aggression, such as sarcasm, obstructionism and self-righteous anger, consistent with the incidence of Passive-Aggressive Personality Disorder in 15% of a sample of clinic patients diagnosed with a co-existing personality disorder (St. Laurent, Henderson & Zimbardo, 1997).

Sixty-seven percent of the sample received a diagnosis of Avoidant Personality Disorder. Because DSM III-R and IV criteria for Avoidant Personality Disorder include a belief that one is inadequate and vulnerable to others in social situations, we expected that both shame and anger would be elevated in these individuals. In fact, our previous study with a general sample of shyness clinic patients showed elevations on MMPI scales measuring vulnerability and anger (Greene, 1991; Henderson, 1997). Because our earlier sample revealed this pattern, we hypothesized that those diagnosed with AVPD might be higher yet. Individuals diagnosed with Avoidant Personality Disorder have demonstrated less actual social skills in some research and have been seen

as qualitatively different from social phobics (Turner, Beidel, Dancu & Keys, 1986). Note, however, that Herbert et al. (Herbert, Hope & Bellack, 1992), failing to replicate Turner's findings, pointed out that the earlier DSM III criteria that Turner used for the diagnosis of Avoidant Personality Disorder included a bigger emphasis on hypersensitivity to rejection.

Avoidant Personality Disorder has sometimes been shown to be refractory to current treatment interventions for shyness and social phobia (Blalock, Levine, Holzer, Seay & Spath, 1997), and we have suspected that this may be due to a lack of specific emphasis on self-blame and shame. In a recent exploratory study with shy college students, eight-week Social Fitness Treatment groups included attributional and self-concept restructuring with good results. Of those who met criteria for AVPD at pre-test, only 25% met criteria at post-test (Henderson, Martinez & Zimbardo, 1997).

We now suspect that other-blame, in addition to self-blame, needs to be addressed more specifically in shyness and social phobia, and our current research is focused on the exploration of anger and other-blame and its relationship to shame and self-blame. To that end, we are assessing the presence of different aspects of anger in chronic shyness, social phobia and Avoidant Personality Disorder. Our current review of the literature revealed that techniques which have been effective in reducing anger, such as cognitive-relaxation coping skills (CRCS), have also reduced shyness (Hazaleus & Deffenbacher, 1986), which hints at further links between shyness and anger and may provide direction in treating the anger component more specifically.

In order to focus on and assess the presence of shame and anger in our shyness clinic sample and to look at their contributions to avoidance and aggressive tendencies, we utilized the test results of patients from a recent comorbidity study (St. Laurent et al., 1997).. Our hypotheses were: 1) that shame and anger (both suppressed and inappropriately expressed) would be positively correlated in our sample and positively correlated with blaming others; 2) that patients diagnosed with Avoidant Personality Disorder would be found to be more shame-prone and more other-blaming and angry than those who did not carry this diagnosis; and 3) that anger (both suppressed and expressed), in addition to shame, would predict social avoidance, self-abasement, self-defeating behavior patterns and passive aggression.

METHOD

Data included in this study were taken from the records of consecutively evaluated individuals seeking treatment at the Shyness Clinic between 1991 and 1997. The original sample included 69 men (61%) and 45 women (39%) with a mean age of 35 ± 9.9 years (ranging from 16 to 65 years). Table 1 includes the demographic data (St. Laurent et al., 1997). Our present study includes data on over 100 patients, but numbers for each analysis vary and are reported in the tables.

Measures were administered to patients as part of their initial evaluation. The MMPI (Butcher, Dahlstrom, Graham, Tellegen & Kaemmer, 1989; Hathaway & McKinley, 1940) has been administered since 1982, and the MCMI (Millon, 1983) was added to the evaluation in 1993, resulting in 82 patients who were evaluated with this instrument. Scoring was done by the NCS Interpretive Scoring System to ensure accuracy and standardization (Millon, 1987). Avoidant Personality Disorder and Passive Aggressive Personality Disorder were diagnosed according to the MCMI (NCS Interpretive Report), and degree of avoidance, self-abasement, self-defeating behavior and passive aggression were measured by elevations on their respective scales.

Anger was measured by three scales from the MMPI: the Anger content scale (ANG), purporting to measure irritability, impatience, hotheadedness, stubbornness and lack of control (Greene, 1991); the Overcontrolled-Hostility Supplementary Scale (O-H), on which high-scorers are described as overcontrolled, socially alienated, rigid and denying psychological symptoms (Greene, 1991); and the Psychopathic Deviancy Scale (*Pd*). In the context of anxiety and schizoid tendencies, the *Pd* scale suggests interpersonal distrust, anger and resentment, a view of the world as dangerous and of other people as rejecting and unreliable (Greene, 1991).

Blaming others was measured by the Paranoia (*Pa*) Scale of the MMPI, because this scale has been linked to externalizing responsibility, as well as to sensitivity to criticism (Greene, 1991). Shame was measured by two instruments: the Personal Feelings Questionnaire (PFQ) (Harder & Lewis, 1986), and the Test of Self-conscious Affect (TOSCA). The shame subscale of the PFQ is purported to measure shame, in contrast to guilt, with test-retest reliability at two weeks .85 and at five weeks .78. The revised scale (Harder Personal Feelings Questionnaire-2 (PFQ-2) was substituted in 1993 (Harder, Rockart & Cutler, 1993). The TOSCAS, a subscale of a scenario-based measure of shame and guilt

(added to our evaluation in 1994), was a revision of the the Self Conscious Affect and Attribution Inventory (SCAAI, Tangney, 1990), on which estimates of internal consistency (Cronbach's alpha) ranged from .72 to .82, and test-retest reliabilities over a 1 to 5 week period were .79. Internal consistency for the TOSCA shame subscale was .76 (Tangney, 1991).

Shyness was measured using the 20-item Revised Cheek and Buss Scale (RCBSHY, Melchior, et al., 1990) Scores could range from 20 to 100. The scale had high internal consistency, the alpha coefficient being .94 (See Table 1.1 for questionnaire scores from the original sample).

RESULTS

The first hypothesis, that shame and anger would be positively correlated in our sample and positively correlated with the externalization of blame, was tested using Pearson correlational analyses. Table 2 contains the correlations of shame and anger as measured by their respective subscales. Only the PFQ is associated with *Pd*, but not with ANG, and neither shame scale reaches significance in its association with *Pa*. This is in contrast to earlier results with the TOSCAS and the Symptom Checklist 90 (SCL-90) (Derogatis, Lipman & Covi, 1973; Tangney, Wagner & Gramzow, 1992) in which the TOSCAS was associated with paranoid ideation, hostility and anger, and interpersonal sensitivity in three separate studies.

Pa is associated with both ANG and *Pd*. O-H is uncorrelated with the PFQ and the TOSCAS, and with *Pa*, perhaps not surprising since it has been associated with the denial of psychological symptoms. O-H is also significantly negatively correlated with ANG, which follows logically because it refers to covert rather than overt anger.

MANOVA was used to test our second hypothesis: that those diagnosed with Avoidant Personality Disorder would be significantly higher than the rest of the sample in shame, anger and the externalization of blame. Table 3 presents the means of those with and without the diagnosis of Avoidant Personality Disorder. MANOVA revealed that the groups were significantly different: $F(6, 67) = 2.53, p < .05$.

Univariate ANOVAS indicated that *Pa* and TOSCAS were the main effects; that is, the groups were significantly different in the tendency to

externalize blame: $F(1, 72) = 5.04, p < .05$ and in shame, $F(1, 72) = 7.14, p < .01$. There were no significant differences obtained in *Pd*, *ANG* or *O-H*.

Our third hypothesis, that anger (both suppressed and expressed), in addition to shame, would predict social avoidance, self-abasement, self-defeating behavior patterns and passive aggression, was tested using multiple regression (see Table 4). Elevation on the Avoidance scale of the MCMI, was predicted by the TOSCAS, $t_s(2, 79) = 3.70, p < .001$; and the PFQ, $t_s(2, 79) = 2.84, p < .01$; $adj. R^2 = .28$. In the following analyses, these same predictors were used.

Elevation on the Self-abasement Scale was predicted by *Pa*, $t_s(4, 72) = 3.15, p < .01$; PFQ $t_s(4, 72) = 3.54, p < .01$; and TOSCAS, $t_s(4, 72) = 3.51, p < .01$; and was negatively predicted by *O-H*, $t_s(4, 72) = -2.74, p < .01, F(4, 72) = 21.96, p < .001, adj. R^2 = .53$. Elevation on the Self-defeating Scale was significantly predicted by both PFQ $t_s(2, 79) = 3.91, p < .0001$; and TOSCAS, $t_s(2, 79) = 3.37, p < .01; F(2, 79) = 20.70, p < .001, adj. R^2 = .33$. *ANG* and TOSCAS were the significant predictors of elevation on the Passive Aggression scale, $t_s(2, 73) = 4.99, p < .001; t_s(2, 73) = 2.18, p < .05, F(2, 73) = 17.47, p < .001, adj. R^2 = .31$.

Exploratory Analyses.

Several exploratory analyses were performed. First, we wanted to see if self- and other-blame, shame and anger would be more apparent in those with Schizotypal Personality Disorder because cognitive and emotional control is reduced in these individuals, and 8.5% of the original sample received this diagnosis, according to the MCMI. Second, we wanted to look at the relationship of shame, anger and externalization of blame to problems in the workplace and to negative attitudes toward treatment, in order to see if the findings were consistent with our clinical observation that they would predict difficulty. We also wanted to see to what degree shame and anger would predict social introversion, as measured by the MMPI. Third, we were curious about other possible ways to view our subgroups and used a cluster analysis to explore ways to organize the data.

We used the MCMI diagnosis of Schizotypal Personality Disorder and three other MMPI scales: Social Introversion (*SI*), Work Interference (*WRK*) and Negative Treatment Indicators (*TRT*). MANOVA was used to determine whether there were differences between those diagnosed with and without Schizotypal Personality Disorder. MANOVA revealed that there were significant differences: $F(6, 67) = 5.98, p < .001$. ANOVAS indicated that those diagnosed with Schizotypal Personality Disorder were significantly higher in PFQ: $F(1, 72)$

= 23.04, $p < .001$; TOSCAS, $F(1, 72) = 3.99$, $p < .05$; ANG, $F(1, 72) = 15.77$, $p < .001$; and approached significance in Pa , $F(1, 72) = 3.45$, $p < .08$.

PFQ, TOSCAS and Pa significantly predicted elevations on Work Interference, PFQ, $t(3, 76) = 3.34$, $p < .01$, TOSCAS, $t(3, 76) = 4.71$, $p < .001$, Pa , $t(3, 76) = 3.60$, $p < .01$, $F(3, 76) = 30.20$, $p < .001$, $adj. R^2 = .53$. Pd , Pa and TOSCAS significantly predicted elevations on Negative Treatment Indicators, Pd , $t(3, 77) = 3.18$, $p < .01$, Pa , $t(3, 77) = 2.77$, $p < .01$, TOSCAS, $t(3, 77) = 5.07$, $p < .001$, $F(3, 77) = 22.32$, $p < .0001$, $adj. R^2 = .44$. Regression analyses revealed that PFQ and TOSCAS were the only significant predictors of SI , PFQ, $t(2, 82) = 3.60$, $p < .01$; and TOSCAS, $t(2, 82) = 4.54$, $p < .001$, $F(2, 82) = 26.55$, $p < .001$, $adj. R^2 = .38$.

Finally, we used Cluster Analysis as a heuristic to look for qualitatively distinct subgroups and/or useful dimensions along which to view them. We added the guilt subscale from the PFQ, the Revised Cheek and Buss Shyness Scale (Cheek, 1983), the MCMI Avoidance Scale, the MMPI Work Interference and Negative Treatment Indicators scales and the MCMI Abasement Scale. We tried two, three and four cluster solutions. The only interpretable one was a two cluster solution, in which Cluster 1 was significantly more elevated than Cluster 2 on all variables except suppressed or overcontrolled hostility, on which it was less elevated, which suggests considerably more distress and avoidance in Cluster 1 and less overcontrolled hostility (See Table 5).

DISCUSSION

In summary, our first hypothesis, that shame, anger and the externalization of blame would be elevated in our sample and correlated, was only partially confirmed. Shame and resentment were correlated and resentment was correlated with the externalization of blame, consistent with findings of earlier clinicians and researchers (Scheff, 1987; Tangney et al., 1992; Wurmser, 1981), but only the externalization of blame was correlated with expressed anger. Overcontrolled or suppressed hostility was negatively correlated with expressed anger, suggesting less distress, possibly at the cost of a repressive defensive style which may not facilitate behavior change. However, the average scores were near the mean of normative data, so no conclusions can be drawn.

Those diagnosed with Avoidant Personality disorder were significantly higher in the externalization of blame as well as shame, consistent with our second hypothesis, but not in anger, contrary to expectation. The first finding suggests that these individuals are the ones who may well externalize blame in

order to reduce shame and experience the most vulnerability and mistrust of others. However, their scores overall were in the high end of the normal range, not outside it. Elevations on the Pd scale of the MMPI have been observed across two samples at our clinic, reflecting the resentment and hostility observed clinically in chronic shyness, but those diagnosed with AVPD were not significantly higher than the rest of the sample.

Expressed anger was around the mean of the general population, which is not surprising due to evaluation concerns and inhibition, but the same was true of overcontrolled hostility. The Overcontrolled Hostility Scale of the MMPI was designed to predict eventual overt aggression, however, and it may well not be the best measure to assess hostility in this population. In fact, studies using this scale with other populations have not demonstrated high predictive validity.

The lack of differences in anger may be due to these rather gross measures, which may not differentiate between the more passive subtle expressions of anger and expressed anger. It may be that chronically shy individuals do not express anger openly and perhaps are not aware of it. One of the needs in treatment may be to help them to articulate and express anger constructively.

Recently we have added the State-Trait Anger Expression Inventory (STAXI) (Spielberger, 1979) to our Initial Evaluation, and preliminary results with this questionnaire appear more promising, due to the breakdown in subscales. Patients can report how frequently they experience anger in contrast to how much they they express it (Spielberger, Reheiser & Sydeman, 1995)*. The behavior observed in shy individuals when they are feeling resentful or angry needs to be explored in future research.

Shame was a significant predictor of social avoidance, self-abasement, self-defeating behavior and passive aggression, as we predicted in our third hypothesis, providing additional support for the role of shame in maladaptive behavior chronic shyness. Expressed anger predicted passive aggression only, suggesting further studies that differentiate fear-related vs. anger-related social avoidance.

The more obvious findings with the anger scales used in this study were in relation to Schizotypal Personality Disorder. Patients with this diagnosis were significantly higher than the rest of the sample in expressed anger as well as shame, possibly reflecting the general loosening of cognitive and affective control in this group.

It is important in treating shyness to be aware of the significant elevations on Work Interference predicted by shame and the externalization of blame, accounting for over half the adjusted variance. Assertiveness and the appropriate handling of anger may be particularly important in this domain. Negative Treatment Indicators are also predicted by shame, resentment, and the externalization of blame. We have found the discussion with patients during the initial evaluation that the experience of shame may come up in treatment has been useful in preventing attrition and demoralization. We also plan in advance how to deal with shame and anger if they do occur. Often people will speak to the group therapist privately even if they do not wish to address the emotion in the group.

When we addressed attribution style and shame specifically with shy college students in eight-week treatment groups, they significantly reduced self-blaming attributions in their most challenging interpersonal situations from pre- to post-test. State-shame was concomitantly reduced in these situations. Because ninety-six percent of our sample met criteria for Social Phobia, our results may be applicable to the treatment of social phobia, as well as shyness and AVPD. This was a single treatment study, and how these results will compare with other treatments in controlled studies is as yet unknown and will be part of future research.

Our cluster analysis suggested that either a subgroup of our patient sample is in more substantial distress overall or that the subgroup with the significantly lower scores on our variables may tend to be using repressive defenses or coping mechanisms, rather than the more usual hypervigilant mechanisms that many shy and socially anxious individuals employ. We are addressing this issue in planning a study of defensive styles of shy and socially avoidant individuals.

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Table 1. Demographic Profile of Chronically Shy Patients
(N=114)

Characteristic	n	%
Sex		
Female	45	39.5
Male	69	60.5
Age		
16-29	34	29.8
30-44	61	53.5
45-64	18	15.8
65>	1	.9
Mean	35.3 ±9.9	
Marital Status		
Never Married	85	74.6
Married	15	13.2
Separated	3	2.6
Divorced	9	7.9
Widowed	2	1.8
Education		
Less than high school	3	2.6
High school, some college	38	33.3
College	32	28.1
Advanced degree (partial and completed)	41	36.0
Mean	16.2 ±3.2	
Occupation		
Employed	83	72.8
Unemployed	9	7.9
Student	19	16.7
Homemaker	3	2.6
Ethnicity		
Caucasian	97	85.1
African American	2	1.8
Hispanic	4	3.5
Asian	8	7.0
Other	3	2.6

Table 2. Correlations of Shame, Anger and Externalization of Blame

PEARSON CORRELATION MATRIX

	PFQSHAME	Pd	Pa	ANGER	TOSCAS	OH
PFQSHAME	1.000					
Pd	0.341*	1.000				
Pa	0.296	0.324*	1.000			
ANGER	0.270	0.175	0.362*	1.000		
TOSCAS	0.380**	0.056	0.286	0.186	1.000	
OH	-0.060	-0.126	-0.171	-0.412**	-0.175	1.000

Note. Scales: PFQ, Personal Feelings Questionnaire; Pd, MMPI Psychopathic Deviancy Scale; Pa, MMPI Paranoia Scale; ANG, MMPI Anger Scale; TOSCAS, Test of Self-conscious Affect Shame Scale;

O-H, MMPI Overcontrolled Hostility Scale.

N = 106, *p<0.05; **p<0.01

Table 3. Means of Patients Diagnosed with and without Avoidant Personality Disorders

	APD N = 51	Without APD N = 23
PFQ-Shame		
M	2.06	1.83
SD	.10	.15
TOSCA-Shame		
M	3.25**	2.83
SD	.09	.13
Pd-Resentment		
M	64.55	60.39
SD	1.72	2.56
Pa-Externalizing		
M	62.88*	56.87
SD	1.50	2.22
Anger		
M	47.37	47.70
SD	1.10	1.64
Overcontrolled hostility		
M	51.77	48.13
SD	1.42	2.12

Note.* $p < 0.05$; ** $p < 0.01$

Table 3.1 Means and Standard Deviations for age, education, ADIS severity rating, Questionnaires, and selected subscales from the MMPI and MCMI-II

Measure	Avoidant PD		Non-Av PD		
	n = 61		n = 30		n*
	M	SD	M	SD	
Education	16.0	2.7	17.1	3.5	
Age	33.5	10.0	37.4	11.8	
Severity Rating (ADIS)	6.3	1.0	6.0	1.2	(n=60, 28)
State-Trait Anx Invent-Tr %	91.5	12.0	82.8	20.9	(n=61, 29)
Beck Depression Inventory	14.3	8.4	10.8	7.8	(n=61, 30)
Coopersmith Self-esteem	39.0	19.1	49.3	22.5	(n=60, 30)
PFQ - Shame	2.1	.5	1.9	.9	(n=61, 30)
Tosca-S (Shame-scale)	3.3	.65	2.9	.68	(n=59, 25)
MMPI Anger Scale	47.9	9.5	48.3	7.3	(n=53, 24)
MMPI Overcont Hostility (O-H)	50.9	8.6	47.2	12.2	(n=57, 28)
MMPI D-scale (Depression)	72.7	13.3	64.9	13.4	(n=57, 27)
MMPI Pd-scale (Psychopath Dev)	65.2	11.9	61.1	12.5	(n=57, 27)
MMPI Pa-scale (Paranoia)	64.0	11.1	59.4	12.7	(n=57, 27)
MMPI Pt-scale (Anxiety)	73.4	14.6	63.9	11.1	(n=57, 27)
MMPI Sc-scale (Schizophrenia)	67.7	12.7	59.5	12.7	(n=57, 27)
MMPI Lse-scale (Low self-esteem)	66.8	11.4	59.8	12.7	(n=53, 24)
MMPI Trt-scale (Neg.Trmt attitudes)	62.3	12.3	58.3	11.8	(n=53, 24)
MMPI Wrk-scale (Neg.work attitudes)	63.4	11.2	57.6	13.0	(n=53, 24)

*Subject numbers vary due to differences in earlier evaluations

Table 4. Simultaneous Regression Analyses:

Avoidance
N=82

Variable	<u>B</u>	<u>SE B</u>	<u>B</u>
PFQ	8.37	2.95	0.29**
TOSCAS	12.01	3.25	0.37***

Note. Adj. Mult. $R^2 = .28$; *p <.05, **p <.01, ***p <.001

Abasement
N=77

Variable	<u>B</u>	<u>SE B</u>	<u>B</u>
PFQ	6.63	1.87	0.31**
PA	0.38	0.12	0.27**
TOSCAS	7.38	2.10	0.31***
OH	-0.33	0.12	-0.22**

Note. Adj. Mult. $R^2 = .53$; *p <.05, **p <.01, ***p <.001

Self-defeating Behavior
N=82

Variable	<u>B</u>	<u>SE B</u>	<u>B</u>
PFQ	12.08	3.07	0.38***
TOSCAS	11.46	3.41	0.33**

Note. Adj. Mult. $R^2 = .33$; *p <.05, **p <.01, ***p <.001

MCMJ Passive Aggression
N=76

Variable	<u>B</u>	<u>SE B</u>	<u>B</u>
ANG	1.67	0.33	0.49***
TOSCAS	9.75	4.48	0.21*

Note. Adj. Mult. $R^2 = .31$; *p <.05, **p <.01, ***p <.001

Table 5. Two Clusters of Shyness Clinic Patients on Selected Variables

SUMMARY STATISTICS

VARIABLE	BETWEEN SS	DF	WITHIN SS	DF	F-RATIO	PROB
PFQSHAME	11.287	1	57.294	121	23.837	0.000
PFQGUILT	15.654	1	58.079	121	32.614	0.000
SHY/RCBS	7.741	1	23.794	116	37.737	0.000
PD	4534.330	1	14315.637	117	37.059	0.000
PA	5464.220	1	11987.242	117	53.333	0.000
MCAVOID	15692.685	1	21588.259	87	63.241	0.000
ANG	1319.645	1	7782.545	108	18.313	0.000
NEG WRK	10022.727	1	5715.491	108	189.390	0.000
NEG TRT	7104.145	1	8701.309	108	88.176	0.000
TOSCAS	12.213	1	30.350	90	36.216	0.000
OH	903.467	1	11378.500	118	9.369	0.003
MCMABASE	13299.068	1	9675.921	88	120.952	0.000

CLUSTER NUMBER: 1

STATISTICS

VARIABLE	MINIMUM	MEAN	MAXIMUM	ST.DEV.
PFQSHAME	1.00	2.30	5.80	0.78
PFQGUILT	0.80	2.19	3.90	0.70
SHYRCBS	3.00	4.22	5.00	0.44
PD	48.00	69.94	92.00	10.28
PA	51.00	68.56	97.00	10.39
MCAVOID	76.00	101.77	118.00	11.70
ANG	36.00	51.85	82.00	10.12
WRK	55.00	71.42	87.00	7.84
TRT	54.00	68.40	101.00	9.22
TOSCAS	2.10	3.50	4.60	0.58
OH	30.00	47.25	65.00	9.19
MCMABASE	48.00	68.64	87.00	10.70

CLUSTER NUMBER: 2

STATISTICS

VARIABLE	MINIMUM	MEAN	MAXIMUM	ST.DEV.
PFQSHAME	0.60	1.69	3.00	0.55
PFQGUILT	0.00	1.48	2.90	0.67
RCBS	2.25	3.70	4.40	0.45
PD	32.00	57.58	84.00	11.67
PA	34.00	55.00	75.00	9.64
MCAVOID	7.00	75.17	110.00	19.00
ANG	32.00	44.93	60.00	6.26
WRK	39.00	52.33	65.00	6.52
TRT	35.00	52.33	79.00	8.55
TOSCAS	1.53	2.77	4.00	0.57
OH	24.00	52.75	79.00	10.33
MCMABASE	24.00	44.30	70.00	9.99

Note. PFQ = Personal Feelings Questionnaire (shame); RCBS = Cheek and Buss Revised Shyness Scale; PD = MMPI Pd scale (resentment); PA = MMPI Pa scale (externalization of blame); MCAVOID = MCI Avoidance Scale (interpersonal avoidance); ANG = MMPI Anger Content Scale (expressed anger); WRK = MMPI Work Interference Content Scale; TRT = MMPI Negative Treatment Indicators Content Scale; TOSCAS - Test of Self-Conscious Affect Shame Subscale; OH = MMPI Overcontrolled-Hostility (O-H) Supplementary Scale (suppressed hostility); MCMABASE = MCI Self-abasement Scale.

STAXI (STATE TRAIT ANGER EXPRESSION INVENTORY)
SHYNESS CLINIC SAMPLE
N=22

Anger Experience Suppression (Anger-in) Expression (Anger-out) Control

Mean	58	80	58	46
SD	29	22	27	28

note. Percentile Scores

Anger suppression is associated with higher systolic blood pressure (SBP) and diastolic blood pressure (DBP)(Gentry, Chesney, Gary, Hall & Harburg, 1982; Harburg, Blakelock & Roeper, 1979)

Gentry, W. D., Chesney, A. P., Gary, H. E., Hall, R. P., & Harburg, E. (1982). Habitual anger-coping styles: I. Effect on mean blood pressure and risk for essential hypertension. Psychosomatic Medicine, 44(2), 195-201.

Harburg, E., Blakelock, E. H., & Roeper, P. J. (1979). Resentful and reflective coping with arbitrary authority and blood pressure. Psychomatic Medicine, 3, 189-202.

Statements about Others

To what extent do you relate to each of these statements? Please make a rating on a 7 point scale from 1 (not at all) to 4 (moderately) to 7 (very much).

<u>Shy</u>	<u>Non-shy College Students</u>	
<u>N=15</u>	<u>27</u>	
3.6	2.5	1. ___ People do not care about me.
3.0	2.2	2. <u>x</u> When people see my discomfort they feel superior.
3.2	2.2	3. <u>x</u> People do not identify with me when I am uncomfortable.
3.5	2.3	4. <u>x</u> People will be rejecting and hurtful if I let them close to me.
3.3	1.6	5. <u>X</u> People do not relate to my problems.
3.9	2.4	6. <u>X</u> If I'm not watchful and careful, people will take advantage of me.
4.6	2.1	7. <u>X</u> I must not let people know too much about me because they will misuse the information.
3.5	1.5	8. <u>X</u> People are more powerful than I am and will take advantage of me.
3.2	1.8	9. <u>X</u> If people see my discomfort they will feel contempt for me.
3.0	2.1	10. <u>x</u> People are indifferent to my feelings and don't want to know about me.
2.9	1.7	11. <u>X</u> People will make fun of me and ridicule me.
2.8	1.9	12. ___ If I let people know too much about me they will say hurtful things to me, or talk about me behind my back to others.

note. x, p. < .05; X, p. < .01

Statements about Others

To what extent do you relate to each of these statements? Please make a rating on a 7 point scale from 1 (not at all) to 4 (moderately) to 7 (very much).

SHY

Students Clinic patients

N=15

8

- | | | |
|-----|-----|---|
| 3.0 | 3.1 | 2. <u>x</u> When people see my discomfort they feel superior. |
| 3.9 | 3.1 | 6. <u>X</u> If I'm not watchful and careful, people will take advantage of me. |
| 3.2 | 3.6 | 9. <u>X</u> If people see my discomfort they will feel contempt for me. |
| 3.0 | 3.7 | 10. <u>x</u> People are indifferent to my feelings and don't want to know about me. |
| 2.9 | 3.7 | 11. <u>X</u> People will make fun of me and ridicule me. |

note. $x, p. < .05$; $X, p. < .01$