Shame and Anger in Chronic Shyness and Social Anxiety Disorder

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Abstract

Research has revealed that shy people are self-critical, blame themselves for perceived social inadequacy, and experience more shame than controls. These tendencies are greater in extremely shy people who are undergoing treatment. A related question that warrants consideration is whether shy people are critical of others, and if this tendency is also greater for shy people in treatment. If so, the interpersonal consequences of mistrust and resentment are likely to be different from the consequences of perceived inadequacies in the self, and call for different kinds of cognitive and behavioral strategies to overcome these tendencies. Previous studies have shown that chronically shy adults in treatment report significant interpersonal mistrust and resentment, and shy college students report more negative thoughts about others than non-shy students. In order to determine the extent to which these thoughts and emotions predicted maladaptive behavior and interpersonal problems, we utilized the initial evaluation results of a sample of shyness clinic clients. We hypothesized that clients' scores on measures of shame would correlate with measures related to mistrust, resentment, and interpersonal problems, and would predict maladaptive behavior. Results revealed that shame, resentment, and interpersonal mistrust were related, and were also related to avoidance, distance, and hostility in relationships. Resentment and shame predicted self-abasement, self-defeating behavior and passive aggression. Clients diagnosed with avoidant personality disorder reported significantly more shame, mistrust and resentment, as well as interpersonal problems related to coldness and vindictiveness than those without the diagnosis.

Introduction

The association of shyness, shame and internal attributions for negative social outcomes has been reported frequently in the clinical and research literature (Arkin *et al* 1980; Buss, 1980; Girodo *et al* 1981; Henderson, 1992; Henderson, 2002; Teglasi, 1982). Chronically shy and socially anxious individuals report shaming as a means of discipline in their families (Bruch and Heimberg, 1994) and shame and self-blaming attributions have been reported by adolescents and adults (Henderson, 1992; Henderson, 1994; Henderson and Zimbardo, 2001a; Zimbardo, 1977). Children probably become sensitized to frequent criticism, developing an increasing emotional sensitivity to others in the anticipation of painful emotional states, while this vigilance promotes emotional reactivity and instability. Vigilance also promotes the internalization of parental blaming behavior, with the result that children learn to blame others as well as themselves (Benjamin, 1993).

Clinical observation and self-reports demonstrate that chronically shy individuals blame others as well as themselves, seeing others as dangerous, rejecting and unreliable (Henderson, 1994; Henderson, 1997; Henderson and Zimbardo, 1998; Henderson and Zimbardo, 2001b). Furthermore, because shame is a painful emotion, the practice of externalizing blame is thought to dampen the pain of self-blame in the short run and to protect one's self-esteem (Lewis, 1971; Lewis, 1979). It seems likely that at least some of the motivation to blame others is related to reducing negative emotion.

Blaming others has negative interpersonal as well as intrapersonal consequences and is associated with hostility and resentment toward the self and others (Bartholomew and Horowitz, 1991; Henderson and Zimbardo, 2002; Tangney and Fischer, 1995; Tangney *et al* 1992; Tennen and Affleck, 1990). Furthermore, shame has been found to be negatively correlated with

measures of empathy (Feshbach and Lipian, 1987; Tangney, 1991), which would modulate anger and reduce potentially maladaptive behavior. Beyond the interpersonal consequences of hostility are health problems such as high blood pressure and increased risk for hypertension (Gentry *et al* 1982).

Both interpersonal sensitivity and a sense of threat from others were documented in an MMPI study of shyness clinic clients (Henderson, 1997). A significant majority (67%) of clinic clients also received a diagnosis of avoidant personality disorder (APD) in a co-morbidity study, a diagnosis that implies extreme sensitivity to criticism. A diagnosis of passive-aggressive personality disorder was also present in 15% of clients (St. Lorant *et al* 2000). Similar findings have been shown in studies of social anxiety and social anxiety disorder (Alden and Wallace, 1995; Cloitre *et al* 1992; Erwin *et al* 2003; Herbert *et al* 1992; Leary and Atherton, 1986).

Because DSM criteria for avoidant personality disorder (APD) include a belief that one is inadequate and vulnerable to others in social situations, both shame and anger were expected to be more elevated in individuals with APD than those with generalized social anxiety disorder without APD (Greene, 1991; Henderson, 1997). Shame and self-blame have been reduced with specific instructions to restructure self-blaming attributions (Henderson and Zimbardo, 2001). Therefore it seemed useful to measure the associations of shame and resentment to see both how they predicted interpersonal difficulties, and to provide a rationale for specific restructuring techniques for tendencies to blame others (Blalock *et al* 1997).

In order to assess the presence of shame and anger in shyness clinic clients, and their associations with avoidance and aggressive tendencies, we utilized the test results of shyness clinic clients. Our hypotheses were: 1) that shame and anger would be positively correlated in our sample and positively correlated with negative thoughts about others; 2) that patients

diagnosed with APD would evidence more shame, more negative thoughts about others, anger, and interpersonal mistrust than those without APD; and 3) that anger, in addition to shame, would predict self-abasement, self-defeating behavior patterns and passive aggression.

Method

Sample: Data in this study included data from a co-morbidity study of 114 clients at the Palo Alto Shyness Clinic (St. Lorant *et al* 2000). The present study includes data on these 114 clients, plus baseline assessment data on clients entering the program since those data were collected. Clients are interviewed by licensed clinicians using The Anxiety Disorders Interview Schedule for DSM-IV (DiNardo *et al* 1994). 94% meet criteria for generalized anxiety disorder, and 70% for avoidant personality disorder according to The Millon Clinical Multiaxial Inventory (MCMI; Millon, 1987; Millon, 1998). Clients in the co-morbidity study were also given the Minnesota Multiphasic Personality Inventory (MMPI; Butcher, 1989; Greene, 1991). Table 1 includes the age and gender data for our current participants. Sub-sample sizes vary for each analysis.

Materials: Each participant was administered standard assessment instruments as part of the initial evaluation. The Millon Clinical Multiaxial Inventory (MCMI; Millon, 1987), with the NCS Interpretive Scoring System, was used to ensure accuracy and standardization (Millon, 1987). Degrees of avoidance, self-abasement, self-defeating behavior and passive aggression were measured by elevations in scores on their respective scales.

Shame was measured by two instruments: the Personal Feelings Questionnaire (PFQ-2; Harder *et al* 1993), and the Test of Self-conscious Affect (TOSCA; Tangney, 1995). The shame subscale of the PFQ is purported to measure trait shame, the tendency to endorse the frequent experience of shame, in contrast to guilt, with test-retest reliability of 0.85 at two weeks and 0.78 at five weeks. The TOSCAS, the shame sub-scale of a scenario-based measure of shame and

guilt is a revision of the Self Conscious Affect and Attribution Inventory (SCAAI**;** Tangney, 1990), on which estimates of internal consistency (Cronbach's alpha) ranged from 0.72 to 0.82, and test-retest reliabilities over a 1 to 5 week period were 0.79. Internal consistency for the TOSCA shame subscale was 0.76 (Tangney, 1991).

Anger was measured by the anger/in scale of the State-Trait Anger Expression Inventory (STAXI**;** Spielberger, 1988; Spielberger, 1996). Because of the specificity in the STAXI's sub-scales, respondents can report how frequently they experience anger in contrast to how much they express it (Spielberger *et al* 1995). The anger/in scale is an eight-item scale that indicates feelings of anger that are suppressed. Internal consistency is 0.84 for males and is 0.81 for females.

Blaming others was measured by the externalization scale of the TOSCA (TOSCAE) and our Estimations of Others Scale (EOS) (Henderson and Horowitz, 1998). The Estimations of Others scale is a 12-item scale based on statements of clients during treatment and measures the tendency to report negative thoughts about others. We have gathered normative data on college students (see Table 2) and our clinic patients. The scale shows good internal consistency, Chronbach's Alpha being 0.90.

Interpersonal problems were measured by the 64-item Inventory of Interpersonal Problems (Horowitz *et al* 1988; Horowitz *et al* 2000), an assessment of self-reported interpersonal problems which include interpersonal mistrust and hostility. The scale has good psychometric properties and demonstrates high internal consistency with an alpha of 0.96) and test-retest reliability of 0.78.

Shyness was also measured by the Henderson/Zimbardo Shyness Questionnaire (ShyQ), which includes items related to shame, negative attributions, and resentment (Henderson and

Zimbardo, 2000, 2002; Bortnik *et al* 2002). Internal consistency for six samples is 0.92, and test-retest (2 weeks) reliability is 0.87. Criterion validity as measured by its correlation with the 20-item Revised Cheek and Buss Scale is between 0.60 and 0.67 in two college student samples, and 0.74 in a shyness clinic sample (Cheek and Melchior, 1990; Henderson and Zimbardo, 2002).

Results

The first hypothesis, that shame and anger would be positively correlated in our sample and associated with the externalization of blame, was tested using Pearson correlation analyses. Table 3 contains the correlations of shame and suppressed anger as measured by their respective subscales.

As expected, the PFQ shame scale, which measures the trait-tendency to experience the emotion of shame, and the TOSCA shame scale, the scenario based measure, were both significantly correlated with suppressed anger ($p < 0.0001$). Both were also correlated with negative thoughts about others ($p < 0.0001$), and the externalizing scale of the TOSCA ($p < 0.02$, $p < 0.0001$). They were also correlated with interpersonal coldness (IIPDE, PFQ shame, $p < 0.01$; IIPDE, TOSCA shame, $p < 0.0001$) and hostile vindictiveness (IIPBC, PFQ shame, $p < 0.001$; IIPBC, TOSCA shame, $p < 0.0001$).

The second hypothesis, that those diagnosed with avoidant personality disorder (APD) would score significantly higher than the rest of the sample in shame, anger and the externalization of blame, was tested by Univariate ANOVAS. Table 4 presents the means of those with and without the diagnosis of APD. Those diagnosed with APD were higher in both measures of shame $F(1, 181) = 10.3$, $p < 0.001$; $F(1, 179) = 6.7$, $p < 0.01$.

The APD group reported significantly more negative automatic thoughts about others $F(1,76)=4.07$, $p<0.05$, more coldness, mistrust and distance in relationships (IIPDE) $F(1,103)=11.93$, $p<0.001$, and more hostile vindictiveness (IIPBC) $F(1,103)=6.42$, $p<0.02$, according to the Inventory of Interpersonal Problems. Clients diagnosed with APD also scored at the 83rd percentile on the Anger-in Scale of the STAXI while those without APD scored at the 73rd percentile. They did not differ, however, on the externalization scale of the Tosca (TOSCAE).

The third hypothesis, that shame would predict self-defeating behavior and passive aggression, was tested using multiple regression (see Table 5). Self-abasement was predicted by shame (PFQ, F, (4, 72)=3.54, $p<0.01$; TOSCAS, t, (4, 72)=3.51, $p<0.01$). Self-defeating behavior was also significantly predicted by shame (PFQ, F, (1, 79)=3.91, $p<0.0001$; TOSCAS, t, (1,79)=3.37, $p<0.01$; $F(2,79)=20.70$, $p<0.001$). Shame also predicted elevation on the Passive aggression scale, t, (1,73)=4.99, $p<0.001$; t, (1,73)=2.18, $p<0.05$, $F(2,73)=17.47$, $p<0.001$). Interestingly, shame also predicted elevations on the MMPI sub-scale, Work Interference (WRK), (PFQ, t, (1,76)=3.34, $p<0.01$, TOSCAS, t, (1,76)=4.71, $p<0.001$), not surprising, given the tendency to passive aggression.

Exploratory Analyses: Shame is also likely to affect treatment compliance and success. Consequently, we examined the relationship of shame and anger to negative attitudes toward treatment from the earlier co-morbidity sample (St. Lorant *et al* 2000 measured by the MMPI sub-scale, Negative Treatment Indicators (TRT). Shame on the TOSCA, but not the PFQ, predicted elevations on Negative Treatment Indicators (TOSCAS, t, (1,77)=5.07, $p<0.001$). Interestingly, the only negative predictors of self-reported goal attainment in this sample were

higher scores on interpersonal avoidance (IIP) and externalizing tendencies (TOSCAE) at post-test (R^2=0.52, p<0.0001).

Discussion

Results were consistent with our first hypothesis, that shame, anger and the externalization of blame would be elevated in relation to normative samples, and correlated with each other. Shame and resentment were also correlated with the externalization of blame, consistent with findings of earlier clinicians and researchers (Lewis, 1971; Scheff, 1987; Tangney *et al* 1992; Wurmser, 1981). Our results are also consistent with recent results for social anxiety disorder (Erwin *et al* 2003).

Patients diagnosed with APD were significantly higher in shame and anger, consistent with our second hypothesis, but not in the externalization of blame as measured by the TOSCA, contrary to expectation. However, those with APD were significantly higher in negative thoughts about others, suggesting that these individuals may not be aware of the implications of their negative thoughts about others, nor of their the interpersonal implications, seeing such thoughts only as related to their own vulnerability and natural caution.

Chronically shy individuals sometimes are not aware of anger and tend not to express it openly. Clinical observation has shown that effective treatment goals for many shy clients include helping them to articulate and express anger constructively (Henderson, 1992). The ways in which shy individuals behave when they feel resentful or angry represent a fertile domain for further research.

As we predicted in our third hypothesis, shame was a significant predictor of self-abasement, self-defeating behavior and passive aggression. This finding provides further evidence that shame plays an important role in the formation of maladaptive behavior within the

chronically shy population. Further studies that differentiate fear-related vs. anger-related social avoidance are needed.

The elevations on the Work Interference Scale, as predicted by shame and the externalization of blame, point to the significance of problems in occupational functioning among shy individuals. Treatment interventions concerned with assertiveness and the appropriate handling of anger may be particularly important in this domain. Assertiveness training, however, will not likely be sufficient without specific restructuring of negative automatic thoughts about others as well as oneself.

Negative Treatment Indicators were also predicted by shame, resentment, and the externalization of blame. Our clinical experience has been that alerting patients to expect issues around shame and anger to be occasioned in treatment, developing plans to handle the negative feelings and to planning avenues for perception checks, in addition to systematic hypothesis testing, appears to ameliorate attrition and demoralization. Following such discussions at initial evaluation, patients often speak to the group therapist privately if they do not wish to address the emotions in the group.

We have been addressing negative thoughts about others, interpersonal mistrust, and tendencies to blame others in treatment at our Shyness Clinic, with a recent study revealing that negative thoughts about others was a significant negative predictor of self-reported goal attainment (Bortnik *et al* 2002).

Limitations of this study are its correlation nature, which does not allow us to assess causality, and the use of self-report data and clinical interviews without behavioral observations by contemporaries outside the groups. Findings are consistent with clinical observation, but more fine-grained analyses of interaction patterns are needed in this population. Experimental studies

of dyadic interactions with shy and non-shy college students are in progress (Henderson *et al* 2002).

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Table 1. Demographic Profile of Shyness Clinic Clients

Paper	Number in sample	Percent
Sex		
Female	140	36.8
Male	240	63.2
Age	252	
Range	18 to 65	—
Mean age	35±9	—
Marital status	114	
Never married	85	74.6
Married	15	13.2
Separated	3	2.6
Divorced	9	7.9
Widowed	2	1.8
Education	114	
Mean education	16.2±3.2	—
Occupation	114	
Employed	83	72.8
Unemployed	9	7.9
Student	19	16.7
Homemaker	3	2.6
Ethnicity	114	
Caucasian	97	85.1
African American	2	1.8
Hispanic	4	3.5
Asian	8	7.0
Other	3	2.6

Table 2. Mean Scores on the Estimations of Others Scale (EOS) Comparing Shy and Non-shy College Students, and College Students with Shyness Clinic Clients

	Shy Students n = 73	Non-shy Students n = 124	+Students n = 136	Clinic Sample n = 8
Mean	2.8	2.2*	2.3	4.4*
SD	1.04	0.9	1.3	1.4

*$p < 0.001$. Internal consistency (Chronbach's Alpha) 0.90 (n = 221).
+second student sample; Henderson and Horowitz, 1998.

Table 3. Intercorrelations Between Scales for Shyness Clinic Clients

Scale	ShyQ	Shame	Toscas	Anger-in	EOS	Toscae	IIPBC	IIPDE
ShyQ	—	0.72 (n=36)	0.80 (n=36)	0.58 (n=36)	0.71 (n=36)	0.49 (n=36)	0.58 (n=36)	0.48 (n=36)
Shame		—	0.46 (n=234)	0.34 (n=191)	0.57 (n=91)	0.16 (n=234)	0.30 (n=122)	0.25 (n=122)
Toscas			—	0.36 (n=189)	0.47 (n=94)	0.32 (n=239)	0.45 (n=125)	0.34 (n=125)
Anger-in				—	0.54 (n=95)	0.19 (n=189)	0.38 (n=127)	0.37 (n=127)
EOS					—	0.41 (n=94)	0.47 (n=94)	0.36 (n=94)
Toscae						—	0.30 (n=125)	0.13 (n=125)
IIPBC							—	0.61 (n=127)
IIPDE								—

Note: ShyQ. = Henderson/Zimbardo Shyness Questionnaire; Shame = Personal Feelings Questionnaire; Toscas = Tosca Shame Scale; Anger-in = Anger-in Subscale of STAXI; EOS = Estimations of Others Scale; Toscae = Tosca Externalizing Scale; IIPBC: = Vindictive/self-centered subscale of the Inventory of Interpersonal Problems; IIPDE: = Cold/Distant subscale of the Inventory of Interpersonal Problems (IIP).

Table 4. Mean Ratings of Clients with and without the Diagnosis of Avoidant Personality Disorder

Measure	Diagnostic Status					
	Avoidant Personality			No Avoidant Personality		
	n	M	SD	n	M	SD
Trait-Shame (PFQ)	131	2.0	0.56	51	1.7	0.55
Tosca shame (TOSCAS)	130	3.1	0.68	50	2.8	0.68
IIP vindictiveness	78	10.4	5.0	26	7.6	4.3
IIP coldness/ distance	78	15.3	5.1	26	10.8	7.2
Tosca Externalizing (TOSCAE)	non-significant			non-significant		
Estimations of Others (EOS)	57	3.9	1.2	20	3.3	1.3
Anger-in	114	83rd percentile	19	46	73rd percentile	26
Shy Q	24	3.6	0.39	6	2.9	0.68