Shyness, Social Anxiety, and Social Phobia

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Introduction

In 1971, one of us conducted the now well known, Stanford Prison Experiment (Zimbardo, 1977). The purpose of the study was to examine the role of situational factors in producing behaviors, thoughts and feelings typically assumed to manifest themselves as dispositional attributes of the person, such as sadism or submissiveness. Preselected normal college students, randomly assigned to play the roles of prisoner or guard in a simulated prison, were having such extreme stress reactions that they had to be released early—as prisoners, or were behaving brutally and sadistically—as guards. The study demonstrated how powerful context and situation are in producing the syndrome of affect, behavior and cognition relating to authoritarianism, aggression, submission and despair. Upon reflection, the coercive control that typified the guard mentality and the passive-reactive mentality of the prisoners seemed to be combined in the mental makeup of the shy person. The "guard self" issued constraining demands that limited the freedoms of the behaving aspect of the "shy self", the shy person reluctantly submitted, and thereby lost personal autonomy and a sense of personal esteem. That conceptualization led to considering the situational and personal determinants of shyness in adults, and in turn, to a long-term research program, The Stanford Shyness Program (Zimbardo, 1977). The Stanford Clinic was founded in 1977, and later renamed The Shyness Clinic.

From the outset, the Shyness Clinic's programs were designed to meet the expressed needs of people in our community. Responses to the initial Stanford Shyness Survey (see appendix in Zimbardo, 1977) served as guidelines for selecting techniques to help shy individuals who sought its services. Therapists helped clients implement strategies that addressed their concerns about their negative thoughts, inhibited or overactive behaviors, painful emotions, and difficulty regulating uncomfortable physiological arousal. Over the three decades that followed, we have learned much from our interactions with clients, from our own

empirical research, and emerging relevant developments in the fields of social psychology, personality theory, and clinical psychology.

During the personal growth movement, which straddled the 1970s, many people adopted the posture that it was up to us individually to make our lives better. "I can do it" captured the directives of the day: self-responsibility and self-efficacy. Following that period, psychology became increasingly medicalized. Extreme shyness was conceptualized as a psychological disorder, social phobia, a relatively rare but serious problem located in the person, which could be treated by doctors/professionals acting on the person. Unfortunately, this scheme would logically serve to increase the passivity and pessimism of those already feeling that they are helpless and passive observers of life. Our overarching treatment mission at the clinic -- one about which we are both passionate -- has been to guide individuals in ways that empower them to help themselves. We have sought to promote in our clients the idea that they can overcome their inhibitions and become more socially comfortable and competent; indeed, even that they should do so, given that each of us, as social beings, have important and valuable contributions to make to the general community.

Due to the experience of directing the Shyness Clinic over for over 25 years, one of us developed a new model to guide our treatment program (Henderson, 1994). Currently we operate our Clinic based on the belief that shyness, even extreme shyness, is best conceptualized as a state of *"social fitness,"* analogous to physical fitness. We deem this analogy useful in several ways and on several levels. It allows an ecological analysis that takes into account the fit between characteristics of the individual, the individual's goals, and the demands and expectations of the social environment as each varies over time and across situations. Rather than dichotomizing people into categories of "socially phobic" or "not socially phobic," "socially anxious" or "not socially anxious," "shy" or "not shy," the model admits to a continuum for each dimension, which we believe better accords with reality: Few

of us may be considered world-class social athletes, just as few are world-class physical athletes. Moreover, the model accommodates varying definitions of "world-class" across cultures, and across situations within a given culture. An example of the usefulness of the metaphor is illustrated by the fact that social fitness, like physical fitness, is importantly determined by the amount of time and effort spent exercising social skills (working out) and learning (through observation and instruction) the social norms and expectations (rules) of various socio-cultural niches (sports or games).

In the intervening time since we contributed to the first edition of this book we have added an emphasis in our work with groups on resisting the negative social stereotyping of ordinary shyness, which has grown during the last 50 years. The research of Claude Steele and others has taught us about the power of negative stereotyping on a target's level of self-consciousness (whether inside or outside awareness) and on a person's well being in general (Davies, Spencer, & Steele, 2005; Eagly & Karau, 2002; Steele, 1997). Recent research reveals the effects of the negative stereotyping of shyness as a personality trait and the assigning of moral blame to individuals, reframing the problem, if there is one, as outside society (Lane, 2007; Scott, 2006).

We believe that it is important to help clients not only to recognize stereotyping when it is happening, and to counter it, at least internally, but to contribute to effectively educating the larger society regarding both the potential strengths of some aspects of shyness, and the harmful effects of stereotyping any temperament or personality style, all of which have particular strengths and weaknesses. Given the recent statistics that 50 to 60% of college student samples report being shy, one has to wonder to what degree the trait is adaptive, given that it occurs not only more frequently in the population, but now constitutes more than half of college student samples. A recent study of 1194 college students revealed that 36% of 57.7% of self-reported shy people did not see it as a problem. In contrast to earlier studies, only 1.3 %

denied ever having been shy. Strangers, people of the opposite sex, and individual authority continue to remain the biggest challenges, as they were in our earlier surveys (Carducci, Stubbins, & Bryant, 2008). It appears that we may be increasing people's awareness of shyness, allowing people to be more open to acknowledging it, but we are not sufficiently distinguishing between ordinary "garden variety" shyness and problematic shyness, or acknowledging the negative stereotyping of shyness due to a more extreme emphasis in the U.S. on personal dominance and extraversion, particularly in males.

Clinicians and researchers alike continue to struggle with definitional problems, and problems of convergent and discriminant validity between the constructs "shyness", "social anxiety", and "social phobia". Each of these constructs shares similarities: continua of severity are seen in each, ranging from mild, infrequent, and transitory difficulty to severe, chronic and debilitating problems. Yet, each has been used to define distinct aspects of psychological life vis-à-vis interpersonal functioning. The challenge in agreeing on definitions related to shyness will be creating and clarifying shared definitions that neither omit important components of a construct nor generalize to the extent that terms are interchangeable and thus devoid of precise meaning.

Definitions

The constructs of social anxiety, social phobia, and shyness obviously share much common ground, but the following definitions focus on the unique features of each of them. Social anxiety is defined as a cognitive and affective experience that is triggered by the perception of possible evaluation by others (Schlenker & Leary, 1982). It includes unpleasant physiological arousal, and fear of psychological harm (Leary & Kowalski, 1995). The definition focuses on a *feeling* or state of *arousal* that is centered on interactions with others.

Social phobia is defined as a "marked and persistent fear of one or more situations in which the person is exposed to possible scrutiny by others and fears that he or she may do

something or act in a way that will be humiliating or embarrassing" (p. 416; Association, 1994). Although there are exceptions, a diagnosis of social phobia usually involves marked behavioral avoidance of one or more social situations. By definition, a phobia, such as a snake phobia, requires the notion of an avoidance response. A phobic response is the behavior of avoiding a feared stimulus or situation of a particular kind.

Shyness has been defined as "a heightened state of individuation characterized by excessive egocentric preoccupation and over concern with social evaluation, ... with the consequence that the shy person inhibits, withdraws, avoids, and escapes" (Zimbardo, 1982; pp. 467- 468). William James considered shyness a basic human instinct, following Darwin (James, 1890). Izard described shyness as a discrete, fundamental emotion (1972). An emotion profile in a "shy" situation includes interest and fear, which interacts with shyness (Izard, 1972; Mosher & White, 1981). Carver and Scheier defined shyness in self-regulation terms, with unfavorable social outcome expectancies leading to disengagement in task efforts (Carver & Scheier, 1986).

While most definitions of these constructs involve discomfort and the motivation to escape situations that contribute to it, we need to acknowledge that shyness per se does not necessarily involve problematic emotion or avoidance of goals important to the shy person. One distinction to be made is that shyness may include social anxiety as an emotional component, but social anxiety does not necessarily lead to shyness behaviorally. Shyness may combine both feeling and behavior, but need not. Shy extroverts do not avoid and shy introverts may be phobic and not socially anxious. The avoidant behavior has already been conditioned to external stimuli and is not triggered by feelings of anxiety.

Although social phobics have been described as more avoidant than the shy, these comparisons were based on samples of normal college students, and the authors pointed to the dearth of empirical studies of shyness treatment samples (Turner, Beidel & Townsley, 1990).

They also reported that social phobia was defined by specific criteria while shyness was not. Although shyness is part of common language and described both as an emotional state or trait, specific criteria for chronic problematic shyness were delineated when treatment at the Stanford Shyness Clinic was initiated in 1977. Chronic shyness was defined as "a fear of negative evaluation that was sufficient to inhibit participation in desired activities and that significantly interfered with the pursuit of personal or professional goals" (Henderson, 1992).

Recent research has supported our belief and the early findings of Turner, et al., that shyness is heterogeneous (1990). Interestingly, many people who say they were excessively or extremely shy as children do not meet criteria for any psychiatric disorder as adults. Furthermore, 50% of people with a lifetime history of complex social phobia did not view themselves as very shy as young people (Cox, MacPherson, & Enns, 2005). Their findings were consistent with those of Heiser, Turner, and Beidel who found only modest support, at best, for a direct relationship between even extreme childhood shyness and social phobia later in life (2003).

We believe that final definitions await descriptions of the emotional states and self-reported traits of those who refer themselves to shyness treatment in comparison with those who refer themselves to social phobia treatment, particularly given that a somewhat different pattern of comorbidity was revealed in our shyness clinic sample from the pattern found in social phobia treatment samples (St. Lorant, Henderson & Zimbardo, 1999). We continue to search for qualitative differences between these categories in both normative and clinical samples.

We define chronic shyness almost entirely in terms of the person's self-report, in order to avoid an external performance standard according to which observers assign individuals to diagnostic categories. Research in personality psychology suggests that self-reports are more valid for personality traits than observer ratings, particularly among those who openly report

their traits (Lamiell, 1997; St. Lorant, et al., 1999). We believe that social phobia definitions imply that significant impairment in functioning is comparable across groups. Assessment of impairment is, at best, imperfect among clinical evaluators, particularly across settings and instruments, in spite of suggested guidelines for the global assessment of functioning in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (Association, 1994). For instance, socioeconomic status and cultural influences often constrain what shy people are able to do. Those who are not performing well in school may be constrained by extraverted teachers who value active and competitive verbal exchanges over written expression and more collaborative verbal interaction with an emphasis on listening skills (Aronson et al., 1978; Henderson, 2006). Those who appear higher functioning in some settings, by virtue of social class and privilege, may be under-achieving in relation to their peer group (Henderson, Martinez & Zimbardo, 1999).

In summary, definitions of clinical samples of shy and socially phobic individuals are similar, but show differences as well. The emotional states of both shyness and social anxiety are probably nearly universal in normative samples, and people who are shy, socially anxious, or socially phobic in only one or two situations likely never present to clinicians. Such individuals may construe their distress as an intransigent temperamental factor, or simply a natural part of life. Furthermore, they may not be motivated to change if highly verbal participation or dominant assertive behavior is infrequently required in significant areas of their daily lives. Notably, adding to the literature concerning the heterogeneity of shyness, recent research has revealed a substantial proportion of highly shy people who report no social fears in diagnostic interviews (Heiser, et al., 2009).

Prevalence

Over the last 30 years, estimates of the prevalence of social phobia in the general population have increased from 2% to over 12% with 26% of women and 19% of men

reporting they were "very shy" growing up (Cox, et al., 2005; Kessler et al., 2005). Estimates of self-reported dispositional shyness, have also increased during this time frame, from 40% to 58% (Carducci, et al, 2007; Carducci & Zimbardo, 1995; Zimbardo, 1977). Sixty-four percent of those who label themselves as shy said they do not like being shy, and 65% considered it to be a personal problem for them. Among children, 38% of a sample of fifth graders said they were shy (Lazarus, 1982) and 32% of girls and 28% of boys were said to be shy by parents in a sample of 8-10 year olds in the early studies (Caspi, Elder & Bem, 1988). More recent adolescent self-reports include rates as high as 61% (Henderson & Zimbardo, 1993). In cross-cultural comparisons of shyness among 18-21 year olds in the mid-seventies, the range of shyness prevalence in eight countries varied from a low of about 30% in Israel to a high of nearly 60% in Japan and Taiwan, with Mexico, Germany, India, Newfoundland, and the United States in between these extremes (Zimbardo, 1977). Highest levels of shyness in the US samples were also found among Asian Americans, while Jewish Americans were typically least shy. Remarkably, the current levels of shyness in the US now approximate those reported earlier in Japan and Taiwan. We are not aware of evidence regarding the current prevalence of shyness in those Asian countries.

Cultural Influences

Cultural factors affect social anxiety and shyness. Culturally based self-definitions mediate social anxiety, and particular self-construals are related to particular types of social anxiety (Zimbardo & Zoppel, 1984). For example, in Japan the focus is on not offending others with one's behavior or appearance, while in the US the focus is a concern for public scrutiny of oneself, or embarrassment.

Among the Japanese shyness is promoted by a host of cultural conditions, among them, training in emotional control and inhibition of emotional expression, as well as a focus on fine details of social rituals in order to avoid the shame of violating social protocol. "Amae" is a

uniquely Japanese construct of passive dependence on and unquestioning loyalty and obedience to authority and superiors. Amae is practiced and experienced at every level of Japanese society and is a central determinant of the control of social, political, and personal actions (Zimbardo & Zoppel, 1984).

In Israel, by contrast, the societal focus is on rewarding risk-taking by giving full credit to the actor for succeeding, or for even trying, while attributing blame for failure on external circumstances rather than on dispositional inadequacies. Such a culturally sanctioned orientation leads to tendencies to take social and intellectual risks since the individual has nothing to lose by trying: You get the credit for a hit; they get the blame for a miss. Not only does this action orientation reduce shyness, it leads to the development of the Yiddish concept of "chutzpa," a sense of self-sufficiency that helps to propel one's self to initiate actions toward desired goals--regardless of talent, merit, seniority, or traditional constraints on risky actions (Pines & Zimbardo, 1978).

The consequences of shyness are also affected by one's culture. Swedish boys' careers are not negatively affected by shyness as they are in US (where shy men enter careers later than the non-shy, while they show no psychopathological problems). However, Swedish girls attain lower levels of education than non-shy girls, in contrast to American girls who do not differ from their peers (Kerr, Lambert & Bem, 1996). In both countries shy women assume more traditional roles. A study of shy children in China revealed that, shy-inhibited children were more accepted than their peers and more likely to be considered for leadership positions, in contrast to studies of Western children (Xinyin et al., 1995). Teachers also regarded them as more competent. Collectivistic countries in general appear more accepting toward socially reticent and withdrawn behaviors than individualistic countries, but personal norms do not differ and social anxiety and fear of blushing is higher in collectivist cultures, perhaps due to strict social norms (Heinrichs et al., 2006). However, China was not included in the sample,

and recent results reveal self-reported shyness as lower in a Sri Lankan sample than in a British sample (Abeysinghe, 2009).

Stockli, in a study of teacher-ratings of shy vs. non-shy children raises the question of whether the negative connotations attributed to shyness in the west disadvantages shy children scholastically (2002). Interesting as well, a review of the literature on giftedness in children revealed that the majority of gifted children are introverted and many are quite sensitive due to heightened interpersonal awareness (Henderson, 2006). One wonders to what degree that these children are labeled as shy. While no differences have been found in levels of intelligence between the shy and the non-shy, shy children in Switzerland have also been found to underestimate their mathematical abilities. Cultural values and belief systems, coupled with societal practices and social norms, influence shy behavior, as well as how such behavior is viewed by others (Zimbardo & Zoppel, 1984).

Comorbidity in a Shyness Treatment Sample

A high degree of comorbidity in chronic shyness is consistent with comorbidity in social phobia studies, according to our recent study of 114 patients between 1991 and 1997 (St. Lorant et al., 2000). Ninety-seven percent of our sample received a diagnosis of generalized social phobia, according to the Anxiety Disorders Interview Schedule (ADIS), a structured interview with good inter-rater reliability designed specifically to assess anxiety and related disorders (Di Nardo & Barlow, 1988). The most common additional disorders were dysthymia (29%), and generalized anxiety disorder (27%).

A striking percentage (94%) received a coexisting personality disorder diagnosis, according to the Millon Clinical Multiaxial Inventory-II (MCMI-II), an instrument designed specifically to assess the criteria for personality disorders as specified in DSM-III-R (Association, 1987; Millon, 1987). Avoidant personality disorder was the most frequent (67%), followed by schizoid (35%), and dependent (23%) personality disorders. Less frequently found

were obsessive-compulsive (7.3%), and schizotypal (8.5%) personality disorders. The Minnesota Multiphasic Personality Inventory (MMPI), the most frequently researched objective personality assessment tool (Greene, 1991), further suggested compulsive (21%) and passive aggressive personality disorders (15%). In our treatment sample, we appear to have a larger percentage of schizoid personality disorder diagnoses than many samples of social phobics and a lower incidence of panic disorder (St. Lorant et al., 2000). Although method variance (the use of different measures and methods of evaluation) needs to be taken into account, these findings suggest that clients who present to the shyness clinic may have a somewhat different overall profile than clients who present to anxiety disorders clinics.

Alcohol abuse/dependence was suggested in less than 2% of Shyness Clinic clients according to the MMPI, in contrast to some samples of social phobics, where abuse appears to be higher (Schneier & al., 1989). Some of our clients use alcohol to reduce social anxiety, but tend to restrict intake, and many do not drink. Many clients also report fearing a loss of control if they "drink too much," consistent with earlier studies of shy college students in which shyness was negatively associated with alcohol use, except when positive expectancies existed (Bruch et al., 1992).

Development of Chronic Shyness

A number of factors are seen as instrumental in the development of problematic shyness, including parental and peer rejection, and parental over-protection, leading to a lack of self-efficacy. Specific conditioning events play a role, such as being teased or shamed by teachers or other children in front of others, performance failures, traumatic events, and emotional or physical abuse or neglect (Zimbardo, 1982). Observational learning may also contribute to shyness, for example, viewing siblings or classmates who are humiliated or harshly treated, and thus imagining similar negative consequences to oneself.

Previous investigations of the relationship of shyness and social phobia suggested that

the onset of social phobia was characterized by negative conditioning experiences while the onset of shyness was not (Turner et al., 1990). This suggestion was challenged by Zimbardo's findings because many negative conditioning experiences were reported by shy individuals on the Stanford Shyness Survey (Zimbardo, 1977). Another important possibility to be considered in light of current research is to what degree the negative stereotyping of shyness in Western countries is leading to the rise in cases of social anxiety disorder.

Our current theory of the development of shyness is based on the work of previous researchers who studied the associations of private self-consciousness, attribution style, and negative emotional states (See Ingram for a review, 1990). Because negative affective states draw attention inward, they are likely to lead to the trait of private self-consciousness, which is simply the tendency to focus inward on one's thoughts and emotions. It is frequently associated with seeing the self as responsible for external events.

We have demonstrated that self-blame and shame are exacerbated by private self-consciousness in shy adolescents and young adults (Henderson, 1992; Henderson & Zimbardo, 1993). We argue that children who experience rejection, and negative emotions in response to that rejection, will focus inward more frequently and become more attentive to these painful states. They begin to believe that they cause or contribute disproportionately to the negative or undesirable events occurring around them. This process generates further negative thinking, which in turn contributes to negative emotion in a dynamic, reciprocal downward spiral. 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 look dangerous and the self appears vulnerable. If one is shy, others look attractive, but potentially critical and rejecting. If one does not measure up in one's own eyes and is ashamed, others appear contemptuous and the self-abased. If one is angry, other people appear untrustworthy and hurtful. These vicious attribution cycles are likely to develop at relatively young ages,

some evidence for which has been provided by Rubin and Krasnor (1986). We also believe that these ruminative cycles lead to negative beliefs about the self, others, and potential social transactions. In line with our theory, Trew and Alden have recently shown that rumination linked social anxiety to trait anger and also to outward anger expression (2009).

Consistent with our research, social phobics who attribute their condition to genetic or somatic factors have been shown to demonstrate more severe symptomatology before and after cognitive-behavioral treatment (Heimberg, et al., 1995). Are these findings evidence of the influence of genetic or temperament factors in social phobia? Alternatively, as we believe, are they evidence of lower self-efficacy expectations and less motivation for change than if they believe the cause of their problem has been learned and thus can be unlearned by retraining?

Empirical findings call into question the idea that inherent temperament components on the part of the shy inevitably must prevent adequate social behavior or social acceptance. Skilled social behavior by the shy has been demonstrated when their socially based shyness arousal is misattributed to an external source, such as a neutral noise source (Brodt & Zimbardo, 1981). Furthermore, a study of shy and non-shy college students involved in social interaction suggested that the actual experience of the two groups was not different. What differed was the belief on the part of the shy group that their feelings and thoughts were abnormal (Maddux, Norton & Leary, 1988). Whatever the origins of shyness, social anxiety, and social phobia, there appears to be a good deal of room to modify social perception and social behavior, whether early or later in the life span.

Areas of Overlap

Somatic symptoms tend to be similar for shy, socially anxious, and socially phobic adults, as are frequent negative cognitions (Leary & Kowalski, 1995; Turner et al., 1990; Zimbardo, 1977). Adolescent shy clients report frequent negative thoughts, including self-blame for negative social outcomes. Interestingly, socially phobic children do not report

negative cognitions with the same frequency as adults (Beidel & Morris, 1995). However, spontaneous thoughts about self-presentational issues occur in children by age eight, which suggests the presence of negative thoughts in socially anxious children (Banerjee & Yuill, 1998). Whether or not they are reported may be due to differences in expressive behavior tendencies rather than to differences in the actual frequency of their occurrence.

Deficits or biases in children's social cognition have been suggested as playing a role in social anxiety, and perhaps shyness as well (Crick & Ladd, 1993). We found that socially anxious children had poorer recognition of self-presentational motives and less appreciation of the links between beliefs, intentions, and emotions in faux pas situations, particularly when they were high in high negative affect (Banerjee & Henderson, 2001).

Situations that present some form of perceived social difficulty are also similar across the three constructs. Socially phobic children say that the most common upsetting event for them is an "unstructured peer encounter" (Beidel & Morris, 1995). This is also among the challenging situations that are most frequently reported retrospectively by Shyness Clinic clients and normative samples of shy adults (Henderson, 1992; Zimbardo, 1977). Specific upsetting events in childhood that have led to or exacerbated social distress is also common to all three phenomena (Heimberg, Dodge & Becker, 1987; Leary & Kowalski, 1995; Zimbardo, 1977).

Age of Onset

Social anxiety is reported in elementary school (Beidel & Morris, 1995) and shy college students in treatment report a mean age of onset of 10 years for problematic shyness (Henderson, Zimbardo & Martinez, 1999). Forty percent of a sample of shy college students reported an onset in early childhood (Bruch, Giordano & Pearl, 1986). Interestingly, males with early development reported the most behavioral problems. Social withdrawal becomes

noticeable in early childhood and may or may not be a precursor to later shyness or social phobia (Rubin, Coplan & Bowker, 2008).

Social phobia usually begins in early to mid adolescence, with an average age of onset of around 16 and generally has a chronic, unremitting course (Turner, et al., 1990). The second most frequent onset is elementary school, and it tends to be earlier for generalized than non-generalized social phobics (Beidel & Morris, 1995).

Social phobia researchers have understandably reasoned that shyness started much earlier than social phobia given the results of infant studies in which evidence of "behavioral inhibition" was seen as early as 21 months (Kagan & Reznick, 1986; Kagan & Snidman, 1991; Turner et al., 1990). Kagan has referred to this 10-15 % of infants who reveal a variety of signs of inhibition as illustrating a "push from nature" in that negative direction. An equivalent percentage is pushed in the opposite direction toward being "bold," while the majority fall between these extremes. Jonathan Cheek was one of the first researchers to point out that a significant portion of a sample of inhibited infants were not shy at age seven. He also distinguished shyness from behavioral inhibition, in that shyness involves a cognitive concern about evaluation (Cheek & Briggs, 1982). Most researchers agree that shyness is a separate phenomenon, and that behavioral inhibition is a precursor to shyness in some children, but is demonstrably not in a significant proportion of them, nor is it a stable trait.

Adolescent Onset

Adolescence appears to be the age of onset for many kinds of social anxiety, phobic avoidance, and chronic shyness. Perspective-taking ability has been seen as one of the major reasons, in that awareness of discrepancies between the perspectives of others and the view of the self can promote painful negative social comparisons. The accuracy of perspective taking in relation to the self, however, appears to vary both in shy children and adults (Alden & Wallace, 1991; Rubin & Asendorpf, 1993).

Self-blaming tendencies may lead to misperceptions of others' views of the self (Henderson & Zimbardo, 1993). Increased interpersonal avoidance also limits opportunities for feedback that can counter negative self-perceptions and provide occasions for receiving constructive feedback.

The awareness of a discrepancy between how one sees oneself and how one would ideally like to be seen by others or by the self, creates many kinds of discomfort and negative behavior, according to a large body of both clinical and empirical literature (Carver & Scheier, 1986; Henderson & Zimbardo, 1993; Higgins, Klein & Strauman, 1987). These discrepancies may exert considerable influence on the development of chronic shyness and social phobia in adolescence. It will be important, to continue to differentiate shyness, social phobia, and social anxiety in children and adolescents, because the phenomenology and precursors may differ in systematic ways.

Zimbardo identified two additional primary contributors to the elevation of shyness levels in this adolescent age group. One was a newfound concern about one's attractiveness to the opposite sex. A second contributor appeared to be the onset of sexual desire and sexual thoughts, which adolescents felt had to be concealed and actively suppressed (see Zimbardo & Radl, 1981). Among adolescent girls another factor to consider, which is related to these two, is the dramatic changes in their body shape as they begin to look more sexually mature. In some cases, the men in their lives, fathers, brothers, uncles and friends, may modify earlier patterns or holding or touching them as they move from being a girl to a women.

Individual Differences in Shy and Socially Phobic Individuals

Shyness has been conceptualized as more heterogeneous than social phobia (Turner et al., 1990). The heterogeneous appearance of shyness may reflect not only the continuum of mild defensive caution to extreme fears and social inhibition, but also the different domains of difficulty found in shyness. Some people report few negative thoughts, but are inhibited and

avoidant; others report physiological responses that interfere with cognitive processing; still others report a great deal of worry, but display little overt behavioral difficulty (Pilkonis, 1977). Some report the presence of negative emotions like shame and resentment, but little physiological arousal (Henderson, 1992). Clinical observation also reveals many socially anxious individuals who attribute their anxiety to more general feelings of insecurity, denying both shyness and phobic tendencies.

More recent research with social phobics, however, has also revealed considerable heterogeneity in levels of social anxiety, social skill, degree of avoidance, and physiological arousal (Beidel & Morris, 1995; Heimberg, et al, 1995; Hofmann & Roth, 1996). Heterogeneity in social phobia may be related to degree of social anxiety, transient states of shyness vs. trait-shyness, and degree of phobic avoidance or behavioral inhibition.

The behavior genetics concept of "niche picking," that is, selecting the environment most suited to one's traits may be the factor that separates problematic shyness, social anxiety, and social phobia from adaptive shyness, transient social anxiety, and transient social avoidance (Rowe, 1997; Scarr & McCartney, 1983; Xinyin, Rubin & Boshu, 1995). Communal and collaborative environments rather than highly competitive or authoritarian environments that place a strong value on personal dominance, may provide more and better opportunities for the contributions of the shy.

Subgroups

These observations have led to several attempts to define subgroups. For example, Buss classified fearful shy individuals vs. self-conscious shys (Buss, 1986). In the former group, fear of novelty and autonomic reactivity is hypothesized to be the major component; in the latter group, it is excessive awareness of public aspects of one's self. Pilkonis (1977) distinguished the privately shy from the publicly shy using cluster analysis. The privately shy were socially

skilled but self-doubting and uncomfortable, the publicly shy were more visibly uncomfortable and less skilled.

Zimbardo (1977) divided shy individuals into two groups, shy introverts and shy extraverts. Shy introverts often preferred to be alone, liking ideas and inanimate objects. They were less socially skilled than shy extraverts, were reluctant to approach others, and dated infrequently. Turner, Beidel and Townsley (1990) speculated that this group in the extreme resembled schizoid personality disorder and indeed this diagnostic group may comprise a proportion of our clinic sample. These individuals do, however, report desiring at least some connection with others.

The second group Zimbardo (1977) identified was socially skilled, but suffered internally. They were constrained by social expectations and concerned about social rules. Turner, Beidel and Townsley (1990) speculated that these were the most likely candidates for social phobia, being both sociable and shy. Shy extroverts appeared to function best in highly structured situations where everyone knew and played their roles as expected. Many talk show hosts, standup comedians, and professors in large lecture courses rather than seminars report being shy.

Characteristics of Shy and Socially Phobic Individuals

Somatic symptoms

Heart palpitations, shakiness, blushing, muscle twitching, sweating, and urinary urgency are reported by social phobics and are also common physiological responses in shy and socially anxious college students and in our clinic patients (Beidel, Turner & Dancu, 1985; Henderson, 1992; Zimbardo, 1977). However, there are fewer reports of nausea and chills among adult social phobics than reported for socially phobic children (Beidel, Christ & Long, 1991). Shyness clinic clients also infrequently report these symptoms. Parental ratings of shyness and

higher heart rates in a stressful task have been modestly correlated in children. There are, however, some contradictory findings. When heart rate was continuously monitored, by a portable microcomputer, there was no association between shyness and heart rate reactivity (Asendorpf & Meier, 1993).

Reports of higher cardiac rates also vary across studies of adult social phobics, with increased heart rates shown in socially challenging situations in some studies, but not others. Interestingly, specific social phobics demonstrate the highest cardiac rates (Levin et al., 1993; Turner, Beidel & Larkin, 1986). Pilkonis's description of the privately shy mentioned previously, those who reported more internal discomfort, but less behavioral difficulty, may be similar to the specific social phobics (Pilkonis, 1977). No differences between social phobics, the shy and the non-shy were shown on physiological measures in other studies, although the shy and the socially phobic perceived more arousal (Edelman & Baker, 2002; Heiser, et al., 2009). Socially anxious college students showed the same pattern during a public speaking task, (Mauss & Gross, 2004). In our clinic sample cardiac rates have not been measured directly, but most of our clients report high subjective anxiety ratings when engaging in simulations of feared social situations.

The exception is a small group of clients who report little somatic distress and low subjective anxiety ratings during simulated exposures. These clients tend to be behaviorally passive in interaction and often initiate little social contact outside the context of the group. We wonder if these individuals resemble the adult version of passive isolation in familiar situations (Rubin & Asendorpf, 1993). This pattern may be related to the reciprocal effect of biological differences interacting with growing psychological inhibition in the face of rejection and negative experiences.

Cognitive features and perception

The cognitive components of shyness, social anxiety, and social phobia have been the

subject of considerable interest over the past 30 years. Early clinical observation and empirical studies revealed a plethora of findings regarding the tendencies to: 1) worry; 2) to regard normal experiences of shyness as shameful and unacceptable; 3) to be preoccupied to the point of interference with performance and empathic behavior; 4) to appraise interpersonal situations in threatening ways; and, 5) to make maladaptive attributions for social behavior (Beidel et al., 1985; Carducci & Zimbardo, 1995; Cheek & Briggs, 1982; Zimbardo, 1977). Our clients demonstrate a double standard in that they do not judge others, including other group members, for responses such as blushing, for which they expect negative judgment for their reactions. Recent research has also revealed a double standard wherein socially anxious women expect to be judged for acknowledging anxiety more than others would be judged, while simultaneously understanding the likelihood of negative social outcomes for hiding anxiety, which emotion-suppression research confirms (Voncken, Alden & Bogels. 2006).

Self-blaming attributions are common in our shyness clinic clients, as are entrenched negative beliefs about the self. There are also frequent negative thoughts and beliefs about others. We have developed a new scale called the Estimations of Others Scale (EOS) to assess these negative thoughts and beliefs (Henderson & Horowitz, 1998). The scale has high internal reliability (.91 alpha) in a college student sample. Shy students score significantly higher on this scale than the non-shy, and clinic clients score significantly higher than the students.

Our research on perceptions of facial expressions of emotions has revealed that shy college students and Asian American students are slower to recognize disgusted facial expressions than the non-shy, being *less*, not more sensitive to social threat emotions, as we had originally predicted. Asian Americans were slower to recognize facial expressions of anger than the non-shy and the shy group did not differ from Asian Americans or the non-shy. Groups did not differ in sensitivity to fear, surprise or sadness, and the shy and the Asian Americans were slower to recognize happiness. Earlier research had shown that shy and Asian

Americans tend to value harmony and are higher in interdependent self-construals. In addition, they have a more reflective intellectual style that may make them less willing to acknowledge social threat emotions until they are obvious and the context is considered, particularly if they are not directed at them. We also suggest that less sensitivity to happiness expressions may be related to valuing pleasant vs. high intensity positive emotion (Henderson, Kurita & Zimbardo, 2006).

Affective features

Compared to normative samples, shy clients report considerably higher levels of social anxiety, shame, guilt, depression, and resentment, with higher levels of shame and anger predicting passive aggression (Henderson & Zimbardo, 1998, August). However, embarrassment is correlated with shyness in normative samples (Crozier & Russell, 1992). In contrast, one-third of an extremely shy group without social phobia reported no social fears during a diagnostic interview (Heiser, et al., 2009). Social anxiety, depression-related emotions and embarrassment are frequently reported in the social phobia treatment literature (Turner, et al., 1990). The study of negative emotionality in socially anxious children is a growing area of research (Banerjee & Henderson, 2001).

Behavior

Behaviors associated with chronic shyness are similar to those associated with social anxiety and generalized social phobia, that is, shy people speak less in social settings, less often initiate new topics of conversation, avert their gazes, exhibit nervous mannerisms, and show fewer facial expressions (Leary & Kowalski, 1995; Turner & Beidel, 1989; Zimbardo, 1977). Shy behaviors are usually described by shys and observers alike as reticent, quiet, awkward, or overactive (Cheek, 1981; Zimbardo, 1982). Shy college students are less visible and less assertive in the work place, and are less likely to use career-planning resources (Cheek & Busch, 1981). They display less verbal fluency and fewer leadership skills. They also show less

verbal creativity when faced with evaluation (Cheek & Stahl, 1986).

Conversations between the shy are dominated by talk about the immediate physical/social setting rather than talking about themselves and leave ambiguous who is to speak next (Manning & Ray, 1993). The exception to this is for "favored" topics that are discussed extensively. Although most strangers seek "common ground" topics when starting conversations, it may become a dominant strategy for the shy because it offsets the painful silence when neither party talks. Shy individuals are less self-disclosing, even to the point of telling physicians and psychologists too little about problem areas to obtain adequate help (Zimbardo & Piccione, 1985). Genuine self-disclosure may also involve the risk of communicating negative thoughts and feelings about the self, which increases inhibition (Henderson, 1992).

When we consider non-verbal behavior, shy people keep others at a greater physical distance than those who are less shy (about 12 inches further away). The difference is greater with an opposite sex stranger than with a same sex stranger, and when a stranger is coming toward them than when they are moving toward the stranger (Carducci & Webber, 1979; Zimbardo, 1977). They maintain minimal eye contact and little smiling, have a closed, "defensive" posture, low speaking voice, and constrained bodily movements, with minimal hand and arm gesturing (Zimbardo, 1977).

However, a recent study of socially anxious college students conducted by Alden and Bieling (1998) reveals that negative behaviors can be readily changed when negative appraisals of social situations are altered by an experimental manipulation. When told that their personality profiles were similar to their conversational partners, indicating that they would easily relate well to each other, anxious individuals were indistinguishable from non-anxious individuals in likeableness, appropriateness, and similarity.

Moreover, clinical observation has suggested that when shy clients are not self-focused,

their behavior is indistinguishable from non-shys and is often highly skilled. These observations lend at least clinical credence to the idea that behavioral deficits may disappear when critical self-consciousness is reduced and shy clients are focused on a cooperative task with others.

Family Characteristics

Parenting characteristics that may promote shyness are controlling, insensitive, or over-protective styles that involve frequent correction and shaming (Bruch, 1989;). The important issue is when and how much parents should encourage or refuse to protect inhibited children so that they receive adequate socialization experiences. Social phobics who report parental overprotection are less responsive to the behavior of a conversation partner, and their failure to respond to friendly overtures leads to rejection (Alden & Taylor, 2006). Many patients report minimal social interaction with peers, and a lack of family support for such interaction. Some also report little interaction with family friends or relatives. Because extended family socializing predicts less shyness in young adults (Bruch, 1989), parental sociability in itself appears conducive to preventing shyness in children. Engfer (1993) found that parents of shy children were less sensitive to children's expressed needs and more prone to use strongly assertive strategies.

The self-critical tendencies of shy adults may be the result of restrictiveness and rejection by parents because these parental behaviors have been shown to be related to the development of self-criticism in adolescents more generally, particularly when received from the same-sex parent (Koestner, Zuroff & Powers, 1991). Self-criticism remains stable into young adulthood for women, but not for men. However, men exhibit a relationship between self-criticism and inhibited aggressive impulses.

Treatment

Treatments for shyness, social anxiety, and social phobia generally include cognitive restructuring, social skills training, and role-plays of threatening situations. A meta-analysis of social phobia treatment suggested that both cognitive and behavior therapy treatments were effective for social phobia and some researchers suggest that exposure appears to be the most powerful mechanism for producing ameliorative change (Feske & Chambless, 1995; Turner & Beidel, 1992). Two studies of social anxiety treatment concluded that treatment is useful and that response to treatment is not significantly differentiated by approach or modality (DiGiuseppe, McGowan, Simon & Gardner, 1990; Leary & Kowalski, 1995). However, one carefully controlled study demonstrated that exposures with cognitive restructuring were superior to exposures without cognitive restructuring for severe social phobia (Mattick, Peters & Clarke, 1989). A recent treatment update revealed no differences between exposures only and exposures with cognitive restructuring (Jorstad-Stein, & Heimberg, 2009). Type of treatment, mode of delivery, number of sessions or length of treatment so far do not appear to affect outcome.

An important treatment consideration involves assessing the degree to which shyness or social phobia is a consequence of inadequate social skills, or symptomatology related to other disorders. Skill deficiencies need to be differentiated from inhibition or anxious behavior, and addressed in treatment. We agree with Caballo and Turner (1994), for example, who indicated that physical self-care may need to be addressed, particularly among those who fear dating. In contrast, high-functioning individuals with Asperger's Syndrome will exhibit shy behavior, but primarily need very concrete social skills training.

Butler & Wells (1995) noted that social phobics in treatment enter feared situations, but disengage using subtle strategies such as avoiding eye contact. Some clients achieve more effective desensitization when simply asked to "stay in the moment" during conversation role-plays (Henderson, 1999). Wallace and Alden (1997) suggest that self-protective motivation accounts for continued avoidance of feared situations in spite of successful exposures.

Cognitive restructuring may fail to demonstrate impressive response rates in many studies because treatment may often neglect negative attributions and beliefs about the self and others that accompany severe shyness and social phobia (Henderson, 2002). We believe that

the frequent relapse seen in studies of social phobia is at least partially due to inadequately addressed maladaptive attribution styles and negative beliefs. Consequently, since the early nineties we have included a specific focus in our treatment on negative attributions and negative beliefs about the self and others. We also focus on the negative emotions that these attributions and beliefs engender: shame if the beliefs are about the self, and resentment and hurt if they are about others. Therapists also help clients link thoughts and emotions to early experiences in order to help clients develop insight into their anxiety and motives for interpersonal avoidance.

Addressing Attribution Style in Treatment and Assessing Results

We address self-blame and shame in social fitness training, as well as how the presence of private self-awareness exacerbates painful emotion and unsupportive thinking. We developed specific challenges to negative attributions and beliefs about the self and applied such challenges concomitantly with the usual cognitive restructuring techniques during exposures to feared situations and have gathered data regarding the results of attribution retraining.

Pre- and post- testing of shyness clinic clients in 26-week groups has revealed that internal, global, stable, and self-blaming attributions in clients' three most challenging situations are significantly and substantially reduced in treatment, as is shame. Interestingly, shy students who were in an eight-week treatment at Stanford, who were also higher in general fearfulness, according to the fear scale of Buss and Plomin's EAS Temperament Survey for Adults (Buss & Plomin, 1984), were the most self-blaming at pre-test. These results are sufficiently interesting to warrant more extensive investigation in relation to sub-groups of shy clients.

A telephone follow-up study of clients treated between 1994 and 1999 also revealed that clients, on the average, were maintaining treatment gains in the form of reduced distress

and avoidance, but with considerable variability. It is that variability which motivates our efforts to identify subgroups and to develop more specific treatment strategies for particular individuals, as well as new methods for enhancing treatment generalizability.

Naturalistic investigations of shyness clinic samples have also revealed that a coping style that is primarily internalizing predicts better outcomes in Social Fitness Training. In addition, a flexible coping style, that is, being able to use both internalizing and externalizing coping strategies flexibly is an additive predictor in reducing shyness as measured by our clinically sensitive shyness questionnaire, the ShyQ. (Clinton, 2009; Henderson & Zimbardo, 2002; Kimpara, Henderson & Beutler, 2008).

We also think that the approach of Beutler (2009) is better for assessing treatment outcome than to rely solely on the results of randomized control treatment comparisons of different structured treatments. He found few differences in benefits to patients after reviewing meta-analytic studies and a large mega-analysis comparing empirically supported treatments (ESTs) and treatment as usual conditions (TAUs). Effect sizes associated with comparisons between and among structured treatments also approximated zero (Beutler, 2009). He argues, therefore, that not all research questions are effectively addressed with RCT designs, and has demonstrated that several patient moderating variables increase the power of treatments to produce benefits. Thus, Social Fitness Training was found to produce a strong effect size (d = .85) among internalizing patients. Beutler integrates multiple research and statistical methods to study variables that include not only treatment variables, but also client and therapist variables, the treatment alliance, and treatment compatibility.

Shyness Clinic Treatment

The Shyness Clinic has been a freestanding fee-for-service organization that functioned on a private practice model until recently, when the clinic was moved to Pacific Graduate School of Psychology in CA, now re-named Palo Alto University in 2009. This move has

enabled us to train graduate students as well as post-graduates and practicing psychologists. Students also have access to our clinic database for research studies. Research findings from personality theory, social psychology and clinical psychology are used to inform techniques we use with clients. Although the major therapeutic work is done in small groups, prior to group assignment there is an initial evaluation of three to seven individual sessions depending on the degree of comorbidity.

Groups are mixed gender and include six to eight participants, who meet weekly for two hours over 26 sessions. The first 13 weeks consist primarily of simulated exposures to feared situations, and include reports of behavioral homework and goal setting for the following week. Clients also conduct homework assignments together, in pairs or small groups, such as, telephoning each other, challenging each other's negative thoughts, and attending events together. In-group exposures involve other clients, research assistants and volunteers who play the roles of conversational partners, employers, dating partners, and others. Group members and confederates provide feedback in the form of indicating which specific behaviors could be changed or eliminated in order to make them feel more comfortable. Specific skills for providing and receiving helpful versus non-helpful feedback are taught throughout this period. Another strong emphasis of the educative component is that the quality of social interactions are negotiated and relative: the goal is for clients to learn to see themselves as one of the definers and initiators of social interactions, rather than attempting to follow perceived performance "rules" that "everyone else knows" and will be imposed upon them.

The second 13 weeks is directed toward specific skill training to address the areas of difficulty experienced by extremely shy clients. Self-disclosure, listening skills, expressing feelings verbally and nonverbally, trust-building, handling criticism, negotiation, anger management, and assertiveness training are among the topics included. Clients role-play various situations in small groups in order to practice these skills with treatment "partners" with

whom they are becoming more intimate. This serves as a model for deepening friendships and developing intimacy as well as navigating relationships in particular contexts, such as on the job, meeting new people, and dating. Videotaping is provided for some group exercises and interactions, if clients are open to it. As clients self-disclose earlier experiences that led to their shyness to group members, therapists help clients link these experiences to current fear and avoidance.

In addition to the focus on behavioral skill training, we try to create a safe place, a large "sandbox" where clients can experiment, practice, and play. Playing includes non-verbal exercises taken from theater improvisation and sensitivity training groups in order for clients to learn to "live in their bodies," creating a greater sense of physical and emotional freedom. Attention is given to how clients hold themselves, their posture and walk, in order to help them understand what they are communicating non-verbally to others and to themselves, and to facilitate the making of deliberate choices regarding their non-verbal communication.

Shy clients tend to be over ideational, they ruminate at great length about their performance in social situations, which not only perpetuates painful emotional states, but also interferes with taking action. These exercises help them to trust themselves more at a "gut" level. We also help them experiment with deliberately altering attentional focus. They practice interactions in which they are focused on paying attention to how they are doing in the conversation. They practice focusing on internal states, and they practice focusing on the other person by looking for interesting things about the other and areas they have in common. These exercises afford clients the opportunity to experience for themselves what is most pleasurable about social interactions, and to discuss the differences in these experiences. Learning how to give and how to receive compliments is also a vital skill we promote in sessions. For example, the response to a compliment is a simple "Thanks," as soon after it is received. It can be reciprocated by adding some phrase such as, "Coming from you, that makes me feel good,

because you: dress so well; write so well; have such a good sense of …"

The exposures and skill building components of the group are based on social cognitive theory, which stresses both the development of competency and cognitive-emotional self-regulation (Bandura, 1997). Rules and strategies guide action though observational learning, exploration, instruction, and original cognitive syntheses of information, and skill execution varies with changing situations and purposes (p. 34). While reinforcement, non-reward, and modeling have been demonstrated to lead to the learning of social norms and behavior (Bandura, 1986), social cognitive theory presupposes a more complex and reciprocal causality among people and between people and the environment. Perceived self-efficacy is pivotal because it influences motivation and choice of activities. Self-efficacy plays an essential role in behavioral persistence in the face of challenging social tasks. If clients can increase their sense of personal self-efficacy in the form of taking responsibility for their behavior, but not for social outcomes over which they have no control, they are more likely to maintain the cognitive, emotional, and behavioral gains that accrue in treatment.

Interpersonal process theory provides an additional theoretical framework during the second 13 weeks (Leary, 1957). Harry Stack Sullivan (1953) suggested that peer relationships were the foundation of respect, interpersonal sensitivity and cooperation. He emphasized special close relationships in particular as places where mutuality and reciprocity develop. We also use interpersonal motives theory to inform therapists' responses to clients' bids to be led or dominated (Horowitz, et al., 2006). Therapists take care to gently counter bids to be led or dominated with egalitarian behavior and invitations to collaborate and lead in learning together.

Because extremely shy adults are often withdrawing by adolescence, providing a place to experiment socially in the safety of the group is likely to enable clients to utilize their own cognitive and emotional resources more effectively. They also have the opportunity to experience some emotional security through the process of interaction in the group, helping to

provide a model of mutuality and reciprocity on which they can continue to build. Clients use the model to guide their practice in current homework exercises, and can continue to use it in future non-therapeutic settings and relationships. We are also working to develop a more systematic focus on mindfulness and compassion, based on the current research and clinical work of Paul Gilbert (2009).

Social Fitness Model

We have chosen social fitness as our model of helping people deal with shyness, social anxiety, and social phobia because it best fits our goal to transfer research and theory from social and personality psychology into behavioral, cognitive, and emotional regulation strategies that help individuals thrive in social interaction. As individuals learn about the strategies and the theory behind them, practice new behaviors that are informed by them, and then practice those behaviors in their own lives outside the clinic, we believe they will become increasingly "socially fit." Perhaps more importantly, they will, in a sense, become practicing social researchers not only to develop an understanding of their own social fitness, as we have understood it, but also to contribute further to theory and new practices themselves. Continuing homework exercises contribute to the generalizeability of treatment effects, such as meeting with other graduates for coffee and goal setting, telephoning/texting/twittering each other, or meeting for support and consultation.

The concept of social fitness provides an umbrella term within an evolutionary framework that is continuous and dynamic, including many levels of social competence and incompetence, social comfort and discomfort. Nevertheless, it contains categories that are phenomenologically discrete, such as personality types. Moreover, finding one's social "sport" or niche may involve matching discrete differences in personality to situations in which these characteristics are seen as strengths. We have noted previously that shyness, social anxiety, and social phobia appear to be, at least to a certain extent, discrete. They are phenomenologically

different from each other, according to the differing self-reports of people who endorse one, but not the others, as appropriate to their self-construals. It is also apparent that there is considerable variability in stimulus situations that trigger these reactions, as well as the nature and features of the reactions.

Using our physical fitness analogy as an example, both a long-distance runner and a tennis player may be highly coordinated and athletic along a continuum of genetic capabilities and a state of physical fitness earned through considerable effort, disciplined practice, and persistence. However, a tennis player is not a long-distance runner, and the two sports require some differing capabilities, different types of conditioning and practice, and perhaps temperamental differences. Furthermore, there are many ways in which to be physically fit and to enjoy one's own physical health and well-being -- by jogging, hiking, surfing, playing soccer, volleyball, or football. Analogously, social fitness implies some measure of learned skill and a belief that one is "fit" enough to slip and fall, lose a surfboard, miss a goal, bungle a shot, make an error, or even be tackled with someone's full weight, and not only recover, but learn from the experience, trusting that one can still play, individually, and on the team.

Whether socially anxious, shy, or phobic regarding social situations, people can achieve some measure of social fitness and social success, both by "working out" and by choosing activities and situations to pursue that are suited to their individual temperaments. They can also understand that "temperament" is sometimes a word for well-ingrained habit patterns developed adaptively in situations that were traumatic or non-rewarding, but no longer serve a useful purpose. As behavior change in social fitness training occurs, along with new emotions and revised emotional and cognitive understandings, new "temperament" variables may appear.

In working with shyness groups over the years, LH has been sufficiently impressed with certain personality traits, such as ethical and caring behavior toward others, which incoming group members already possess, that she has undertaken an interview study of "shy leaders."

People are interviewed who are known to be outstanding leaders, either locally or in larger contexts and who report that they are shy. Interviews are also conducted with at least one associate. Using independent ratings of transcribed interviews by the author and two researchers according to personality questionnaires, we are attempting to delineate the particular strengths of shy leaders. Pilot results suggest they tend to lead from behind and let others take the spotlight, are careful observers of people, attentive listeners, are empathic, and feel strongly about their values in relation to their work. They are motivated, determinedly persevering, strategic and genuine, over-prepare for public speaking tasks, push past shyness to get the job done, and are somewhat androgynous, showing both masculine and feminine traits. They may be more likely than others to be recruited into leadership roles, rather than to seek them, and some report cultivating certain kinds of self-assertion.

Consistent with our observations, Kurtz and Tiegreen (1984) have shown that the Big Five personality variables of agreeableness and openness to experience as measured by the NEO-PI-R are significantly correlated with ego development. Interestingly, the facet scale scores that were most predictive of ego development were Aesthetics and Modesty. Both are qualities we see consistently in our shyness clients, and qualities that are associated with shyness in the research literature (Ziller, 1984). Shy leaders who are effective in achieving their goals and those of their association, while also modest, may allow others to share credit for success and thus build better team morale.

In conclusion, we believe that the pursuit of social fitness is an idealized quest in support of the overall health of individuals, cultures, and the planet as a whole. We know that social support networks are the best prophylactics against the negative effects on the body, mind, and spirit associated with social isolation. Social fitness should contribute to increasing the vitality of these networks. Personal social fitness in a healthy social ecology is essential for enhancing meaningful social support and thereby, to strengthening the bonds of the human

connection.

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