Social Fitness Training: Integrated Short-Term Treatment for Chronic Shyness

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Social fitness training integrates current, empirically supported treatment approaches to chronic shyness and social phobia with the author's development of a model that employs physical fitness as a metaphor for "social fitness." Social fitness training includes techniques aimed at interrupting a pattern of negative multidirectional dynamic relationships between cognitive, affective, behavioral, and physiological domains. It comprises cognitive-behavioral techniques, educative components, a coaching approach to promoting social exercise, and practice designed to increase social strength and growth.

The integration of widely-practiced treatment techniques and contemporary theoretical orientations with the concept of social fitness is a product of the author's 17 years as director of The Shyness Clinic, an organization offering a specialized treatment program which originally grew out of observations developed from the results of the well-known Stanford Prison Experiment (Zimbardo, 1986). Designed to examine the effects of social roles on the person, the mock-prison study revealed sadistic behavior on the part of the "guards," while "prisoners" relinquished basic human rights and demonstrated internalizing symptoms: anxiety, depressive emotion, and sleep disturbances. A student in Zimbardo's seminar likened these dynamics to the intrapersonal and interpersonal dynamics experienced by the problematically shy: the shy person submits to critical and authoritarian aspects of the self and others, and becomes unduly compliant or avoidant.

Definitional problems surround the terms "chronic (or extreme) shyness," and "social phobia." While shyness has been historically considered a milder and more heterogeneous condition than social phobia, current research suggests that social phobia is more heterogeneous than previously suspected (Beidel & Morris, 1995; Heimberg, Liebowitz, Hope & Schneier, 1995) and that chronic shyness has more serious consequences than previously believed (Henderson & Zimbardo, Submitted for publication). Considerable overlap attends these terms: Some people may demonstrate socially phobic avoidance patterns, but are not required by their environment or life circumstances to perform feared behaviors or to enter feared situations. Other people may label themselves as shy, but not see it as a problem. Psychologists treating or conducting research pertaining to these phenomena are attempting to sort out critical issues related to physiology, temperament, development, current environment, and life events (Aron & Aron, 1997; Kagan et al., 1994; Rubin & Asendorpf, 1993).

Nearly all (97%) of clients who seek treatment at The Shyness Clinic meet criteria for generalized social phobia, and 94% have a coexisting personality disorder, the most common being avoidant (67%), less prevalent are, schizoid, and dependent (St. Lorant, Henderson & Zimbardo, 1997). At the Clinic, a useful definitional posture includes a perspective that states of social anxiety and shyness are common in the general population, as is occasional avoidance of feared situations. When these become severe

enough to interfere with goal pursuit, it may be sensible to use the terms “extreme shyness” or “generalized social phobia.”

Social fitness training, the current treatment program, incorporates research findings from work associated with the Clinic and from other research published in the psychological literature. The method constitutes a health- or sports-oriented model wherein social “exercise,” like physical exercise, is conceptualized as an effective means to promote and maintain overall socioemotional health and well being. The components of the comprehensive six-month group treatment regimen include: social skills training; exposures to feared situations with cognitive retraining (emphasizing attributional factors and the examination of beliefs regarding the self); and verbal and non-verbal communication training, including conflict resolution, managing anger, negotiating skills, and assertiveness training.

A sophisticated approach to understanding and treating shyness must include a developmental perspective. The social fitness model incorporates a theory of the development of shyness based on previous research on self-focus, attribution style, and negative emotional states (Henderson, 1992; Ingram, 1990). The author’s research has shown that the combination of internal focus and self-blame in shy adolescents is correlated with significantly more discomfort than is seen in shys who do not demonstrate this combination (Henderson & Zimbardo, 1996). It may be argued that children who experience negative emotion, whether discomfort in the face of novelty, or in response to rejection, will focus inward more frequently and attend more to the negative state. This attention to negative emotion may generate negative thoughts which in turn contribute to negative emotion in a dynamically reciprocal fashion. The inward focus may lead the developing person to believe that they are responsible for negative events which they cannot control. Thinking patterns and maladaptive attributions of responsibility may be influenced by whatever emotion is present, whether fear, shyness, shame, or anger. If one is afraid, others appear dangerous and the self becomes vulnerable. If one is shy, others look attractive, but powerful and potentially hurtful. If one does not measure up in one’s own eyes and is ashamed, others appear contemptuous and the self is abased. If one is angry, other people appear untrustworthy and hurtful.

Specific clinical techniques include a focus on how clients assign responsibility for perceived success or failure in social interaction and having clients challenge self-blame and negative beliefs about the self that are likely to arise *after* social encounters. Such cognitive patterns are associated more with embarrassment, shame, and depressive affects than they are with uncomfortable physiological arousal. The model for treating embarrassment, shame and self-blame in the chronically shy, integrates interpersonal and psychodynamic concepts and techniques, and includes strategies for preventing and mitigating relapse, resistance to treatment, and social isolation during and after treatment. Such strategies include recognizing the importance of the initial evaluation, and the identification of individual differences predicting problems in treatment that can be anticipated and effectively addressed when they arise. Clients with dependent personality disorder, for example, have difficulty with self-assertion, and don’t recognize their own strengths or leadership abilities. Many clients with avoidant personality disorder have trouble trusting others, and may struggle with shame-based self-concepts (i.e., self-schemas that include social inadequacy, and interpersonal schemas that include the anticipation of ridicule or humiliation by others).

Data collected in pre-and post-testing at the Clinic show significant reductions in social anxiety, fear of negative evaluation, shame, depression, and subjective discomfort in relevant situations (Henderson, 1995). Data collected on eight-week treatment groups with Stanford students show significant reductions on these same indicators, and additionally, significant reductions on internal, global, stable, and self-blaming attributions for negative social outcomes (Henderson, Martinez & Zimbardo, 1997).

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