Running head: TREATMENT FOR SOCIAL PHOBIA AND SHYNESS

Testing Treatment Fit Among Social Phobic and Shy Patients: In Search of Specific Treatment Effects

Satoko Kimpara, Lynne Henderson, and Larry E. Beutler[1]

Palo Alto University

Stanford University

Key words: Social Phobia, Shyness, Social Anxiety, Internalization, Specific Effects

[1] Correspondence to the author. Email: lbeutler@paloaltou.edu Address: Palo Alto University, 1791 Arastradero Road Palo Alto, CA, 94304

Abstract

Chronic shyness is prevalent and disruptive. Those who have this condition are frequently diagnosed with Social Anxiety Disorder. While treatments are available, treatment for social anxiety does not respond as well to conventional behavioral treatments as the closely related, phobic disorders (Henderson & Zimbardo, 1997). Shy individuals blame themselves for social failures and experience feelings of shame. To compensate for the weak treatment effects in other treatments, the Social Fitness Model, a psychotherapy model for problem shyness developed by Henderson integrates cognitive behavioral, interpersonal, and psychodynamic therapy techniques, following relevant principles of integration outlined by Beutler, Bongar, and Clarkin (2000). This study examined the degree to which the outcome associated with this integrated treatment was associated with compliance with salient principles extracted by Beutler and colleagues for working with such "internalizing" patients. Results revealed that the effectiveness of the integrative approach incorporated into Social Fitness Training was mediated by level of internalizing coping styles.

Testing Treatment Fit Among Social Phobic and Shy Patients: In Search of Specific Treatment Effects

People have diverse ways of coping with stressful situations and these differences are not often captured in diagnostic labels. Coping styles vary both in quality and in intensity, with the latter dimension ranging from mere personality differences to pathological conditions. Ways in which one copes with stress may be both descriptive and predictive in that they describe individual differences that have been suggested to serve as indicators for the selection of specific interventions that vary in treatment focus.

A brief description of how coping styles, personality, and psychopathology may interface may be helpful in understanding the role of treatment fit for these conditions. Moos and Holahan (2003) argue that people are distinguished along a dimension that is indicative of their processes of adapting to threat and change. At one end of this dimension is those who rely heavily on cognitive/emotional-focused coping strategies (i.e, "internalization"), and at the other end are those who rely on behavioral or active (i.e., "externalization") coping strategies. Groups of individuals reflecting the spectrum of "internalization" have in common the tendency to give credit to others for success and to assign failure to themselves in social situations; they also tend to be inhibited, self-blaming, and reticent (Arkin, Appelman, & Burger, 1980; Clark & Arkowitz, 1975; Girodo, Dotzenroth & Stein, 1981; Henderson & Zimbardo, 1997; Minsky, 1985; Teglasi & Hoffman, 1982).

Some investigators have suggested the value of using these personality-based coping style descriptions as differential predictors of psychotherapy outcomes. Beutler and Clarkin (1990), from a comprehensive literature review of factors that are associated

with psychotherapeutic change, for example, defined two generalizable and stable coping styles—"externalizing" and "internalizing" that differentiated treatment efficacy. "Externalizers" manifest a coping style that is characterized by descriptions like impulsive, hedonistic, action or task-oriented, gregarious, aggressive, stimulation-seeking and lacking in insight. In contrast, "internalizers", share a common set of descriptive characteristics that include being shy, retiring, self-critical, withdrawn, self-contained, emotionally avoidant, overly controlled, self-reflective, worrisome, and inhibited. These two general coping styles were found in this initial review, to be differentially affected by two distinctive psychotherapeutic interventions. In this and several updated reviews in the following years, Beutler and colleagues (Beutler, Clarkin, & Bongar, 2000; Beutler, Harwood, Alimohamed, & Malik, 2002) became increasingly convinced that coping style held promise as a specific moderator of psychotherapy. This conclusion stimulated a number of specific studies designed to test this hypothesis (e.g., Beutler, Clarkin, & Bongar, 2000; Beutler, Moleiro, Malik, Harwood, Romanelli, Gallagher-Thompson, & Thompson, 2003; Castonguay & Beutler, 2006). Both the consistency and robustness of this aptitude-treatment interaction (ATI) effect has recently been confirmed in a meta-analysis of studies accumulating over a 20 year period (Beutler, Harwood, Kimpara, et al, in press). The fit of coping style to treatment focus earned a moderate to strong effect size (d) of .55.

While coping style defines a general personality trait, a case can be made that it also bears a strong (if indirect) relationship to relevant diagnostic conditions like social anxiety disorders and social phobia and to non-diagnostic conditions like shyness (Beutler, Harwood, Kimpara, et al, in press). Indeed, Lorant, Henderson, and Zimbardo

(2000) found that 97 % of clients who seek treatments for shyness met diagnostic criteria for social anxiety disorder, 57% of them had a comorbility with Axis I disorders (e.g. GAD-27%, Dysthymia-29%) and 95% of them had a comorbility with Axis II disorders (e.g. Avoidant-67%, Schizoid-35%, Paranoia 23%). If the intensity of an internalizing coping style is selectively associated with a uniquely and differentially powerful response to insight oriented treatments, over symptom oriented ones, then identifying a treatment strategy that may outperform the conventional symptom-focused approach of cognitive-behavioral treatments may be important to advancing both the theory and the specificity of psychotherapy.

In 1984, Henderson began to develop an integrative treatment program for problem shyness that followed this general intervention pattern. The intervention was dubbed "Social Fitness Training" (Henderson, 1994) and was a combination of an initial CBT-like intervention followed by interpersonal and psychodynamic therapy. The intervention was designed to take place within a 26 week period, the first half of which was based on a model of symptom exposure and extinction and the second half, on gaining self-understanding and insight (Henderson, 1994; Henderson, & Zimbardo, 1998, 2001). Though this training was not developed with "coping style" differences in mind, the patterned use of symptom-focused CBT early on, followed by psychodynamic treatment, happened to fit the structure that has been hypothesized to be optimally effective among those with dominantly internalizing coping styles (Beutler, Clarkin, & Bongar, 2000; Beutler & Harwood, 2000). The incidental fit of Henderson's treatment to that population of individuals that are most likely to include internalizing coping styles, offered a unique, real world opportunity to test the assumption that the effectiveness of

this integrative treatment would correspond with the degree to which the individual patient manifest an internalizing coping style.

From their research, Beutler and colleagues have articulated two main principles, out of 18 initially identified (Beutler, Clarkin, & Bongar, 2000), that peculiarly characterize an "optimal" treatment for internalizing shy/socially phobic individuals: 1) therapeutic change is most likely if the initial focus of change efforts is to alter disruptive symptoms, and 2) therapeutic change is likely to be greatest when the subsequential focus of change among internalizing individuals employs insight and self-discovery procedures (Beutler & Harwood, 2002). Since social fitness training complies consistently with these principles, in this study we predicted that the rate of benefit would closely coincide with the level of internalization that characterized the patients in the study.

Method

Participants

Participants consisted of 121 residents of northern California, who presented with problem shyness and social avoidance, and who sought treatment at the Shyness Clinic in Palo Alto, California. The sample included 72 males (59.5%) and 49 females (40.5%) with a mean age of 34.5± 9.7 years (ranging from 18 to 65 years). Additional demographic data for this sample are presented in Table 1.

Insert Table 1 about here

All participants were informed of the purpose of the study and offered copies of the consent forms to read. Consent forms would contain contact information for the primary investigator, graduate program advisor and Institutional Review Board Chair at

Palo Alto University. For purposes of confidentiality, all participants were assigned a code number that were used on all further testing forms.

Procedure

Social Fitness Training for Shyness

The eight therapists who worked in the shyness clinic all served in this project. Six (four females and two males) were licensed psychologists and two (females) were licensed master's level therapists. All therapists went through specialized and supervised training in the Social Fitness model of treatment. Training consisted of reading, co-leading groups with the program director (Henderson), individual case supervision, and ongoing supervisor review throughout their tenure in the program. Therapists were not allowed to be the primary group facilitator until they had demonstrated their expertise to the satisfaction of the program director.

During the first 13 weeks of Social Fitness Training/Therapy, clients met in groups to engage in simulated and in vivo exposures to reduce anxiety and avoidance. Specifically, therapists and clients first construct a hierarchy of ten feared situations (e.g., saying hello to strangers; speaking out in front of colleagues; and negotiating with a boss or manager) and set specific behavioral and cognitive goals for treatment. Clients are then taught cognitive restructuring techniques with a particular focus on negative attributions and self-blame, and are encouraged to expose themselves to anxiety-provoking situations via role-playing desired behavior in simulated exposures and practicing their newly-learned coping skills in vivo between sessions.

During the second 13 weeks, the psychotherapists help the clients practice building and deepening intimacy in their relationships (through self-disclosure, building

trust, expressing emotions, exploring their psychodynamic history, and resolving conflicts) through interpersonal/dynamic interventions. Throughout the program, therapists particularly are attuned to the frequent expressions of embarrassment and shame that have accumulated through their history of aversive experiences with family and others on one hand. At the same time, therapists are trained to encourage clients to discuss feelings of embarrassment and shame and to facilitate their working through these feelings and exploring their development and significance in their relationships with self and family/others. Interpretive processes and the use of the patient-therapist transference are used to help them change their own behaviors in concert with emerging insights (Henderson, 2002). Therefore, it is essential that the psychotherapist provide a safe environment that facilitates the expression of emotion and helps the client identify the underlying meanings and dynamic history of feelings and behaviors as they engage in interpersonal interactions (Henderson, 1992; Henderson & Zimbardo, 2001).

Thus, consistent with the two aforementioned STS principles, social fitness treatment, as applied to those who present internalizing coping styles, works to 1) reduce symptoms first, and then, 2) to utilize interpersonal and insight interventions that match the coping style of the client.

Screening. Participants were screened for eligibility to participate by premorbid presentation of social phobia and other associated DSM diagnoses assessed by the Anxiety Disorders Interview Schedule-IV [ADIS-IV; DiNardo, Brown, and Barlow, 1994]. Participants were also required to be fluent English speakers and over 18 years-of-age. Interviewers included all of the therapists in the clinic who were all trained to criteria levels of reliability with the ADIS. Final selection of participants was based on an intake

conference where patients were reviewed before all the therapists and students in the program.

Predictor Variables. A pre-treatment Minnesota Multivariable Personality Inventory-2 [MMPI-2: Butcher, 1990] was used to assess each patient's coping style. Patients were assigned a continuous score reflecting the degree of internalization tendencies based on the Internalization Index formula, expressed as a mean T score, using the procedure described by Beutler and colleagues (e.g.,Beutler, Clarkin, & Bongar, 2000; Beutler & Harwood, 2002; Beutler et al., 1991; Beutler & Mitchell, 1981). This procedure identified the strength of Internalization tendencies using a ratio of eight MMPI-2 clinical subscales. The mean sum of the first set of four scales (Hs, D, P, Si) were used to assess internalization and the mean of the sum of the second set of four scales (Hy, Pd, Pa, Ma) were used to assess externalization (Beutler, et al, 2003). The difference between the two sets of scales indicated strength of internalization relative to externalization.

In order to further clarify the role of internalization, we also extracted independent estimates of two specific and psychodynamically related aspects of this dimension that have treatment implications (Harder & Lewis, 1986). These dimensions reflected guilt and shame and were based on the administration of the Personality Feelings Questionnaire (PFQ; Harder & Lewis, 1986). The PFQ includes 10 items each with 5 point rating scales (0, never, to 4, continuously or almost continuously) to assess proneness to shame and guilt. Harder and Lewis reported that test-retest reliability of two weeks was .85 and at five weeks was .78 for these dimensions.

Outcome. The Beck Depression Inventory-Second Edition (BDI-II) (Beck, Steer, & Brown, 1996) was used as the primary outcome measure. The BDI-II includes 21 multiple choice questions that assess the presence and severity of depressive symptoms in adolescents and adults. Each multiple-choice item has four potential answers with corresponding scores from 0-3, with the score increasing with the severity of the symptom. The maximum score is a total of 63. Scores from 0-13 are considered within the normal range. Scores from 14-19, 20-28, or more than 29 are considered indicative of mild, moderate, and severe depressive symptoms, respectively. Beck et al. (1996) reported a high internal consistency of .92 among outpatient and .93 among college student samples on the level of severity of the items, and a high stability (test-retest) coefficient of .93 over a one-week period on a mixed sample.

Data Analysis

Intercorrelational analyses initially were conducted to describe the characteristics of the samples. Relationships between the STS predictor variables (i.e., the levels of internalizing and externalizing coping styles) and other predictor variables (i.e., the pre-treatment level of depressed mood, and levels of shame and guilt) were examined.

Results

Before testing the hypothesis that patient internalization would be a predictor of treatment outcome among shy patients, we first tested the assumption that shyness was related to internalizing coping style. To check this assumption, the STS Coping Style Index, which was comprised of a ratio of externalizing to internalizing symptoms, was used to identify each individual's coping style. The ratio score method provided a

categorical indication of subjects' externalizing or internalizing coping styles to complement the continuous measure derived from the ratio itself. Levene's *t*-test was used to examine mean differences in internalizing and externalizing coping style scores between these two groups to ensure adequate separation of the two subgroups.

Individuals with chronic shyness were expected to display both a general style of internalization (as defined by internal sensitivity, introversion, emotional restriction, and dysphoria) and exaggerated feelings of both shame and guilt. The mean of the sum of the four "internalizing" scales (Hs, D, P, Si) and of the four "externalizing" scales (Hy, Pd, Pa, Ma) were calculated and compared to the expected normative T score mean of 50 (Beutler, et. al., 2003). The means of the internalizing and externalizing scores were 66.4 and 56.3 and the mean standard deviations of these were 9.81 and 8.26, respectively. The standard errors of mean were .89 and .75.

The standardized means of the internalizing scales were subtracted from the standardized means of the externalizing scales to derive a continuous measure of internalizing as a coping mechanism, compared to externalizing. A constant was added to this number to keep it positive. The results confirmed that internalization was a dominant and distinguishing characteristic of this group of patients. When assessed categorically, one hundred seven (88.4%) of the participants were classified as adopting an internalizing coping style (Internalizing- Mean 67.6, SD 9.49; Externalizing-Mean 55.6, SD 8.01) while only 14 (11.6%) of the participants produced an externalizing coping style (Internalizing- Mean 57.2, SD, 7.23; Externalizing-Mean 61.4, SD 8.01). The Levene *t*-test confirmed the significance of this categorical classification.

Hypothesis Testing

To address the main hypothesis, Hierarchical Linear Modeling (HLM) was used in order to view the predictors on multiple levels and to compensate for missing outcome data. Post-treatment BDI-II scores were inserted as the dependent variables, and predictors included the pre-test scores denoting depression as well as the internalization continuous measure, and guilt and shame scores. To explore the meanings of the findings further, four subgroups were identified using a median split procedure on two cross-tabbed dimensions. The first two subgroups were comprised of those that earned high and low scores on the continuous measure of internalization. The second two subgroups were comprised by a similar median split on the composite shame/guilt score. Positive change scores were calculated by reference to Walker (1991) and demographic variables were controlled by ANCOVA Analysis.

A positive main effect of internalization level on outcome was expected. The two-way interaction of internalization and the level of guilt/shame was also expected to be differentially associated with improvement during Social Fitness Training. Overall, the degree of benefit experienced was expected to be highly related to the intensity of internalization (high vs. low) and guilt/shame (high vs. low) initially present.

In the HLM analysis, we initially entered the pre-treatment level of depression, which was a good predictor of post-treatment scores. More directly, the second block included levels of internalization, and guilt/shame scores (separately scored). Only the "internalization" factor was predictive of post-treatment depression. The "shame and guilt" scores did not make unique contributions to reduced depressive symptoms.

The third block contained post-treatment guilt and shame scores. The overall model, utilizing all three blocks, indicated that shame/guilt carried the burden of weight for the outcomes, within internalization being fully subsumed by this latter factor. The result confirmed that shy individuals who were prone to feel shame/guilt experienced reduced depressive symptoms at the end of treatment.

In order to evaluate the relationship between coping style and shame/guilt, an additional analysis was undertaken. This analysis was based on a median split procedure, using the coping style and shame/guilt dimensions, and is shown in Figure 1.

In examining change in depression over treatment, we identified four subgroups using a median split procedure on two of the study dimensions, internalizing coping style scores and shame/guilt scores. An ANCOVA analysis was then conducted, using the four subgroups previously described, to determine if the subgroups of patients differed significantly in performance on the positive change scores. Demographic variables served as covariates.

Insert Figure 1 about here

Results of the ANCOVA indicated that the four subgroups differed significantly in positive change scores ($p<.001$; Power =.99), after controlling for the influence of demographic characteristics. Results of the paired comparisons between the four subgroups revealed that the mean positive change scores of subgroup 4 differed from the mean scores for the other two subgroups (1 and 2) (see Figure 1).

In addition to the analysis above, the study found that the four subgroups that were identified by the median splits between the scores of the externalizing coping style

and the shame/guilt scores in Figure 1 produced significant differences. Results of the ANCOVA indicated that the four subgroups differed significantly in positive change scores ($p<.001$; Power =.96), even when controlling for the influence of demographics. Results of the paired comparisons between the four subgroups were identified. The mean positive change scores for two subgroups (3 and 4) differed from the mean scores for the other two subgroups (1 and 2) (see Figure 1-2).

These explanatory analyses between two kinds of subgroups demonstrated that although matching levels between internalization and shame/guilt influenced positive change scores, matching levels between externalization and shame did not influence positive change scores. Moreover, the levels of both coping styles may increase positive change scores.

Discussion

This study confirmed the role of coping styles in predicting the value of including insight-focused interventions in psychotherapy. In keeping with the principles identified by Beutler and colleagues (Beutler & Clarkin, 1990; Beutler, Clarkin, & Bongar, 2000). Social Fitness Training, which applied two of the principles that Beutler and colleagues concluded would be associated with change among internalizing patients, demonstrated that internalization among shy people was highly related to the likelihood of a beneficial outcome. These findings have some potentially important clinical implications. In particular, they suggest that there is a differential role for insight- and symptom-oriented interventions and that they can be patterned in time to increase the efficacy of treatment for social anxiety/shyness.

The level of internalization and the level of shame and guilt also were expected to be differentially associated with improvement in Social Fitness Training, and the degree of benefit experienced was expected to be directly associated with the intensity of internalization and shame and guilt initially present. Both a high internalizing style with a proneness to shame and guilt and a high externalizing coping style with/without a proneness to shame and guilt may impact the positive outcome of psychotherapy.

The social fitness model, which combines early CBT with later psychodynamic therapy, may be an appropriate intervention for individuals who are strongly prone to utilize internalizing coping styles. In the current study, we restricted the sample to those with chronic problems with shyness, confirming that this problem was, in turn, associated with internalization processes. In future studies, other populations may serve to further confirm the extent of generalization. Samples of those with avoidant personality disorders or those who are raised in cultures whose dominant patterns of coping with change are through self-inspection and self-criticism (e.g., Asian and Asian-American samples), would be good examples. There is a need for future research to explain functional outcome data besides the data on depressive symptoms. There is also a need to investigate effective approaches in the treatment of painful feelings of shame and guilt. Outcome studies during the first 13 weeks of CBT treatment and after the final 13 weeks of dynamic/interpersonal therapy are needed to assess treatment effectiveness systematically. Lastly, the predictor variables may be associated with demographic variables not included in this study.

When working with shy individuals, clinicians may find that the intensity of levels of internalization and feelings of shame will be good indicators for the

effectiveness of interventions in accordance with the proposals of Beutler et al's STS system (Beutler, Clarkin, & Bongar, 2000). Clinicians and researchers, alike, may need to look at more functional differences as well as positive outcome predictors of several interventions systematically between the levels of both the internalizing and externalizing coping styles.

Limitations of the Study

The findings of this study are limited by the absence of participants whose cultural differences may have cast a different perspective on coping style. The findings may have special significance for work with cultural groups who are dominantly internalizing. When researchers consider non-Western cultural populations, it is unknown whether or not culture by itself encompasses stable and measurable coping predispositions, and, furthermore, whether cultural values actually can serve as a substitute for assessing coping styles when making decisions about which type of therapy may be most beneficial to given individuals. For instance, evidence in current cross-cultural and international studies has demonstrated that the relationship between social norms and social anxiety has shown significant differences between individual (Western), and collectivistic (Eastern) cultures (Henriches, Rapee, Alden, Bogels, Hofmann, Ja Oh, & Sakano, 2006). Additionally, the evidence shows that social anxiety itself is an Eastern cultural factor (Draguns, & Tanaka-Matsumi, 2003).

Therefore, assessing the relationships between each of the coping styles and associated social differences that occur in Western and Eastern cultures respectively may result in significantly different results for different cultural groups If so, matching interventions somewhat differently to each of the two cultures may be necessary for

effective clinical work and for future psychotherapeutic research testing STS principles, similar to matching interventions to individual differences within each culture (eg, self-awareness/insight-oriented treatment for those individuals with comorbid social anxiety disorder and avoidant personality disorder).

Conclusion

This study investigated some of the central characteristics of shy individuals, that is, coping styles, depressive symptoms, and levels of shame, and guilt. Results showed that shy individuals may benefit from psychodynamic and interpersonal psychotherapeutic strategies after reducing their subjective distress levels through the use of CBT in simulated and vivo exposures.

Reference

Arkin, R. M., Appelman, A. J., & Burger, J. M. (1980). Social anxiety, self-preservation, and the self-serving bias in causal attribution. *Journal of Personality and Social Psychology, 38*(1), 23-35.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *BDI-II manual*. San Antonio, CA: The psychological corporation, Harcourt Brace & Company.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Beck Depression Inventory: Second Edition Manual* San Antonio: The psychological Corporation.

Beutler, L. E., & Clarkin, J. F. (1990). *Systematic treatment selection: Toward targeted therapeutic intervention*. New York: Brunner/Mazel.

Beutler, L. E., Clarkin, J. F., & Bongar, B. (2000). *Guide lines for the systematic treatment of the depressed patient*. New York: Oxford University Press.

Beutler, L. E., Engle, D., Mohr, D., Daldrup, R. J., Bergan, J., Meredith, K., et al. (1991). Predictors of differential response to cognitive, experiential, and self-directed psychotherapeutic procedures. *Journal Of Consulting And Clinical Psychology, 59*(2 (Print)), 333-340.

Beutler, L. E., & Harwood, T. M. (2002). *Prescriptive psychotherapy: A practical guide to systematic treatment selection*. New York: Oxford University Press.

Beutler, L. E., Harwood, T. M., Alimohamed, S., & Malik, M. (2002). Functional Impairment and Coping Style. In J. Norcross (Ed.), *Psychotherapy Relationships that Work: Therapist Contributions and Responsiveness to Patient Needs* (pp. 145-170). New York: Oxford University Press.

Beutler, L.E., Harwood, M.T., Kimpara, S, Verdirame, D., & Blau, K. (2010, in press) *Coping Style.* J. Norcross (Ed.) Psychotherapy relationship that work. Oxford: Oxford University Press.

Beutler, L. E., & Mitchell, R. (1981). Differential psychotherapy outcome among depressed and impulsive patients as a function of analytic and experiential treatment procedures. *Psychiatry, 44*(4 (Print)), 297-306.

Beutler, L.E., Moleiro, C., Malik, M., Harwood, T.M., Romanelli, R., Gallagher-Thompson, D. & Thompson, L. (2003). A comparison of the Dodo, EST, and ATI factors among co-morbid stimulant dependent, depressed patients. Clinical *Psychology & Psychotherapy, 10*, 69-85.

Beutler, L. E., Moos, R. H., & Lane, G. (2003). Coping, treatment planning, and treatment outcome: Discussion. *Journal of Clinical Psychology, 59*(10), 1151-1167.

Butcher, J. N. (1990). *MMPI-2 in psychological treatment.* New York: Oxford University Press.

Castonguay, L. G., & Beutler, L. E. (2006). *Principles of Therapeutic Change that Work.* New York: Oxford University Press.

Clark, J. M., & Arkowitz, H. (1975). Social anxiety and self-evaluation of interpersonal performance. *36*, 211-221.

DiNardo, P. A., Brown T. A., & Barlow, D. H. (1994). *Anxiety disorders interview schedule for DSM-IV: lifetime version (ADIS-IV-L).* Albany, NY: Graywind Publications.

Draguns, J. G., & Tanaka-Matsumi, J. (2003). Assessment of psychopathology across and within cultures: issues and findings. *Behaviour research and therapy, 41,* 755-776.

Girodo, M., Dotzenroth, S. E., & Stein, S. J. (1981). Causal attribution bias in shy males: Implications for self-esteem and self-confidence. *Cognitive Therapy and Research, 5*(4), 325-338.

Harder, D. W., & Lewis, S. J. (1986). *The assessment of shame and guilt*. Hillsdales, NJ Lawrence Erlbaum.

Henderson, L. (1992). Shyness Groups. In McKay, M. & Paleg, K. (Eds.), *Focal Group Psychotherapy*. Oakland, CA: New Harbinger Press.

Henderson, L. (1994; 2002-7). *Social Fitness Training: A Cognitive-Behavioral Protocol for Shyness and Social Anxiety Disorder*. Palo Alto: Shyness Institute.

Henderson, L. (2002). Fearfulness predicts self-blame and shame in shyness. *Personality and individual differences, 32*, 79-93.

Henderson, L., & Zimbardo, P. (1998). *Shyness* (Vol. 3). San Diego: Academic Press.

Henderson, L., & Zimbardo, P. (2001). *Shyness as a clinical condition: The Stanford model*. New York: Wiley.

Henderson, L., & Zimbardo, P. (1997). Shyness: Encyclopedia of Mental Health [Electronic Version]. Retrieved February 22, 2010 from http://www.shyness.com/encyclopedia.html.

Heinrichs, N., Rapee, R. M., Alden, L. A., Bogels, S., Hofmann, S. G., Oh, K. J., & Sakano, Y. (2006). Cultural differences in perceived social norms and social anxiety. Behaviour research and therapy, 44, 1187-1197.

Lorant, T. A., Henderson, L., Zimbardo, P.G. (2000). Comorbidity in chronic shyness. *Depression and Anxiety, 12,* 232-237.

Minsky, S. (1985). Social anxiety and causal attribution for social acceptance and rejection. *46*, 2632A.

Moos, R. H., & Holahan, C. J. (2003). Dispositional and contextual perspectives on coping: Toward an integrative framework. *Journal of Clinical Psychology, 59*(12), 1387-1403.

Teglasi, H., & Hoffman, M. A. (1982). Causal attributions of shy subjects. *Journal of Research in Personality, 16*, 376-385.

Walker, C. E. (ed.) (1991). *Clinical psychology: Historical and research foundations*. New York: Plenum.

Table 1

Demographic Profile of Chronically Shy Patients

Characteristics	n[a]	%
Sex		
Female	49	40.5
Male	72	59.5
Age		
18-29	40	33.1
30-44	64	52.9
45-64	17	14.0
Mean Age	34.5± 9.7	
Marriage Status		
Never married	88	72.7
Married	18	14.9
Separated	3	2.5
Divorced	10	8.3
Widowed	2	1.7
Education		
Less than high school	4	3.3
High school, some college	34	28.1
College	39	31.4
Advanced degree (partial And completed)	44	36.4
Mean Education	15.9±2.8	
Occupation		
Employed	87	71.9
Unemployed	13	10.7
Student	17	14.0
Homemaker	4	3.3
Ethnicity		
Caucasian	101	83.5
African American	2	1.7
Hispanic	6	5.0
Asian	10	8.3
Other	2	1.7

[a]n=121

Figure 1

Figure 1-1, Positive Change Scores between Four Subgroups (1) Low Internalizing and Low Shame/guilt, (2) Low Internalizing and High Shame/guilt, (3) High Internalizing and Low Shame/guilt, (4) High Internalizing and High Shame/guilt

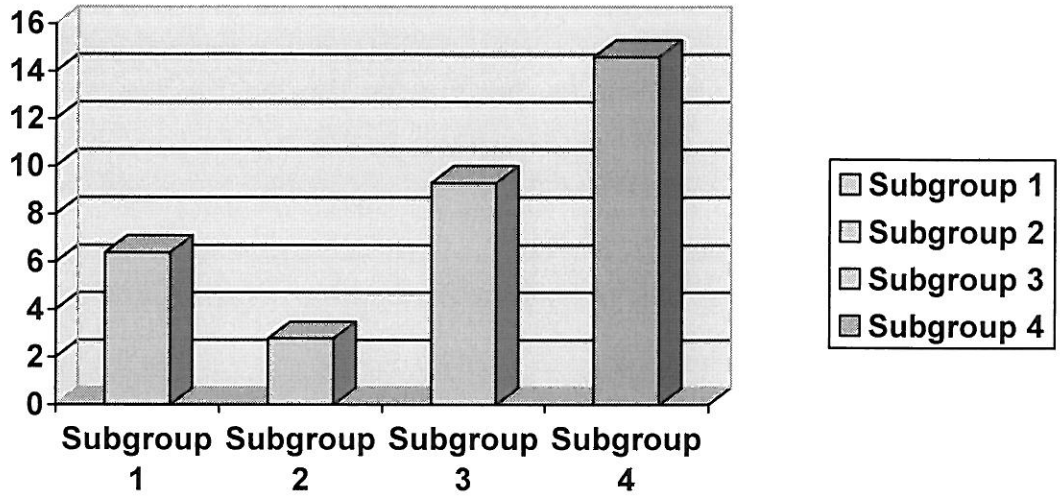

Figure 1-2, Positive Change Scores between Four Subgroups (1) Low Externalizing and Low Shame/guilt, (2) Low Externalizing and High Shame/guilt, (3) High Externalizing and Low Shame/guilt, (4) High Externalizing and High Shame/guilt