

**When social anxiety and narcissism coincide: An exploration of narcissistic social anxiety subgroups**

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## Abstract

This thesis develops an argument for the existence of narcissistic social anxiety subtypes. The genesis of this argument came from a review of historical and contemporary literature on social anxiety revealing that some socially anxious individuals exhibit narcissistic characteristics. This review supported an argument for the existence of distinct overt and covert narcissistic social anxiety subtypes.

Two studies were conducted to explore narcissistic social anxiety subtypes. Study one comprised 349 individuals (204 women ( $MAge = 32.02$ ), 145 men ( $MAge = 31.69$ ), and study two 612 individuals (380 women ( $MAge = 26.27$ ) and 232 men ( $MAge = 26.92$ ). Study one identified five subgroups, four of which were socially anxious, and one non-socially anxious. Of the four socially anxious subgroups, three were associated with elevations on multiple narcissism scales. Two had elevations on covert narcissism, though differed on anger. These groups were classified as *angry covert* and *covert narcissistic social anxiety* subgroups. The third group was characterised by elevations on overt and covert narcissism and was classified as the *narcissistic social anxiety* group. Further exploration of the subgroups revealed the narcissistic social anxiety subgroups reported more shame, depression, anxiety and stress and worse personality organisation than the non-narcissistic social anxiety subgroup. The angry covert narcissistic subgroup was the most impaired.

Study two replicated study one and identified similar subgroups in a different sample. In addition to greater social anxiety and psychological distress, the covert narcissistic groups experienced greater Taijin-Kyofusho (TKS) related anxiety. The narcissistic subgroup reported higher social rank than the other social anxiety subgroups, although despite this, had poor personality organisation.

Overall, the key contribution of this thesis was the identification of four unique social anxiety subgroups. The two covert narcissistic social anxiety subgroups represent severely maladjusted individuals. The narcissistic social anxiety subgroup, while not as maladjusted as the covert groups, represents a subgroup of social anxiety not captured in the DSM-5 diagnostic criteria. These individuals reported high social anxiety, psychological distress and shame concerning personal efficacy. Yet this occurred alongside higher perceived social rank, and a greater likelihood of being in a relationship relative to the covert narcissistic groups. The new subtypes identified provide a way to bridge several theoretical models of social anxiety, including

evolutionary, contemporary psychodynamic and cognitive theories. The results of the two studies also have implications for the diagnosis and treatment of social anxiety.

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### **Declaration by candidate**

This thesis contains no material which has been accepted for the award of any other degree or diploma, except where due reference is made in the text of this thesis. To the best of my knowledge this thesis contains no material previously published or written by another person except where due reference is made in the text. Where the work is based on joint research or publications, the relative contributions of the respective authors are disclosed in the text.

Signed: \_\_\_\_\_

Dated: \_\_\_\_\_

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## Chapter 1: Introduction and Overview

Interpersonal difficulties surrounding social interactions are a universal, widespread, and heterogeneous phenomenon. These social and interpersonal fears are generally subsumed under the rubric of *social anxieties* (Brunello et al., 2000). Social anxieties are complex and debilitating (Keller, 2003), and better understanding of the nature of social anxieties could lead to improvements in the way the disorder is treated.

In this thesis, a review of the historical literature on social anxiety was conducted to better understand social anxieties. This revealed a number of core ideas consistent across many early models of social anxiety (e.g., Hartenberg, 1901), but which are absent from major contemporary models of social anxiety (e.g., Clark & Wells, 1995, Rapee & Heimberg, 1997). Principally, there was strong support in the historical literature for the idea that socially anxious individuals are often characterised by co-occurring narcissistic characteristics. This idea also appears in some more recent contemporary reformulations of social anxiety, and in East Asian literature on *Taijin-Kyofusho* (TKS; conceptually similar to social anxiety). A review of the literature on narcissism provided further support for this idea. In addition, consideration of the differences between overt and covert narcissism led to the argument it is likely that there are multiple narcissistic social anxiety subtypes, with distinct overt and covert narcissistic social anxiety subtypes.

Identification of narcissistic social anxiety subtypes is important for several reasons. Understanding the degree to which socially anxious individuals evidence narcissistic characteristics provides a more comprehensive overview of distinct, more complex presentations of social anxiety, not represented in the current psychiatric nomenclature (i.e., DSM-5, American Psychiatric Association [APA], 2013). Identifying the difference between narcissistic socially anxious and non-narcissistic socially anxious individuals on other characteristics (e.g., depression, anger, and shame) is important in that it provides a more complete profile of the nature of the narcissistic socially anxious individuals.

Knowledge of the types of narcissistic socially anxious individuals and the nature of these individuals also has treatment implications. Specifically, this knowledge could be important in improving response to treatment, and reducing post-treatment treatment dropout rates (Abbott & Rapee, 2004). Therefore, given the benefit of understanding the degree to which socially anxious individuals evidence narcissistic characteristics, the focus of the current thesis was on the exploration of narcissistic

socially anxious subtypes. The following sections present an overview of the chapters of the thesis.

Chapter two, three, and four present an overview of social anxiety. Chapter two presents a historical review of the concept of social anxiety, to identify the level of support in historical and contemporary models of social anxiety for the argument that for many socially anxious individuals, their social anxiety co-occurs with narcissistic characteristics. Chapter two first reviews early French contributions, before moving to psychodynamic and early behavioural theories. Following this, cognitive behavioural and other recent theories of social anxiety are described, with a focus on interpersonal theories, contemporary psychodynamic theories, attachment theories, and ethological theories of social anxiety. Chapter three extends upon the literature reviewed in chapter two, and considers cross-cultural models of social anxiety. This was to examine if cross-cultural models of social anxiety support the argument that many socially anxious individuals are characterised by elevated narcissism.

Chapter four focuses on the representation of social anxiety in the psychiatric nomenclature. A historical review of the diagnosis of Social Anxiety Disorder (SAD) and related conditions (e.g., Avoidant Personality Disorder) is presented, focussing on changes in the diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM; APA, 2013) and International Classification of Diseases (ICD; World Health Organisation [WHO], 1992) over time. The degree to which representations of social anxiety in the psychiatric nomenclature capture the complexity of the disorder identified in the historical review in chapter two is discussed. Chapter four also reviews recent attempts to explore alternative social anxiety subtypes and discusses the extent to which the subtypes identified in this literature support the argument that many socially anxious individuals are characterised by elevated narcissism.

Chapters five and six explore the literature on narcissism, to provide further support for the core argument of this thesis that many socially anxious individuals are characterised by elevated narcissism. Chapter five presents an overview of the clinical perspective on narcissism, beginning with historical literature which drove this perspective, and ending with contemporary clinical models of narcissism. Chapter six focuses first on the major alternative to the clinical perspective on narcissism, the social-personality perspective. Following this, chapter six presents a discussion of the literature which distinguishes overt and covert narcissism.

The empirical results of this thesis are presented in chapters seven and eight. Chapter seven presents the results of the first study, and chapter eight, the results of the second study. Across both studies, five subgroups were identified, four socially anxious and one non-socially anxious. Of the four socially anxious subgroups, three were associated with elevations on multiple narcissism scales. Study one found that the narcissistic social anxiety subgroups were more maladjusted than the non-narcissistic social anxiety subgroup on a number of indices (e.g., depression, anxiety, stress, shame, personality organisation). Study two expanded on the results of study one and found that the new social anxiety subgroups also differed meaningfully in social rank, with the narcissistic social anxiety subgroup (NSA) reporting higher social rank and representing relatively more dominant individuals than the other socially anxious subgroups.

Chapter nine presents a general discussion of the thesis findings. Specifically, similarities between the subtypes identified in the current thesis in relation to those identified in previous research are discussed. The theoretical implications of the current thesis are also discussed. The chapter concludes with a consideration of the limitations of the thesis, and a discussion of directions for future research.

## Chapter 2: Historical Review of Social Anxieties

This chapter provides a historical review of theories of social anxieties. Krantz (1965) noted that historical analyses make researchers aware of their biases, and the way these biases colour their hypotheses, and the theoretical and broader epistemological (Rapaport, 1966) frameworks within which they interpret their results. He elaborated that historical analyses provide an “awareness of the past as it influences the present” (p. 282) and allow researchers to develop hypotheses unconstrained by the current zeitgeist.

This review begins with an overview of the late 19<sup>th</sup>/early 20<sup>th</sup> century descriptive French work on social anxiety. The review then moves to an overview of Freud’s contributions, and subsequent work on social anxiety from the 1920s through to the 1950s which was embedded within a psychodynamic framework.

The chapter then focuses on behavioural reformulations of social anxiety (Marks & Gelder, 1966). From here, current cognitive-behavioural perspectives are discussed. Finally, a discussion of recent alternatives to and extensions of the cognitive-behavioural model, including interpersonal theory, contemporary psychodynamic theory, attachment theory and evolutionary/ethological theories is undertaken.

The review attempts to illustrate ideas about social anxiety that cross temporal and theoretical boundaries. Specifically, the idea of a relationship between social anxiety and narcissism and between social anxiety and anger is a dominant theme across a number of theoretical perspectives. However, these themes are not explored in all contemporary models.

### French contributions in the late 19<sup>th</sup> and early 20<sup>th</sup> centuries

There has been a long historical interest in self-consciousness, social anxieties and related phenomenon. Charles Darwin (1896) was fascinated by blushing, linking it to excessive self-consciousness. Early psychiatric literature discussed related conditions such as agoraphobia (Gélineau, 1880; Maudsley, 1895), and ereuthophobia (blushing phobia; Casper, 1901; Macevoy, 1903). However, the earliest comprehensive analyses of social anxieties were undertaken in France at the end of the 19<sup>th</sup> century and the beginning of the 20<sup>th</sup> century.

**Dugas.** The earliest psychological research on social anxiety was conducted by French psychologist Dugas (cited in Binet, 1896). Dugas utilized the introspective method common to Psychology in the 19<sup>th</sup> century (Berrios, 1999), and undertook literary analysis of various autobiographical texts (notably, Jean-Jacques Rousseau’s

*Confessions*). He distinguished social anxiety (timidity) from fear noting that timidity is always caused by the presence of others whereas fear is caused by other objects as well. He suggested that timidity “*paralyse la volonte*” [paralyses the will] (cited in Janet, 1903, p. 351) and was a result of poor adaptation of the individual to the social environment. He saw timidity as associated with a combination of physiological (e.g., motor symptoms, physical awkwardness), and psychological (e.g., disordered thought and difficulty concentrating) symptoms. Dugas also recognised that timidity was often associated with *maladie d'ideal* [disease of idealism] noting that the timid prefer fantasy life to reality (see Trout, 1897). He also observed that the timid were often characterised by impulsivity and misanthropy (Binet, 1896).

**Paul Hartenberg.** Hartenberg (1901) published the first empirical study of shyness and social anxieties. For Hartenberg, emotions were at the core of shyness. He suggested that for an individual to be considered shy, “...il faut d'abord être enclin à éprouver une certaine émotion, dans certaines circonstances” [one must be inclined to feel certain emotions in certain circumstances] (Hartenberg, 1901 p. 2). Hartenberg identified the core emotions in shyness as shame (which he saw as comprising of confusion, moral sensitivity, and blushing) and fear (comprising of physiological symptoms, such as sweating and trembling). Hartenberg argued that unlike the fear felt in the presence of actual danger, the fear felt by socially anxious individuals is not related to any physical threat to the self. Hartenberg classified this as *false fear*.

Similarly, Hartenberg distinguished between what he termed *real shame*, in which the individual's choice of actions leads them to feel ashamed, and the *false shame* of the socially anxious individual, which he reasoned is not linked to behaviours of the individual. Hartenberg elaborated on fear and shame in socially anxious individuals, stating that “l'émotion du timide nous apparaît donc comme une combinaison, en proportions variables, de peur et de honte” [the emotions in shyness are a combination, in varying proportions of fear and shame] (p. 3). He suggested that in some individuals (false) fear is the predominant emotion, while for others it is (false) shame. Hartenberg stated that the fear of the socially anxious individual is specific to social situations, noting that once socially anxious individuals are alone, the anxiety and negative emotions tend to dissipate (Fairbrother, 2002; Hartenberg, 1901; Lloyd, 2006).

Hartenberg suggested that certain personality characteristics tend to be associated with social anxiety including sensitivity, pessimism, and misanthropy. Perhaps the most interesting personality characteristic Hartenberg linked to social

anxiety was excessive pride (Lloyd, 2006; Pace, 1902). In a review, Lloyd discussed the seemingly contradictory portrait of the socially anxious individual presented by Hartenberg, observing that he described the socially anxious individual as having an “all or nothing” (p. 146) personality. Hartenberg suggested that the most prominent of these contradictions is the co-occurrence in socially anxious individuals of shyness, sadness, and pessimism with “misanthropy, pride and the desire to live up to unreachable ideals” (p. 146). Hartenberg noted that although socially anxious individuals tend to be modest and humble in reality, their fantasies tend to be tinged with grandiose and omnipotent themes. He suggested that it is the difference between the fantasy and reality of the socially anxious individual that is responsible for their overt reticence (Hartenberg, 1901). Thus, the presence of narcissistic characteristics in socially anxious individuals was identified in the earliest comprehensive overview of the disorder.

**Pierre Janet.** The third major French contribution at the start of the 20<sup>th</sup> century came from Pierre Janet. Although some of his work has been translated into English (e.g., Janet, 1914) his major contribution to the understanding of phobic and anxiety states *Les Obsessions et la Psychasthénie* [The Obsessions and Psychasthenia] (Janet, 1903; Janet & Raymond, 1903) has not yet been translated. For Janet, behaviours were guided by affects, which he believed were secondary mental states. The effectiveness of the affect depended on its energy (force) and integrative capacity (tension; Berrios, 1999). Janet believed that problems with the force or integration of affective states led to problems of adaptation to reality, resulting in rumination, tics, obsessions, phobias, and anxieties, which Janet incorporated under the broad clinical term *psychasthénie* (Berrios, 1999; Pitman, 1984). Janet proposed that timidity was often an antecedent or comorbid personality characteristic of psychasthénics. This is interesting given that psychasthénie was a much broader clinical category than social anxiety, indicating that Janet believed that social fears underlie many anxiety and obsessional disorders.

Like Hartenberg (1901), Janet suggested that social anxiety was “caractérisée par des phénomènes d'émotion et d'angoisse” [a phenomenon characterised by emotion and anxiety] (Janet & Raymond, 1903 p. 108), and that it was different to phobias, in that these responses were not contingent on a particular phobic object. Rather, he noted that in the case of social anxiety, fears were related more broadly to the presence of others. Janet noted that although emotions were important in social anxiety, that *abulia* (lack of will or initiative) was also important. Janet (1903) observed that social anxiety was transitory, and does not persist when the individual is alone. Additionally, Janet

saw the disorder as characterised by contradictory personality characteristics. As an illustration of this contradictory nature, Janet noted that socially anxious individuals often desire social contact, however, their fear of offending others causes inhibition of this aim.

**Summation of early French theories of social anxiety.** Comparison of the early French contributions to social anxiety reveals a remarkable convergence of ideas. One point of consistency is the idea that social anxiety (timidity) is a complex, multifaceted and contradictory disorder. These contributors considered socially anxious individuals to be defined by fearfulness and anxiety in the presence of others, and although they desire social contact, their fears prevent them from seeking it. In addition to characteristics such as pessimism, sadness and hopelessness, socially anxious individuals are seen to show narcissistic characteristics, and are described as often being misanthropic, and prone to excessive pride. Each contribution also emphasised the tendency of the socially anxious to prefer fantasy life over reality, an additional element congruent with narcissistic personality (Raskin & Novacek, 1991; A. Reich, 1960). What makes these congruencies more compelling is the fact that the three contributors came to much the same conclusion despite methodological differences (i.e., the use of introspection by Dugas and empirical evidence by Hartenberg and Janet). While developed independently, Hartenberg's notion of the contradictory nature of social anxiety – that is the manifest reticence coupled with narcissistic grandiose fantasies is conceptually congruent with psychodynamic theories of social anxiety.

### **Freud's Theories on Anxieties and Phobias**

Freud developed several key theories to explain anxieties and phobias over the years from 1893 to 1926, beginning with broader explanations, and progressively elaborating more specific theories. The following sections review key theoretical models postulated by Freud to explain anxieties and phobias. A discussion of Freud's specific references to social anxiety is then undertaken, placing them within the context of his broader theories of anxieties and phobias.

**Anxiety (anxiety neuroses and psychoneuroses).** Freud's initial exploration of anxiety was embedded within his *discharge* theory of affects. In this model, Freud applied the *principle of constancy* suggesting that there was an "inherent tendency in the nervous system to reduce, or at least keep constant, the amount of excitation present in it" (Strachey, 1953, p. 78). Freud proposed that affects (including anxiety) resulted from the discharge of this accumulated excitation. The excitation which was *transformed* into

affects was presumed to have two distinct origins – psychic (internal) and somatic (physiological) (Freud, 1894/1953).

One of Freud's most important contributions to the theory of anxiety was to argue for the separation of *anxiety neurosis* from the broad category of neurasthenia (exhaustion of the nervous system) (Freud, 1894/1953). Freud described anxiety-neurosis as a chronic state characterised by a diverse group of symptoms including lowered self-confidence, pessimism, hypochondria, obsessions, phobias and depression (Brill, 1912; Donley, 1911; Freud, 1893/1953). Freud included anxiety neurosis and neurasthenia under the grouping of *aktual* (actual) neuroses (Freud, 1898/1953; Jones, 1913) and suggested that the aetiology of the actual neuroses lay in somatic tensions (e.g., “incomplete satisfaction of physico-sexual needs” Jones, 1911, p. 1). Alongside the actual neuroses, were the *psychoneuroses*, which comprised hysteria and compulsion neuroses (such as doubts, obsessions and phobias; Brill, 1912).

Freud postulated that the aetiology of the psychoneuroses lay in *intrapsychic tensions* (i.e., in conflict between sexual and ego instincts). Although Freud's emphasis was on anxieties which had an intrapsychic aetiology, he also distinguished what he termed *realistic* anxiety from neurotic anxiety, stating that realistic anxiety was “a reaction to the perception of external danger...connected with external danger and it may be regarded as a manifestation of the self-preservative instinct” (Freud, 1898/1953, p. 394; see also Freud, 1898). Despite the fact that anxiety-neurosis (and more broadly, the actual neuroses) continued to play a role in Freud's theories of anxiety, his emphasis gradually shifted to the psychoneuroses.

After the introduction of his topographic model, viz. the systems unconscious (Ucs), preconscious (Pcs) and conscious (Cs) (Freud, 1900/1953a; 1900/1953b, 1923/1953), Freud shifted his emphasis, proposing that the discharge of affects (including anxiety) was related to ideas or wishes in the Ucs which are incompatible with the Pcs (Freud, 1900/1953a; 1900/1953b). Freud suggested that it was the possibility of these ideas and wishes becoming conscious which led to anxiety or *unpleasure* and resulted in defensive repression to eliminate the anxiety. Although his ideas were altered to incorporate the later structural theory, the modifications to his theory of anxiety were still framed within the earlier dynamic theory and the source of the energy which was later discharged and experienced as anxiety had to be specified. Freud broadly suggested five sources of anxiety (Compton, 1972):

- (1) Response to danger (external)
- (2) Transformation of Psychic Libido
- (3) Transformation of Somatic Libido
- (4) Somatic dysfunction
- (5) Insufficiently disguised repressed wishes

Following his analysis of “Little Hans”, Freud modified his theory, suggesting that after repression of a wish or idea, anxiety can be transformed into *any* other affect. Along these lines, Freud discussed the relationship between various forms of hostility and anxiety (Freud, 1909/1953).

**Phobias (anxiety-hysteria).** For Freud (1909/1953) phobic anxieties (anxiety-hysteria) were part of the psychoneuroses (Freud, 1895/1953). Freud suggested that unlike in anxiety neuroses (and psychoneuroses proper) where anxiety was transformed into other affects *after* repression, in anxiety-hysteria, the anxiety was *free*. Freud (1909/1953) suggested this anxiety attached itself to ideas or objects, which become phobias, with these phobias “binding” the anxiety.

Later, Freud (1917/1953) described three distinct varieties of phobia. The first was *normal phobias*, or phobias related to actual danger. The second he suggested were phobias of potentially dangerous situations or objects. The third, labelled *anxiety-hysteria* was those phobias with no basis in realistic fear. Freud suggested that anxiety-hysteria represented the most common form of psychoneurotic disorder and postulated that the cause of anxiety-hysteria was problems in development of psycho-sexual instincts (Jones, 1911).

**Inhibitions, Symptoms and Anxiety.** Freud’s last major contribution to his theory of anxieties and phobias was in *Symptoms, Inhibitions and Anxiety* (Freud, 1926/1953). With the formulation of the *structural* theory (the id, ego and superego) (Freud, 1923/1953, 1926/1953), Freud moved away from the idea that affects were always the result of the discharge of accumulated excitation. Instead, he suggested that anxiety originated in the ego and demarcated three types of anxiety – neurotic, moral and real, which could be differentiated on the basis of whether the anxiety was related to danger faced by the ego from the id (neurotic anxiety), the superego (moral anxiety) or the external world (real anxiety).

**Freud's views of social anxiety.** Freud discussed social anxieties several times in his writings. The first reference was in *Further remarks on the Neuro-Psychoses of Defence* (Freud, 1896/1953). Here, Freud discussed social anxiety in relation to obsessional neuroses, the aetiology of which, at this stage, Freud believed lay in repressed sexual activity of childhood, and suggested that whereas the genesis of some obsessional neuroses lay in the *repressed material* returning to consciousness (to wit memory of the actual sexual activity), that the genesis of another class of obsessional neuroses lay in the individual's *self-reproach* (viz. self-reproach in relation to the actual sexual activity) becoming conscious. He indicated that after it became conscious, this self-reproach could then be transformed into other (unpleasurable) affects, and indicated that "self-reproach (for having carried out the sexual act in childhood) can easily turn into *shame* (in case someone else should find out about it)...into *social anxiety* (fear of being punished by society for the misdeed)...into *delusions of being noticed* (fear of betraying the act to others)" (p. 171).

Freud's next mention of social anxiety was in *On Narcissism* (Freud, 1914/1953), written after Freud had abandoned his seduction theory. Here, Freud discussed the place of social anxiety in relation to the ego ideal (a subsystem of the superego), and postulated that social anxiety was the result of conflict between the individual's narcissistic desires and the social side of their ego ideal. He elaborated that it was *Schuldbewußtsein* (guilt) about not meeting the standards of others that leads to social anxieties. Developmentally, Freud postulated that "originally this sense of guilt was a fear of punishment by the parents, or, more correctly, the fear of losing their love; later the parents are replaced by an indefinite number of fellow-men." (p. 101). Thus for Freud, social anxiety as a fear of others was fundamentally rooted in a developmentally earlier fear of parents (related to castration anxiety).

The following year, Freud made brief reference to social anxiety in *Repression* (Freud, 1915/1953b). He once again linked the concept of social anxiety to obsessional neuroses, and suggested that when an individual's attempts to repress a sadistic impulse failed, that the "vanished affect comes back in its transformed shape as social anxiety, moral anxiety and unlimited self-reproaches" (p. 157). Thus, according to his *Repression* paper, the fear of others he outlined in *On Narcissism* was sometimes grounded in repressed sadistic impulses directed towards others.

Freud later suggested a broader understanding of social anxieties, and proposed that social anxieties (or an individual's fear of punishment by others) was a core

component in the development of the individual's conscience (Freud, 1915/1953c) stating "it has long been our contention that 'social anxiety' is the essence of what is called conscience" (Freud, 1921/1953, pp. 74-75).

In *Inhibitions, Symptoms and Anxiety*, Freud (1926/1953) argued that with "depersonalization" of the parents (with whom castration anxiety, and therefore superego anxiety originated), the source of the danger perceived by the child became less well defined. Freud (1930/1953) later elaborated on this point, arguing that the source of danger broadened "to the extent that the place of the father or the two parents is taken by the larger human community" (p. 125).

**Freud's key contribution on social anxiety.** Perhaps Freud's most important contribution was to distinguish between anxiety caused by external triggers and anxiety caused by internal (intrapsychic) stressors, and his differentiation of normal anxieties (and phobias) from neurotic anxieties (and phobias). It is possible that these distinctions correspond to the difference between relatively simple "phobic" anxieties and more complex anxieties related to *a disturbance of the sense of self*. This differentiation between simple phobias and complex multifaceted anxiety disorders is now being rediscovered by contemporary researchers, indicating the contemporary usefulness of Freud's theories (e.g., APA, 2013).

### **Developments in the Understanding of Social Anxiety: 1926 – 1950**

Following Freud, there were sporadic discussions of social anxiety and social neuroses among psychodynamic writers. Most of these contributions expanded upon Freud's (1926) idea that social anxiety represented a super-ego based *moral* anxiety. These contributions are now reviewed, and points of convergence are discussed.

**Hampton.** For Hampton (1927), fear of inferiority and fear of "being looked down upon" (p. 128) were central elements of social anxiety. Hampton noted that although self-consciousness was important, it was not unique to the disorder, and was not necessarily an indicator of maladjustment. Hampton indicated that among some socially anxious individuals the desire to hide perceived inferiority led to exaggerated self-assertion, with the individual becoming "self-assertive and argumentative, or truculent and aggressive" (p. 128). Hampton (1927) viewed social anxiety (and shyness) as related to self-abasement (analogous to masochism). He suggested that masochistic elements are a core component of social anxieties and were the result of a conflict between the desire for self-assertion (related to narcissism), and self-abasement (related to masochism). Hampton also suggested that the aetiology of this conflict was a normal

instinct (the desire to self-enhance) being inhibited by overuse (or misuse) of another normal instinct (submission).

**Edward Glover.** For Glover (1931, 1939), social inhibitions (including social anxieties) were the result of a combination of anxiety, guilt and aversion. Symptoms could be separated into those that affect the individual (e.g., lack of concentration, poor learning capabilities), and those that affect interpersonal relationships (e.g., blushing, shyness, and feelings of inferiority). Glover considered social anxieties to be “expressed through a personality reaction instead of being localized in the form of a phobia” (Glover, 1939, pp. 104-105), noting that “the defensive reactions tend to be built into personality as a whole” (Glover, 1931, p. 288).

Glover defined two different stages in anxiety. The first was the reaction to the social situation. Glover suggested that social anxieties are often focused on social situations in which the individual is threatened with loss or injury of *symbolic significance*, or situations in which there is the possibility of being negatively appraised. The second does not always occur, but happens when the individual finds the anxiety experienced in the social situation “objectionable” and thus, is a *reaction* to the anxiety experienced. Glover suggested that these reactions may take the form of “hate reactions, anger and irritability” (Glover, 1931, p. 288), which he indicated often leads to feelings of guilt.

Glover suggested that social anxiety is related to both internal (intrapsychic) and external factors. The important intrapsychic factor is fear of *internal* criticism, and the important external factors are anxiety regarding loss of love and anxiety surrounding *external* criticisms. Glover suggested that these factors (intrapsychic and external) are not mutually exclusive, and are difficult to differentiate due to the processes of projection and introjection. For instance, as an example, he noted “aggression of external authority is exaggerated by projection” (p. 287).

**Otto Fenichel.** Fenichel (1939, 1945) did not ascribe a single aetiology to social anxieties, but suggested that they could be the result of one of three factors. First, he postulated that incomplete internalization of (normal) infantile fears (originating with fear of the parents) might result in social anxiety. Second, he indicated that social anxieties may be related to a re-projection of the superego onto the external world. In this instance an individual’s judgement of objects in the external world is expected to be unduly influenced by their superego (rather than by the actions of the objects). Last, Fenichel noted that parental inconsistencies which left the child unsure of what

behaviour would result in the parents' affection, or loss of it, might result in social anxieties.

Fenichel (1945) suggested a qualitative (rather than quantitative) difference between normal social anxieties and pathological social anxieties and proposed that more severe (maladjusted) forms of social anxiety tended to be related to paranoid characteristics (which he differentiated from paranoia proper by arguing that the socially anxious individual fears that "others *might* be against me", whereas the paranoid believes that "others *are* against me"). He proposed that social anxieties are pathological when "social anxiety overshadows all other object-relationships or when judgement of expected criticisms and punishments is objectively wrong." (Fenichel, 1945, p. 477).

For Fenichel (1945), social anxiety was a combination of a number of mechanisms – a narcissistic need for an external source of admiration, flight from potential loss of love objects, regressive sexualisation of social feelings and conflicts surrounding the desire for exhibitionistic display. He also suggested that aggressive feelings were particularly salient for the socially anxious individual and postulated the manifest polite, accommodating and considerate behaviour of some socially anxious individuals was a reaction formation of aggressive tendencies.

**Schilder.** Schilder (1938) defined social neurosis broadly as any (psychological) suffering which occurs with social contact, with worse suffering attributed to being in the presence of groups. For Schilder, narcissism was a central component of social neurosis. He suggested that the core function of social neurosis is to serve as a *defence against narcissistic injuries*, proposing that these patients desire to be admired (e.g., for intelligence, appearance) and seek continuous praise and approval from others. However, fear of being disappointed or rejected leads to the overt reticence of social neurosis. Schilder considered that the genesis of these narcissistic characteristics lies in early parent-child interactions, with the parents' love of the child being conditional on physical and intellectual achievements. Schilder further proposed that this behaviour of the parents leads the child to develop an increased self-love and self-admiration, but one that is contingent upon external sources of approval.

Despite this focus on achievement, Schilder (1938) suggested that parents frequently had also "pushed" the child into a position of passivity which he believed results in later masochistic trends in the adult patient. Schilder believed that this pattern

of parent-child interactions resulted in the high frequency of narcissistic and masochistic attitudes he saw in individuals with social neurosis.

**Kaufman.** Kaufman (1941) further elaborated on narcissistic and masochistic elements in social neurosis. Expanding on Fenichel's (1939, 1945) idea that social neurosis was originally related to *fear of conscience* or *castration anxiety*, Kaufman suggested that an important element of social neurosis was a perceived need to be punished, coupled with a *dread of punishment*. In a brief case report of the treatment of a socially anxious individual, Kaufman noted that in the beginning phases of the analysis, the man was characterised by extreme passivity. Over the course of the analysis, however, he became increasingly hostile and prone to paranoid fantasies which often bordered on being delusional. In a similar single case presentation of a patient whose symptoms included social anxieties, Kraüpl (1948) also reported that the social anxieties of the patient tended to be related to passivity and masochistic trends.

**Lewinsky.** Lewinsky (1941) classified social anxieties on the basis of the presence of physiological and psychological symptoms and on the desire to avoid social situations. She observed that social anxiety was often related to narcissistic personality characteristics and ego-centric tendencies. As an example, she proposed that the act of blushing may represent a repressed desire for exhibitionistic display, noting that by blushing one "unwittingly attracts more attention, so that a repressed desire for self-display and exhibitionism is gratified in this symptom" (p. 111). Although she did not elaborate, she suggested that social anxiety might be developmentally related to masochism, sadism and castration fear.

**Myerson.** Myerson (1944) saw extreme self-consciousness as important to social neurosis, suggesting that anticipatory anxiety differentiated the disorder from other anxiety neurosis. Myerson also differentiated several *phases* of the disorder. The first phase included shyness, timidity and self-consciousness. In this phase, the individual was focused upon personal embarrassment. The second phase of the disorder included fear of offending others. This phase was also associated with a constant need to please others, and in extreme cases, paranoid characteristics. In some socially anxious individuals, their paranoia revolved around others harming them (i.e., phase one focused), whereas for others their paranoia focused on the idea that some aspect of them (i.e., bodily functions) could adversely affect those around them (i.e., phase two focused). Thus, for Myerson, social anxiety reflects a fear of *being injured* and a fear of

*injuring*. Myerson proposed an evolutionary, rather than psychodynamic explanation for this, suggesting the fear related to the pressures of group living in modern humans.

### **Points of Convergence in the Social Anxiety Literature 1926-1950**

The literature of this period presents a remarkably complex, multifaceted conceptualization of social anxieties, with social anxieties identified as an anxiety disorder (anxiety neurosis) rather than a simple phobic reaction. There was also a remarkable degree of convergence across the various accounts. Common themes were: the relationship between social anxiety and inhibition of aggression (and frequent aggressive dyscontrol), and the existence of contradictory characteristics in socially anxious individuals; that is, overt reticence and narcissistic characteristics. Also prominent are discussions of paranoid features of socially anxious individuals (fantasies of the self being harmed, and of the self causing harm), and an apparent belief in the need for self-punishment, manifested in the form of masochistic personality characteristics.

Overall, what was apparent from these early accounts was a view of social anxiety as a complex *disturbance of the self* which has a pervasive effect on the individual and their interpersonal relationships.

### **Dixon, Sandler and De Monchaux's Contributions**

It was not until the 1950s that empirical studies of social anxiety began to be undertaken. This represented an outgrowth of a growing empiricism in psychological research, evident in both personality and behavioural research (e.g., Wolpe, 1958). The first major empirical study of social anxieties was undertaken by Dixon, Sandler and De Monchaux (1957a, 1957b). Although critical of the tendency to view phobias as discrete entities (arguing on theoretical and statistical grounds that phobias cluster into superordinate groupings) they saw social anxiety as phenomenologically distinct. The following sections review their contribution and critically evaluate it in relation to the historical literature predating these studies.

Dixon et al. (1957a) began their empirical investigation of social anxieties by identifying 26 items in the Tavistock Self-Assessment Inventory (TSAI; Sandler, 1954) which measured problems related to social anxieties. Following this, 250 clinical patients completed the items, which were then subjected to factor analysis. Results indicated the presence of a *general* social anxiety factor and four distinct factors; *Social Timidity* (Type A), *Fear of loss of control, especially bodily control* (Type B), *Fear of exhibitionism* (Type C), and *Fear of revealing inferiority* (Type D). Dixon et al.

suggested that the general factor indicated the overall level of an individual's social anxiety and the four factors identified the type or focus of their social anxiety. Despite discussing them as distinct variations of social anxiety, Dixon et al. viewed the types as *prototypes*, comprised of multiple dimensional attributes, indicating that overlap between categories could occur.

Dixon et al. (1957a) discussed interesting similarities and differences among the types. They noted that in both Type A and Type C the social situation causes the anxiety. The types differ, however, as Type A individuals focus on awkwardness and embarrassment in social situations, whereas Type C individuals focus on situations in which the individual is explicitly the centre of attention. Though these two types appear superficially similar, a Type A individual would be expected to be most anxious about meeting a stranger, whereas a Type C individual would be most anxious about feeling exposed before a group.

Dixon et al. also contrasted Type B and Type D, suggesting that these forms of social anxiety relate to situations where the individual feels "at fault or judged to be at fault" (p. 111). They differentiated the two types by noting that Type B individuals fear judgement because of uncontrolled or "involuntary" behaviours whereas Type D people fear being judged because of controlled or "voluntary" behaviours. They argued that the social anxiety types could also be distinguished on the basis of fears of expressive acts (Types A and B) and fears of adverse assessment (Types C and D).

In a follow-up study, Sandler, De Monchaux, and Dixon (1958) conducted additional quantitative analyses to further elucidate the nature of the social anxiety types. A second sample of 200 clinical patients from the Tavistock Clinic completed the scale. They correlated the four social anxiety types with the remaining 850 items of the TSAI. Identifying items which correlated significantly, with one social anxiety type, but not significantly with any other social anxiety type, enabled further elucidation of the differences among the types.

On the basis of these correlations, Sandler et al. (1958) described a Type A (*social timidity*) individual as someone who has a tendency to withdraw from contact, is submissive, pessimistic, prone to rumination and has difficulty concentrating. They reported that Type A women also tend to have feelings of inferiority, and often are embarrassed by perceived bodily defects. Type B (*Fear of loss of control*) individuals are described as having hypochondriacal concerns, obsessional characteristics (though not severe enough to warrant a separate diagnosis) and a tendency to experience shame.

Sandler et al.'s (1958) description of the Type C individual (*fear of exhibitionism*) indicated that these individuals believe that others look critically upon them and they have excessively hostile feelings directed toward people whom they dislike. They also enjoy being in charge of other people, but have the feeling that others do not know what an important person they are. They often have contempt for those seen to be inferior. Additionally, they are often hypersensitive and frequently have phobic anxieties (e.g., spiders, animals). Lastly, the Type D (*fear of revealing inferiority*) individual is characterised as someone who is embittered, irrational and prone to depression. They have both persecutory (paranoid) and grandiose (narcissistic) fantasies. Additionally, they reveal overt masochistic features often feeling that they do not suffer enough. They also tend to be perfectionists. Sandler et al. concluded that at a broader level, social anxieties can be usefully distinguished on the basis of conscious anxiety and differentiated anxiety focused on the self (somatic and intrapsychic factors) and conscious anxiety focused on others (strangers and acquaintances and familiar others).

**Overview of the contributions of Sandler et al.** Sandler and colleagues' (Dixon et al., 1957a; Dixon, De Monchaux, & Sandler, 1957b; Sandler et al., 1958) contribution is important for several reasons. First, they provided the first large scale empirical study of social anxiety. Second, they used large clinical samples which support the clinical validity of the social anxiety types they found. A limitation of the research, however, is that it was not clear what participants had sought treatment for, and sample details are limited. Nevertheless, their work needs to be viewed from the perspective of the dominant theoretical paradigm of that time (psychoanalysis), and from the perspective that these studies predate the publication of comprehensive diagnostic criteria which would have permitted differentiation of patients based on their initial (intake) diagnosis. Despite this, it is arguable that an analysis of social fears cutting across diagnostic boundaries provided a more clinically useful understanding of social anxieties, rather than selecting individuals whose primary concern was social anxiety, which could conceivably present a narrow and less clinically meaningful picture of the disorder. Last, they demonstrate that although sharing similarities, these social anxiety types represent qualitatively distinct variants of social anxiety. The types presented are complex and multifaceted, and although Dixon et al. (1957b) saw them as possessing underlying dimensional attributes, the groups did not simply represent different points along any one measurable dimension (e.g., number of feared situation,

or type of feared situation), but rather seemed to represent distinct profiles of social anxiety.

There are a number of points of convergence between Sander et al.'s descriptions and the earlier descriptions of French contributors (Hartenberg, 1901; Dugas cited in Trout, 1897). Like the French, Sandler and colleagues described the contradictory nature of social anxiety, specifically the co-occurrence of feelings of inferiority and grandiose narcissistic fantasies. Additionally, like the French contributions, Sandler and colleagues also suggested a tendency for the socially anxious to experience overt hostility and anger towards others. This provides further support for the earlier French studies, since it is not clear that Sandler and colleagues were aware of the French work (certainly they did not cite it), and even if they were, they did not set out with any a priori assumptions about the types of social anxiety groups they would find, thus reinforcing the importance of this convergence.

### **The Shift Towards Behavioural Models of Anxieties and Phobias**

Around the same time that psychodynamic models were becoming dominant in Continental Europe, a parallel theoretical development, behaviourism, was occurring in Russia (e.g., Yerkes & Morgulis, 1909) and the United States. The move toward behaviourism was largely instigated by Watson's (1913, 1914) treatise on behavioural psychology, and his attempts to reformulate psychopathology in behavioural terms (J. B. Watson, 1916) and by the later work of Wolpe (1958, 1982).

Wolpe (1958) explained the origin of neuroses using learning theory. For Wolpe, a predisposing condition, defined as a factor which facilitates neurosis, such as a pre-disposition to experience anxiety, led to a conditioned response to previously neutral stimuli. Wolpe outlined three ways in which an anxiety response could become attached to neutral stimuli. The first corresponded to the Pavlovian model, the second occurred when an individual was exposed to a small number of noxious stimuli, and the last, was when the individual was exposed to a large number of noxious stimuli. In addition to anxiety being attached to specific objects, Wolpe also described *free floating anxiety* in which the object of the anxiety is less clear or in which the individual's anxiety continues in the absence of the noxious stimuli (which is often less specific in these instances).

Although Wolpe (1958, 1982) did not specifically describe social anxiety or social neuroses, he did describe *interpersonal anxiety* which shares similarities with social anxiety. Wolpe (1982) indicated that a core problem with interpersonal anxiety

was problems with assertiveness, and suggested that these individuals often had problems related to submissiveness and a lack of control in social situations. Wolpe indicated that assertiveness training produced good results with some of these individuals.

The first behavioural theory to specifically address social anxiety in detail came from Isaac Marks (Marks, 1970a, 1970b; Marks & Gelder, 1966), although Marks' used the term social *phobia* rather than social anxiety or interpersonal anxiety. Marks emphasised that social phobics tended only to fear a single social situation, although he postulated that the types of social situations which could be feared varied. He noted that social phobia is more severe than other phobias (e.g., animal phobias) with social phobics tending to have other phobias. He also observed that social phobics tended to acquire (eye blink) conditioned responses more relatively rapidly, which could account for their propensity to develop phobias.

Later, Marks (1995) suggested that social phobia could be separated into two types: one reflecting a social skills deficit, and one which he referred to as "classic" social phobia. He did not, however, elaborate extensively on the difference between the types. He did observe that while "classic" social phobia tended to occur at the same rate in men and women, that the social skills deficit variety was more common in men.

While Marks did not address the aetiology of social phobia, from a purely behavioural (conditioning) perspective, social phobia was believed to be the result of past negative social experiences (e.g., Leary, 1983b; Schlenker & Leary, 1982; Zimbardo, 1977). Support for the conditioning theory of social phobia was based largely on retrospective reports of patients and the assumption that social phobia functioned in a similar way to other acquired phobias. The strongest empirical support for the behavioural theories comes from studies showing systematic desensitisation to be effective in reducing social phobia symptoms (e.g., Bandler, Steinke, Allen, & Mosher, 1975; Kondas, 1967; Mitchell & Orr, 1974; Orr, Mitchell, & Hall, 1975; Rachman, 1959). Yet, despite strong evidence for the efficacy of behavioural interventions, Leary (1983b) noted that the cause and treatment of a condition are not necessarily related, and that the success of desensitisation was not direct support for the conditioning theory of social phobia.

In summary, the main contribution of behaviourism was the reclassification of social *anxiety* (cf. Dixon et al., 1957a; Hartenberg, 1901) as a discrete, circumscribed phobic reaction resulting from an early social experience. This led to move away from

the idea that social anxieties are multifaceted, complex and contradictory. Despite the prevalence of behaviourism, and its continuing influence (e.g., Moore, 2011; Skinner, 1985), the last 20 years have witnessed a gradual paradigmatic shift. There has been a movement away from the conceptualization of social anxiety as a purely conditioned phobic reaction and toward the understanding that social anxiety is a complex, multifaceted disorder (Hofmann, Heinrichs, & Moscovitch, 2004).

### **Cognitive-Behavioural Theories of Social Anxiety**

Beginning in the 1950s, there was growing dissatisfaction with purely behavioural theories. A paradigmatic shift occurred which began with Noam Chomsky's (1959) critique of Skinner's (1957) behavioural theory of language development, which Chomsky intended to serve as a broader critique of behavioural attempts to describe higher order mental processes.

Although Chomsky (1959) was instrumental, he was not the only critic of radical behaviourism, and behaviourism was criticised on philosophical as well as scientific grounds. Analyses of behaviourism from a philosophy of science perspective resulted in the accusation that behaviourism contained a number of fatal flaws – primarily centred on the focus of behaviourists on observables at the expense of unobservable theoretical constructs (Moore, 2010). Thus, as a result of these criticisms, radical behaviourism began to be replaced from the 1970s onwards by alternative theoretical models, most notably, cognitive and cognitive behavioural theories. The following sections review cognitive-behavioural theories of social anxiety and discuss points of convergence with earlier studies.

**Self-presentation model of social anxiety.** Schlenker and Leary (1982) developed the self-presentation model to address limitations of earlier behavioural models. They suggested that a fundamental part of people's identities are their self-images (conceptualized as schemas), and the content of these self-images has implications for the person's view of themselves, and the way they are treated by others. Schlenker and Leary suggested that in social situations, individuals "project" certain self-images (a process conceptually congruent with the idea of impression management; Schlenker, 1980), and that "some projected images will result in desired reactions from others; other images will make undesired impressions and generate undesired reactions" (p. 643).

Central to the self-presentation model is the attempt of the individual to control the image they present to real or imagined audiences, and to control the content of their

self-images. For Schlenker and Leary (1982), socially anxious individuals are focused on making a particular impression on others, but doubt their ability to do so. They suggested that the more socially anxious individuals believed that they were not likely to elicit the desired reaction from others, the greater their anxiety, and that these processes are more apparent in situations which are important to the individual.

Fundamentally, Schlenker and Leary (1982) argued that in situations where individuals do not care how they are perceived, or where they are confident of making the desired impression on others, social anxiety will not occur. An important consideration within the self-presentation model, is that the individual is not necessarily motivated to make a positive impression on others (Leary & Kowalski, 1995). For example, an individual might desire to be perceived as powerful and important, or feared, rather than liked. Thus, what is important is the degree to which the individual can make the desired impression.

One of the strengths of the self-presentation model is that it can complement other theoretical models. For example, it would be possible to use the behavioural and conditioning models to explain *why* an individual believes they will not elicit the desired response from others. Second, it has been noted that the self-presentation model is congruent with evolutionary theory (Vertue, 2003). Reinterpretation (or extension) of self-presentation theory through an evolutionary lens suggests that the reason people are concerned with the type of impression they make is that they are concerned about exclusion from social groups, with social inclusion having strong value in terms of survival and reproductive success. Additionally, the self-presentation model does not subscribe to earlier, more extreme behavioural theories which ignore the importance of subjective cognitive appraisals of the situation (e.g., Skinner, 1985).

**Clark and Wells' cognitive model of social anxiety.** The first comprehensive cognitive behavioural model of social anxiety was proposed by Clark and Wells (1995). For Clark and Wells, social anxiety is related to a number of core beliefs. First, they suggested that socially anxious individuals tend to be perfectionists and have unrealistically high standards by which they judge their social performances (e.g., they might believe they should never pause or stumble over words in casual conversation). Juster, Heimberg, Frost, and Holt (1996) elaborated on this, and argued that this perfectionism in socially anxious individuals could be broken into three types: *concern over mistakes*, *doubt about actions* and *perceived parental criticism*. In an empirical review of these concepts, they identified two of these types of perfectionism that were

significant predictors of social anxiety severity: concern over mistakes and doubts about actions.

Further support for the importance of these two dimensions of perfectionism came from a broader clinical study by Antony, Purdon, Huta, and Swinson (1998). They established that socially anxious individuals showed significantly higher scores on measures of both concern over mistakes, and doubt over actions than individuals with panic disorder, obsessive compulsive disorder and specific phobia. Additionally, Ashbaugh, et al. (2007) found that post-treatment changes in social anxiety were also related to changes in levels of concern over mistakes and doubt over actions pre to post treatment. In a more recent analysis, Alden, Ryder, and Mellings (2002) suggested that a two component model of perfectionism could account for the type of perfectionism unique to socially anxious individuals. For Alden et al., perfectionism in social anxiety extends to both performance expectations (which may or may not be pathological), and maladaptive self-appraisal. They argued it is the combination of these two factors which leads to the maladaptive perfectionism of socially anxious individuals.

As well as holding exceptionally high personal standards, Clark and Wells (1995) observed that socially anxious individuals apply conditional criteria to these standards (e.g., they might think that pausing in a conversation could be perceived by the interaction partner as a sign of low intellect). Alden et al. (2002) reviewed evidence that socially anxious individuals hold high personal standards, and suggested that these high standards contribute to the social distress and self-criticism of socially anxious individuals.

Clark and Wells (1991) also proposed that socially anxious individuals have an exaggerated tendency to perceive danger in the external world. This overestimation of the probability of negative events and the perception of danger was argued to lead to a range of cognitive, behavioural and physiological symptoms of anxiety (Roth, 2004). Research assessing attentional biases in socially anxious individuals has provided support for this aspect of the model. In a study examining attention to photographs of faces, Pishyar, Harris and Menzies (2004) found that a high socially anxious group displayed an attentional bias toward negative faces, whereas individuals low in social anxiety displayed a bias toward positive faces. A follow up study showed that this tendency was reduced post cognitive behavioural treatment, with post-therapy reductions in social anxiety severity related to reduced attention to threatening faces. Additionally, changes in processing of social threat faces pre to post treatment was only

found for the individuals who underwent Group CBT, with the attentional biases of a wait list control not differing significantly during the same time period (Pishyar, Harris, & Menzies, 2008).

In a more naturalistic study, consistent with the tendency for socially anxious individuals to have an exaggerated tendency to perceive danger, Veljaca and Rapee (1998) found that socially anxious individuals were faster and more accurate at detecting negative audience behaviours relative to non-socially anxious controls. Lange, Keijsers, Becker and Rinck (2008) reported slightly more complex results, finding a tendency for socially anxious individuals to avoid angry faces when angry faces were displayed with neutral faces (with a greater number of angry faces related to greater distancing). However, they found that while angry faces displayed with happy faces also resulted in distancing, the number of angry faces was not related to the rate of distancing. They suggested that both threatening and non-threatening emotional expressions in others might result in the triggering of an avoidance response in socially anxious individuals.

In addition to elucidating core beliefs, Clark and Wells' (1995) theory provides a complex model describing how socially anxious individuals experience social situations. Clark and Wells stated that upon entering a social situation, socially anxious individuals activate these dysfunctional beliefs, and shift the direction of their attention towards the somatic and behavioural symptoms they experience. These manifestations of anxiety also become a source of anxiety themselves, and hyper-vigilance to these anxiety responses during the social situation results in divided attention. This impairs the processing of social cues that could disconfirm theories about inadequacy in social situations. In addition to a focus on their own anxiety, when socially anxious individuals are in a social situation (through either choice or necessity) they frequently engage in a series of *safety behaviours* (e.g., eye gaze avoidance, talking quickly, or holding a cup tightly to avoid their hands visibly shaking). The purpose of these safety behaviours is to avoid feared outcomes.

Paradoxically, however, safety behaviours have the opposite effect and a number of researchers (E. J. Kim, 2005; Salkovskis, Clark, Hackmann, Wells, & Gelder, 1999) discovered that they tend to negatively impact the socially anxious individual in a number of ways. First, safety behaviours frequently provide confirmation of the fears of the socially anxious individual. This is because while engaging in safety behaviours, the individual assumes any social success (or a lack of social failure) is the result of their

use of the safety behaviours, rather than their own social performance (E. J. Kim, 2005). Additionally, because the socially anxious individual focuses on safety behaviours rather than on the reactions of the interaction partner, they miss important cues which would contradict their maladaptive beliefs. Additionally, one of the problems of the safety behaviours is that in successfully helping the socially anxious individual avoid social failure, they do not allow the individual to disprove their belief of the catastrophic consequences of social failure. Paradoxically, these safety behaviours also tend to elicit responses in interaction partners perceived as confirming beliefs of social ineptness which heightens self-consciousness (e.g., a socially anxious individual might avoid eye contact and be perceived as aloof or indifferent).

An important aspect of Clark and Wells (1995) model is the role played by distorted self-images of socially anxious individuals. They suggest that socially anxious individuals tend to focus on themselves as social objects and to imagine themselves in social interactions in third, rather than first person. That is to say, they view themselves from the perspective of observers. Vassilopoulos (2005) proposed that a core problem is that socially anxious individuals do not view themselves accurately (as others would view them), but rather, see distorted negative self-images. These distorted negative self-images then interfere with the individual's ability to process information that would disconfirm these negative images. In addition to influencing the socially anxious individual's perception of their own social performance, negative imagery influences the opinion of observers (Hirsch, 2004). Thus, it is possible that the focus on negative self-imagery increases the chances that interaction partners respond in ways which confirm the negative self-image.

In addition to in-situation anxiety, according to this model, social anxiety is also affected by anticipatory anxiety (prior to the event) and post-event anxiety. Although Clark and Wells (1995) do not elaborate on the importance of shame in social anxiety, they suggest that it is this post-event processing or post-mortem analysis of perceived social failures which account for the shame-proneness of socially anxious individuals. Clark and Wells point out that unlike depressed individuals, who tend to have universally negative self-views, socially anxious individuals are characterised by more unstable self-schemata. Although they tend to hold negative views of themselves in social domains, they often have more positive self-views of themselves in non-social domains.

**Rapee and Heimberg's cognitive behavioural model of social anxiety.** Rapee and Heimberg (1997) presented a complimentary model of social anxiety, which was developed concurrently (though independently) from Clark and Wells (1995). Rapee and Heimberg's cognitive behavioural model of social anxiety begins with the core assumption that socially anxious individuals assume that other people are inherently critical of them. According to the Rapee and Heimberg model, the core concern of these individuals is positive appraisal in social situations. What is unique about this model is that it can be applied to present social situations, to possible future social situations or to past social situations (which are ruminated over). For Rapee and Heimberg, a number of processes maintain this anxiety.

Upon entering a social situation, socially anxious individuals form a mental representation of themselves. At the same time, they engage in continuous scanning of the social environment for possible threats. The mental representation is thought to be a composite of information from long term memory (e.g., recollection of appearance, and memory of prior experiences in similar situations), incoming physiological sensations (e.g., physical symptoms) and external cues (e.g., reactions of audience). The socially anxious individual then compares the mental representation against what they believe the audience expects of them and assesses the degree of discrepancy between the two positions. On the basis of the discrepancy, the socially anxious individual judges the likelihood of being evaluated negatively. In instances where a large discrepancy is present, physical, cognitive and behavioural symptoms of anxiety are experienced. These anxiety symptoms feed back into the mental representation and reinforce beliefs in social ineptness. Like Clark and Wells (1995), Rapee and Heimberg also suggest that increased attention to the symptoms of anxiety coupled with continuous threat scanning of the environment, lead the socially anxious individual to miss potential cues in the social environment that could disconfirm theories about social inadequacies, and challenge beliefs about the degree to which the audience is critical.

**Summation of cognitive behavioural models.** The cognitive models share a focus on the process of social anxiety rather than on the aetiology or evolutionary basis of the disorder. Additionally, the cognitive models do not discuss the relationship between personality and social anxiety, although both major cognitive models make references to personality characteristics of socially anxious individuals. Roth (2004) suggested that the key area of convergence between the two major cognitive models is their descriptions of the processing of the self as a social object undertaken by the

socially anxious individual while in social situations. Additional areas of convergence between the models are the importance of anticipatory and post-event anxiety, the processing of the audience (real and imagined), and the feedback loop created between physiological signs of anxiety and the subjective experience of social anxiety.

Both cognitive models indicate that perfectionism is important to the socially anxious individual and suggest that socially anxious individuals are self-focused, focusing on the self in social situations to the detriment of the processing of other social cues, and that they are hypersensitive to possible social criticism. The contradictory nature of social anxiety outlined in previous studies (Dixon et al., 1957a; Hartenberg, 1901) is not apparent in the cognitive behavioural models. Despite this, Clark and Wells (1995) indicate that although socially anxious individuals may hold negative views of the self in social domains they leave open the possibility of more positive self-views existing in non-social domains (e.g., intrapersonal domains such as mastery).

### **Alternative Models of Social Anxiety**

The cognitive-behavioural theories provide detailed models of the processes of social anxiety. However, the cognitive-behavioural models do not address all aspects of social anxiety covered in the historical literature. In parallel with the cognitive-behavioural work on social anxiety, a number of researchers have explored social anxiety using alternative theoretical paradigms. The strength of these models is that they consider aspects of social anxiety which the cognitive-behavioural models do not. It is further possible that whereas major contemporary models do not include many aspects of social anxiety outlined in the historical literature, that alternative models may better incorporate these aspects. The following sections review alternative theoretical models of social anxiety and discuss the contributions of these models.

**Interpersonal theory of social anxiety.** A central tenant of interpersonal theory is that humans are fundamentally social animals, and seek to build and maintain social bonds. Considering this, interpersonal theorists suggest that many problems of individual maladjustment are the result of maladaptive interpersonal relationships (Alden, 2005). Like object-relations and psychodynamic theories (e.g., Bowlby, 1953, 1969; Kernberg, 1985), interpersonal theories suggest that maladaptive styles of relating to others have their root in early relationships (particularly caregiver-infant relationships). These early relationships are believed to be responsible for the formation of *relational schema* (conceptually analogous to internal working models of attachment,

e.g., Bowlby, 1980/1991; or internal representations of self and others; e.g., Kernberg, 1985).

Relational schemata are identified as the cognitive structures that contain representations of the self, representations of others, and representations of self in interaction with others, and are coloured by affective responses (Alden, 2005). Baldwin (1992) suggested that relational schemata also contain a series of *interpersonal scripts*, which are knowledge about patterns of interactions which tend to be repeated over time. Interpersonal scripts contain beliefs about the types of responses that the behaviours of the socially anxious individual are likely to elicit from interaction partners. If repeated enough, these scripts become automatic, and might be applied inappropriately or in the wrong situation.

One of the main reasons that maladjusted interpersonal relationships are maintained over time, however, is that individuals are believed to seek interaction patterns which are congruent with their representations of self and others in the relational schema (Alden, 2005). They also filter experiences through the lens of their expectations. This is similar to the idea of the defensive distortion of information (Bowlby, 1980/1991) or psychoanalytic ego defence mechanisms (A. Freud, 1966). These processes also share similarities with the psychodynamic theory of transference and countertransference, and it has been demonstrated that even subtle cues can trigger particular interpersonal scripts and thus result in the re-enactment of early patterns of relationships (Baldwin & Main, 2001). Extending on this, Alden (2005) noted that the concept of re-enacting past relationships is not always simple, and the individual may not always play the same role they did in the past. Alden reported two distinct ways in which relationships can be re-enacted. The first, and most straightforward, is simple re-enactment (i.e., the individual plays the same role in relation to the other that they did in past relationships). The second, identification, is a situation in which the individual identifies with and enacts the role of the *other* from past interactions.

Viewed from an interpersonal perspective, as a result of early interpersonal relationships, the socially anxious individual develops a set of relational schemata. These schemata include representations of the self, others, and of the self-in-relation to others and rules and expectations about social interactions (Alden, 2005). For social interactions to remain congruent with existing internal representations, the socially anxious individual selectively attends to cues which confirm existing beliefs about the self and others, and engages in an active process of distortion of incoming sensory

information. Additionally, the socially anxious individual tends to re-enact patterns of relationships, by seeking certain types of social interactions, and through eliciting (or “pulling”) certain responses from others. Many of the major aspects of the interpersonal model are consistent with current cognitive models, which also posit that socially anxious individuals selectively attend to cues which confirm their social inadequacies (e.g., D. M. Clark & Wells, 1995).

**An attachment theory perspective on social anxiety.** Attachment theory emerged from John Bowlby’s reformulation of psychodynamic theories (Bowlby, 1953, 1969, 1969/1991, 1973/1991, 1980/1991). Bowlby was unsatisfied with both psychodynamic and behavioural explanations of the importance of the mother-infant bond, and was concerned with the emphasis that psychodynamic theories (particularly Kleinian theories) placed on the role of fantasy rather than actual experience in theories of the intergenerational transmission of neuroses (Gullestad, 2001; Holmes, 1994; Karen, 1994). Turning to an emergent field, ethology, and inspired by ethological studies (e.g., Lorenz, 1961), and by evolutionary theory, Bowlby proposed a reformulation of psychodynamic theory, and, suggested that the mother-infant bond is a primary behavioural instinct in the child (Bowlby, 1958, 1969/1991). Bowlby proposed that an infant whose caregivers are cold/unresponsive or inconsistently responsive might react by becoming anxious, clinging to parents or by becoming compulsively self-reliant (Holmes, 1993).

Over time, interactions with caregivers become internalized into what Bowlby called *Working Models of Attachment* (Bowlby, 1973/1991). Working Models of Attachment were thought to contain representations of the self, and representations of others. Bowlby suggested that these working models were initially built around actual experiences, but later incorporated the child’s subjective interpretation of events, conflicts, wishes, fantasy, and defensive distortions of representations of self and others (Eagle, 1997; Knox, 1999, 2001, 2003). Over time, representations become hierarchically organised, with general views of self and others at the top of the hierarchy (that is to say broadly positive or negative views of the self and others; see Bartholomew & Horowitz, 1991), and representations of specific relationships lower in the hierarchy (Vertue, 2003). Vertue (2003) suggested that certain internal working models might make a person predisposed to experience social anxiety. She further suggested a reinforcing cycle, in which, over time, social failures become internalized into the internal working model (viz. representations of the self as lacking social

competence and worth). This further enhances the likelihood of the person experiencing social anxiety in future situations.

In summary, unlike some alternative models of social anxiety, the attachment perspective elucidated by Vertue (2003) does not seem to allow for the occurrence of contradictory characteristics (i.e., social reticence and narcissism). It is assumed within Vertue's model that at the broadest level, an individual has an overall positive or overall negative view of the self and others. Attachment theory as articulated by Bowlby (1973/1991, 1980/1991), however, allows for multiple working models, and multiple, hierarchically organised representations of self and others. It is possible, therefore, that a socially anxious individual might have an overall negative view of the self in social domains, but might have more positive views of the self (or grandiose self-views) in either non-social domains, or in specific relationships (i.e., self with partner vs self with stranger). Thus, although the presence of contradictory personality characteristics in socially anxious individuals, is not supported within Vertue's specific attachment model, it is congruent with the broader tenants of attachment theory (Bowlby, 1973/1991, 1980/1991).

**Contemporary psychodynamic theories of social anxiety.** Although it would be wrong to describe contemporary psychodynamic theories as unified, they tend to share a core group of assumptions. Shedler (2006) suggested that core features of contemporary psychodynamic and object-relations theories are:

- Consideration of unconscious mental life
- Internal contradictions - conflicts or ambivalence about self and others
- The importance of early relationships (particularly early attachment relationships) to later relationships
- The idea of transference – repetition of patterns of relationships across time
- The importance of defence, which is the tendency for individuals to utilize a repertoire of cognitive and behavioural strategies to avoid unsettling or dissonant information

Only a small number of contemporary psychodynamic theorists have attempted to elucidate a psychodynamic model of social anxiety, and generally, these models are based on clinical observation rather than empirical research.

Gabbard (1979, 1992) provided one of the first attempts to integrate contemporary psychodynamic theory with current cognitive behavioural and biological

models of social anxiety. He suggested that, from a psychodynamic perspective, social anxiety can be considered to be a compromise between unacceptable wishes and fantasies on the one hand, and defences against those wishes and fantasies on the other. For Gabbard, the underlying wish of socially anxious individuals is a narcissistic one, and he proposed that socially anxious individuals' desire to be the centre of attention and to receive positive evaluations and affirmation from others. However, fear of disapproval of others leads to their overt reticence and to feelings of shame (Gabbard, 1992). This need to be the centre of attention often leads to aggressive thoughts directed towards those seen as competitors or rivals for this attention. However, Gabbard suggested that these aggressive thoughts toward others frequently cause feelings of guilt in the socially anxious individual. Thus, like the early French work (e.g., Hartenberg, 1901), for Gabbard, shame and anger (aggression) are central to the experience of social anxiety.

Zerbe (1994) also explored the potential contribution of psychodynamic theory to the understanding of social anxiety. Like Gabbard, she emphasised the centrality of conflicts over aggression for socially anxious individuals, specifically noting that avoidance of social situations by socially anxious individuals is driven as much by these aggressive conflicts as by lower self-esteem and excessive self-criticism. In describing the nature of the aggressive conflicts of socially anxious individuals, Zerbe suggested that socially anxious individuals project a harsh and critical superego onto people in the external world, and that, faced with individuals who they perceive to be hostile, the socially anxious individual feels safer perceiving of themselves as humiliated rather than as hostile.

German work on formulating a psychodynamic theory of social anxiety differs somewhat to that produced in Britain and North America. Hoffmann (1999, 2002) suggested that social anxiety is comprised of a number of narcissistic self-dynamics. First, he noted that social anxiety is often associated with "Die defizitäre Konzeption des eigenen Selbst" [deficient self-concept] (p. 54). The second characteristic Hoffmann suggested is "die kompensatorisch überhöhte Selbstsicht" [compensatory inflated view of self] (p. 55), with Hoffmann suggesting that some (but not all) socially anxious individuals have an unconscious grandiose self-view. Hoffmann suggested that in these individuals, this unconscious grandiose self-view contributes to social anxiety because the socially anxious individual bases their expectations of social situations/interactions upon it.

The last narcissistic dynamic Hoffmann (1999, 2002) suggested is important for social anxiety is “Der Affekt der Scham” [the affect of shame] (p. 56). Hoffmann builds on Gabbard’s (1979, 1992) work on the link between narcissism and shame, but clarifies that for the socially anxious individual, the source of the shame may be external (e.g., not living up to the perceived expectations of others), or internal (e.g., not living up to one’s own ideas). Moreover, at the most general level, he argued the shame of the socially anxious individual is related to a perception of the self as damaged.

### **Ethological/evolutionary models of social anxiety.**

***Paul Gilbert’s ethological model of social anxiety.*** The most comprehensive evolution/ethologically theory of social anxiety is that of Paul Gilbert (Gilbert, 1989; Gilbert & Trower, 1990). Gilbert’s general ethological theory emphasises the role of problematic interpersonal relationships in psychopathology, the evolution of the human brain and evolved mental states, and the importance of perceptions of social rank in group living animals. Gilbert’s evolutionary and ethological model of social anxiety emanates from his more general ethological model.

*General ethological model.* For Gilbert, it is important for theoretical models of psychological disorders to account for the process of natural selection (Darwin, 1878). Following Dawkins (1976), Gilbert emphasised that natural selection was not just about *individual* survival, but also about *genetic* survival. Gilbert suggested that neurosis viewed through a Darwinian lens, represents ineffective functioning of adaptive evolutionary processes or “context-inappropriate use of innate potential” (Gilbert, 1989, p. 12; see also Sloman, 2002). Gilbert saw the struggle for *optimal space* as important and suggested this was reflected in conflicts between assimilation (the extreme variant of this being *enmeshment*) and autonomy (the extreme of this being *isolation*). Thus, for Gilbert, the “vast majority of mental distress, from personality disorders to depression, social anxieties...may be viewed as representing difficulties of self in relation to others” (p. 20).

*Evolved mental systems.* An important aspect in the evolution of the human brain, was the evolution of separate, but interacting brain systems (Chance, 1988b). Chance noted that a bimodality in brain systems was independently discovered by a number of ethological psychologists and sociologists and noted that the two systems were classified as the *agonic mode*, in which concern is focused on self-security, and the individual is preoccupied with acceptance by the group, and the *hedonic mode*, a focus

on relationship networks which offer the possibility of mutual support, which fulfils safety needs and allow for intellectual and creative exploration (Chance, 1988a).

Extending on Chance's (1988b) work, Gilbert (1989) suggested that the agonic and hedonic systems are better conceptualized as manifestations of two broader subsystems, defence and safety. The *defence* system is conceptualized as concerned with avoidance of all forms of threat, injury and attack and is designed to protect the animal. It is comprised of the non-social defence subsystem (dealing with predator threats, and related to sensory hyperarousal and rapid shifts in arousal), and the social defence subsystem. The social defence subsystem can be further broken down into the *territorial system* and the *agonic mode*.

The *territorial system* involves the territorial forms of social living common in reptiles and birds, in which, dominance hierarchies are built around territory held and capacity to acquire mates (via intersexual display behaviours; i.e., colour or plumage in birds). Intraspecies conflict over resources in this model is enacted via *ritualistic agonistic behaviours* (RABS), which are a series of display behaviours designed to communicate status from one animal to another. RABs evolved as a way of terminating or avoiding fatal conflict between conspecifics. Animals that lose in hierarchical encounters engage in what Gilbert termed an *Involuntary Defeat Strategy* (Sloman, 2002), which involves withdrawal, inhibition of challenge behaviours and the display of yielding behaviours.

The *agonic mode* on the other hand evolved with group living animals and involves inhibition of RABs. The idea of *social rank* is central within the agonic mode, and social groups are organised via complex hierarchies around dominant individuals. Given the evolutionary advantage of remaining part of the social group, rather than flee, as in the territorial system, the lower ranked individuals send signals of submission and appeasement, designed to proactively diffuse challenge behaviours in the dominant individual. This allows the lower ranked animal to stay in the proximity of the dominant individual while reducing the likelihood of further attacks. Gilbert (1989) suggested that in humans, submissive states (such as social anxiety) are related to the agonic model, whereas more severe defeat states (such as depressive disorders) are related to the territorial system, where there is withdrawal of challenge behaviours and display of yielding behaviours. In many group living animals, dominance hierarchies are built around assessment of relative resource holding power (RHP), which is the case for humans (G. A. Parker, 1974).

The purpose of the *safety* system is to reduce attention to threatening stimuli and to encourage exploration behaviours. The safety system is broken into the non-social safety system (analogous to the non-social threat system), the attachment system (a system prominent in infancy which allows the infant to reduce safety behaviours and engage in exploratory behaviours – see also Bowlby, 1969/1991) and the hedonic mode (Chance, 1984, 1988b).

Unlike the agonistic mode which is organised around hierarchical competition and self-protection, the hedonic mode is concerned with *mutual dependence*. As in the agonistic mode, the individual signals they are not a threat, however, the signals are not submissive but rather are reassurance signals (e.g., characterised by more relaxed interactions). Thus, the hedonic mode makes possible a series of social behaviours such as confidence giving, mutual support and reassurance. Significantly however, the hedonic mode is not synonymous with a lack of competitiveness, but the nature of the competitiveness differs. Price (1992) points out that both modes are associated with competitive behaviours, but whereas the competition for resources in the agonistic mode revolves around intimidation based strategies, competition in the hedonic mode is for *social* resources and individuals “vie for attractiveness in the eyes of one or more third parties” (p. 4).

Gilbert (2006) proposed the concept of Social Attention Holding Power (SAHP), and suggested that shifts from the agonistic to the hedonic mode were associated with a shift away from assessment of *Resource Holding Power* (RHP) and toward *Social Attention-Holding Power* (SAHP). Although Price et al. (2007) noted that *prestige* based competition (viz. SAHP) added to, but does not replace agonistic forms of competition (viz. RHP). Thus, individuals in determining social rank could be cognisant of both RHP and SAHP to differing degrees depending upon reliance upon either the agonistic or hedonic modes. An interesting implication of the SAHP is that whereas ranking judgements are made by the individuals themselves in the agonistic mode (i.e., an individual assess their own social rank), they are not in the hedonic mode (with social rank determined by ratings of social attractiveness by others). In addition to the hedonic mode not being equivalent to lack of competition, at least for humans, the agonistic mode is not synonymous with a lack of co-operation. Rather, the form that co-operative behaviours take differs between the agonistic and hedonic modes.

Expanding on the agonistic and hedonic modes, Price (1992) suggested that they are useful in describing strategies within relationships. Although they are located within

different systems (viz. the defence and safety systems), and related to different goals, Price suggested that individuals tend to use both modes within relationships, with some relationships being classified as “agonic” and some relationships as “hedonic”.

*Social rank.* Social rank is central to both the agonic and hedonic modes, and more broadly the defence and safety systems. Although, the way social rank is determined differs between the different modes, and is affected by perceived organisation of the group, and the degree to which hierarchical power relationships are emphasised. Wilson (2002a) postulated that the reason that humans and other group living animals are hyper-vigilant to social rank, is that greater resources are generally available to higher ranked individuals. Additionally, higher ranked individuals are seen to make more attractive allies than lower ranked individuals as they have greater social support available to them.

Social rank and its contribution to the understanding of mood and anxiety disorders has been the focus of several studies. Price et al. (2007) observed that although studies have established that depressed individuals display behaviours and characteristics congruent with a low ranked individual, the relationship between perceived social rank and psychopathology is complex. Price et al. noted that initially, it was assumed that emotional disorders were related to perceived social rank (e.g., it was assumed that depression was related to low social rank, and conversely, lack of depression with higher social rank). This assumption, however, proved to be problematic for several reasons. First, mood and anxiety disorders exist in people who are high (or higher) in social rank and some individuals who perceive themselves to be low in social rank do not have these disorders. Price et al. observed that in these instances, it is important to consider *ambition for social rank*, and that if an individual has no ambition for a higher social rank (i.e., they are satisfied with their social rank), the correlation between social rank and depression might be weaker or non-existent. Additionally, they suggested that multiple hierarchies might exist, with an individual depressed because they see themselves in a low social rank within a specific context despite seeing themselves as in a higher rank in other contexts.

Instead of seeing ambition for social rank as central, Trower and Gilbert (1989) argued that the interpersonal goals of the individual are key to determining the strategies used in managing relationships with others. Specifically, they indicated three levels of goals. In first level goals, the individual seeks to increase their attractiveness (via increases in RHP, or SAHP), using RABs (which in group living animals would

comprise social dominance behaviours) to gain dominance over others. First level goals are also pursued by individuals who already see themselves in dominant positions, and who use RABs to maintain their dominance.

In contrast to first level goals, Trower and Gilbert (1989) suggest that second level goals have two possible (not mutually exclusive) purposes; to avoid harm and rejection by others (those seen to be dominant and higher in social rank), and to maintain a relationship with the dominant individual. This is important, because, as noted earlier, individuals higher in social rank are seen to be important allies. The strategies used by individuals pursuing second level goals are “reverted escape” (displaying escape behaviours while remaining in the proximity of the dominant individual), submissive appeasement (i.e., the appropriate response to the RAB of the dominant individual), and the adoption of a subordinate position.

When second level goals are not successful, Trower and Gilbert suggest that individuals employ third level goals. These are concerned with avoiding perceived threat from dominant individuals where the individual’s response to the dominant’s RABs did not result in de-escalation of these behaviours.

*Gilbert’s ethological model of social anxiety.* In a series of publications, Gilbert and colleagues (e.g., Trower & Gilbert, 1989) applied Gilbert’s general ethological model to explain the occurrence of social anxiety. This ethological model of social anxiety viewed social anxiety as a complex and multifaceted disorder, and suggested that despite social reticence some socially anxious individuals are motivated by the desire for social dominance.

In humans, rather than being related to fear of actual attack, Gilbert (2001) argued that social anxiety is related to fear surrounding *loss of status* (SRHP). Building on the earlier theoretical model of Trower and Turland (1984), Trower and Gilbert (1989) argued that the core of social anxiety is the overuse of the defence system, and suggested that it is the overuse of this system which plays a key role in the maintenance of social anxiety. This is because use of the defence system results in a tendency to orient to most relationships from a competitive mentality or in terms of dominance hierarchies (Gilbert, 2001; Gilbert & Trower, 1990; Trower & Gilbert, 1989; Trower, Gilbert, & Sherling, 1990). A result of this is that social anxiety is characterised by a “dominance schema”, which dictates the nature of the social reality of the individual.

As a result of use of the “dominance schema”, Gilbert (2001) proposed that socially anxious individuals are highly attuned to the competitive nature of interpersonal

relationships, and the importance of competitiveness and the eliciting of the support and approval of others. Socially anxious individuals approach social situations with a belief that they are inferior, seeing themselves as being low in social rank. A result of this is that they utilize what Trower and Gilbert (1989) referred to as second level goals, namely, submissive and appeasement strategies. Nevertheless, they noted that social anxiety is not always related to a single level of goal, and that dominant individuals (individuals who pursue first level goals) might be vulnerable to some forms of social anxiety (e.g., public speaking anxiety) if weaknesses in their perceived social dominance was revealed. The idea of an individual characterised by dominance *and* social anxiety is consistent with Gabbard's (1992) contemporary psychodynamic model of social anxiety, and consideration of Gabbard's work in light of Trower and Gilbert's model strongly suggests that these individuals would show both social anxiety and narcissistic characteristics.

While Trower and Gilbert's (1989) model suggests that socially anxious individuals who pursue first level goals are likely to show narcissistic characteristics, an argument can be made that some socially anxious individuals who pursue second level goals might also show narcissistic characteristics. To clarify, while Trower and Gilbert's theoretical description accounts for differences in social rank *sought* (distinct from perceived social rank), their descriptions of social anxiety did not incorporate this. Thus, incorporating Price et al.'s (2007) notion of *ambition for social rank*, it is possible that individuals who utilize second level goals, but who wish to pursue first level goals (and be dominant) might represent a different type of socially anxious individual. Like socially anxious individuals who pursue first level goals, these individuals may also show narcissistic characteristics, consistent with arguments by Hoffmann (1999, 2002). In contrast, it could be argued that an individual who utilizes second level goals but who has no ambition for higher social rank is less likely to show narcissistic characteristics. Thus, Trower and Gilbert's model implies the existence of narcissistic and non-narcissistic social anxiety, and further suggests at least two different types of narcissistic socially anxious individual.

Gilbert considered shame to be one of the core emotional experiences related to uncertainty regarding social rank (Gilbert, McGuire, & Andrews, 1998). Unlike the cognitive models (e.g., Clark & Wells, 1995; Rapee & Heimberg, 1997) which mention, but do not elaborate on shame proneness in socially anxious individuals, in Gilbert's model shame is a central affect in the experience of social anxiety (Gilbert, 1998).

Gilbert (2003) postulated that for the socially anxious individual, shame is associated with the perception of low social rank and acts as a warning signal that one may not be eliciting the desired response from a social partner. Gilbert indicated that shame may originate from two distinct sources: *internal* (the socially anxious individuals own assessment of themselves) and *external* (the response of dominant others to the socially anxious individual; Gilbert, 2004). Empirical work supports this link with shame being found to be related to both perception of social rank and submissive behaviours (Gilbert, 2000b).

### **Review of Alternative Models of Social Anxiety**

The previous sections have reviewed alternative models of social anxiety. The idea that social anxiety can sometimes be associated with contradictory characteristics is either explicitly mentioned (e.g., psychodynamic and ethological models) or at least not incongruent (e.g., attachment theory) within most of the alternative theoretical models reviewed.

These models are also complimentary, rather than mutually exclusive. For example aspects of German psychodynamic theories of social anxiety (Hoffmann, 1999, 2002) are theoretically congruent with the ethological model of social anxiety (Gilbert, 1989; Trower & Gilbert, 1989). Both emphasise that where a person desires to be higher in social rank than they currently perceive themselves to be, social anxiety tends to be more severe. In addition, both suggest that severe social anxiety tends to be associated with elevated shame proneness. Thus, a more comprehensive understanding of social anxiety is possible by considering multiple theoretical models.

### **Chapter Summary**

This chapter has reviewed the changes in the conceptualization of social anxiety over time. A shift was identified away from pre-behavioural descriptions of social anxiety as a multifaceted, contradictory disorder toward the understanding that social anxiety is a phobic reaction. Although the behavioural theory of social anxiety was dominant for a number of years, recent reformulations of social anxiety have moved away from the idea that social anxiety is a phobic reaction, and, consistent with earlier ideas, have begun re-conceptualizing social anxiety as a complex, multifaceted disorder. The idea that social anxiety is often associated with contradictory personality characteristics, although absent from behavioural and cognitive behavioural models, was apparent in some of the recent alternative models of social anxiety.

Throughout the theoretical review, strong support emerged for the core argument of this thesis, that social anxiety is often associated with contradictory characteristics; specifically, that socially anxious individuals often show narcissistic characteristics. This is even more compelling given support for this proposition is present in the majority of theoretical accounts of social anxiety over the past 100 years. However, while this argument is compelling, the focus of the current historical review was on Western conceptualizations of social anxiety. However, cross-cultural perspectives of social anxieties differ from those presented in the Western literature, and a complex understanding of social anxiety is not possible without considering non-Western conceptualizations of social anxiety. The next chapter provides an overview of cross-cultural perspectives on social anxiety, and on the East Asian concept of *Taijin-Kyofusho* (TKS).

### Chapter 3: Taijin-Kyofusho

Although the previous chapter outlined the history and development of the concept of social anxiety, the literature reviewed was confined to European and North American perspectives. Despite the prominence of these models, an alternative model of social anxiety has been presented in the East Asian Psychiatric literature, predominately in the literature of Japan and Korea. While there are similarities between East Asian and Western conceptualizations of social anxieties, there are also a number of points of divergence. A comprehensive understanding of social anxiety is not possible, therefore, without consideration of these East Asian perspectives, which allow a fuller understanding of the nature of social anxieties.

This chapter reviews the East Asian concept of Taijin-Kyofusho (TKS). To provide the context necessary to understand the development of TKS, the chapter begins with a brief historical review of the work of Japanese Psychiatrist Shoma Morita (1928/1998) and of the concept of Shinkeishitsu. The contemporary literature on TKS is then reviewed and areas of convergence and divergence between TKS and Western concepts of social anxiety are considered. Finally, the emerging research assessing TKS in Western countries is reviewed.

#### Shoma Morita

Shoma Morita (1928/1998), was a contemporary of Freud. Like Freud, he developed a new therapeutic system. As part of his therapeutic system, he elucidated a number of core principles he believed contributed to psychological maladjustment and continuity of patterns of maladjustment.

Central to Morita's (1998) therapy was *Shiso-no-mujun* (the contradiction by ideas) "the opposing tendency between one's desire that life and a sense of self be a certain way, and the facts about how life is and who one is" (p. 3). Morita noted that these contradictions were often the result of incongruence between subjectivity and objectivity, emotion and knowledge and Taitoku (experiential embodied understanding) and Rikai (intellectual understanding).

In relation to the conflict between subjectivity and objectivity, Morita (1998) believed that by directly acknowledging and focusing on symptoms, rather than letting them pass, that patients become "trapped in an illusory subjective world, independent of any objective stimuli that correspond to objective reality" (p. 5). Extending on this idea, Morita suggested that an excessive focus on the individual's own subject experience was the cause of symptoms of *shinkeishitsu* (described later). Moreover, if this occurred

while the patient was in an emotional state, Morita believed that the use of logic to try to explain the patient's symptoms to them would be ineffective.

Morita's approach to therapy is clearly different to dominant Western paradigms such as Cognitive Behavioural Therapy. Morita saw anxiety and obsessions as variations of normal experiences. Rather than seeking to treat the symptoms which arose from these conditions, Morita instead focused on increasing an individual's *tolerance* of their symptoms (Chen, 2010). Morita discouraged an excessive focus on the symptoms themselves, which he believed led the individual to obsessive self-preoccupation. To Morita, the *emotional experience* of the individual is paramount.

**Shinkeishitsu and the development of Taijin-Kyofusho.** The core diagnosis within Morita's (1928/1998) theoretical system was that of *shinkeishitsu* (sometimes later referred to as Morita neuroses; Nakamura, 1992). Morita saw *shinkeishitsu* as a broad personality trait or disposition, and suggested that central characteristics of *shinkeishitsu* were a nervous temperament, with *shinkeishitsu* individuals tending to be introverted, having high personal standards, and a hypersensitivity to physiological symptoms. He observed that as a result of this, these individuals could become easily preoccupied with "trivial" perceived physiological and psychological dysfunctions (Kirmayer, 1991; Takahashi, 1989).

From an interpersonal standpoint, Morita (1998) suggested that *shinkeishitsu* was related to a desire for dominance in social relationships, and said that fear of being ashamed was closely related to a desire to be superior (Nakamura, 1992). He argued that unlike individuals with hysteria, who were thought to not be psychologically minded, people with *shinkeishitsu* had a greater awareness of the aetiology and nature of their disorder.

Morita's (1998) description of *shinkeishitsu*, was broad, like the Western concept of neurasthenia, and he observed that *shinkeishitsu* could be related to a range of possible symptoms, including physiological symptoms (e.g., headaches, feelings of dizziness, palpitations), cognitive symptoms (e.g., difficulty concentrating), and emotional symptoms (e.g., shame, lust, anxiety). He noted that often the experiences of *shinkeishitsu* patients was similar to those of normal experiences, but that it was the subjective interpretation of the events which led to the anxiety and distress. Furthermore, over time, anticipatory anxiety developed, and this anticipatory anxiety increased an individual's fixation on their symptoms.

Morita (1928/1998) suggested that many individuals with *shinkeishitsu* developed obsessive ideas. For some individuals, those obsessive ideas took the form of obsessions surrounding shame. Morita indicated that these individuals often feared blushing, giving off inappropriate facial expressions, looking at others, and visible manifestations of anxiety symptoms (Takahashi, 1989). Morita classified this cluster of symptoms as *Taijin-Kyofusho* (TKS). Morita noted that TKS tended to be related to introversion, and that individuals with TKS had an excessive introspective focus, which lead to a preoccupation with psychological and physiological self-aspects, and that this extended to a preoccupation with self-presentation (Ono et al., 2001).

#### Current Research on *Taijin-Kyofusho*

Contemporary Japanese psychiatrists have expanded upon Morita's concept of TKS, defining the disorder more precisely, and creating more specific diagnostic criteria (Kinoshita et al., 2008). Ono et al. (2001) suggested that fundamentally, TKS is a fear of interpersonal relations. Kasahara (1987) suggested that TKS is associated with a number of premorbid personality characteristics, including meticulousness, perfectionism, idealism, tenacity for life and excessive introspection.

Like other early work on social anxiety (e.g., Hartenberg, 1901), Kasahara (1987) noted that TKS is associated with contradictory characteristics, indicating that it was related to both a lack of self-confidence, and excessive egoism and narcissistic concerns. Ono et al. (2001) noted that, while TKS superficially resembles social anxiety, it is broader, and that TKS overlaps with various DSM (APA, 2000, 2013) diagnostic categories, such as hypochondriasis, and body dysmorphic disorder. Unlike the diagnostic criteria for Social Anxiety Disorder in the DSM, which exclude cases with psychotic symptoms, TKS encompasses both psychotic and non-psychotic variants. Additionally, TKS is often associated with delusional characteristics (Takahashi, 1989).

**Taijin-Kyofusho subtypes.** Kasahara (1987) separated TKS into four types on the basis of symptom severity: a simple type (which is common, and often found in adolescents, or during periods of transition in life), a "pure" phobic (or alternatively neurotic) type, a "severe" type with allocentric (or altruistic) characteristics, which also has delusional characteristics and is alternatively characterised as a borderline type, and a type in which TKS symptoms are a prodrome for schizophrenia, or are a manifestation of post-psychotic symptoms experienced during remission (Kasahara, 1986, 1987; K.

Kim, 1987; Suk Choo, 1997). Kasahara suggested that the phobic and allocentric types correspond to “TKS proper”.

*Offensive and neurotic subtypes of Taijin-Kyofusho.* An alternative to Kasahara’s (1986, 1987) proposed subtypes, is the differentiation of TKS into *neurotic* and *offensive* types, with the offensive type sometimes referred to as a delusional type (Nakamura, Kitanishi, Miyake, Hashimoto, & Kubota, 2002) or quasi-delusional type (Kleinknecht, Dinnel, Tanouye-Wilson, & Lonner, 1994). The neurotic type of TKS is similar to Western conceptualizations of social anxiety, and is closer to Morita’s original conceptualization of *shinkeishitsu* (Sasaki & Tanno, 2006). It describes individuals who feel inadequate in social situations, who experience shame, anxiety, and fear in social situations, and who are afraid they will be unable to maintain healthy interpersonal relationships. Additionally, they feel unaccepted, despised and avoided by others (Lee & Oh, 1999; Nakamura, 2006).

Kleinknecht et al. (1994) proposed that the primary difference between the neurotic variant of TKS, and Western conceptualizations of social anxiety is that in TKS, the individual is preoccupied with the idea that they may offend or embarrass other people, whereas in social anxiety the individual’s fears revolve around personal embarrassment and humiliation. Kleinknecht, Dinnel, Kleinknecht, and Hiruma (1997) suggest that this difference in focus is due to the cultural norms among Japanese people that the behaviour of one member of an in-group could cause shame and embarrassment to all members of the group. Rector, Kocovski and Ryder (2006) also suggest that relative to those with social anxiety, individuals with neurotic TKS have less fear of negative evaluation. It could be argued, however, that rather than fearing the negative evaluation of others, neurotic TKS individuals might fear their own negative evaluations of themselves for not living up to prescribed social norms.

Although the *neurotic* type of TKS corresponds to Western conceptualizations of social anxiety, the *offensive* subtype is distinct. Le and Oh (1999) suggest that individuals with offensive TKS differ from the neurotic type in two ways. First, they believe that they have a defect in a particular body part (e.g., eyes, or general appearance) or bodily sensation (e.g., body odour). Second, they believe that because of this perceived defect, they harm others, or cause unpleasant feelings in others, and that as a result, others avoid them.

Kinoshita, et al. (2008) identified support in the Japanese literature for two distinct varieties of offensive TKS, a *conviction* and a *tension* subtype. These subtypes

differ in terms of the belief in the likelihood that their perceived bodily defect will harm or cause unpleasant feelings in others. The *conviction* subtype is characterised as an individual who has a “strong belief and fear that others will be offended by one’s own inadequacies” (p. 307). The *tension* subtype on the other hand describes individuals who have the same fears, but who are not convinced that their bodily defect could really harm or cause unpleasantness in others. Thus, the *conviction* subtype is representative of a more delusional form of offensive TKS. Kinoshita, et al. suggested that a more comprehensive understanding of social anxiety is possible by incorporating “offensive” symptoms, and “conviction” of offensive symptoms, noting that this would result in three types of social anxiety (no-offensive symptoms, offensive symptoms without conviction, and offensive symptoms with conviction).

**TKS outside of Japan and Korea.** Initially TKS, particularly the offensive subtype, was believed to be unique to Japan (Kyoichi, 1987; Tarumi, Ichimiya, Yamada, Umesue, & Kuroki, 2004). Yet, recent research has indicated that this is not the case. Early studies indicated that TKS was common in Korea, and Lee (1987) found support for Kasahara’s (1987) neurotic, borderline and schizophrenic TKS subtypes in Korean populations. More recently, cases of TKS have begun to be identified in Western countries.

In one of the earliest attempts to demonstrate TKS in a Western population, Kleinknecht, et al. (1994) explored differences in self-reported social anxiety and TKS scores between Hawaiian university students with and without Japanese cultural background, finding no significant difference between the two groups on social anxiety or TKS scores. Clarvit, Schneier, and Liebowitz (1996) expanded upon this, and reported several cases of individuals with offensive type TKS who were not Japanese. Clarvit et al. found offensive TKS in patients who were born in Colombia, Pakistan and Haiti, which also have strong cultural norms favouring the group over the individual.

In a larger clinical study with an Australian population, Jinkwan, Rapee, and Gaston (2008) found that eight out of 94 participants diagnosed with social anxiety disorder also indicated TKS related concerns about having unusual physical characteristics. However, despite this, no participant met diagnostic criteria for the disorder, and Jinkwan et al. suggested that cultural differences between East Asian and Western cultures might explain why no patients met diagnostic criteria. Alternatively, the diagnostic criteria employed by Jinkwan et al. might have been too restrictive.

It is likely that Jinkwan et al.'s (2008) conclusions about TKS outside of East Asian countries were overly cautious, and their results were more promising than they had believed. It is possible that by only including cases which met DSM-IV-TR (APA, 2000) diagnostic criteria for Social Anxiety Disorder, and therefore applying DSM-IV-TR Criterion C, which requires that the patient acknowledge that their fears are unreasonable or excessive as an exclusion criteria, Jinkwan et al. might have inadvertently excluded patients who might have met criteria for TKS. Many individuals with TKS do not acknowledge their fears as unreasonable, and the most severe TKS offensive cases are firmly convinced in their beliefs (Kinoshita et al., 1994). It is unlikely that individuals who acknowledge their fears are unreasonable are likely to report having a (strong) delusional belief, which might have been interpreted in this study as a firm conviction.

It is possible that a greater number of participants would have met diagnostic criteria for TKS if the study by Jinkwan et al. (2008) had been conducted as part of a larger epidemiological study (rather than restricting the sample to only participants who met diagnostic criteria for Social Anxiety Disorder). This would have also allowed for an assessment of which DSM diagnostic category corresponds to the diagnosis of offensive subtype TKS. It is possible that even if the diagnostic overlap between Social Anxiety Disorder and TKS is only small to moderate, that individuals who do not meet criteria for Social Anxiety Disorder might meet criteria for TKS. It is also possible that if the study were to be repeated using DSM-5 criteria (see Chapter 4) which has removed Criterion C, that the overlap would have been stronger.

Treatment results in Jinkwan et al.'s study support the idea that social anxiety and TKS might represent different aspects of the same condition. Scores on both TKS scales were significantly lower post-CBT treatment, indicating that the cognitive restructuring that is successful in treating social anxiety was also effective in reducing TKS related impairments. As further support, TKS has also been shown to be effectively treated using similar drug treatments to those shown to be effective for social anxiety, such as selective serotonin reuptake inhibitors (SSRIs; Matsunaga, Kiriike, Matsui, Iwasaki, & Stein, 2001; Nagata et al., 2006), and newer serotonin–norepinephrine reuptake inhibitors (Nagata et al., 2003; Nagata, Wada, Yamada, Iketani, & Kiriike, 2005).

More convincing evidence that TKS offensive type is not culture specific has also been provided in a brief cross-national review of cases of offensive TKS conducted

by Kinoshita et al. (2008). Kinoshita et al. found evidence of TKS offensive cases which met their proposed diagnostic criteria in Holland, Korea, Australia and the United States. They concluded that TKS might not be as culture bound as previously believed and endorsed consideration of TKS symptoms when assessing social anxiety in Western countries.

### **Comparison of Taijin-Kyofusho with Western Accounts of Social Anxiety**

Despite the fact that TKS was developed from a completely different theoretical tradition to social anxiety, there are interesting similarities between TKS and the Western concept of social anxiety. Early descriptions of TKS are remarkably similar to early conceptualizations of social anxiety, with TKS being described as a complex and multifaceted disorder. Although Morita (1928/1998) described it as a phobic reaction, his descriptions of premorbid personality characteristics, and his linking it to his concept of *shinkeishitsu*, which he saw as a pervasive personality trait indicate that he did not believe that TKS was a simple phobic reaction. Instead, he seemed to indicate that TKS was a complex disorder of self, characterised by phobic like avoidance.

Like early French accounts (e.g., Hartenberg, 1901), and recent reformulations of social anxiety (e.g., Hoffmann, 1999, 2002), Morita (1928/1998) suggested that TKS was associated with narcissistic features. He observed that the disorder was associated with an excessive introspective self-focus (a preoccupation with the self), perfectionism, and a desire for social dominance. In this way, the Japanese concept of TKS is congruent with ethological accounts of social anxiety, which suggest that at the root of social fears is conflict surrounding perceptions of low social rank (or the desire for higher social rank).

Whereas Western concepts of social anxiety are divided between perspectives that emphasise that social anxiety is a simple phobic reaction (Marks, 1970a), and theoretical perspectives that suggest that social anxiety is a more complex, multifaceted and pervasive disorder, the Japanese seem to have better covered both possibilities with TKS. At the low end of the severity spectrum, TKS is thought to manifest as a phobic reaction, and at the severe end is associated with greater personality pathology (e.g., narcissistic, delusional and paranoid characteristics; Kinoshita et al., 2008).

Perhaps the most striking convergence between Western and Eastern ideas comes from Myerson's (1944) account of social anxiety discussed in Chapter 2. Myerson split social anxiety into two phases, with his first phase resembling social anxiety as it is generally conceptualized (focus on personal embarrassment and shame),

and his second phase resembling TKS (with the individual fearing offending others, and focused on the approval of others). Myerson suggested that less severe cases fell into “phase one” and more severe cases into “phase two”. But Myerson’s account is an exception in Western research in drawing attention to two types of social anxiety. It could be argued that Eastern research has focused on what may be a severe variant of social anxiety, with Western research focused on a less severe variant. This is supported by the fact that TKS has delusional and paranoid variants, whereas social anxiety does not (APA, 2013). This is also congruent with the suggestion of Kinoshita et al. which places TKS related social fears at the more severe end of the spectrum in comparison to Western social anxiety. Therefore, to properly assess social anxiety, consideration needs to TKS related fear. Of course, both types of fears may exist on continuums of severity (that is to say, fear of personal embarrassment and fear of offending others), however currently this possibility remains unanswered.

### **Chapter Summary**

The current chapter provided more compelling support for the core argument of this thesis, that for some socially anxious individuals, their social anxiety co-occurs with narcissistic characteristics. Specifically, the current chapter reveals that not only is there support for this argument across most Western social anxiety models over the past 100 years, but there is also support for this argument in theoretical models developed in other cultures. Thus, support for this argument crosses cultural as well as temporal boundaries.

More broadly, the current chapter also indicates that a potential problem with contemporary social anxiety models is their exclusive focus on Western interpretations of the disorder. Given that it has been demonstrated that TKS is not exclusively an East Asian disorder, complete understanding of social anxiety can only be achieved by integrating models of TKS with contemporary models of social anxiety.

The focus of the previous two chapters has been on theoretical models of social anxiety. Equally important to consider, are representations of social anxieties in the psychiatric nomenclature, which have both shaped and been shaped by the theoretical literature. The next chapter considers the psychiatric diagnoses of social anxiety and related conditions, and the degree to which these psychiatric models are consistent with the core argument of the present thesis, that for some socially anxious individuals, their social anxiety coexists with narcissistic characteristics.

#### **Chapter 4: Social anxiety in the psychiatric nomenclature**

To understand social anxiety as a psychiatric construct, it is necessary to place it in the evolving theoretical context which has influenced the way social anxiety is conceptualized. Shifts in theoretical focus (outlined in Chapter 2) have resulted in concomitant shifts in the way the disorder is represented in the psychiatric nomenclature, and representations of social anxiety in the psychiatric nomenclature have affected theoretical developments. Thus, theoretical and nosological representations of social anxiety are closely intertwined. The aim of the current chapter is to review the diagnostic status of social anxiety and to illustrate that, just as the theoretical concept of social anxiety has changed over time, so too has social anxiety changed as a psychiatric diagnosis.

The chapter begins with a historical review of Social Anxiety Disorder (SAD) and Avoidant Personality Disorder (AVPD) within the DSM, reviewing changes in the diagnostic criteria from DSM I (APA, 1952) to DSM 5 (APA, 2013). The DSM criteria are then compared to the primary alternative classification system, the ICD-10 (WHO, 1992), focusing on differences between SAD and AVPD in the DSM and Social Phobia and Anxious (Avoidant) Personality Disorder in the ICD. This review is then extended beyond these widely accepted diagnostic systems to also consider the Psychodynamic Diagnostic Manual [PDM], focussing on aspects of this alternative classification system which are not part of DSM and ICD, for example, pathoplasticity, which describes the interaction between the interpersonal system and psychopathology, such that different subgroups of people may experience the same symptoms but they may manifest differently depending on interpersonal characteristics (Przeworski et al., 2011).

Following the overview of the diagnostic systems, the review turns to examining how the DSM has provided a foundation for studies exploring alternative types of social anxiety. This review first covers proposed alternative subtypes that are extensions of the current DSM SAD subtypes.

#### **Social Anxiety in the Diagnostic and Statistical Manual of Mental Disorders**

Table 4.1 presents a comparative summary of diagnostic criteria relevant to Social anxiety disorder from DSM-I (1952) to DSM-IV-TR (2000). The recently released DSM-5 diagnostic criteria are presented in Table 4.2. The following sections discuss the history and defining features social anxiety in the DSM and evaluate the impact of changes made over time.

**DSM I and II.** Despite a long history of research on social anxieties (e.g., Hartenberg, 1901; Janet, 1903), social anxiety was not classified as a distinct disorder in the first or second edition of the DSM (APA, 1952, 1968). The framework of DSM I and II was a psychodynamically informed psychological and sociological model, which did not favour discrete diagnostic categories. Rather, it viewed presumed aetiology as more important than symptoms, and the boundaries between “normal” and pathological as dimensional rather than categorical (see Galatzer-Levy & Galatzer-Levy, 2007; Mayes & Horwitz, 2005). Despite this, social anxiety fell under the general category of *Psychoneurotic Disorders* in DSM I (APA, 1952) and the category of *Neuroses* in DSM-II (APA, 1968; see Table 4.1). The DSM I and II conceptualization of neurosis was theoretically congruent with prevailing psychodynamic formulations and emphasised the theory that phobias (anxiety hysteria) were the result of a displacement of fear from one object to another (i.e., the result of “free-floating” anxiety being bound to a particular object or idea; Freud, 1926/1953). Although social anxiety had been empirically investigated and classified as a discrete anxiety disorder prior to the publication of DSM-II (e.g., Dixon et al., 1957a; Sandler et al., 1958) the social anxieties subtypes identified by Sandler and colleagues were not incorporated within the DSM-II nosology.

**DSM-III.** The inclusion of social anxiety as a separate diagnostic category in DSM-III (APA, 1980) emanated from a broader paradigmatic shift in American Psychiatry toward a neo-Kraepelinian biomedical, descriptive model of psychopathology (see Feighner et al., 1972 for a precursor). The shift was manifested as a reconceptualization of the definitions and boundaries of disorders but, philosophically, it represented a shift from Plato’s categorization based on underlying “essences” of phenomena to Aristotle’s method of categorising phenomena on the basis of similarities in observable features; (Galatzer-Levy & Galatzer-Levy, 2007). The change was achieved by placing a greater emphasis on precisely operationalised symptom based criteria and less emphasis on unsubstantiated theoretical explanations, particularly on theoretical explanations of the presumed aetiology of the disorders (Galatzer-Levy & Galatzer-Levy, 2007).

Table 4.1  
*Social anxiety diagnostic criteria from DSM-I to DSM-IV-TR*

	DSM I / II	DSM III	DSM III-R / IV / IV-TR
Diagnosis	I: Psychoneurotic Disorders II: Neuroses	Anxiety Disorders	Anxiety Disorders
Classification	I: 000-x04 Phobic Reaction II: 300.2 Phobic Neurosis	300.23 Social Phobia	300.23 Social Phobia (Social Anxiety Disorder)
Criteria	I:A. Anxiety of patient becomes detached from a specific idea, object or situation and is displaced to some symbolic idea or situation in the form of a specific neurotic fear. B. Patient attempts to control his anxiety by avoiding the phobic object or situation. II: A. Characterised by intense fear of an object or situation which the patient consciously recognises as no real danger. B. Apprehension may be experienced as faintness, fatigue, palpitations, perspiration, nausea, tremor, and even panic C. Phobias are generally attributed to fears displaced to the phobic object or situation from some other object of which the patient is unaware.	A. A persistent and irrational fear of, and compelling desire to avoid, a situation in which the individual is exposed to possible scrutiny by others and fears that he or she may act in a way that will be humiliating or embarrassing B. Significant distress because of the disturbance and recognition by the individual that his or her fear is excessive or unreasonable C. Not due to another mental disorder, such as Major Depression or Avoidant Personality Disorder	A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed Panic Attack. Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people. C. The person recognizes that the fear is excessive or unreasonable. Note: In children, this feature may be absent. D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress. E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia. F. In individuals under age 18 years, the duration is at least 6 months. G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic Disorder With or Without Agoraphobia, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder). H. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it
Subtypes	Not specified	Not specified	Generalised: Used when fears are related to most social situations.
Differential diagnoses	Not specified	Criterion C Simple Phobia, Schizophrenia, Major Depression, Obsessive Compulsive Disorder, Paranoid Personality Disorder, Avoidant Personality Disorder	Criterion G Panic Disorder, Separation Anxiety Disorder, Anxiety Disorder, Avoidant Personality Disorder, Social anxiety that occurs as part of another mental disorder, Social anxiety that occurs as part of another medical condition
Major change		Inclusion of social phobia as a discrete category	

As part of the reconceptualization, the broad category of neuroses (which was seen as imprecise, and reflective of psychodynamic theories of aetiology) was removed (Townsend & Martin, 1983). With the removal and splitting up of the former category of neuroses, social anxiety was incorporated into the anxiety disorders, and on the basis of Marks' behavioural studies of phobias (e.g., Marks, 1970a; Marks & Gelder, 1966), was classified as a phobic reaction. Within the DSM-III, the label *social phobia* was employed rather than the previously accepted *Social Anxiety* (e.g., Dixon et al., 1957a). The new diagnostic category (and more broadly the new philosophical and theoretical approach of the DSM-III) was an improvement over the vague and imprecise criteria of the DSM I and II. The new method of conceptualizing disorders provided greater definitional specificity, and resulted in substantially improved interrater agreement (see Townsend & Martin, 1983; Woods, 1979).

Despite the improvements of the revised nosology, there were a number of problems associated with the diagnostic category of Social Phobia as it was presented in DSM-III. First, the classification of social anxieties as a phobic condition and the concomitant assumption that phobic reactions are related to a circumscribed stimulus led to the erroneous assumption that individuals generally only fear one type of social situation (Hofmann et al., 2004; Turner, Beidel, & Townsley, 1992). So, although the DSM-III allowed for the possibility that social phobia may be caused by a number of factors (e.g., "fears of speaking or performing in public, using public lavatories, eating in public, and writing in the presence of others" p. 227), the DSM did not consider that an individual could fear several social situations, stating that "generally an individual has only one Social Phobia" (p. 227).

A second problem was that DSM-III did not allow for a comorbid diagnosis of Avoidant Personality Disorder (AVPD) and Social Phobia. A diagnosis of Social Phobia was ruled out in instances where individuals met criteria for AVPD (see criterion C and differential diagnosis, p. 228). Widiger (2005) suggested that this was in line with the DSM requirement that more pervasive disorders be given diagnostic precedence. Moreover, one of the requirements of the diagnosis of Social Phobia was that the individual's social phobia adversely affects their life "(there is) an increasing constriction of normal activities" (p. 227; words in parenthesis added). However, the decision as to what constitutes adverse impairment was left to clinical judgement, and different interpretations of this criterion led to differences in diagnosis rates (Furmark, 2002).

An additional problem lay in the perceived severity of the disorder, with the DSM descriptive text suggesting that “unless the disorder is severe, it is rarely in itself incapacitating.” (p. 228). This statement seemed to imply that generally Social Phobia was not related to a substantial level of impairment, a factor that is at odds with a substantial body of later literature which emphasises the pervasive and disabling nature of the disorder (e.g., Izgiç, Akyüz, Doğan, & Kuğu, 2004; Nardi, 2005; Turner et al., 1992; Wittchen & Fehm, 2003).

**DSM-III-R.** The introduction of the DSM-III-R (APA, 1987) substantially modified the diagnostic criteria for Social Phobia. There was an increase from the three diagnostic criteria in the DSM-III to seven in the DSM-III-R (see Table 4.1), although some of this was the result of individual DSM-III criteria being separated into multiple criteria in the DSM-III-R (e.g., DSM-III criterion B became Criteria E and F in DSM-III-R). The first major change was that the differential diagnosis and the related criterion B were modified to allow individuals to be diagnosed with both Social Phobia and AVPD: “In Avoidant Personality Disorder, there may be marked anxiety and avoidance of most social situations. In such cases both Social Phobia and Avoidant Personality Disorder should be considered” (p. 242).

One of the most significant changes to the diagnosis of Social Phobia introduced in the DSM-III-R was the separation of the disorder into two distinct subgroups through use of a specifier embedded within the diagnostic criteria. Individuals who feared most (or all) social situations were now classified within a *generalised* subgroup (GSP), and the text indicated that in these instances, the comorbid diagnosis of AVPD should be considered. Alternatively, if individual’s fears were circumscribed, they were given the general diagnosis of Social Phobia. Although researchers later classified this group as a *non-generalised* (Heimberg, Holt, Schneier, & Spitzer, 1993), or *specific* social phobia group (Carter & Wu, 2010), the DSM-III-R did not specifically label those individuals who did not fit within the GSP group. Problematically, however, the DSM-III-R criteria did not make it clear how many situations an individual would need to fear to be assigned to the generalised group. Additionally, it was not clear whether greater weight should be given when individuals feared commonly encountered situations, or whether the decision should be made purely on number of situations feared (Turner et al., 1992). Thus, the boundary between Social Phobia and GSP was poorly defined.

Another major change was that the DSM-III-R moved away from a purely behavioural view of Social Phobia in a number of ways. First, rather than suggesting, as

Marks' (1966) behavioural model did, that Social Phobia involved a circumscribed fear, the DSM-III-R indicated that social phobic fear may be:

“circumscribed...(however,) in other cases the social phobic fears may involve most social situations, such as general fears of saying foolish things or not being able to answer questions in social situations” (p 241; words in parenthesis added).

Second, the descriptive text was more explicit about avoidance in Social Phobia, recognising that for some individuals, Social Phobia led to avoidance, whereas others “force himself or herself to endure the situation, but it is experienced with intense anxiety” (p. 214). Although the DSM-III had not explicitly suggested that Social Phobia always leads to avoidance of social situations, this possibility (that the socially anxious individual might not always avoid social situations) was not explicitly acknowledged in either the diagnostic criteria or the descriptive text.

**DSM-IV and DSM-IV-TR.** While the DSM-IV (APA, 1994) and DSM IV-TR (APA, 2000) continued to use Social Phobia as the primary label for the condition, beginning with DSM-IV “Social Anxiety Disorder” was parenthetically included following this. However, in both, the descriptive text still referred to Social Phobia rather than Social Anxiety.

The diagnostic criteria did not change much between the DSM-III-R and the subsequent DSM-IV and DSM-IV-TR. Yet, the descriptive text became substantially more detailed between DSM-III-R and DSM-IV. In particular, the DSM-IV descriptive text elaborated on some of the features of socially anxious individuals, including a “hypersensitivity to criticism, negative evaluation, or rejection; difficulty being assertive; and low self-esteem or feelings of inferiority.” (p. 413). It can be argued that within the descriptive text, a number of characteristics align with Gilbert's (1989; Trower & Gilbert, 1989) ethological/evolutionary theory of social anxiety which emphasises the centrality of perceptions of social rank in social anxiety (e.g., difficulty being assertive and feelings of inferiority). The descriptive text also noted that for some socially anxious individuals, their fear (and avoidance) may revolve around visible signs of anxiety, stating that they “may fear public speaking because of concern that others will notice their trembling hands or voice... (or) they may avoid eating, drinking,

or writing in public because of a fear of being embarrassed by having others see their hands shake” (412).

Despite the seven year gap between the DSM-III-R and the DSM-IV, a number of the problems with the DSM-III-R criteria were not adequately addressed. Despite frequent acknowledgements of the lack of precision in delineating the boundary between Social Phobia and GSP (e.g., Holt, Heimberg, & Hope, 1992; Turner et al., 1992), DSM-IV did not attempt to more precisely define the number of social situations an individual must fear to be classified under the generalised specifier. A result of this confusion was that the boundary between Social Phobia and GSP was subsequently defined in different ways by different researchers (Bögels et al., 2010; El-Gabalawy, Cox, Clara, & Mackenzie, 2010; Hofmann et al., 2004). This resulted in different reported rates of GSP, and made direct comparisons of prevalence rates across studies problematic. Additionally, there were doubts as to the need for a generalized specifier, with some studies indicating that few individuals met the operational criteria for DSM-IV generalized subtype (Stein, Torgrud, & Walker, 2000). Notably, however, those individuals who did were found to be more impaired on a number of indices.

Importantly, the DSM-IV was the first edition to suggest that the North American and European conceptualization of Social Phobia may not be universal, and to describe some elements of *Taijin-Kyofusho* (see Chapter 3). Within the descriptive text under “Culture, Age and Gender features”, the DSM-IV stated that:

“In certain cultures (e.g., Japan and Korea), individuals with Social Phobia may develop persistent and excessive fears of giving offense to others in social situations, instead of being embarrassed. These fears may take the form of extreme anxiety that blushing, eye-to-eye contact, or one's body odor will be offensive to others (*Taijin kyofusho* in Japan)” (p. 413).

However, although *Taijin-Kyofusho* (TKS) was mentioned, elements of TKS were not incorporated into the diagnostic criteria, presumably because TKS was thought to be specific to East Asian culture. This interpretation is supported by the inclusion of TKS in the DSM IV-TR Glossary of Culture Bound Syndromes (APA, 2000, p. 903), which included disorders seen to be “generally limited to specific societies or culture areas and are localized, folk, diagnostic categories that frame coherent meanings for certain repetitive, patterned, and troubling sets of experiences and observations” (p. 898).

In view of recent research which increasingly challenges the assumption that TKS is a culture bound condition (J. Kim, Rapee, & Gaston, 2008; Kinoshita et al., 2008), further changes to the DSM were warranted. For example, the DSM-IV-TR was limited as it did not incorporate all manifestations of TKS. TKS is sometimes related to a fear of offending others and in extreme cases, the individual with TKS believes that a defective part of themselves may *harm* others (Kleinknecht et al., 1997). Individuals at the less extreme end understand that this belief is unreasonable, whereas individuals at the more extreme end are convinced that they will harm others (Kinoshita et al., 2008).

At the broadest level, another difference that may have precluded the inclusion of all types of TKS within social anxiety as defined by the DSM-IV-TR is that TKS does not require the individual to acknowledge that their social fears are excessive or unreasonable to meet criteria for diagnosis (Nakamura et al., 2002). It is possible that this element was not included in the DSM because within the DSM-IV-TR nosology individuals whose social anxieties involve delusional characteristics are excluded from diagnosis.

**DSM-5.** The DSM-5 (APA 2013) represented a substantial revision of the diagnostic criteria for SAD (see Table 4.2). First, in line with suggestions leading up to the publication of the DSM-5 (Bögels et al., 2010), the DSM-5 adopted *Social Anxiety Disorder* as the primary label for the condition, with *Social Phobia* appearing parenthetically. This change represents an important shift in the way the disorder is conceptualized, and represents the culmination of a number of subtle shifts, beginning with DSM-IV, away from the previous idea of social anxiety as a circumscribed phobic reaction, and toward the idea that social anxiety is a complex *disorder of self*. As Bögels et al. observed, a change from *Social Phobia* to *Social Anxiety Disorder* may result in greater appreciation of the severity of the disorder in general medical practice (see also Heimberg et al., 2014).

The second major change to the diagnostic criteria in DSM-5 is the change to Criterion C. In previous editions of the DSM (see Table 4.1), Criterion C required that individuals acknowledge that their social fears are unreasonable. Bögels et al. (2010) noted that this criterion was originally included to differentiate social anxiety from psychotic disorders, but argued that DSM-IV-TR did not have a similar criterion for many other anxiety disorders. In DSM-5, this criterion, which is now Criterion E, suggests that fear or anxiety must be out of proportion to the actual threat posed to the individual. Thus, importantly, there is more explicit scope for clinical judgement in

instances where individuals do not believe their social fears are excessive or unreasonable. As well as bringing social anxiety diagnostic criteria in line with other anxiety disorders, this change also brings DSM conceptualized social anxiety closer to the Japanese conceptualization of TKS, which does not require that the individual be aware that their fear is unreasonable.

Table 4.2

*DSM-5 Diagnostic criteria for SAD*

Criteria	Description
A	Marked fear or anxiety about one or more social situations in which the individual is exposed to possible scrutiny by others. Examples include social interactions (e.g., having a conversation, meeting unfamiliar people), being observed (e.g., eating or drinking), and performing in front of others (e.g., giving a speech). <b>Note:</b> In children, the anxiety must occur in peer settings and not just during interactions with adults.
B	The individual fears that he or she will act in a way or show anxiety symptoms that will be negatively evaluated (i.e., will be humiliating or embarrassing; will lead to rejection or offend others).
C	The social situations almost always provoke fear or anxiety. <b>Note:</b> In children, the fear or anxiety may be expressed by crying, tantrums, freezing, clinging, shrinking, or failing to speak in social situations.
D	The social situations are avoided or endured with intense fear or anxiety.
E	The fear or anxiety is out of proportion to the actual threat posed by the social situation and to the sociocultural context.
F	The fear, anxiety, or avoidance is persistent, typically lasting for 6 months or more.
G	The fear, anxiety, or avoidance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
H	The fear, anxiety, or avoidance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.
I	The fear, anxiety, or avoidance is not better explained by the symptoms of another mental disorder, such as panic disorder, body dysmorphic disorder, or autism spectrum disorder.
J	If another medical condition (e.g., Parkinson's disease, obesity, disfigurement from burns or injury) is present, the fear, anxiety, or avoidance is clearly unrelated or is excessive.

The third major change in DSM-5 is the removal of the generalised specifier. Instead, in DSM-5, a *Performance only* specifier is included for individuals whose social fears are restricted to speaking or performing in public. Given the problems with the generalised specifier outlined previously, its removal from DSM-5 represents a significant improvement to the diagnostic criteria. Nevertheless, despite the progress made in DSM-5, there are strong arguments for the inclusion of additional, more specific social anxiety subtypes. For example, in relation to TKS, although DSM-5 now explicitly indicates that an individual's fears may centre upon offending others, the more extreme variants of TKS are still not adequately captured. While, the idea that TKS symptoms are sometimes experienced with delusional intensity is noted in the descriptive text, instances in which an individual's anxieties revolve around fear that a

defective part of the self could harm others or, in more extreme cases, a firm conviction that a defective part of the self *will* harm others is missing from the diagnostic criteria. Future revisions of DSM criteria could potentially capture these subtypes by including *fear of causing harm* and/or *conviction* subtypes.

The final major change to the DSM-5 criteria is the shift to more cross-culturally valid diagnostic criteria. As noted, in line with conceptualizations of TKS, Criterion B now includes specific references to fear of offending others. In addition, the descriptive text now explicitly refers to TKS. Importantly, whereas in DSM-IV-TR, symptoms of TKS were assumed to be restricted to East Asian cultures, DSM-5 indicates that they appear in non-Asian settings also. The text also indicates that prevalence rates of social anxiety might be underreported owing to different presentations of social anxiety.

### **Avoidant Personality Disorder in the DSM**

The alternative representation of social anxieties in the DSM is Avoidant Personality Disorder (AVPD). The following sections describe the evolution of the diagnosis of AVPD contrasting it with Social Phobia (Social Anxiety Disorder). Although DSM-I and DSM-II included a section outlining personality disorders, neither included a diagnosis within personality disorders which was similar to AVPD. Thus, the current review begins from DSM-III, when AVPD was formally introduced into the psychiatric nomenclature.

**DSM-III.** Unlike Social Phobia, which, was heavily influenced by Marks' (Marks & Gelder, 1966) behavioural conceptualization and classified as a phobic reaction, the classification of AVPD in the DSM-III was largely based on Millon's (1969, 1981) descriptions of social avoidance and social detachment (Widiger, 2005). Millon saw AVPD as a stable, pervasive disorder characterised by active, rather than passive, social withdrawal (Millon, 1981). Thus, on the basis of Millon's work, AVPD was classified as a Personality Disorder in DSM-III. Within the DSM-III, personality disorders were considered to be caused when a person's

“enduring pattern of perceiving, relating to, and thinking about the environment and oneself... (becomes) inflexible and maladaptive... (causing) either significant impairment in social or occupational functioning or subjective distress” (p. 305; words in parenthesis added).

The primary difference between Social Phobia and AVPD in the DSM-III criteria was that Social Phobia was related to a circumscribed situation (e.g., public speaking fear), whereas AVPD was thought to reflect more general avoidance of personal relationships. Moreover, unlike Social Phobia, AVPD did not require the individual to be aware of the irrational nature of their fears and nor were the presence of delusions listed under the exclusion criteria. The DSM-III diagnostic criteria for AVPD are presented in Table 4.3. In line with Millon's (1969) differentiation between active and passive social withdrawal, the criteria for AVPD were focused on differentiating the social avoidance of individuals with AVPD, who despite avoidance of personal relationships, do *seek* personal relationships (Criteria D), with the social avoidance in schizoid individuals which was not associated with a desire for social contact (Rettew, 2000).

Table 4.3

*DSM-III diagnostic criteria for AVPD*

Criteria	Description
A.	Hypersensitivity to rejection, e.g., apprehensively alert to signs of social derogation, interprets innocuous events as ridicule.
B.	Unwillingness to enter into relationships unless given unusually strong guarantees of uncritical acceptance.
C.	Social withdrawal, e.g., distances self from close personal attachments, engages in peripheral social and vocational roles.
D.	Desire for affection and acceptance.
E.	Low self-esteem, e.g., devalues self-achievements and is overly dismayed by personal shortcomings.
F.	If under 18, does not meet the criteria for Avoidant Disorder of Childhood or Adolescence.

The descriptive text of DSM-III elaborated on the impaired personal relationships of individuals with AVPD, stating that because of high sensitivity to rejection and fear of shame and humiliation, AVPD individuals tend to “withdraw from personal relationships because of fearful expectation of being belittled or humiliation” (p. 323), and so tend to have very few close friends. This is in contrast to Social Phobia, in which an individual whose social fears revolved solely around public speaking fear could have otherwise normal personal relationships. Thus, in the DSM-III, the descriptive text for AVPD indicates that AVPD represents a more severe form of social fears than Social Phobia.

One of the most interesting features of the DSM-III AVPD criteria is the similarity between AVPD and narcissism. Like narcissists (see Chapter 5 on clinical

theories of narcissism) individuals with AVPD were characterised as hypersensitive to rejection (Criteria A), desiring uncritical acceptance from relationships (Criterion B), and having a desire for acceptance (Criterion D). Additionally, there are suggestions that AVPD, like narcissism is associated with a strong sense of entitlement. This is most evident in the expectation of the individual for the uncritical approval of others.

It is possible that the greater overlap between social fears and narcissistic characteristics evident in AVPD (certainly when compared to Social Phobia) is because AVPD does not assume that social withdrawal was a phobic reaction. An analysis of DSM-III personality disorders by Bursten (1982) supports this speculation. Bursten concluded that each of the DSM-III personality disorders were characterised by narcissistic elements. He suggested that AVPD is characterised by “strong narcissistic underpinnings which are not expressed” (p. 418). The link is supported by the fact that the excessive shyness of individuals with AVPD is also a characteristic of some narcissists.

Bursten (1982) suggested that the underlying grandiosity of AVPD individuals might become apparent to the therapist over the course of therapy (e.g., via patterns of transference and countertransference). He proposed that the narcissism of AVPD individuals is similar to that of dependent individuals, but indicated that the two can be separated on the basis of the rage felt by AVPD individuals when they do not receive the uncritical approval from others they feel they are entitled to. While interesting, Bursten’s suggestions are yet to be evaluated empirically.

The DSM-III conceptualization of AVPD did not completely address the contradictory nature of social anxieties which formed part of the early literature (see Chapter 2). There was, however, an explicit acknowledgement that AVPD was associated with a simultaneous desire for personal relationships as well as avoidance of them. It was also suggested in the diagnostic criteria that an individual with AVPD might seek “peripheral” social contact (in which there was less threat of rejection) by choosing particular social and occupational roles (Criterion C).

**DSM-III-R.** The major change in the diagnosis of AVPD in DSM-III-R (APA, 1987), was the expansion of the diagnostic criteria from six diagnostic criteria in DSM-III to seven. A list of DSM-III-R criteria for AVPD is displayed in Table 4.4. However, the DSM-III-R only required five of the seven criteria be met. This left open the possibility of slightly different presentations of AVPD depending upon which set of five criteria were satisfied.

Table 4.4

*DSM-III-R diagnostic criteria for AVPD*

Criteria	Description
1	Is easily hurt by criticism or disapproval
2	Has no close friends or confidants (or only one) other than first-degree relatives
3	Is unwilling to get involved with people unless certain of being liked
4	Avoids social or occupational activities that involve significant interpersonal contact, e.g., refuses a promotion that will increase social demands
5	Is reticent in social situations because of a fear of saying something inappropriate or foolish, or of being unable to answer a question
6	Fears being embarrassed by blushing, crying, or showing signs of anxiety in front of other people
7	Exaggerates the potential difficulties, physical dangers, or risks involved in doing something ordinary but outside his or her usual routine, e.g., may cancel social plans because she anticipates being exhausted by the effort of getting there

Unlike DSM-III, which dealt primarily with social withdrawal, the DSM-III-R (APA, 1987) criteria also make reference to the behaviour of AVPD individuals in social situations. It is proposed that they are “reticent in social situations because of a fear of saying something inappropriate or foolish, or of being unable to answer a question” (p. 353; Criterion 5). The DSM-III-R also added a fear of showing visible symptoms of anxiety (Criterion 6). These criteria and Criterion 4, “avoids social or occupational activities that involve significant interpersonal contact” (p. 353) all significantly overlap with the criteria for Social Phobia (Widiger, 1992). It could be argued that because AVPD no longer precluded a diagnosis of SAD, that strict differentiation of the disorders was no longer necessary. Yet, the blurring of the difference between SAD and AVPD created confusion as to whether the DSM was describing two distinct disorders, or two manifestations of the same disorder (Rettew, 2000). Widiger (2005) suggested some of these criteria were included on the basis of criticisms that the DSM-III AVPD criteria did not include some elements associated with the “phobic character” in psychodynamic theory. However, the result was for social phobia and AVPD to overlap.

The descriptive text of DSM-III-R is also more detailed than DSM-III. In particular, a core component of the DSM-III description that was elaborated on was the suggestion that AVPD was associated with a strong desire for uncritical acceptance and a lack of personal relationships. The DSM-III-R specified that these characteristics of AVPD often lead to a number of outcomes, including more general timidity, and an aversion to new experiences because of an overestimation of the dangers and risks

associated with such activities. This description is important for two reasons. First, it allowed for some degree of differentiation between AVPD and Social Phobia, given that the avoidance of situations is assumed to be broader (i.e., not strictly related to social fears) in AVPD than Social Phobia. Furthermore, this description further reinforced a major difference between Social Phobia and AVPD in relation to understanding the irrational nature of fears. Thus, as with DSM-III, an individual would not be excluded from a diagnosis of AVPD if their symptoms had a delusional basis.

**DSM-IV and DSM-IV-TR.** Like Social Phobia, the diagnostic criteria did not change much between DSM-III-R in 1987 and DSM-IV in 1994, and DSM-IV-TR in 2000. DSM-IV diagnostic criteria for AVPD are displayed in Table 4.5. The primary difference introduced in DSM-IV was that the descriptive text was expanded, with more specific descriptions of characteristics of individuals with AVPD. In particular, the descriptive text is clearer on the disability associated with AVPD, reinforcing its severity, noting that the individual's desire for uncritical approval might lead them to turn down employment opportunities and may make interpersonal intimacy difficult, or unlikely. This text differentiated SAD and AVPD and illustrates that AVPD is associated with more substantial impairment. For example, where individuals with SAD might have severe social anxieties surrounding interacting with strangers, unlike many individuals with AVPD, they may have no difficulty in interacting with a romantic partner once in a romantic relationship (notwithstanding the difficulty of initiating such a relationship).

Table 4.5

*DSM-IV diagnostic criteria for AVPD*

Criteria	Description
1	Avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection
2	Is unwilling to get involved with people unless certain of being liked
3	Shows restraint within intimate relationships because of the fear of being shamed or ridiculed
4	Is preoccupied with being criticized or rejected in social situations
5	Is inhibited in new interpersonal situations because of feelings of inadequacy
6	Views self as socially inept, personally unappealing, or inferior to others
7	Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

Within the DSM-IV (APA, 1994) the “Associated Features” expanded slightly on the relationship between AVPD and narcissistic characteristics. In addition to discussing hypersensitivity to rejection and criticism, the text notes that AVPD individuals have a tendency to “fantasize about idealized relationships with others” (p. 663). Additionally, given the lack of personal relationships, the text observes that individuals with AVPD become unusually attached to, and dependent upon the few social contacts they have.

**DSM-5.** The biggest change introduced in the DSM-5 (APA, 2013) in relation to personality disorders is the inclusion of an alternative method of dimensionally conceptualizing personality disorders in the Emerging Measures and Models section of DSM-5. The broad diagnostic criteria for personality disorders are presented in Table 4.6. Within this framework, personality disorders are assessed based on impaired personality functioning (Criterion A), pathological personality traits (Criterion B), which leads to impairments in functioning (Criteria C) which are stable over time (Criterion D).

Table 4.6

*DSM-5 general criteria for personality disorders*

Criteria	Description
A	Moderate or greater impairment in personality (self/interpersonal) functioning.
B	One or more pathological personality traits.
C	The impairments in personality functioning and the individual’s personality trait expression are relatively inflexible and pervasive across a broad range of personal and social situations.
D	The impairments in personality functioning and the individual’s personality trait expression are relatively stable across time, with onsets that can be traced back to at least adolescence or early adulthood.
E	The impairments in personality functioning and the individual’s personality trait expression are not better explained by another mental disorder.
F	The impairments in personality functioning and the individual’s personality trait expression are not solely attributable to the physiological effects of a substance or another medical condition (e.g., severe head trauma).
G	The impairments in personality functioning and the individual’s personality trait expression are not better understood as normal for an individual’s developmental stage or sociocultural environment.

The proposed alternative diagnostic criteria for AVPD (see Table 4.7) correspond to general criteria A and B presented in Table 4.6. The proposed alternative criteria for AVPD are similar to DSM-IV (APA, 1994) criteria for AVPD, and again, highlight some overlaps with narcissistic characteristics, such as excessive shame (A1), sensitivity to criticism (A3) and perfectionism (A2).

Although the DSM-5 (APA, 2013) presents the alternative dimensionally based diagnostic criteria for AVPD in section 3 (emerging measures and models), within section 2 (diagnostic criteria and codes), the categorical conceptualization of personality disorders is retained, consistent with previous editions of the DSM. In section 2, the diagnostic criteria for AVPD remain unchanged from those in DSM-IV (APA, 1994).

Table 4.7

*DSM-5 proposed alternative criteria for AVPD*

Criteria	Description
A	<ol style="list-style-type: none"> <li>1. Identity: Low self-esteem associated with self-appraisal as socially inept, personally unappealing, or inferior; excessive feelings of shame.</li> <li>2. Self-direction: Unrealistic standards for behaviour associated with reluctance to pursue goals, take personal risks, or engage in new activities involving interpersonal contact.</li> <li>3. Empathy: Preoccupation with, and sensitivity to, criticism or rejection, associated with distorted inference of others' perspectives as negative.</li> <li>4. Intimacy: Reluctance to get involved with people unless being certain of being liked; diminished mutuality within intimate relationships because of fear of being shamed or ridiculed..</li> </ol>
B	<ol style="list-style-type: none"> <li>1. Anxiousness (an aspect of Negative Affectivity): Intense feelings of nervousness, tenseness, or panic, often in reaction to social situations; worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful, apprehensive, or threatened by uncertainty; fears of embarrassment.</li> <li>2. Withdrawal (an aspect of Detachment): Reticence in social situations; avoidance of social contacts and activity; lack of initiation of social contact.</li> <li>3. Anhedonia (an aspect of Detachment): Lack of enjoyment from, engagement in, or energy for life's experiences; deficits in the capacity to feel pleasure or take interest in things.</li> <li>4. Intimacy avoidance (an aspect of Detachment): Avoidance of close or romantic relationships, interpersonal attachments, and intimate sexual relationships.</li> </ol>

### **The Relationship Between SAD and AVPD**

Heimberg et al. (2014) noted that in DSM-III, clinicians used the category of Social Phobia to represent cases where social fears were limited to one discreet situation. In contrast, the diagnosis of AVPD is used in cases where social fears were more widespread.

Beginning with the DSM-III-R (APA, 1987) this changed given that Social Phobia/SAD and AVPD could be diagnosed as comorbid conditions. Furthermore,

revisions to the criteria of AVPD within subsequent editions of the DSM further blurred the boundary between the two conditions. Some AVPD criteria became more similar to SAD criteria. Indeed, empirical investigations of SAD and AVPD have identified a high degree of overlap, although analysis of the overlap between the conditions is difficult, and depends upon the edition of the DSM, and on how the distinction between GSP and SAD is made (i.e., how the researchers determine what constitutes “most” social situations) .

In a cluster analytic study, Chambless, Fydrich, and Rodebaugh (2008) identified mixed support for the differentiation of AVPD and GSP. In a clinical sample, they identified two clusters, one characterised by GSP alone, and one by GSP and AVPD. Initial analyses revealed a number of differences between the groups, however, after controlling for severity of social phobia, the groups only differed on self-esteem, fear of negative evaluation and shyness, with the GSP and AVPD group evincing worse adjustment. On this basis, they concluded that AVPD was best conceptualized as a severe form of SAD rather than a distinct category. Although all participants met criteria for SAD, and were selected based on behavioural manifestations of anxiety, it is unclear whether inclusion of participants on the basis of AVPD rather than SAD criteria would have changed the results. Nevertheless, Chambless et al.’s sample size ( $N = 55$ ) was relatively small and this might have made differentiation of the classes difficult after controlling for severity of Social Phobia.

Whereas Chambless et al. (2008) examined AVPD in individuals diagnosed with SAD, Ralevski et al. (2005) examined the relationship between SAD and AVPD in a sample with a primary diagnosis of AVPD. Comparing AVPD alone to AVPD and SAD, they found the two groups could not be meaningfully distinguished on comorbid disorders or treatment outcomes. On this basis, they differed somewhat from Chambless et al., and suggested that the two disorders should be merged in future editions of the DSM. Similarly, Tillfors, Furmark, Ekselius, and Fredrikson (2004) observed that socially anxious individuals with and without AVPD could not be differentiated in terms of social distress or number of feared situations. However, socially anxious individuals with AVPD had greater reductions in functioning relative to those without AVPD.

The results of Chambless et al. (2008), Tillfors et al. (2004), and a number of other studies suggest that SAD and AVPD exist on a continuum, with AVDP representing a more severe manifestation of social anxieties (Turner et al., 1992). For

example, it has been shown that individuals with AVPD (with or without SAD) are more distressed and have more interpersonal problems than individuals with SAD alone (Hummelen, Wilberg, Pedersen, & Karterud, 2007). Additionally, those with AVPD are also more depressed (E. J. Brown, Heimberg, & Juster, 1995; Huppert, Strunk, Ledley, Davidson, & Foa, 2008), have poorer social skills (Tran & Chambless, 1995; Turner et al., 1992) and report more social avoidance and social distress (Herbert, Hope, & Bellack, 1992; Turner et al., 1992; van Velzen, Emmelkamp, & Scholing, 2000).

An alternative way of examining the SAD/AVPD overlap came from Carter and Wu (2010) who proposed that while GSP and AVPD seem to fall on a continuum, “single social phobias”, similar to earlier behavioural ideas of a discrete social phobia, appeared more similar to a *fear* based disorder, whereas GSP and AVPD were more *distress* based disorders. Thus, Carter and Wu suggest that social anxieties might be a phenomenon best represented by changes along two dimensions; fear and distress.

Suggestions as to how the overlap between SAD and AVPD should be addressed in subsequent editions of the DSM vary. For example, it has been suggested that AVPD should be deleted, and changes made to the SAD criteria to incorporate the more severe elements of AVPD (J. Reich, 2000). Widiger (2005) observed that arguments for deleting AVPD often revolve around the success of treatments (e.g., brief psychopharmacological treatments) for AVPD which is taken as strong evidence against the assumption that social anxieties are best represented as a personality disorder (i.e., “enduring patterns of perceiving, relating, and thinking about the environment...(causing) significant functional impairment or subjective distress” (APA, 2000, p. 686; words in parenthesis added).

The idea that efficacy of AVPD treatment meant that SAD ought to be retained over AVPD, however, was criticised by Widiger (2005). Specifically, Widiger argued, that this proposition was based on an erroneous assumption about personality disorders. Indeed, the DSM states “the coding of personality disorders on Axis II should not be taken to imply that their pathogenesis or range of appropriate treatment is fundamentally different from that for the disorders coded on Axis I” (APA, 2000, p. 28). Thus, even if AVPD responds to pharmacotherapy, this does not necessarily indicate that it is better represented as an anxiety disorder and a number of reviews have suggested that pharmacotherapy can result in symptom reduction in personality disorder patients (Davis, Janicak, & Ayd, 1995; Sperry, 2006).

### **Social Anxieties in the International Classification of Diseases (ICD)**

Although British and North American Psychiatry tends to focus on a DSM nosology, an alternative classification system is the International Classification of Disease (World Health Organisation [WHO], 1992). Unlike the DSM, which includes a single set of diagnostic criteria for clinical use and research, the ICD has separate diagnostic criteria for research and clinical use. The following discussion relies on the clinical diagnostic criteria.

**Social Phobia.** ICD also treats social anxiety as a phobic condition and subsumes Social Phobia under the category of phobic anxiety disorders, which is part of the broader category of Neurotic, Stress-related and Somatoform Disorders. However, the ICD-10 (WHO, 1992) has fewer, and less restrictive criteria than the DSM (Kaminer & Stein, 2003).

Within the ICD-10, a diagnosis of social anxiety is made on the basis of three criteria (A to C) which must all be met. Criterion A is an exclusion criterion differentiating social anxiety from social fears revolving around delusional or obsessional thoughts. Criteria B and C revolve around the phobic aspects of social anxiety. For Criterion B to be met, anxiety must be restricted predominantly to social situations, where Criterion C requires that phobic situations are avoided wherever possible.

In the ICD, there are two subtypes of social phobia. The first is a *discrete* subtype in which the individual's anxiety is focused on a specific fear (e.g., public speaking). This is similar, but more flexible than the DSM-5 (APA, 2013) performance only subtype, in that it allows for specific fears in other domains. The second is a *diffuse* subtype, which describes an individual whose anxiety involves "almost all social situations outside the family" (p. 137). This corresponds with SAD in the DSM.

Like the DSM, the ICD-10 is largely based on a Western perspective. Reference is made in the descriptive text that "direct eye-to-eye confrontation may be particularly stressful in some cultures" (p. 137), which appears to be based on early TKS studies (e.g., Kasahara, 1986). Yet, there are no references to TKS in the diagnostic criteria.

Analysis of the DSM-5 (APA, 2013) and ICD-10 (WHO, 1992) criteria reveal interesting differences. Whereas the ICD requires that individuals avoid phobic situations where possible, DSM is more explicit that avoidance is not always a characteristic, and allows for the possibility that some individuals may not avoid the social situations, but may endure them with marked distress (Criterion D). On the other hand, the DSM specifies that the diagnosis of social anxiety should only be made in

instances where social anxiety impacts the individual's normal routine or functioning, while the ICD does not have a comparable criterion.

**Anxious (avoidant) personality disorder.** Like the DSM, the ICD also has a second diagnosis related to social fears, *Anxious Personality Disorder* (AnPD), which corresponds to the DSM AVPD. Unlike the ICD description of Social Phobia, the diagnostic criteria for AnPD are brief. A diagnosis of AnPD is made on the basis of six criteria. A number of the AnPD criteria are almost identical to the DSM criteria, and AnPD criteria B, C, and D have direct equivalents in the DSM AVPD criteria (Criteria 6, 4 & 2).

Unlike AVPD, the criteria for AnPD include general feelings of anxiety and worry ("pervasive feelings of tension and apprehension"; Criterion A), and make reference of a restricted lifestyle because of a need for Physical security (Criterion E). Thus, the primary difference between AVPD and AnPD is the inclusion in the AnPD criteria of elements of broader anxiety and worry.

### **Psychodynamic Diagnostic Manual (PDM)**

Alongside the DSM (APA, 2013) and the ICD (WHO, 1992), diagnostic manual, the *Psychodynamic Diagnostic Manual* (PDM; PDM Taskforce, 2006) was developed in 2006. The PDM was developed to supplement the DSM and ICD by providing a complimentary idiographic (Halasz, 2008) rather than nomothetic approach to diagnosis. Despite its grounding in psychodynamic theory, the PDM has been reported as useful by psychologists from a range of theoretical perspectives (e.g., CBT and systems; Gordon, 2009). In a study of psychologists of various theoretical perspectives (including CBT), Gordon found that over 90% of participants viewed the PDM favourably, with psychologists reporting that they felt that the PDM could help them understand a person's full range of mental health. They also reported that the PDM illustrated the usefulness of borderline as a personality organisation rather than as a disorder.

Gordon (2009) also found that psychologists believed the PDM's conceptualization of levels of personality organisation were useful to clinical practice, although this was rated lower by CBT oriented psychologists than by other psychologists. The differentiation of three levels of personality disorders is a unique feature of the PDM. The first level, healthy personality, includes symptomatic individuals with adequate coping techniques. In contrast, individuals with neurotic personality disorders are described as more rigid, responding to stressors with a limited

range of defences and coping mechanisms. Finally, individuals with borderline personality disorders have recurrent relationship difficulties, problems with emotional intimacy and work, and are at greater risk of self-harm via reckless behaviours than those with neurotic personality disorders.

The PDM compliments a DSM diagnosis of Social Anxiety Disorder by allowing concurrent assessment of an individual's level of personality disorder. An individual with DSM-diagnosed Social Anxiety Disorder would be expected to present with different problems, and respond to anxiety provoking situations differently, depending on the Personality level at which they were functioning. For example, an individual at a neurotic level might present differently, and need different types of interventions than an individual at a borderline level. Thus, the PDM provides a pathoplastic view of anxiety disorders, suggesting that although people may experience the same anxieties around social interactions, evaluation and appraisal, the way they respond to this anxiety differs. Rather than just representing different levels of severity, qualitative rather than quantitative differences are expected between neurotic and borderline socially anxious individuals.

The idea of social anxiety as a pathoplastic disorder is consistent with Japanese theories of TKS. As reviewed in the previous chapter, Kasahara (1987) differentiated between *neurotic* and *delusional* TKS (which is conceptually congruent with the borderline level of personality organisation). Thus, a combination of the PDM and DSM provides a closer approximation to the Japanese conceptualization of the disorder.

### **Summation of Social Anxiety as a Diagnosis**

Reviewing the diagnostic history, and current status of social anxiety within the psychiatric nomenclature, it is clear that the diagnosis of social anxiety has developed in parallel with particular theoretical lines, notably intersecting with behavioural and cognitive-behavioural theories. Additionally, with the exception of the PDM, which does not specifically describe social anxiety, the depictions of social anxiety are still largely based on behavioural theories, or on extensions of behavioural theories of social anxiety. As of DSM-5, however, this has begun to shift (i.e., change from social phobia as the primary label to Social Anxiety Disorder).

A result of this theoretical focus is that neither the DSM nor the ICD conceptualizations of social anxiety account for many of the characteristics of the disorder described in earlier pre Marks (Marks & Gelder, 1966) literature, such as the contradictory nature of social anxiety, and the co-existence of reticence and shyness

with misanthropy, excessive pride and narcissistic characteristics (e.g., Dixon et al., 1957a; Hartenberg, 1901). It is certainly possible that one of the factors which contributed less empirical attention on these elements of social anxiety is that they do not appear in the official psychiatric nomenclature.

A possible explanation as to why these elements are not well covered in the DSM, is that between DSM-III (APA, 1987) and DSM-IV-TR, changes to the social anxiety diagnostic criteria took the form of minor revisions rather than major changes (although arguably the changes in DSM-5 were more substantial). Thus, within the Psychiatric nomenclature the paradigmatic shift away from a conceptualization of social anxiety as a phobic reaction and toward the understanding that social anxiety is a complex, multifaceted disorder of self (as noted in Chapter 2) is a slow one. Nevertheless, as noted, the DSM-5 (APA, 2013) does represent a substantial shift toward this.

### **Social Anxiety Subtypes**

Many of the attempts to explore alternative manifestations of social anxiety have grown out of research attempting to identify distinct subtypes of social anxiety. The following sections review recently proposed alternative subtypes to those in the DSM.

**Alternatives to the DSM subtypes.** Recent research has begun to consider alternatives to classifying SAD on the basis of number of feared situations (Stein et al., 2000; Vriends, Becker, Meyer, Michael, & Margraf, 2007) or type of feared situations (Perugi et al., 2001; Piqueras, Olivares, & López-Pina, 2008; Stein & Deusch, 2003). Some of these studies have considered extended conceptualizations of SAD, which share similarities with the contemporary theoretical extensions of social anxiety discussed in Chapter 2. Additionally, these studies have explored aspects of the disorder that, although covered in historical and contemporary theoretical literature (see Chapter 2), are not currently well covered within the DSM. The two primary models are those of Kachin, Newman and Pincus (2001), who discussed friendly-submissive and hostile dominant subtypes, and Kashdan and colleagues (e.g., Kashdan, Collins, & Elhai, 2006), who described avoidance motivated and approach-motivated subtypes.

***Friendly-Submissive and Hostile-Dominant Subtypes.*** Kachin, Newman, and Pincus (2001) argued that one way to improve the DSM conceptualization of social anxiety is to consider a broader range of ways of coping with social anxiety. Consistent with a pathoplasticity model, they suggested that an analysis of interpersonal aspects of social anxiety might reveal distinct patterns of coping with these symptoms and

resultant problems. Consistent with earlier social anxiety literature (e.g., Hartenberg, 1901), Kachin et al. suggested that for some individuals, social anxiety symptoms might result in maladaptive responses such as lack of emotional expression, perfectionism, dominant and controlling behaviours, and hostility.

To explore the importance of interpersonal aspects, Kachin et al. (2001) compared three groups comprising 30 participants who met DSM-IV-TR (APA, 2000) diagnostic criteria for Generalised Social Phobia, 30 participants who met criteria for non-generalized social phobia, and a group of 30 non-anxious controls. An initial comparison of interpersonal characteristics of the three groups revealed a complex and contradictory portrait of socially anxious individuals. Individuals who met DSM-IV-TR criteria for Generalised and non-generalised social phobia were more socially avoidant, unassertive and exploitable than controls. However, individuals who met criteria for Generalised Social Phobia were also more domineering, vindictive and cold than both non-generalised individuals and controls.

Extending on this, in an attempt to identify unique groups based on interpersonal characteristics, Kachin et al. (2001) conducted a cluster analytic study of Inventory of Interpersonal Problems Circumplex Scale (IIP-C; Alden, Wiggins, & Pincus, 1990). They found support for two types of social anxiety: a *friendly-submissive* variant, and a *hostile-dominant* variant. Compared to the friendly-submissive-group, the hostile-dominant group was more domineering and vindictive. The friendly-submissive group, on the other hand, had greater problems surrounding assertiveness, exploitability and over nurturance (relative to the hostile-dominant group).

Despite some differences between the two groups, Kachin et al. (2001) found that the two groups did not differ on the interpersonal dimensions of coldness or intrusiveness. There were also no significant differences in level of self-reported social anxiety, clinician rated social anxiety related impairment, or number of situations feared and avoided between the new subtypes. Nor were there significant differences in anxiety, depression or comorbid diagnoses. Importantly, these results suggest that these new social anxiety subtypes cannot be subsumed within the dimensional symptom severity models (e.g., Vriends et al., 2007).

Moreover, the groups were not simply alternative labels for existing DSM groups. An assessment of the composition of the groups also revealed no significant group differences in ratio of DSM-IV-TR classified Generalized Social Phobia and non-generalized social phobia. Thus, this alternative grouping appeared to have incremental

validity over the existing DSM classification (Kashdan & Hofmann, 2008). Based upon this, Kachin et al. suggested that although both groups have similar experiences of social anxiety, they experience different reactions from others, which serve to maintain and reinforce their social anxiety. This is interesting, because it extends on the cognitive-behavioural (e.g., D. M. Clark & Wells, 1995) theories of reinforcement of social fears, and could potentially be used to understand treatment relapse and non-response.

***Approach-Motivated and Avoidance-Motivated Subtypes.*** Extending on Kachin et al.'s (2001) research, Kashdan et al. (2006) explored the relationship between social anxiety, risk taking and aggressive behaviours. Situational expectancies (positive or negative) were found to mediate the relationship between social anxiety and risk-taking/aggressive behaviours. Socially anxious individuals who had strong positive expectancies engaged in more risk taking and aggressive behaviours. Kashdan et al. suggested that the goal of such behaviours could be to enhance social status. Alternatively, these behaviours could represent a strategy allowing the individual some perceived control over their anxiety symptoms.

Kashdan et al. (2006) suggested that concerns about social rank might explain the tendency for some individuals to engage in risky behaviours, proposing that from an evolutionary perspective, such strategies could be aimed at securing higher social rank. It is possible, however, and consistent with Gilbert's (1989, 2001) evolutionary/ethological model which emphasises the importance of social rank, that the behaviour of socially anxious individuals who do not engage in risky behaviours (as well as the behaviour of those who do) can also be explained by social rank theory. In this framework, both groups might be concerned with higher social rank, but use different strategies to achieve this goal.

Extending on Kashdan et al.'s (2006) link between social anxiety and risk-taking/aggressive behaviours, Kashdan and Hofmann (2008) observed that Cognitive-Behavioural theories tend to emphasise the hypersensitivities of socially anxious individuals to the social cost of negative outcomes. According to these theories, this hypersensitivity leads socially anxious individuals to utilize what Kashdan and Hofmann described as an *avoidance-motivated* strategy (e.g., avoidance, inhibition and passivity) to cope with their social anxiety. Kashdan and Hofmann proposed that Kashdan et al.'s (2006) results suggest that a small number of socially anxious individuals might use alternative *approach-motivated* strategies (e.g., impulsivity,

exploratory tendencies and a tendency to engage in risky behaviours) to cope with their social anxiety symptoms. They pointed out that although the strategies are qualitatively distinct, their goals are the same; that is, regulation of social anxieties.

To test the notion that there might be distinct social anxiety subtypes, which utilize alternative strategies to cope with social anxiety symptoms, Kashdan and Hoffmann (2008) conducted a cluster analysis of a clinical sample of 82 participants diagnosed with DSM-IV-TR (APA, 2000) Generalised Social Phobia. They found support for two subtypes of social anxiety, which corresponded to the *avoidance-motivated* (characterised by avoidance patterns and low novelty seeking) and *approach-motivated* variants (characterised by high novelty seeking) they had postulated. The subtypes did not differ in social anxiety severity. There were gender differences, however, with significantly more men classified in the *approach-motivated* group.

In a replication and extension, Kashdan, Elhai, and Breen (2008) identified support for three social anxiety groups, a “low” social anxiety group, and the *approach-motivated*, and *avoidance motivated* groups identified previously. Multivariate results revealed that the *approach-motivated* group was less well adjusted, with more frequent anger, less psychological flexibility, and greater problems with interpersonal relationships. An assessment of various behavioural frequencies revealed that the approach-motivated group engaged in more frequent social interactions, substance use and aggression. Interestingly, the approach-motivated group had a greater level of social activity than the “low” social anxiety and the avoidance-motivated group. Kashdan et al. indicated, however, that the quality of these social activities was lower, with the approach-motivated individuals reporting the highest levels of in-situation negative self-appraisals. This result further reinforces that social anxiety definitions centred upon passivity and withdrawal are narrow and do not capture all socially anxious individuals.

Further support for the two social anxiety subtypes comes from a larger study conducted by Kashdan, McKnight, Richey, and Hofmann (2009). A latent class cluster analysis was conducted on National Comorbidity Survey-Replication Data, comprising 679 individuals with a current diagnosis of social anxiety, and 1,143 individuals with a lifetime diagnosis of social anxiety. Results supported the two social anxiety subtypes previously identified by Kashdan and colleagues (Kashdan et al., 2008; Kashdan & Hofmann, 2008). Importantly, Kashdan et al. (2009) found that the subtypes could not be accounted for by social anxiety symptom severity, type of situations feared, or

number of feared situations, indicating that the subtypes were not redundant within alternative methods of classifying social anxiety.

***Summation of Kachin et al. and Kashdan and colleagues subgroups.*** Although there are differences in the subtypes identified by Kachin et al. (2001) and Kashdan and colleagues (Kashdan et al., 2008; Kashdan & Hofmann, 2008), there are a number of points of convergence. Both research groups deal with social anxiety subtypes that are qualitatively distinct from the current DSM-5 conceptualizations. Furthermore, both groups find that the types of social anxiety identified are not redundant with previous DSM-IV-TR (APA, 2000) or current DSM-5 subtypes. Both the *hostile-dominant* and the *approach-motivated* subtypes describe individuals who are domineering, aggressive and vindictive, who engage in more social interactions, but who have more severe maladjustment.

Although Kashdan, et al. (2006) made reference to evolutionary theory in attempting to explain why some socially anxious individuals engage in risk-taking behaviours, they did not consider the possibility that the strategies of both social anxiety subtypes they identified (the approach motivated and the avoidance motivated) could be understood with reference to social rank theory. As discussed in Chapter 2, Gilbert (2001; Trower & Gilbert, 1989) proposed that individuals differ in the types of goals they pursue. It is possible that the *avoidance-motivated* and *friendly-submissive* variants are motivated by second level goals, namely to avoid harm through manifest displays of submissiveness. The *approach-motivated* and *hostile-dominant* subgroups on the other hand, are most likely motivated by first level goals, of being socially dominant.

Another point of convergence between the two lines of research, is that both Kachin et al. (2001) and Kashdan and colleagues' (Kashdan & Hofmann, 2008; Kashdan et al., 2009) models also support a relationship between social anxiety and anger. In line with Sandler et al. (1958) who suggested that overt anger and aggression were a characteristic of a particular subgroup of socially anxious individuals (viz. Social Anxiety Type C), both Kachin et al. (2001) and Kashdan and colleagues (Kashdan et al., 2008) identified a subtype of social anxiety associated with overt anger. It is possible, but hitherto unexplored, that most socially anxious individuals experience high levels of anger, but that some (e.g., the hostile-dominant and approach motivated) experience more overt anger, whereas others experience more covert or self-directed anger (this would be consistent with psychodynamic theories on inhibition of aggression; e.g., Fenichel, 1945). It would be difficult however, to gauge this outside of

a therapeutic setting. The only way to determine this would be to assess, as Kaufman (1941) did whether treatment gains were associated with increased tendencies to express anger.

### **Chapter Summary and Conclusions**

The current chapter has reviewed the history and current status of social anxieties in the psychiatric nomenclature. A number of limitations in the way the disorder is currently presented were identified. Primarily, the disorder is conceptualized in a narrow way, and the DSM and ICD do not cover variants of social anxiety that have been discussed in earlier literature or in recent reformulations of social anxiety. Specifically, the strong overlap between social anxiety and narcissistic characteristics discussed in both historical literature and recent reformulations of social anxiety (Dixon et al., 1957a; Hoffmann, 1999, 2002) is not addressed in either the DSM or ICD.

A number of promising attempts to improve the psychiatric conceptualization of social anxieties by exploring alternative subtypes have been explored. The most interesting alternative subtypes are the *Friendly-Submissive* and *Hostile-Dominant* subtypes proposed by Kachin et al. (2001) and the *Approach-Motivated* and *Avoidance-Motivated* subtypes of Kashdan and colleagues (Kashdan & Hofmann, 2008). Although these subtypes are relatively new, and have not been extensively studied, the validity of these proposed subtypes is reinforced by the fact that there are a number of points of convergence between the subtypes proposed by Kachin et al., and Kashdan and colleagues, such as a focus on social rank, and problems with anger expression. Moreover, it should be noted that the *approach-motivated* and *avoidance-motivated* subtypes have been consistently replicated in a number of clinical (Kashdan & Hofmann, 2008) and non-clinical (e.g., Kashdan et al., 2008) samples, which further supports their validity.

The alternative representations of social anxiety are promising, particularly in that they present an extended conceptualization of social anxiety. Although the relationship between social anxiety and narcissistic characteristics evident in a number of theories discussed in Chapter 2 is not directly discussed, the subtypes elucidated indirectly support such a relationship. Indeed, many of the characteristics of the *hostile-dominant* and *approach-motivated* socially anxious individuals, such as aggressive, domineering, vindictive behaviour, and impulsivity are similar to narcissistic personality characteristics, and are consistent with theories described in Chapter 2. Thus, the models are consistent with the core arguments of this thesis, that for some

socially anxious individuals, their social anxieties co-exist with narcissistic characteristics.

The previous chapters have focused on theoretical and empirical work on social anxiety which provides preliminary support for the idea of a relationship between social anxiety and narcissism. Building on this, the next chapters review theories of narcissism to determine whether a relationship between social anxiety and narcissism is consistent with theoretical and empirical literature on narcissism.

## Chapter 5: The Clinical Perspective on Narcissism

Narcissism is a broad and enigmatic construct which has been defined in various ways to describe a number of dynamic, intrapsychic and interpersonal processes. Broadly speaking, there are two distinct literatures exploring narcissism. Miller and Campbell (2008) classify these as the *clinical* perspective and the *social-personality* perspective<sup>1</sup>. The clinical perspective has developed predominately from psychodynamic models of narcissism and from representations of narcissism in the psychiatric nomenclature (e.g., DSM-5; APA, 2013). This perspective suggests that narcissism is largely maladaptive and is associated with inter and intra personal maladjustment (Kernberg, 1975). The social-personality perspective, on the other hand, conceptualizes narcissism as a dimensional personality trait, that is often adaptive, and although linked to interpersonal problems (e.g., exploitativeness and problematic relationships), is not generally linked to intrapersonal maladjustment (J. D. Miller & Campbell, 2008). While there are areas of overlap (e.g., interpersonal difficulties) the portraits of narcissistic individuals derived from these two perspectives is quite different.

Developed as an attempt to account for the different pictures of narcissistic individuals derived from the clinical and social-personality perspectives, there is a growing literature which explores two different forms of narcissism; overt narcissism (which shares some similarities with both the clinical and social personality-perspectives) and covert narcissism, which describes individuals who are shy, withdrawn and hypersensitive but who have an underlying sense of omnipotence and grandiosity.

Chapter 5 focuses on the clinical perspective. First, the history of the concept of narcissism, covering pre-Freudian, Freudian and early post-Freudian ideas on narcissism is reviewed. Following this, the seminal contributions of Heinz Kohut and

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<sup>1</sup> To allow for differentiation between these two perspectives, this thesis uses Miller and Campbell's descriptors (i.e., *clinical* perspective and *social-personality* perspective). An alternative method would be to classify the social-personality perspective as *adaptive* narcissism, and the clinical perspective as *maladaptive* narcissism, however, the social-personality literature does not portray the trait of narcissism to be entirely adaptive (see Chapter 6). It could also be argued that the clinical perspective be classified as the *psychodynamic* perspective, and Miller and Campbell suggest that the clinical perspective is strongly influenced by psychodynamic models, however, not all clinical literature is psychodynamic (i.e., APA, 2013; Beck, Freeman, & Davis, 2004) and it would be inaccurate to classify it in this way.

Otto Kernberg are discussed. The chapter then discusses post-Kohut/Kernberg contributions and representations of narcissism in the psychiatric nomenclature.

Chapter 6 focuses first on the *social-personality* perspective and then on literature on *covert* narcissism<sup>2</sup>. Following this, Chapter 6 describes Russ et al.'s (2008) attempt to tie together all three literatures, that is, the clinical perspective, the social personality perspective, and the specific literature on covert narcissism. Chapter 6 concludes with a review of Schurman's (2000) empirical investigation of the relationship between narcissism and social anxiety, which, to date, is the only study to empirically investigate the relationship between narcissism and social anxiety.

### **Early History of the Concept of Narcissism**

**The Narcissus myth.** In Ovid's (Publius Ovidius Naso, 1812) version of the narcissus myth, Cephisus (a river god) seduced the Nereid (water nymph) Liriope who gave birth to a beautiful son.

*“And on the Nereid got a lovely boy,  
Whom the soft maids ev'n then beheld with joy.”*

(ibid p. 125)

The beauty of Narcissus caused many to fall in love with him, but he spurned their love, believing them to be unworthy of him. One day, while he was hunting, the Nymph Echo came across Narcissus and fell in love with him. Although Echo longed to reveal her passion to Narcissus, because of her curse, she was unable to do so. She pined away for him, eventually dying, leaving only her voice behind.

*“Where pining wander'd the rejected fair,  
'Till harrass'd out, and worn away with care,  
The sounding skeleton, of blood bereft,  
Besides her bones and voice had nothing left.  
Her bones are petrify'd, her voice is found  
In vaults, where still it doubles ev'ry sound.”*

(ibid, p. 126)

Narcissus continued to spurn the affection of the Nymphs, with one of them praying to Rhamnusia (Nemesis) asking that Narcissus know unrequited love. While hunting, Narcissus stopped to take a drink from a fountain and noticed his reflection in

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<sup>2</sup> While there are links between the covert narcissism literature and the clinical literature, the covert narcissism literature can only be properly understood with an understanding of the *social-personality* perspective. Hence, it is necessary to first review the social personality perspective before moving to the covert narcissism literature.

the water. He instantly fell in love with the youth he saw (whom he did not recognise as himself). He reached out to the youth, but found that the youth evaded his grasp. Eventually, Narcissus realised (too late) that the youth he saw was his own reflection. Because of his strong attraction to himself, and the fact that he could never act on his love, Narcissus became despondent and pined for his reflection. As he wept, he noticed that the reflection of his face became distorted. Eventually, Narcissus died of grief. When the Nymphs came with an urn for his ashes, they found that his body had disappeared, and in its place, a flower (the Narcissus flower) stood.

Ovid's story covers a number of dimensions of narcissism incorporated into psychological theories (Cooper, 1986). Narcissus had an inflated self-view, was arrogant, lacked empathy and was uninterested in interpersonal relationships. Ovid's story also touches on the narcissistic injury elucidated by later writers (e.g., Kohut, 1971), with Narcissus realizing that his idealized self-image is fragile (when the image in the water was distorted by his tears). Narcissus' self-love becomes tinged with masochism in that Narcissus did not relinquish his self-love despite the psychological suffering this caused him. This is interesting, because later theories also describe an intimate relationship between narcissism and masochism (e.g., Cooper, 1989, 2004b).

**Early psychiatric research.** A number of early Psychiatric studies outlined conditions similar to narcissism. Following Esquirol's (1838) introduction of *monomania*, a chronic brain disorder, characterized by intellectual and or emotional impairment, Bucknill and Tuke (1862) described a *monomania of pride* in which the individual is "infatuated with his beauty, his grace, his mind, his dress, his talents, titles, and birth" (p. 185). Bucknill and Tuke suggested that although sometimes these individuals present with delusional characteristics that this was not always the case. Darwin (1896) suggested that monomania of pride was associated with a unique cluster of behaviours reflective of the individual's heightened self-confidence. Thus, monomania of pride described an individual with a tendency for self-aggrandizement and excessive self-regard. Unlike later work on narcissism proper, this early diagnostic category was not concerned with autoeroticism or sexual preoccupation with the self, but rather represented an attempt to describe a unique cluster of behaviours.

**Ellis and Näcke: Auto-eroticism and narcissism.** The earliest research on narcissism was undertaken by sexologist Havelock Ellis. Ellis (1898) described a subset of cases of autoeroticism in which the individuals "fall in love with themselves" (p. 260), and in whom there was a "tendency...for the sexual emotions to be absorbed, and

often entirely lost in self-admiration” (p. 280). Later, Ellis (1905) proposed the term *narcissus* to describe extreme cases in which autoerotic preoccupation leads to a lack of interest in sexual relationships with others. Speculating on its’ aetiology, Ellis (1927) drew on Bloch’s (1902) observation that some individuals became “durch den Anblick ihres Spiegelbildes sexuell erregt werde” [sexually aroused by their mirror image] (p. 201) and suggested that narcissus had its genesis in the child’s first viewing of themselves in a mirror, and concomitant sexual excitement.

Following from Ellis (1898, 1914, 1927), Paul Näcke coined the term *narcissism* (S. Freud, 1914/1953). Näcke defined narcissism as a sexual perversion in which the individual treated their own body the way they would sexual objects.

### **Freud’s theories of narcissism.**

*Freud’s early work on narcissism.* Freud’s (1905/1953) first mention of narcissism was in a footnote discussing the object<sup>3</sup> choice of homosexual men<sup>4</sup>. Freud purported that in homosexuality individuals “proceed from a narcissistic basis, and look for a young man who resembles themselves and whom *they* may love as their mother loved *them*” (p. 144; italics original; see also 1910/1953).

Later, Freud (1905/1953) linked narcissism to libido theory. Freud suggested that the original state of the infant was one in which their libido was invested (cathected) in their ego (Freud labelled ego-cathected libido *ego-libido*). Over time, with developmental maturation, the infant used ego-libido to cathect sexual objects. This process transformed *ego-libido* into *object-libido*. Freud indicated that it was this process of directing libido away from the ego, and toward objects in the external world which allowed the development of object relations proper. The object-libido was not “fixed”, however, and could later be withdrawn from objects and drawn back (re-cathected) into the individual’s own ego. Freud referred to this phenomenon as a

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<sup>3</sup> The term ‘object’ is used in a psychodynamic sense. Jacobs (2010) suggested that from a psychodynamic perspective, ‘objects’, comprise representation of both people and non-human objects. Psychodynamic, objects are often representations, or part representations of significant others and can be influenced by fantasy as well as by actual experience. Objects can also be combined and may represent multiple significant others. Objects can also refer to internalized aspects of the individual.

<sup>4</sup> Although Freud’s comments on the relationship between narcissism and homosexuality are undoubtedly flawed, a consideration of this early stage of the theory of narcissism is important in showing the progression of Freud’s thoughts on the topic. Furthermore, while Freud’s theories of sexuality (e.g., Freud, 1905/1953) contain heterosexist biases, his theories need to be viewed in the historical context in which he developed them. Furthermore, it should be remembered that Freud himself was very progressive in relation homosexuality. Indeed, later commentators (Spiers & Lynch, 1977) noted that Freud actively supported gay rights. Furthermore, Freud is explicit in both his “Three Essays” (S. Freud, 1905/1953) and his “Letter to an American Mother” (S. Freud, 1951) that homosexuality is not an illness, and that persecution of homosexuals was a great injustice. Thus, Freud was considerably more progressive than later Psychiatrists (cf. DSM-II, APA, 1962).

*narcissistic libidinal cathexis of the ego*. Thus, at this stage Freud elucidated two forms of narcissism; the first corresponded to early phases of life in which the individual's libido was cathected in their ego. The second involved re-cathexis of the individual's ego with libido which had formerly been invested in objects.

Later, Freud (1911/1953) elaborated on the original (narcissistic) libidinal cathexis of the ego. Freud no longer described the original state of the infant as a narcissistic one, but instead suggested that narcissism was a normal stage in the development of libido which stood between an "auto-erotic" stage, and an "object-love" stage. Thus, the main departure was that Freud no longer considered the original "auto-erotic" stage to be a manifestation of an early form of narcissism. Freud's description of the transition from auto-erotism to object-relations also changed. He suggested that the original state of the individual is one of autoerotic activity and that "in order to obtain a love-object... (the individual) begins by taking himself, his own body, as his love-object, and only subsequently proceeds from this to the choice of some person other than himself as his object." (p. 60; words in parenthesis added). He noted, however, that in some individuals this transitory phase (taking oneself as a love-object) "lingers", and that this results in some of the features of this stage (narcissistic characteristics) being carried over into later stages. At this stage of his thinking, Freud's theory most resembled the work of Ellis (1898, 1914, 1927) and Näcké (Freud, 1914/1953).

Over time, Freud moved away from the idea of narcissism as a transitory developmental phase. Despite earlier suggesting that Narcissism was predominately related to a libidinal recathexis of the ego, to wit, withdrawal of libido from objects back into the ego, in *Totem and Taboo*, Freud (1913/1953) indicated that narcissism "is never wholly abandoned (and a) human being remains to some extent narcissistic even after he has found external objects for his libido" (p. 89; words in parenthesis added). This assertion represented a shift away from Ellis and Näcké's focus of the centrality of sexual autoeroticism to narcissism.

In *Instincts and their Vicissitudes*, Freud (1915/1953a) combined the autoerotic phase (Freud, 1911/1953) and narcissism, describing this phase as *primary narcissism* (Freud, 1938/1953). In describing primary narcissism, Freud suggested that "at the very beginning of mental life, the ego is cathected with instincts and is to some extent capable of satisfying them on itself. We call this condition 'narcissism' and this way of obtaining satisfaction 'auto-erotic'" (p. 134). In some respects, the combination of the auto-erotic and narcissistic phases actually represented a shift back to his earlier (Freud,

1911/1953) view that the original state of the infant is a narcissistic one. Primary narcissism thus, was characterised by a lack of awareness of self and others (Crockatt, 2006), and preceded the development of object-relations and was distinct from narcissism that arose later as a result of libido being withdrawn from objects and re-catheted into the ego.

*Freud's "On Narcissism"*. In *On Narcissism*, Freud (1914/1953) clarified his position and addressed complications arising from his earlier writing. First, Freud clarified the two forms of narcissism alluded to in his earlier writings. The first corresponded to *primary narcissism* and constituted the original narcissistic state of the individual. The second, consistent with Freud's (1905/1953) libidinal theory of narcissism, was the result of the withdrawal of libido from objects and libidinal re-cathexis of the ego, a process which resulted in "an attitude which may be called narcissism" (p. 75).

Freud's (1914/1953) second contribution was to clarify the type of object which could be cathected with libido. Here, Freud proposed two types of object choice; *anaclitic* and *narcissistic*. The *anaclitic* style had its roots in early mother-child relationships, and became established as a result of the mother (or mother substitute) feeding, protecting and caring for the child. The *narcissistic*, on the other hand, was the result of the individual taking themselves (rather than their mother) as their love object. Freud clarified that individuals were not solely *anaclitic* or *narcissistic*, but that the propensity to rely on one type of object choice more than the other was the result of an individual's early history. Freud suggested several different manifestations of each possible object choice, noting that:

"A person may love:-

(1) According to the narcissistic type:

- (a) what he himself is (i.e. himself),
- (b) what he himself was,
- (c) what he himself would like to be,
- (d) someone who was once part of himself.

(2) According to the anaclitic (attachment) type:

- (a) the woman who feeds him,
- (b) the man who protects him,

and the succession of substitutes who take their place." (p. 90)

Thus, Freud's (1914/1953) elaboration of different types of object choice clarified the contradiction between his assertion that narcissism persisted even after the development of object relations (1913/1953) and his earlier view that libido was either cathected in the ego (narcissism) or in objects (1905/1953).

**Early post-Freudian contributions.** Although there were sporadic references to narcissism in the psychodynamic literature between Freud's contributions and the later reformulations of Kohut (1966) and Kernberg (1975), there was never really a comprehensive attempt to integrate narcissism within psychodynamic models (Bing, McLaughlin, & Marburg, 1959). Hartmann (1949) suggested that this was because it was unclear what place narcissism held in relation to later psychoanalytic metapsychology (see Van Der Waals, 1965), largely because narcissism was never explicitly redefined in relation to Freud's (1923/1953) structural theory. Further confusion arose because of different uses of the term narcissism, with subsequent literature referring to "a narcissistic type of personality ... narcissistic object choice ... (and) narcissism as a topographical problem" (p. 84; words in parenthesis added). Despite this, there were some advances, and consideration of this literature is important because these developments were pivotal in shaping contemporary reformulations of narcissism.

**Karen Horney.** One of the most important contributions was that of Karen Horney (1939, 1945, 1950). For Horney, the core of narcissism was self-love based on self-aggrandizement (e.g., a focus on achievements or abilities that did not conform to reality). Horney suggested that developmental arrests led to the child overvaluing the opinions of others, and creating excessively high personal standards (or to put it another way, constructing a particularly harsh superego). The child's response to the harshness of the superego (assuming they were unable to meet these standards) was to become dependent on others (*masochistic reaction*) and/or to artificially inflate the self (*narcissistic reaction*). Perhaps her most important contribution was Horney's recognition that the masochistic and narcissistic reactions were not distinct, but that "narcissistic trends are combined with other character trends; they may be entangled for example with perfectionistic, masochistic and sadistic trends" (Horney 1939, p. 97). Thus, Horney recognized the close relationship between narcissistic self-enhancement, and masochistic object-relationships (which in some respects foreshadowed Kohut,

1971 and Masterson's 1993 later contributions which also emphasised the tendency for some narcissists to form masochistic like relationships with powerful others).

**Annie Reich.** Reich's (1960) main focus was on the relationship between *normal* self-esteem (which to her, was a product of narcissism), and pathological narcissism. Following Jacobson (1954), Reich suggested that narcissism represented a compensatory effort aimed at bringing the *actual-self* closer to *idealized* representations of the self, and bringing the self in line with the demands of the superego (in this way Reich's theory has parallels with later cognitive theories; e.g., Higgins, 1987 self-discrepancy theory). For Reich (1960), one of the prominent defences against narcissistic injury (instances where there was a discrepancy between the individual's actual self and ideal self) was withdrawal into fantasy, which served the function of wish fulfilment. Reich speculated that these (narcissistic) fantasies had a self-aggrandising function, and were based in part on primitive identification with (internalized) idealized objects. Reich's other important contribution was to suggest that rather than describing pathology at the "psychotic" end of the continuum, that narcissistic pathology could occur at neurotic levels of disturbance also.

Although Freud (1914/1953) had also discussed healthy narcissism, what Reich contributed was an understanding that narcissistic pathology could occur along a continuum, with normal (healthy) narcissism at one end, and severe psychotic variants of narcissistic pathology at the other end. Like Horney (1939), Reich (1960) also acknowledged the fragile nature of narcissists, and suggested that some types of narcissism (in which desexualisation of the individual's body via sublimation was unsuccessful) were related to shifts to "a feeling of utter dejection, of worthlessness, and to hypochondrial anxieties ... (with the individual suffering) from repetitive violent oscillations of self-esteem" (p. 224; words in parenthesis added).

**Contemporary post-Freudian contributions.** The first major contemporary work on narcissism was undertaken separately by Kernberg (1975) and Kohut (1966). These theories stimulated renewed interest in the concept of narcissism, with subsequent theoretical developments extending on these theories (e.g., Masterson, 1993), or contrasting these models with models of narcissism derived from alternative (psychodynamic) paradigms (e.g., Rosenfeld, 1987, 1988).

Unlike contemporary clinical theories of social anxiety (discussed in Chapter 2), which derive largely from behavioural and later cognitive-behavioural models, clinical models of narcissism are almost exclusively conceptualised within psychodynamic

theories (including object-relations and self-psychological theories; see Kernberg, 2011), and there have been only limited attempts to conceptualize narcissism from non-psychoanalytic perspectives (e.g., Beck et al., 2004). The following sections review the various post-Freudian clinical perspectives on narcissism. First, the seminal theories of Otto Kernberg and Heinz Kohut are discussed, followed by an analysis of the degree to which their theoretical perspectives on narcissism are congruent with the core argument of the current thesis that for some socially anxious individuals, their social anxieties co-exist with narcissistic characteristics.

Following a review of Kernberg and Kohut, the major theoretical perspectives which followed from their seminal work are discussed. First, the psychoanalytic models of James Masterson and Arnold Cooper are reviewed, followed by the Cognitive model of narcissism (Beck et al., 2004). Following this is an examination of the degree to which each of the perspectives covered (Masterson, Cooper, and the Cognitive theory) support the core argument of the thesis that for some socially anxious individuals, their social anxieties co-exist with narcissistic characteristics.

**The contributions of Otto Kernberg and Heinz Kohut.** The first major contributions to the clinical understanding of narcissism came from Otto Kernberg (1975) and Heinz Kohut (1966). Although there are similarities between the two models, Kernberg and Kohut differed in their theories on the aetiology of narcissism; in how they saw the relationship between narcissistic and borderline disorders, and in their approach to treatment of narcissism. Specifically, Kernberg agreed with Freud that narcissistic patients were unable to form transference relationships. In contrast, Kohut suggested that narcissistic patients could enter into transference relationships, but that narcissists enter into distinct forms of transference relationships with the therapist. Review of Kernberg and Kohut's theories of narcissism is undertaken with the view of evaluating whether their analyses support the possibility of a relationship between social anxiety and narcissism.

***Otto Kernberg's theory of narcissism.*** Kernberg's main contributions to narcissism came out his work on the treatment of borderline disorders and his development of his pathoplastic model of personality organisation (Kernberg, 1967, 1968). In discussing diagnosis of borderline personality organisation, Kernberg (1967) made reference to narcissism, noting that while he agreed that the term had been overused (see Van Der Waals, 1965), that there existed "a group of patients in whom the main problem appears to be the disturbance of their self-regard in connection with

specific disturbances in their object relationships... (and that) for these patients that I would reserve the term "narcissistic personalities" (p. 655, words in parenthesis added).

Kernberg (1968) observed that these patients had poor prognosis for treatment. While they shared similarities with those who have borderline personality in their use of primitive defences and oral-aggressive conflicts, they differed in that narcissists were generally better functioning, and could achieve some level of success in particular occupations. Additionally, he noted that narcissists had superficially better anxiety tolerance than individuals with borderline personality, although he noted that this often broke down and resulted in withdrawal into narcissistic fantasies. Later, Kernberg (1975) differentiated *normal narcissism* from *pathological narcissism*, which he saw as occurring along a continuum in terms of level of adjustment (Kernberg, 1998b).

*Normal Narcissism.* For Kernberg (1975), at its core, *normal narcissism* constitutes a libidinal investment in the self. He saw an important aspect of normal narcissism to be the successful integration self and object-representations with the individual's self and object representations containing both "good" and "bad" primitive object representations. Normal narcissism is important in that it allows the individual to have a healthy sense of self-regard, and to be able to engage in healthy and adaptive interpersonal relationships.

Kernberg suggested that normal narcissism was maintained via a number of internal (intrapsychic) and external factors. Intrapsychic factors included perceived differences between ideal self-representations (ideals to which the individual aspires; Kernberg, 1998a) and the individual's "actual" self. In normal narcissism, the individual's ideal self-representation is relatively close to their "actual" self. Also important for the maintenance of normal narcissism were the harshness and criticalness of the superego, with normal narcissism related to a less unduly harsh superego. The world of inner objects (object-representations) and specifically the degree to which these object-representations are able to serve a protective function during times of crisis during an individual's life also played an important role, with normal narcissism being related to object-representations which are able to sooth and support the individual. The degree to which the person's physiological needs are met and the degree to which the individual can express sexual, aggressive and dependent needs (Kernberg, 1998a) also play a role in maintaining normal narcissism, with normal narcissism being related to having these core physiological needs met.

Externally, Kernberg (1998a) considered normal narcissism to be maintained through actual relationships with others, and “gratification of ego goals” (p. 320), measured in the social, intellectual and cultural successes of the individual. Thus, for Kernberg (1998a), normal narcissism could essentially be described as normal self-esteem regulation. Importantly, normal narcissism allowed the individual to view the self and others in complex ways (comprising both good and bad aspects), which allowed for a healthy sense of self-esteem, and health object-relations.

*Pathological Narcissism.* Kernberg proposed that pathological narcissism was fundamentally different from both normal (adult) narcissism, and from fixation or regression to normal infantile narcissism (Kernberg, 1989), and proposed several variants of *pathological narcissism* (1975).

Kernberg (1975) suggested that the mildest form of narcissistic pathology involved conflicts around aggression and reduced libidinal investment in self *and* internal/external objects. He indicated that this form of narcissistic pathology is common in many neurotic disturbances, and is somewhat adaptive in that it functions in part to project self-esteem. Thus, according to Kernberg, one would expect to see this level of narcissistic pathology in many anxiety and mood disorders.

In Kernberg’s view, more severe narcissistic disorders represented a failure at an earlier developmental period (Kernberg, 1989). Referring to Mahler’s (1972) developmental stages of separation-individuation and object constancy, Kernberg (1970, 1975) suggested that during these periods, individuals who went on to develop narcissistic disorders did not successfully integrate positive and negative representations of self and others. Instead, Kernberg (1970) indicated that these individuals, after ego boundaries have become stable, fuse their ideal self, ideal object and actual self-images, concomitantly devaluing object images and external objects. Unacceptable self-images are projected onto external objects, resulting in the individual devaluing external objects. The individual then identifies themselves with the fused ideal self-images, which allows them to “deny normal dependency on external objects and on the internalized representations of the external objects” (p. 55).

Kernberg (1975) identified two variants of this severe narcissistic pathology. One of these variants involved individuals who identify and love an object that represents a part of their past or present self. Kernberg argued that in these cases there was still a distinction between self and objects (internal and external) and thus a capacity for object-relations. At a more severe level of pathology, however, Kernberg

(1975) indicated that narcissistic relationships *completely replace* object relationships. In these cases, there no longer exists a relationship between self and objects, but rather there exists a “deterioration of object-relations, in which the relation is no longer between self and object, but between a primitive, pathological, grandiose self and the temporary projection of that same grandiose self onto objects....the relation is no longer self to object, nor object to self, but of self to self” p. 325. Kernberg described these patients as being excessively self-absorbed, but presenting with superficially effective social adaptation.

Kernberg (1975) indicated that these narcissists were characterised by the presence of intense ambition and grandiose fantasies, but that this co-occurred with feelings of inferiority, reliance on external sources of approval (viz. hypersensitivity to social evaluations) and dissatisfaction with life. He also indicated that narcissistic individuals “suffer from chronic feelings of boredom and emptiness, (and) are constantly searching for gratification of strivings for brilliance, wealth, power, and beauty” (p. 331; words in parenthesis added). Last, he noted these narcissistic individuals had an inability to empathise with others, are exploitative and ruthless towards others, and have intense envy toward others, or defences against envy.

In describing the clinical picture of narcissism, Kernberg (1975) indicated that narcissism was a complex, multifaceted disorder and that narcissistic patients frequently have contradictory personality characteristics. He noted that psychoanalytic treatment of narcissists frequently demonstrated that “their haughty, grandiose and controlling behaviour is a defence against paranoid traits related to the projection of oral rage” (p. 228). Psychoanalytic work also revealed that despite seeming to lack object-relations, these patients were characterised by a preponderance of intense, primitive, hostile object relationships, and they have an inability to depend on “good” internal objects (Kernberg, 1985).

Kernberg (1975) observed that the clinical presentation of narcissism varied, and that narcissism was not associated with any specific behaviours or clusters of behaviours. Illustrating this, Kernberg indicated that some narcissistic patients, rather than presenting overt grandiosity, presented to treatment with strong conscious feelings of insecurity and inferiority, and that, these patients had a propensity to oscillate between feelings of insecurity and inferiority on the one hand and grandiosity on the other. He argued that while vacillations between feelings of inferiority and grandiosity characterised these patients, the grandiosity of these individuals was not always

immediately evident, and in some cases only after an intense period of analysis did unconscious grandiose and omnipotent fantasies emerge in the patient.

*Pathological narcissism and Borderline Personality Organisation.* Kernberg (1975) suggested a relationship between narcissistic personality disorders and borderline personality organisation, suggesting that the disorders were structurally related (Kernberg, 1985). Elaborating on this link, Kernberg (1975) proposed that the defensive functioning of narcissists was similar to individuals functioning at a borderline level of personality. Like borderline personality, Kernberg noted that narcissists also utilized primitive defence mechanisms, like splitting, denial, omnipotence and primitive idealization, and also showed intense oral-aggressive conflicts. He differentiated the two, however, suggesting that narcissists have better impulse control and often have relatively good social functioning. Indeed, he noted that narcissists can be quite successful in various fields, whereas true borderlines on the other hand often had poorer social functioning.

***Heinz Kohut: Self Psychology and the theory of narcissism.*** The second major contemporary contribution to the understanding of Narcissism came from Heinz Kohut (1971, 1986). Like Kernberg (1975), Kohut also suggested that narcissism was not always pathological, and was critical of the tendency for all forms of narcissism to be viewed as psychopathology, speculating that the genesis of this misunderstanding lay in the emphasis of psychoanalysts in attempting to replace their patient's narcissistic libidinal cathexis (narcissistic love) with object libidinal cathexis (object love).

Like Kernberg (1975), Kohut (1971, 1986) also emphasised that narcissism was not related to specific behaviours, and that the concept of narcissism could not be described in purely behavioural terms. Kohut extended on Freud's (1914/1953) description of narcissistic object choices and suggested that rather than entailing a lack of object-relations, that object-relations were central to narcissism (Kohut, 1986). Along these lines, Kohut coined the term *selfobjects* to describe a particular intrapsychic element which was neither an aspect of the self, nor an aspect of the object, but rather, an extension of the self which had supportive functions and contributed to mature development (Kohut, 1971). Kohut and Wolf (1978) elaborated two types of selfobjects: mirroring selfobjects, which "respond to, and confirm the child's innate sense of vigour, greatness and perfection" (p. 414), and the idealized parent-*imago*, which, which are those selfobjects to which the child can look up to, and with whom he can "merge as an image of calmness, infallibility and omnipotence" (p. 414).

For Kohut (1971, 1977) healthy development was dependent on the formation of a cohesive-self. The cohesive-self resulted from the interplay between the child, and the selfobjects (Kohut & Wolf, 1978). Broadly speaking, a healthy self was comprised of optimal development along three axis: the grandiosity axis, involving striving for greatness and success; the idealization axis, involving development of healthy goals, ideals and values; and the alter-ego connectedness axis, comprising the individual's capacity to form connections with significant others (Banai, Mikulincer, & Shaver, 2005). Thus, for healthy development to occur, the individual needs to have their narcissistic expressions appropriately responded to (appropriate mirroring experiences), they need powerful others with whom they can experience a sense of strength (appropriate idealizing experiences), and they need positive experiences with others like them (e.g., related to alter-ego connectedness; Schurman, 2000). When these experiences occur in a satisfactory way, the child will, through routine, non-traumatic failures, replace selfobjects and their functions with a healthy sense of self (Kohut & Wolf, 1978). However, when interactions between the child and their selfobjects are faulty, then this leads to the development of a damaged self, and a primary disturbance of the self, which may manifest as psychotic, borderline or narcissistic disorders, depending on the level of severity (Kohut & Wolf, 1978).

Kohut (1966, 1986; Kohut & Wolf, 1978) described two types of selfobject failures when parents do not adequately respond to their child. These two types of selfobject failures result in two distinct forms of narcissistic pathology. First, when the child's mirroring needs were not met, for example, when normal narcissistic displays were condemned by the parents, this resulted in a form of narcissistic pathology Kohut described as the *narcissistic self*. Second, when the child idealizing needs were not met, for example, if the child is unable to idealize the caregivers, this resulted in narcissistic pathology related to the *idealized-parent imago*.

Kohut (1971, 1986) suggested that the idealized parent-imago had its genesis in the same developmental period of Freud's (1938/1953) primary narcissism. Kohut indicated that one strategy which the infant employed to maintain the perception of their grandiosity and omnipotence was to imbue the adult with "absolute perfection and power" (1986, p. 64). Kohut suggested that this idealized object (idealized parent-imago) is cathected with both narcissistic *and* object libido, leading to a line of development quite distinct from the developmental line which would result in object love. As the child's development progresses, the idealized parental imago is internalized

and provides gratification to the child. Kohut suggested that over time the child gradually loses the idealized parent imago, and that this loss is a key component in the formation of the superego, with the idealized object being gradually incorporated into the child's ego-ideal.

Thus, for Kohut, narcissistic-libido is invested in objects, before being reintegrated into the self. When this process occurs successfully (resulting in *healthy narcissism*), the ego-ideal provides the individual with a sense of direction and purpose, and is related to a capacity for a healthy admiration of others (Kohut, 1966, 1971). Kohut (1971) later incorporated the idealized parent imago into his concept of the *omnipotent object*.

According to Kohut (1986) the *narcissistic self*, on the other hand, does not contain the vestige of object love which forms part of the idealized parent imago, but rather is primarily concerned with the self. Kohut envisaged the narcissistic self as also comprising a distinct developmental line, with the narcissistic-self acting alongside the ego-ideal (developed out of the idealized parent imago). He suggested (anthropomorphically) that while the ego-ideal *is* admired and idealized, the narcissistic-self *wishes to be* admired and idealized. For Kohut, the core of narcissistic pathology was a disruption in the development of the narcissistic self, as a result of mirroring failures, where the child's normal narcissistic displays were not consistently responded to, and the parents did not sooth or reaffirm the child. He speculated that such disruptions, and associated effects on the child's self-esteem lead to the repression of grandiose fantasies, with the adult later having trouble regulating normal self-regard, oscillating between "irrational overestimation of the self and feelings of inferiority" (p. 69).

Like the concept of the ego-ideal, Kohut suggested that with what Winnicott (1953) referred to as "good enough parenting" that the narcissistic self could transform into healthy (adaptive) narcissism. When this happens, the narcissistic self is gradually incorporated into the ego, with this healthy form of narcissism contributing to a healthy appreciation of the self, self confidence and self-esteem (Kohut, 1966, 1971). Additionally, Kohut indicated that the ego-ideal worked with the narcissistic self and "absorbed" much of the narcissistic libido, thus preventing the narcissistic self from becoming too infused with narcissistic libido. Kohut (1971) later relabelled the *narcissistic self* as the *grandiose self* and posited that it encompassed "the grandiose and

exhibitionistic structure which is the counterpart of the idealized parent imago” (1971, p. 26).

Thus, for Kohut (1971), these two forms of pathological narcissism (the *grandiose self* and the *omnipotent object*) were the result of two (largely) independent developmental lines. The grandiose self developed as a result of early mirroring experiences, and the omnipotent object as a result of early idealizing experiences. Each of these developmental lines has normal expression, with optimal development resulting in healthy relationships (*omnipotent object*) and a healthy self-esteem and self-confidence (*grandiose self*), and pathological expression (i.e., selfobject failures related to inadequate mirroring and/or idealizing experiences). Kohut indicated that non-optimal development of the grandiose self and omnipotent object were related to different forms of narcissistic disturbance.

*Clinical presentation.* Kohut (1966, 1971, 1977) suggested that narcissistic pathology was not related to a single clinical profile. He did, however, argue that two types of narcissistic patients could be distinguished by differentiating the type of splitting (vertical or horizontal) present (Kohut, 1977).

Kohut (1971) suggested patients with a horizontal split are less common. He described these cases as individuals in whom the grandiose self is in a repressed and inaccessible state, depriving them of narcissistic supplies. These patients display symptoms of “narcissistic deficiency (diminished self-confidence, vague depressions, absence of zest for work, lack of initiative, etc.)” (1971, p. 177; parenthesis in original), and are characterised by an emotional coldness, and a tendency to distance themselves from others.

In contrast to the horizontal split where the grandiose self was repressed and inaccessible, Kohut (1971) proposed that in a second group of patients, the unmodified grandiose self is excluded (split off) from the realistic aspects of the self via a vertical split. In these cases, the grandiose self remains open to consciousness, influencing the individual’s personality and behaviour. Kohut argued that in addition to the vertically split off but accessible grandiosity of these patients, they also had a repressed (horizontal split) grandiose self which is inaccessible to consciousness. The overt manifestation of these patients varied. The vertically split off, but accessible grandiose self meant that individuals displayed overtly grandiose behaviour and denied a need for approval. In addition their vertically split off grandiose self resulted in behaviours

similar to those of the individuals with a horizontal split, such as emptiness and low self-esteem.

Therefore, in individuals with a vertical split, narcissistic disturbances are less overt, and the presentation is more stable. In contrast, individuals with a horizontal split, oscillate between overt grandiosity on the one hand, and emptiness and low self-esteem on the other.

**Compatibility of Kernberg and Kohut's theories with the theory of a relationship between social anxiety and narcissism.** The degree of similarity between Kernberg and Kohut's theories has been discussed at length (e.g., Cooper, 1989; Heiserman & Cook, 1998; Jacoby, 1990). However, the focus here is not a metapsychological comparison of their theories, but rather an analysis of the degree to which their theories support the core argument of the current thesis that for some socially anxious individuals, their social anxieties co-exist with narcissistic characteristics.

Kernberg and Kohut suggest that narcissism is not related to specific behaviours, but rather has several often contradictory overt presentations. Both suggest some narcissistic individuals are characterised by shame, social withdrawal, feelings of emptiness and low self-esteem (with these clinical features present in the case of both the vertical and horizontal splitting for Kohut). Some of the clinical features they describe are also prominent in social anxiety, with narcissists, like socially anxious individuals evincing feelings of insecurity and inferiority, sensitivity to criticism and social rejection (e.g., Gilbert, 2000a). Yet, if one examines descriptions of this presentation of narcissism more closely, the similarities become more remarkable.

For Kohut, in cases of a horizontal split, this presentation (overt emptiness and low self-esteem) is stable, with these individuals rarely consciously experiencing a sense of grandiosity (grandiose self), but rather, their grandiosity remains unconscious, with conscious views of themselves primarily being coloured by emptiness and low self-esteem. This description is consistent with many historical theories of social anxiety discussed in Chapter 2 (e.g., Hartenberg, 1901; Sandler et al., 1958), which suggest that in addition to anxiety, sadness and pessimism, that social anxiety is sometimes associated with narcissistic characteristics (e.g., grandiosity, excessive pride, misanthropy), although these aspects are rarely expressed by these individuals.

In the case of Kohut's vertical split patients, and Kernberg's conceptualization of narcissism, this alternative presentation (overt emptiness and low self-esteem) is not

stable. In these alternatives, this clinical presentation might come about as a result of repeated successive narcissistic failures or narcissistic injuries. Thus, within this proposal, overt presentation (e.g., social anxiety) of these narcissistic individuals would be less stable (to wit. not persistent or chronic), but would be a reflection of the effect of repeated social failures.

Within these models (Kernberg's conceptualization of narcissism and Kohut's vertical split), the impetuses for a conscious experience of the grandiose self would not need to be strong, but could involve a smaller shift in the individual's sense of (social) self-efficacy. According to these models, narcissistic-socially anxious individuals would have greater conscious access to their grandiose self, but the clinical picture for these individuals is less stable than that of Kohut's horizontal split individuals, with more frequent and intense fluctuations between social reticence, shame, and depression on the one hand and overt grandiosity on the other. Alternatively, repeated failures (viz. narcissistic failures or narcissistic injuries) in one domain (e.g., specifically the social domain) might have an effect on how this type of narcissistic individual views their social efficacy, without affecting their broader "grandiose" view of themselves (or sense of self-efficacy in non-social domains). Thus, this type of narcissistic individual could simultaneously hold views of the self as inferior (in relation to "social" aspects of the self) and superior (in relation to non-social (agentic) domains).

Kohut and Kernberg's models might explain narcissistic socially anxious individuals at different levels of severity. The type of individual fitting within Kohut's horizontal split (e.g., no access to the grandiose self, and more frequent experience of internalized negative and self-conscious emotions) may represent more severe psychopathology than one fitting within Kernberg's model, or Kohut's vertical split individuals (in which there is greater access to the grandiose self, and more fluctuations between feelings of superiority and feelings of inferiority).

A unique aspect of Kohut's theory is his discussion of the omnipotent object. Thus, for narcissistic socially anxious individuals, within Kohut's model of narcissism, their narcissistic characteristics might be a result of a developmental disruption in the omnipotent object, stemming from the idealized parent imago, rather than a disruption in the development of the grandiose self.

The importance of the idealization of a perceived omnipotent object is consistent with some of the social anxiety literature reviewed in Chapter 2. For example, within an attachment theory model of social anxiety (Vertue, 2003), within the individuals

working model of attachment, that for specific relationships, the internal representations of others might be characterised as “extremely positive”, with the individual deriving narcissistic satisfaction from a relationship (real or imagined) with a powerful other, while still having a more overarching view that most others are critical, hostile and persecutory (leading to the overt reticence of the socially anxious individual).

Although not discussed directly, the concepts of the omnipotent object and the grandiose self within Kohut’s theory have strong conceptual links to social rank theories (e.g., Gilbert, 2001). Descriptions of the grandiose self and omnipotent object within narcissistic disorders strongly suggest that like socially anxious individuals, narcissistic individuals are hypersensitive to social rank. To elucidate; in order for an individual to see the other as powerful and omnipotent, they need to be able to make comparisons between the *self* and the powerful *object*, and between the specific omnipotent object and other objects.

Similarly, a grandiose self implicitly requires a (social) comparison between the self and others. Thus, Kohut’s theory is consistent with the idea of a relationship between narcissism and social anxiety, and more specifically with Gilbert’s recent theoretical reformulation of social anxiety (Gilbert, 2001; Trower & Gilbert, 1989).

#### **Post Kernberg/Kohut theoretical contributions to clinical narcissism.**

Following the renewed interest in narcissism generated after the publication of Kernberg (1975) and Kohut’s (1966) reformulations of narcissism, a number of alternative clinical models of narcissism emerged. The majority of these were embedded within psychodynamic theories including self-psychology, object-relations theory (and more specifically, Kleinian object-relations theory; Rosenfeld, 1987) and analytic Psychology (Jacoby, 1981, 1990). Although contributions utilizing non-psychodynamic frameworks also emerged, it could be argued that these were largely stimulated by the inclusion of NPD in the DSM (APA, 2000; discussed later) rather than as a result of Kernberg and Kohut’s seminal contributions.

The following sections review the major post Kernberg/Kohut developments in clinical theories of narcissism. Specifically, the review will focus upon the contributions of James Masterson (1993) and Arnold Cooper (1989, 2004b).

***James Masterson’s theory of closet narcissistic disorder of the self.*** The main contribution of James Masterson (1987, 1993, 2004) was to synthesise the object-relations (Kernberg) and self-psychological (Kohut) theories of narcissism. Masterson (1993) also emphasised that narcissism was not always pathological, and suggested

healthy narcissism (the *real self*) was related to a sense of personal efficacy, limited input from fantasy, and healthy relationships with others (concern for others, and healthy self-assertion). For Masterson, healthy narcissism was a differentiation of the self and the object, a “defusion” of the grandiose self and omnipotent object, and the capacity to experience self/object representations as both positive and negative.

Masterson (1993) proposed two distinct forms of pathological narcissism; exhibitionistic narcissism (congruent with NPD in the DSM-IV-TR, APA, 2000; discussed later), and *closet narcissistic disorder of the self* (*closet narcissism*). Masterson suggested that exhibitionistic narcissistic individuals are fixated on a grandiose/omnipotent self-representation, and are characterised by a sense of uniqueness and entitlement, a preoccupation with fantasies of unlimited power, wealth and success, reacting to criticisms with rage, shame and feelings of emptiness (Masterson, 1993, 1995).

Masterson (1993) suggested that the presentation of closet narcissism was qualitatively distinct to that of exhibitionistic narcissism, and that the main characteristic of the closet narcissist was a defensive structure revolving around either idealization or devaluation of the *omnipotent object*. Masterson indicated that the goal of this pattern of defences was to regulate the individual’s sense of personal grandiosity. Thus, Masterson argued that the grandiose self and the omnipotent object were closely related, with the grandiose self fuelled by the fixation on the omnipotent object in closet narcissists.

A core component of closet narcissism is the idea of an *impaired self* which is consciously experienced as “bad, inadequate, ugly, incompetent, shameful, or weak, or as falling apart” (Masterson, 1993, p. 5). A result of the impaired self is the tendency of narcissistic individuals to enter relationships based on the use of narcissistic defences (e.g., relationships with unavailable others). Masterson also noted that closet narcissists frequently form *enmeshed relationships* in which they devalue others or are devalued by others. He noted that they are often attracted to others because of the perceived status, power or success of the other, though frequently are intensely disappointed with the other when the relationship becomes close, and the other fails to live up to the unrealistically high standards of the narcissistic individual.

Work might also be highly invested in by some closet narcissists. Masterson (1993) argued that “the structure of work partakes of their emotional investment in the idealized object” (p. 6), and that rather than investing in an “other” as an idealized love

object, they invest in some other substitute object (such as work). Masterson observed that in these instances, the individual's workaholism (or attachment to work in lieu of an "other") served as a defence against intimacy.

While simultaneously presenting an idealized object from which a personal sense of grandiosity can be derived, this type of "attachment" also protects the individual from experiencing unfulfilling personal relationships. According to Masterson, unlike exhibitionistic narcissists, whom he saw as superficially self-sufficient, but with an underlying object dependency, closet narcissists are *overtly dependant* on, and as a result vulnerable to the object. Masterson indicated that closet narcissists see the object as an omnipotent, powerful provider of narcissistic supplies while their narcissistic defences are successful, and as harsh, attacking and devaluing when their narcissistic defences fail.

Masterson (1993) argued that the intrapsychic structure of these two forms of pathological narcissism is relatively similar, consisting of two fused object-relations units. The first is a defensive unit consisting of an omnipotent object fused with a grandiose self, and connected to feelings of uniqueness, greatness and the perception that one is admired and adored. The second is an underlying aggressive unit that Masterson suggested only becomes apparent during treatment (or because of narcissistic failures) and consists of a fused object-representation that is harsh, attacking and devaluing, and a self-representation that is fragile, empty, humiliated and abandoned. These units are linked by the affect of abandonment depression and fear of self-destruction.

The difference between the two forms of narcissism lies in the patient's fixation, with closet narcissists fixated on the omnipotent object component of the fused object-relations unit, which regulates the grandiose self, whereas the exhibitionistic narcissist is fixated on the grandiose self-component of the fused object relations unit. Masterson also identified another important difference between exhibitionistic narcissism and closet narcissism (stemming from their differences in regulation of the grandiose self) as the propensity of the individual to experience narcissistic injury. Masterson (1993) indicates that in contrast to the exhibitionistic narcissistic, who although vulnerable to narcissistic injury has better capacity to maintain defences against it, the narcissistic defences of the closet narcissistic frequently fail, because the closet narcissist "does not have the capacity consistently to maintain the continuity of defense" (p. 21). Failure of these defences leads to a variety of psychological symptoms, such as anxieties,

obsessions, and depression, and the closet narcissist “projects the underlying attacking object (aggressive fused object-relations unit) with its associated rage and depression on the external object; feels attacked from without, feels humiliated, shamed, vulnerable and inadequate” (p. 21, words in parenthesis added), responding to this by either withdrawing, or by attacking the object back.

Although not explored by Masterson (1993), it is apparent that both exhibitionistic and closet narcissists are intensely aware of hierarchical power relationships between individuals (specifically, the self and the object), and of perceptions of social rank. Indeed, it could be argued that it is the awareness of differences in perceptions of social rank in combination with the aggressive fused object-relations unit that results in the internalized negative emotions (e.g., shame, depression) experienced by the closet narcissist. The aggressive reaction to these internalized negative emotions outlined by Masterson is a reaction to the perception of a low social rank of the closet narcissistic individual, coupled with their desire for a higher social rank (with such desire stemming from the demands of the grandiose self).

Implicit in the foregoing speculative extension of Masterson’s (1993) theory, is that Masterson’s concept of narcissism is not only consistent with ethological and evolutionary models of psychopathology (which emphasise the social nature of humans; see Gilbert, 1989), but is intimately tied with it. Indeed, as discussed previously in relation to Kohut’s (1971) theory, the grandiose self and omnipotent object relations units rely on an awareness of comparative social rank, and it would not be possible to view the object as omnipotent or the self grandiose without some kind of external referent with which to make a comparison.

Although the preceding discussion suggests that perceptions of social rank are important for all narcissists, perceptions of social rank may be central in understanding closet narcissism in particular. Ethological theories (e.g., Gilbert, 2001; Wilson, 2002b) propose that awareness of social rank is important because social rank is tied to social status, with social status assumed to be related to greater access to resources (which could include social resources). Ethological theories also posit that some individuals who see themselves in a lower social rank respond to this situation, and their fear of having less access to resources, by forming relationships with other individuals whom they perceive to be powerful and higher in social rank/social status. These individuals assume that this relationship will benefit them by increasing their own access to resources through their affiliation with the powerful other.

From an evolutionary/ethological perspective, the closet narcissist is an individual who sees themselves in a low social rank, who has an ambition for higher social rank (see Price et al., 2007), and who attempts to achieve this by enhancing the self through affiliation with a (perceived) powerful/dominant other.

*Masterson and the relationship between narcissism and social anxiety.* At a superficial level, there are strong links between Masterson's (1993) closet narcissist and the propensity for social anxiety. This is evident in Masterson's descriptions of the consciously experienced impaired self of the closet narcissist which is related to feelings of inferiority. However, the similarity between closet narcissism and social anxiety is more complex than this. Like socially anxious individuals, closet narcissists are viewed as intensely aware of the hierarchical nature of social relationships and seem hypersensitive to perceptions of social rank (Masterson, 1993). Additionally, like socially anxious individuals, closet narcissists have a tendency to see themselves as being in an unwanted low social rank (often seeing themselves as weak, incompetent) relative to others. Thus, Masterson's concept of closet narcissism appears to be highly consistent with the core argument of the current thesis that for some socially anxious individuals, their social anxieties co-exist with narcissistic characteristics.

It is also likely that there is a relationship between exhibitionistic narcissism and social anxiety. While Masterson's (1993) description of exhibitionistic narcissism emphasised continuous activation of the grandiose self and suggested relatively less access to the unconscious impaired self, he differentiated exhibitionistic narcissism on the basis of three levels of functioning (high, middle and low). In the case of high-level exhibitionistic narcissists, a relationship between narcissism and social anxiety seems unlikely, since Masterson (1993) implies these individuals rarely are seen in treatment. On the other hand, in the case of the middle exhibitionistic narcissists (who are characterised by neurotic symptoms) and low level exhibitionistic narcissists (who are characterised by profound disturbances in object-relations) a relationship between social anxiety and narcissism is more likely.

Thus, with the exception of one specific presentation (i.e., high-level exhibitionistic narcissists) there is strong support within Masterson's theory for the proposal that narcissistic characteristics are evident in some socially anxious individuals. Moreover, within Masterson's framework, it would be expected that there would be at least two types of narcissistic socially anxious individual – one

characterised by more exhibitionism and overt grandiosity, and one characterised as less overtly grandiose.

***Cooper's theory of the relationship between narcissism and masochism.***

Arnold Cooper's (1989, 2004a, 2004b) major contribution to the theory of narcissism was to propose a particular type of narcissistic character in which masochism played a central role. Although the relationship between narcissism and masochism had been outlined earlier (e.g., Horney, 1939; Kasper, 1965), Cooper differed in that he saw masochism not as a character trait that might sometimes define narcissism, but rather as central to the dynamic understanding of narcissistic phenomenon. To understand the theory of a relationship between narcissism and masochism, it is necessary to first provide a brief overview of the psychoanalytic theory of masochism. Following this, Coopers' theory of the narcissistic-masochistic character is presented.

*Masochism.* The term masochism was introduced to the literature by Kraft-Ebing (1892) who was influenced by Leopold Von Sacher-Masoch's (1923/2007) novel *Venus in Furs*, which described sexual masochism, and the relationship between sadism and masochism (Glick & Meyers, 1988). Kraft-Ebing described masochism as "the wish to suffer pain and be subjected to force" (p. 89), suggesting that it was related to a variety of sexual perversions, which fell on a continuum with normal dependence on one end, and sexual masochism on the other (Glick & Meyers).

Freud (1905/1953) first conceptualized masochism as a sexual perversion. Later, Freud (1919/1953) suggested that masochism (and masochistic fantasies) served a defensive function, and were the result of unconscious guilt related to the oedipal conflict. In Freud's (1924/1953) last major contribution on masochism, he linked masochism with his theory of the death instinct, postulating that masochism resulted when elements of the death instinct became fused with libido and were then directed at the self (Glick & Meyers).

Freud (1924/1953) also presented an expanded conceptualization of clinical masochism, and differentiated three forms of masochism: erotogenic (a condition imposed on sexual excitation), feminine (an expression of the feminine nature) and moral masochism (the unconscious need for punishment). Freud indicated that the third form of masochism had only a loose relationship with sexuality, and was more strongly related to a need for punishment.

*The Narcissistic-Masochistic Character.* Cooper (1989, 2004a) suggested that the genesis of masochism lay in early (normal) frustrations experienced by the infant.

Cooper suggested that in the face of discomforts (narcissistic injuries and narcissistic humiliations) and perceived helplessness, the infant attempts to restore their self-esteem by defensively distorting these painful experiences. This defensive distortion allows the infant to regain a sense of control over the situation, by making their suffering “ego syntonic”. To put it another way, the infant comes to believe that they suffer because they choose to suffer. Cooper suggested that when narcissistic humiliations are excessive (because of internal or external narcissistic injuries), the individual experiences a shift in perceptions of the self and perceptions of objects, seeing the object as excessively cruel and refusing, and the self as “incapable of genuine self-assertion in the pursuit of gratifications” (Cooper, 2004a, p. 131). Cooper suggested that in these instances, that the individual derives satisfactions from disappointment, with rejection and refusal easier to control than love. Thus, eliciting rejection, allows the individual to retain a sense of omnipotent control, with the aim of these narcissistic-masochistic defences not being “a fantasised reunion with a loving and caring mother (but) rather ... fantasised control over a cruel and damaging mother” (2004a, p. 131; words in parenthesis added).

Like previous theorists (e.g., Masterson, 1993) who described multiple manifestations of narcissism, Cooper (2004a) also proposed that narcissism was characterised by several different overt presentations, suggesting that in instances in which narcissism dominates the individual, the presentation will be one of grandiose-exhibitionism, but that in cases in which masochism is dominant, the presentation will be one of overt depression, humiliation and shame. Cooper noted however, that both presentations are equally related to grandiosity and hypersensitivity, and that both presentations show oscillations between extreme grandiosity and perceptions of humiliation.

*Compatibility of Cooper’s theory of narcissism with the theory of a relationship between narcissism and social anxiety.* Given the similarities in Cooper’s (1989, 2004a) description of the masochistic-narcissistic character and Kernberg’s (1975) and Kohut’s descriptions of the alternative clinical picture of narcissism, there is strong support within Cooper’s theory of narcissism for the idea of a relationship between narcissism and social anxiety. Indeed, it could be argued that Cooper’s descriptions of the masochistic-narcissistic character (e.g., perception of objects as cruel and the self as incapable of self-assertion) are closer to descriptions of social anxiety (e.g., Fenichel, 1939, 1945) than Kernberg (1975), Kohut (1971) or Masterson (1993). As with the

discussion of the relationship between Masterson's (1993) types of narcissism and social anxiety, Cooper's theories demonstrate two possible forms of narcissistic social anxiety; one characterised by greater (overt) grandiosity and exhibitionism, and one characterised by a greater sense of narcissistic humiliation and disappointment (e.g., the masochistic-narcissistic character).

What is interesting about Cooper's (Cooper, 1989, 2004a) contribution, however, is that in addition to providing evidence in support of a link between narcissism and social anxiety, Cooper describes the psychodynamics of this type of individual. From Cooper's perspective, social anxiety symptoms (e.g., fear of social rejection, shame, etc.) could serve a masochistic function in that in anticipating, and perhaps (through characteristic patterns of interacting with others), eliciting social rejection (real or perceived), the socially anxious individual is able to retain some level of control over their social environment. Within Cooper's theory, it might be seen to be easier for the socially anxious *individual* to elicit rejection (and thus feel some level of self-efficacy) than it is for them to elicit social approval. Thus, taking this interpretation to its (controversial) extreme, Cooper would argue that some socially anxious individuals don't seek social approval, but rather seek social rejection. However, while interesting, this possibility is simply speculation, and it would be difficult, if not impossible, to empirically test this proposition.

***Cognitive theory of narcissism.*** One of the few non-psychodynamic attempts to describe narcissism, is that of Beck et al. (2004). For Beck et al., narcissism is related to a number of core beliefs, conditional assumptions and coping strategies. Consistent with earlier clinical theories (e.g., Kohut, 1971), Beck et al. argued that the primary core belief of narcissists is one of inferiority and perceived unimportance, however, they indicated that this belief is only accessible in certain circumstances (e.g., under conditions of self-esteem threat).

Beck et al. (2004) posited that alternative core beliefs of narcissists tend to be compensatory (attempting to compensate for the primary core belief of inferiority). These secondary core beliefs revolve around superiority of the narcissist, and include beliefs about being a "rare or special person (and of being) superior to others" (p. 249).

Beck et al. (2004) observed that narcissism is associated with a number of conditional assumptions. First they noted that narcissists seek evidence of their superiority (measured through assets, social status, and influence, which the narcissistic individual links to self-value) and interpret non-success in this as a sign that they are

“not worthwhile” (Beck et al., 2004, p. 250). Another method of confirming superiority is through power, with the narcissist assuming that if they are in control of others, then this is evidence of their superiority over others.

In Beck et al.’s model, narcissists are also hypersensitive to social comparisons and their determination of the worth of other people is based on what they could potentially contribute to the narcissistic individual (Beck et al., 2004). Related to this hypersensitivity to social comparisons, Beck et al. noted that interpersonally, narcissists’ opinions of others are shaped by black and white thinking, and the narcissist has a tendency to either devalue the opinion of the other (if they are seen to be inferior) or value the opinion of the other (if they are seen as also “special”). Thus, perception of social rank is a core characteristic of Beck et al.’s model.

Beck et al. (2004) further argued that narcissists demand the complete attention of others, and if they believe that the attention of someone important to them is diverted to a third person, they experience severe anxiety. Interpersonally, they also suggest that narcissists have a biased perception of the degree to which others rely on them, with the assumption that they are important to others being used to justify self-gratifying and exploitative behaviours.

A third feature of the model of narcissism proposed by Beck et al. (2004) is the central importance to the narcissist of the way they are perceived. This relates to the hypersensitivity to social rank of narcissists, and results in excessive attempts to control the image they present to others. Additionally, Beck et al. noted that preoccupation with image is not limited to the narcissists themselves, but extends into preoccupation with the image presented by individuals important to the narcissist (e.g., partner, family). Related to this concern about image, is the tendency for narcissists to interpret comments which are not obviously flattering as criticism, with the narcissist reacting to even trivial remarks of others by becoming angry and aggressive, and in extreme cases destructive and violent.

*Similarity between the cognitive model and the psychodynamic models.* The description of Beck et al. (2004) is remarkably congruent with psychodynamic theories of narcissism (Kernberg, 1975; Kohut, 1971; Masterson, 1993). Like the psychodynamic theories, Beck et al. emphasised the vulnerability of narcissists (underlying core belief of inferiority), the hypersensitivity to social rank and the impaired relationships (with a tendency to view others as either all positive or all negative). The primary difference is that while there is an understanding of the fragility

of narcissists, there is still a more or less explicit assumption that while narcissists may seek treatment for different reasons, that there is primarily one presentation of narcissism. This is in contrast to the psychodynamic models which suggest that narcissism is not associated with one particular clinical presentation.

A second point of divergence concerns Beck et al.'s (2004) perception of vulnerability of narcissists. Specifically, Beck et al. assume that the vulnerability of narcissists, related to the core belief of inferiority, is generally only apparent in certain circumstances, discounting the possibility that for some narcissists, this core belief might be more readily available (such that overt anxiety and depression may be their primary presentation, with their grandiosity being less accessible).

*Compatibility of the cognitive theory of narcissism and the theory of a relationship between narcissism and social anxiety.* Beck et al.'s (2004) theory is compatible with the argument that for some socially anxious individuals, their social anxieties co-exist with narcissistic characteristics. This is most strongly evident in the emphasis in the cognitive model on the importance of perceived social rank for narcissistic individuals. In addition, although only describing one form of narcissism, Beck et al. nevertheless do describe narcissists as being hypersensitive to social comparisons, and preoccupied with the image they are presenting to others, both of which are central characteristics within various social anxiety models (e.g., Rapee & Heimberg, 1997).

**Summary of post-Kernberg/Kohut theories of narcissism.** Although there are points of convergence and divergence in the three major post-Kernberg/Kohut theories of narcissism, they are remarkably consistent in that each of the perspectives reviewed is compatible with the core argument of the current thesis that for some socially anxious individuals, their social anxieties co-exist with narcissistic characteristics. The fact that support for this relationship crosses theoretical boundaries (e.g., psychodynamic and cognitive theories of narcissism) provides strong support. While there is strong theoretical support for this argument, as the next section outlines, the degree to which the DSM conceptualization of narcissism supports the argument is less clear.

**Narcissism in the Psychiatric Nomenclature.** The following sections review narcissism as it is defined in the psychiatric nomenclature, and assess the degree to which conceptualizations of narcissism within the psychiatric literature support the core argument of the current thesis that for some socially anxious individuals, their social anxieties co-exist with narcissistic characteristics. The review first discusses the place of

narcissism in the DSM (APA, 1980, 1988, 2000), and the compatibility of the DSM conceptualization of narcissism with the core argument of this thesis, before reviewing more recently proposed PDM conceptualizations of narcissistic disorders. Narcissism is not represented in the ICD-10 (WHO, 1992).

***Narcissism in the DSM.*** Narcissism was not included in the first or second editions of DSM (APA, 1952, 1968) as a separate diagnostic category, and was formally introduced into the Psychiatric nomenclature in the 3<sup>rd</sup> edition of the DSM (APA, 1980) under the category of Narcissistic Personality Disorder (NPD). DSM-III and III-R (APA, 1987) criteria for NPD are displayed in Table 5.1. As can be seen in Table 5.1, the major change between the DSM-III and DSM-III-R is that the diagnostic criteria became more specific. Both DSM-III and DSM-III-R noted that self-esteem of narcissists was often fragile, with DSM-III-R noting that “self-esteem is almost invariably very fragile; the person may be preoccupied with how well he or she is doing and how well he or she is regarded by others” (APA, 1987, p. 316). Additionally, both DSM-III and DSM-III-R noted that depressed mood was common for narcissists. The DSM-III, but not III-R also indicates that “frequently there is painful self-consciousness (in narcissists)” (p. 316, words in parenthesis added).

Table 5.1

*DSM-III and DSM-III-R Criteria for NPD*

Edition	Criteria
DSM-III	<ul style="list-style-type: none"> <li data-bbox="335 1433 1406 1534">A. Grandiose sense of self-importance or uniqueness, e.g., exaggeration of achievements and talents, focus on the special nature of one's problems.</li> <li data-bbox="335 1545 1406 1646">B. Preoccupation with fantasies of unlimited success, power, brilliance/beauty, or ideal love.</li> <li data-bbox="335 1657 1406 1691">C. Exhibitionism: the person requires constant attention and admiration</li> <li data-bbox="335 1713 1406 1803">D. Cool indifference or marked feelings of rage, inferiority, shame, humiliation, or emptiness in response to criticism, indifference of others, or defeat</li> <li data-bbox="335 1825 1406 1915">E. At least two of the following characteristic of disturbances in interpersonal relationships:               <ul style="list-style-type: none"> <li data-bbox="335 1937 1406 2024">(1) entitlement: expectation of special favours without assuming reciprocal responsibilities, e.g., surprise and anger that people will not do what is wanted</li> </ul> </li> </ul>

- (2) interpersonal exploitativeness: taking advantage of others to indulge own desires or for self-aggrandizement; disregard for the personal integrity and rights of others
- (3) relationships that characteristically alternate between the extremes of overidealization and devaluation
- (4) lack of empathy: inability to recognize how others feel, e.g., unable to appreciate the distress of someone who is seriously ill.

#### DSM-III-R

- (1) reacts to criticism with feelings of rage, shame, or humiliation (even if not expressed)
- (2) is interpersonally exploitative: takes advantage of others to achieve his or her own ends
- (3) has a grandiose sense of self-importance, e.g., exaggerates achievements and talents, expects to be noticed as "special" without appropriate achievement
- (4) believes that his or her problems are unique and can be understood only by other special people
- (5) is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
- (6) has a sense of entitlement: unreasonable expectation of especially favourable treatment, e.g., assumes that he or she does not have to wait in line when others must do so
- (7) requires constant attention and admiration, e.g., keeps fishing for compliments
- (8) lack of empathy: inability to recognize and experience how others feel, e.g., annoyance and surprise when a friend who is seriously ill cancels a date
- (9) is preoccupied with feelings of envy

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There were fewer changes in the diagnostic criteria between the DSM-III-R and the DSM-IV/IV-TR (APA, 1994, 2000). The DSM-IV/IV-TR diagnostic criteria are displayed in Table 5.2.

Table 5.2

*DSM-IV/IV-TR Diagnostic criteria for NPD*

Criteria	Description
1	Has a grandiose sense of self- importance (e.g., exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)
2	Is preoccupied with fantasies of unlimited success, power, brilliance, beauty, or ideal love
3	Believes that he or she is "special" and unique and can only be understood by, or should associate with, other special or high-status people (or institutions)
4	Requires excessive admiration
5	Has a sense of entitlement, i.e., unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations
6	Is interpersonally exploitative, i.e., takes advantage of others to achieve his or her own ends
7	Lacks empathy: is unwilling to recognize or identify with the feelings and needs of others
8	Is often envious of others or believes that others are envious of him or her
9	Shows arrogant, haughty behaviours or attitudes

As noted in Chapter 4, in DSM-5 (APA, 2013), there are two representations of personality disorders, with Section 2 presenting the standard categorical approach, and Section 3 presenting a proposed dimensional approach. For an overview of the proposed general criteria for personality disorders, see Table 4.6. Specific DSM-5 criteria for Narcissistic Personality Disorder are unchanged from DSM-IV-TR (APA, 2000).

Although sharing similarities with aspects of Kernberg's (1975) theory of narcissism, the DSM diagnostic criteria focus almost exclusively on a single form of narcissism, and requires individuals to exhibit a particular set of (exhibitionistic and overtly grandiose) behaviours (Cooper, 1986). In terms of maladjustment, the focus of the DSM diagnostic criteria is on *interpersonal* rather than *intrapersonal* maladjustment, with the DSM focusing on the exploitativeness, lack of empathy and sense of entitlement of narcissistic individuals.

Despite the diagnostic criteria not referring to the fragility of narcissists, this is alluded to in the “associated features” section of the descriptive text. The DSM-IV-TR indicates that narcissists are characterised by vulnerability, are sensitive to (narcissistic) injury, and are hypersensitive to criticism. The descriptive text indicates that although the behavioural manifestations of these characteristics might not be apparent, that when criticised, narcissists often feel humiliated, degraded, hollow and empty.

Although the descriptive text of DSM-IV-TR appears to solve the problem of the exclusive focus of the DSM on a single manifestation of narcissism, it is problematic because these characteristics do not appear in the diagnostic criteria, and thus, are not considered when making a diagnosis of NPD.

*Compatibility of the DSM conceptualization of narcissism and the theory of a relationship between narcissism and social anxiety.* Considering the DSM (APA, 2013) conceptualization of narcissism, an overlap between social anxiety and narcissism seems less likely. This is truer if one considers only DSM SAD and DSM NPD. The major problem underpinning the DSM conceptualizations of these disorders is that the DSM conceptualizations are limited, and do not represent the full range of the phenomenon in question for either social anxiety or narcissism. The fact that there is strong support for a relationship between narcissism and social anxiety when analysing broader theoretical and empirical literatures on both social anxiety narcissism, when extending beyond the DSM conceptualization of these disorders supports this assertion.

Further support for the argument comes from Millon, Grossman, Millon, Meagher and Ramnath (2004). In an overview of NPD, Millon et al. noted that while individuals who are diagnosed with NPD are less likely to be diagnosed with Axis I disorders, that this overlap was possible, and when it happened, that the presence of narcissism influenced the presentation of the Axis I disorder. Interesting, Millon et al. make specific note that clinically one does see narcissists with social phobia, however, they do not indicate if there are any empirical studies to support this.

*Narcissism in the Psychodynamic Diagnostic Manual.* As mentioned in Chapter 4, the PDM (PDM Taskforce, 2006) was recently proposed as an adjunct to the DSM (APA, 2000), with the PDM elaborating on some aspects of disorders (e.g., pathoplasticity) not well covered in the DSM. Within the PDM (PDM Taskforce, 2006), narcissism is included in the Personality Disorders section (P-Axis). The PDM states that narcissism is complex and associated with a variety of clinical presentation. Specifically, it notes that in addition to the clinical presentation covered in the DSM,

some narcissists are “overtly diffident and often less successful... (and) are internally preoccupied with grandiose fantasies” (p. 38).

Aside from differences in conceptualization of clinical presentation, there are a number of additional differences between the DSM (APA, 2000) and PDM (PDM Taskforce, 2006) conceptualizations of narcissism. First, unlike the DSM-IV, which implies a categorical conceptualization of narcissism, the PDM is explicit in stating that it considers narcissism to be dimensional<sup>5</sup>. Second, in line with the emphasis on pathoplasticity in psychopathology, the PDM indicates that narcissism presents differently depending upon the individual’s level of functioning. Specifically, the PDM indicates that narcissism is different for an individual at the neurotic end of the spectrum (described as socially appropriate, successful, but with reduced capacity for interpersonal relationships) than individuals at a more severe level of psychopathology (described as having identity diffusion, and destructiveness). Third, the descriptive text of the PD is more explicit than that of the DSM about the underlying vulnerability of narcissists, and describes associated symptoms (depression, shame, etc.) and comorbidities (hypochondrial preoccupations, somatic concerns, etc.) of this vulnerability.

The most important difference between the PDM (PDM Taskforce, 2006) and DSM (APA, 2000), is that the PDM describes two broad clinical presentations of narcissistic pathology. The first is labelled *Arrogant/Entitled* and corresponds to the description of NPD in the DSM. The second is labelled *Depressed/Depleted*, and describes a clinical presentation which corresponds to Masterson’s (1993) closet narcissism and Cooper’s (1989, 2004a) masochistic narcissistic character. The PDM indicates that these individuals seek others to idealise, are easily wounded, and experience chronic envy toward those they see as more fortunate than themselves.

*Compatibility of the PDM conceptualization of narcissism and the theory of a relationship between narcissism and social anxiety.* Considering the greater emphasis on the vulnerability of narcissists in the PDM, and the multiple presentations (in contrast to the single presentation in DSM) the relationship between narcissism and social anxiety is highly consistent with depiction of narcissism in the PDM.

The PDM conceptualization also leaves open the possibility of several different types of socially anxious narcissistic individual. Given the pathoplastic approach of the

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PDM, it could be argued that there might be qualitative differences between narcissistic socially anxious individuals at the neurotic end of the spectrum of severity and narcissistic socially anxious individuals at more severe levels of maladjustment. Alternatively, narcissistic socially anxious individuals might differ quantitatively from each other (e.g., in severity of social anxiety symptoms and internalized negative emotions like shame and depression). Within Kernberg's (1975) model of narcissism, it would be expected that differences could be both qualitative (in terms of the object-relations of the individuals) and quantitative from the perspective that individuals at lower levels of functioning would be expected to make greater use of primitive defence mechanisms, and poorer impulse control than individuals functioning at a neurotic level.

#### Chapter Summary

As the preceding sections outlined, with the exception of the DSM (APA, 2013), the clinical literature on narcissism strongly supports the core argument of the current thesis that for some socially anxious individuals, their social anxieties co-exist with narcissistic characteristics. For example, in many clinical models of narcissism, many of the clinical features they described are also prominent in social anxiety. Narcissists, like socially anxious individuals were reported to show feelings of insecurity and inferiority, sensitivity to criticism and social rejection. Like socially anxious individuals, many narcissists are fixated on the hierarchical nature of social relationships and are hypersensitive to perceptions of social rank.

In addition to suggesting the existence of a narcissistic socially anxious individual, several of the theories reviewed (e.g., Cooper, 2004a; Masterson, 1993; PDM Taskforce, 2006) suggested that there might be two or more distinct types of narcissistic socially anxious individual.

Although support in the clinical literature for the existence of narcissistic socially anxious individuals was strong, it needs to be borne in mind that the clinical literature on narcissism represents only one strand of research on narcissism. Thus, in order to more fully explore the degree to which theories and research on narcissism support the core argument of the current thesis, it is necessary to explore the conceptualization of narcissism in the other broad strands of research on narcissism; namely, the social-personality psychology and covert narcissism perspectives.

## Chapter 6: The social-personality perspective and covert narcissism

The current chapter focuses on the second major perspective on narcissism, the *social-personality* perspective, and more recent literature examining *covert* narcissism. As discussed in Chapter 5, the primary difference between the clinical and the social personality perspectives is that whereas the clinical perspective views narcissism as a clinical construct and emphasises its maladaptive nature, the social-perspective conceptualizes narcissism as a dimensional personality trait that is often adaptive. While linked to interpersonal difficulties (e.g., exploitativeness and problematic relationships) it is not generally related to intrapersonal maladjustment (J. D. Miller & Campbell, 2008).

The second focus of the current chapter is research on covert narcissism<sup>6</sup>. As noted in Chapter 5, this line of enquiry developed in order to attempt to address the different pictures of narcissistic individuals derived from the clinical and social-personality perspectives. This literature differentiates overt and covert narcissism, describing covert narcissistic individuals as shy, withdrawn and hypersensitive but with an underlying sense of omnipotence and grandiosity.

This chapter first reviews the social-personality theory of narcissism and covert as distinct from overt narcissism, prior to a discussion of the compatibility of these approaches with the core argument of the current thesis that for some socially anxious individuals, their social anxieties co-exist with narcissistic characteristics. Following this, Russ et al.'s (2008) attempt to integrate the three perspectives (i.e., clinical, social personality and covert narcissism) into a single model is presented. The chapter concludes with an overview of the limited empirical research focused on the relationship between narcissism and social anxiety.

### The Social-Personality Perspective

Within the social-personality tradition, narcissism is viewed as a dimensional personality trait with the portrait of narcissism within this tradition based upon self-report studies using largely non-clinical populations. Thus, this perspective is empirically, rather than clinically derived. Although several self-report narcissism scales exist, the majority of the social-personality literature has employed the *Narcissistic Personality Inventory* (NPI) to measure the construct. Given the centrality

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<sup>6</sup> Although the development of the concept of covert narcissism stems in part from early clinical writing, given the influence of the social-personality perspective on the development of this literature, it is necessary to discuss this perspective after consideration of the social-personality perspective.

of the NPI to the social-personality perspective, its development and characteristics will be reviewed.

***The Narcissistic Personality Inventory.*** Raskin and Hall (1979) outlined the development of the NPI prior the publication of DSM-III (APA, 1980). Initially, 223 items were developed based on the seven proposed DSM-III diagnostic criteria, and preliminary psychometric analyses were conducted using small non-clinical samples. As such, Raskin and Hall (1979) observed that “the inventory is not necessarily a measure of a personality *disorder*...at present, it should be regarded as a measure of the degree to which individuals differ in a trait we have labelled ‘narcissism’” (p. 590; italics original).

The first empirical research to employ the NPI used a revised 80-item version to explore the relationship between narcissism and creativity in an undergraduate sample (Raskin, 1980). Subsequent research (Raskin & Hall, 1981) used a revised 40-item version of the scale. Follow-up studies established that the 40-item version of the NPI possessed desirable psychometric attributes (e.g., Auerbach, 1984; P. J. Watson, Grisham, Trotter, & Biderman, 1984; P. J. Watson, Taylor, & Morris, 1987). Contrary to clinical theories of narcissism, the NPI was found to be unrelated to neuroticism, and positively related to psychoticism and extraversion (Raskin & Hall, 1981).

Further evidence that the portrait of narcissism derived from the NPI was different to that derived from the clinical perspective came from a study employing the NPI with a psychiatric sample (Prifitera & Ryan, 1984). Prifitera and Ryan showed the NPI was positively related to the aggressive-histrionic and aggressive-anti-social scales of the Millon Clinical Multiaxial Inventory (MCMI). Yet, surprisingly, they reported a negative relationship with the Negativistic-Unstable MCMI scale. This was unexpected as clinical theories (e.g., Kernberg, 1975; Masterson, 1993) posit the negativistic-unstable component to be central to narcissism. Furthermore, the correlation between the NPI and the clinical MCMI narcissism scale was relatively low, indicating that although the two scales overlapped, the NPI was not measuring “pure” clinical narcissism. This finding was replicated showing that the NPI was not strongly associated with other clinical measures of narcissism (Soyer, Rovenpor, Kopelman, Mullins, & Watson, 2001) and was not useful in differentiating clinical narcissists from non-clinical samples (Vater et al., 2013).

Taken together, these findings support Raskin and Hall’s (1979) original assertion that the NPI measures a dimensional personality trait, and not a personality

disorder. Yet, the positive association that Raskin and Hall found between the NPI and psychoticism suggests that the NPI might not be measuring pure “normal” narcissism either. Rather, Raskin and Hall’s findings suggest that the NPI measures a variant of narcissism standing on the border of “normal” narcissism and mild narcissistic disturbance. While a number of shorter versions of the NPI have been developed (e.g., Ames, Rose, & Anderson, 2006; Gentile et al., 2013), the 40-item version of the NPI tends to be the most frequently employed.

**Factor structure of the NPI.** Although the NPI was originally designed to yield a single *trait* narcissism score (Raskin & Hall, 1979), it was noted that this was at odds with the way the construct was conceptualized in the clinical literature. Subsequently, a number of researchers (e.g., Ackerman et al., 2011; Emmons, 1984; Kubarych, Deary, & Austin, 2004; Raskin & Terry, 1988) factor analysed the NPI, with two, three, four and seven factor solutions proposed.

One of the earliest factor analytic studies was that of Emmons (1984) who found support for four factors; *Exploitativeness/Entitlement* (E/E), *Leadership/Authority* (L/A), *Superiority/Arrogance* (S/A) and *Self-absorption/Self-admiration* (S/S). Emmons found that the factors related differently to outcomes, with the E/E factor related to maladjustment and the other factors to adjustment. Subsequent factor analytic studies (Kubarych et al., 2004; Raskin & Terry, 1988) also found that NPI subscales were differentially related to psychological outcomes, with relatively more adaptive and relatively less adaptive factors identified.

Despite evidence that the NPI is multidimensional, factor scores are rarely used in empirical research. The primary reason for this is that researchers have found very little stability of factor solutions, and there is very little consistency in terms of the number of factors which the NPI is found to comprise (Kubarych et al., 2004). Additionally, psychometric properties of NPI subscales tend to be poor (del Rosario & White, 2005) and there have been very few validation studies to elucidate exactly what the subscales are measuring (J.D. Miller & Campbell, 2008). Thus, most social-personality research utilizes a single NPI score (J. D. Miller & Campbell, 2008) and has not used the subscale scores.

**Empirical research using the NPI.** The portrait of narcissism derived from the social-personality perspective differs from the portrait derived from the clinical literature, primarily in that narcissism in the social-personality perspective is often adaptive, rather than maladaptive. However, empirical literature of the social-

personality perspective has produced mixed results. For example, whereas the NPI has been found to be related positively to some aspects of psychological health (e.g., Sedikides, Campbell, Reeder, Elliot, & Gregg, 2002) it has been found to be related to indices of maladjustment (e.g., aggression, interpersonal difficulties; see J. D. Miller, Widiger, & Campbell, 2010).

The following sections review the relationship between NPI measured narcissism and various indices of adjustment and maladjustment in order to determine if empirical research from within the Social/Personality perspective supports argument of the current thesis that for some socially anxious individuals, their social anxieties co-exist with narcissistic characteristics. Following this, a critique of the NPI and proposal for its revision is presented.

***The NPI and psychological health.*** A substantial literature has explored the relationship between NPI measured narcissism and psychological adjustment. The NPI has been found to be positively associated with a number of indices of psychological health, such as high (explicit) self-esteem (Sedikides et al., 2002; Sedikides, Rudich, Gregg, Kumashiro, & Rusbult, 2004; P. J. Watson & Hickman, 1995; P. J. Watson, Hickman, & Morris, 1996), positive self-images (Rhodewalt & Morf, 1995), assertiveness (P. J. Watson, Morris, & Miller, 1997), optimism (Hickman, Watson, & Morris, 1996), and creativity (Raskin, 1980). NPI measured narcissism is also predictive of the number of positive illusions an individual holds about themselves, and to ratings of personal attractiveness and intelligence (Gabriel, Critelli, & Ee, 1994).

In addition to being predictive of positive psychological outcomes, the NPI has been shown to be negatively related to measures of psychological maladjustment, including social introversion and depression (Raskin & Novacek, 1989), shame proneness (Gramzow & Tangney, 1992; Montebanocci, Surcinelli, Baldaro, Trombini, & Rossi, 2004), internalized negative emotions (Atlas & Them, 2008), irrational beliefs (P. J. Watson & Morris, 1990), anxiety (Emmons, 1984, 1987), and impulsivity (Foster & Trimm, 2008; Vazire & Funder, 2006). Moreover, Atlas and Them (2008) found that NPI measured narcissism was negatively related to sensitivity to criticism, and “neurotic concern”.

Taken together, there is a substantial body of literature which links full scale NPI scores to psychological health. However, Hill and Roberts’ (2012) research indicated that high NPI narcissism was associated with more psychological benefits among adolescents and emerging adults than among adults. Thus, it is possible that a

reliance on undergraduate samples might result in an overestimation of the adaptive nature of high NPI measured narcissism.

***Narcissism and self-esteem instability.*** The positive association between NPI measured narcissism and self-esteem is unexpected, given that clinical research indicates that narcissism is often associated with low, not high self-esteem (e.g., Masterson, 1993). A group of researchers have attempted to account for this unexpected result through a more sophisticated understanding of self-esteem. In a series of studies, Kernis and colleagues (Kernis, Grannemann, & Barclay, 1989, 1992) differentiated between high self-esteem which is stable or secure, and high self-esteem which is unstable (fragile). They discovered that individuals with high but unstable self-esteem (relative to stable high self-esteem individuals) were more sensitive to feedback and sensitive to rejection (Kernis, Cornell, Sun, Berry, & Harlow, 1993). People with high but unstable self-esteem have also been shown to be less likely to seek to be challenged (Waschull & Kernis, 1996), more likely to experience depression (Kernis et al., 1998), and to exhibit greater defensiveness to experimentally induced failures (Kernis, Greenier, Herlocker, Whisenhunt, & Abend, 1997).

In line with Kernis' understanding of self-esteem (Kernis et al., 1993), a series of studies by Rhodewalt, Madrian, and Cheney, (1998) demonstrated a more complex relationship between narcissism and self-esteem than that evident in simple correlational studies. Rhodewalt et al. found that those who were in the upper third of NPI scores, had greater instability of self-esteem than individuals in the lower third of NPI scores. Additionally, Rhodewalt et al. established that high narcissists (relative to low narcissists) had greater fluctuations in day to day mood, and more extreme emotional reactions to day to day events.

The propensity for narcissists to experience more extreme mood reactions was confirmed by later research by Bogart, Benotsch, and Pavlovic (2004). Bogart et al.'s results also suggested that the mood variability of narcissists can be accounted for by their hypersensitivity to social rank, with highly narcissistic individuals being found to experience more extreme positive moods when making downward comparisons with others, and more extreme negative moods when making upward comparisons with others, relative to individuals low in narcissism.

Extending on this work, Jordan, Spencer, Zanna, Hoshino-Browne, and Correll (2003) further explored the instability of narcissists' self-esteem, exploring the relationship between narcissism and Kernis' (Kernis et al., 1993) two forms of high

self-esteem. Consistent with clinical theories of narcissism (e.g., Kernberg, 1975), Jordan et al. found that high scores on the NPI were associated with high explicit self-esteem but low implicit self-esteem. They concluded that although NPI measured narcissism was related to (self-reported) positive self-views this represents a strategy to avoid feelings of self-doubt and insecurity.

Taken together, the research suggests that while there is evidence that the NPI is positively associated with psychological health, this relationship is complex. For example, the high self-esteem found to be related to NPI measured narcissism was demonstrated to be unstable, and thus, less adaptive than had previously been supposed.

While there is less consensus on the issue of whether the NPI is predictive of psychological health, there is greater consensus that the scale is positively related to interpersonal maladjustment (J. D. Miller et al., 2010). These studies suggest that high levels of NPI measured narcissism are detrimental to interpersonal relationships (e.g., Campbell, Bush, Brunell, & Shelton, 2005).

***The NPI and interpersonal maladjustment.*** In an exploration of the interpersonal relationships of narcissists, Rhodewalt and Morf (1995) reported that NPI scores were positively related to hostility, mistrust and cynicism. Consistent with this, Bushman and Baumeister (1998) found high NPI measured narcissism was associated with a greater tendency toward aggression following a variety of ego threats.

In addition to aggression, NPI measured narcissism is also negatively related to empathy. In a non-clinical sample, P. J. Watson et al. (1984) found that the NPI was negatively related to self-report measures of empathy. The specific nature of the deficits in empathy were elucidated in a later study using a multidimensional empathy scale (P. J. Watson, Biderman, & Sawrie, 1994), with NPI scores negatively related to both empathic concern and to perspective taking. Moreover, high NPI was also related to Machiavellianism, a link supported across a number of studies employing the NPI (Jakobwitz & Egan, 2006; Kerig & Stellwagen, 2010).

The relationship between NPI measured narcissism, aggression, and (lack of) empathy suggests that individuals high in NPI measured narcissism have more problematic interpersonal relationships than individuals low in NPI measured narcissism. In an extensive review of the literature, Miller, Widiger, and Campbell (2010) supported this argument, finding that narcissists tended to have impaired romantic relationships. They further noted that although narcissists form relationships

easily, these relationships are less likely to be successful because of the tendency of narcissists to engage in “game playing” and infidelity.

**A proposal to revise the NPI.** Recently, Rosenthal and Hooley (2010) suggested that within the social-personality perspective that over-reliance on a single scale might be problematic. After reviewing NPI items, Rosenthal and Hooley suggested that many NPI items are not representative of narcissism, or appear to measure characteristics of normal high self-esteem, rather than narcissism (either clinical or non-clinical). Related to this, they point out that even if some of these characteristics which are measured by particular NPI items are sometimes related to narcissism, they are not *unique* to narcissism, and are thus, are not efficacious in distinguishing narcissists from non-narcissists.

In an attempt to demonstrate that the full scale NPI is potentially influenced by items that do not measure narcissism, Rosenthal and Hooley (2010) split off items found to successfully measure narcissism from items which do not using three methods. This allowed comparison of full scale NPI scores, with total scores for all items deemed to be “good” NPI items (labelled NPI-*N*), and total scores for all items deemed to be “poor” NPI items (labelled NPI-*X*). The use of three distinct methods of determining “good” NPI items lead to three NPI-*N* and three NPI-*X* scores.

The first method employed by Rosenthal and Hooley (2010) involved asking experts whom they defined as being PhD or MD level clinicians who had also published empirical research on narcissism, to indicate which NPI items they believed reflected clinical or non-clinical narcissism. Rosenthal and Hooley classified NPI items endorsed by over 50% of experts as being “good” indicators of narcissism, and NPI items endorsed by less than 50% of experts as being “poor” indicators of narcissism.

Rosenthal and Hooley (2010) also employed Item-Response Theory (IRT), to determine which NPI items were likely to be endorsed by participants scoring high on the overall NPI, and which by participants who had low overall NPI scores. Using this method, they split NPI items into two groups; those likely to be endorsed by individuals with low narcissism scores, and those likely to be endorsed by individuals with high narcissism scores.

Lastly, Rosenthal and Hooley (2010) split the NPI into two scales on the basis of Emmons (1984, 1987) factor analysis of the NPI. Under the assumption that Emmons Leadership/Authority subscale was not reflective of narcissism, Rosenthal and Hooley

classified the NPI items which formed part of this subscale as “poor” narcissism items, and classified the remaining items as “good” narcissism items.

Rosenthal and Hooley’s (2010) results indicated that the three NPI-*N* scores were more strongly related to a clinical screening tool designed to identify DSM-IV-TR (APA, 2000) NPD than were the three NPI-*X* scores. Moreover, they found that where the NPI-*X* scores were positively related to self-esteem, the NPI-*N* scores were not significantly related to self-esteem. In a second study, they showed that both the full scale NPI and the NPI-*X* scores were positively associated with optimism, happiness and positive affect. Whereas the NPI-*N* scores were unrelated, or only very weakly related to these variables, conversely, both the full NPI and the NPI-*N* scales were positively related to aggression, whereas the NPI-*X* scales were unrelated to aggression. Additionally, whereas the NPI and NPI-*X* scales were weakly negatively related to anxiety sensitivity and negative affect, the NPI-*N* scores were not related to either of these.

Further support for Rosenthal and Hooley’s (2010) arguments came from Ackerman, Donnellan, and Robins (2012). Ackerman et al. conducted an item-response analysis, and calculated item-characteristic curves and test information function scores to enable them to determine which items provide the most information about the latent trait (narcissism). Their results indicated that the NPI items which were most predictive of the overall NPI scores (i.e., those which contribute the most to its overall variance) were those which would fall under Rosenthal and Hooley’s NPI-*X* scale (e.g., Leadership/Authority), which Ackerman et al., consider to be not representative of narcissism. Problematically, they also noted that items which would fall under the NPI-*N* scale (e.g., exploitativeness), despite being better indicators of narcissism were less predictive of the overall NPI score. Thus, evaluated theoretically, items which measure theoretically relevant aspects of narcissism are worse predictors of overall NPI score than items which measure theoretically unrelated aspects of narcissism.

Taken together, Rosenthal and Hooley (2010 and Ackerman et al.’s (2012) findings indicate problems with the NPI. In a follow-up study, Miller et al. (2011) attempted to replicate Rosenthal and Hooley’s (2010) results. Unlike Rosenthal and Hooley, Miller et al. did not find clear differences between the NPI-*N* and NPI-*X* scales. Both scales were positively related to self-esteem, and negatively associated with psychological distress. Miller et al. largely rejected Rosenthal and Hooley’s critique of

the NPI. While agreeing that in some cases it may be advantageous to modify the scale, they did not see the strong overlap between self-esteem and narcissism as a problem.

One possible explanation for the difference between Miller et al.'s (2011) and Rosenthal and Hooley's (2010) results is that the most effective method of identifying the best NPI items has not yet been established and a stricter method of deciding which items are good representations of narcissism might need to be employed. A second possibility is that high NPI scores alone may not be a good indicator of narcissism. That is, there may be two or more qualitatively distinct types of people who have high NPI scores and high NPI scores in non-clinical undergraduate samples might be different to high NPI scores in clinical samples. If this was the case, it would be prudent to include other scales alongside the NPI to clarify the nature of the narcissism in the sample in question.

### **Review of the Social-Personality Perspective**

Although research has established that NPI measured narcissism is associated with psychological health, as the previous review indicates, this relationship is not straightforward. Specifically, although the full scale NPI is predictive of psychological health, some NPI subscales have shown the opposite pattern of associations. Furthermore, even considering the full scale NPI, there is evidence in relation to some aspects of psychological health (e.g., self-esteem), that individuals with high levels of NPI measured narcissism might not be as adjusted as one might assume. Specifically, the self-esteem of individuals with high levels of NPI measured narcissism while high, is unstable, and less adaptive. Furthermore, while there is some evidence of psychological adjustment, there is considerable evidence that individuals with high levels of NPI measured narcissism experience interpersonal problems, and show interpersonal maladjustment (e.g., anger and aggression directed at others).

The research presented does not specifically indicate that a relationship between narcissism and social anxiety is likely. However, considering that high levels of NPI measured narcissism are, for some individuals maladaptive, it is plausible that a subset of socially anxious individuals might be characterised by elevated NPI measured narcissism. Therefore, as was the case with the clinical literature, there is support for the argument that for some socially anxious individuals their social anxiety coexists with narcissistic characteristics. In addition to the clinical and social-personality perspectives on narcissism, there is a growing literature on *covert* narcissism. The chapter now addresses this literature.

### **Overt and Covert Narcissism**

The following sections review the literature which proposes two distinct forms of narcissism. While there is some historical overlap with the clinical perspective, recent interest in this has partly been driven by the different portraits of narcissism derived from the clinical perspective on the one hand, and the social-personality perspective on the other. One of the most comprehensive overviews of the argument that there are two forms of narcissism was provided by Cain et al. (2008). They conducted an extensive review of the theoretical, clinical, and social-personality literature of narcissism, and concluded that the literature described two different phenotypic themes of narcissism, a theme they described as *grandiose-exhibitionistic*, and a theme which they described as *vulnerable-hypersensitive*.

Cain et al. (2008) indicated that grandiose-exhibitionistic narcissists are generally characterised as self-aggrandising, and vain, with open displays of grandiosity, exhibitionism and entitlement (e.g., Broucek, 1982; Wink, 1996). Grandiose-exhibitionistic narcissism also corresponds to the NPD in the DSM (APA, 2000) and shares some features with narcissism described in the social-personality Psychology literature. Yet, while for social-personality theorists (e.g., J. D. Miller & Campbell, 2008) narcissism is often adaptive, this is not necessarily the case for grandiose narcissism (e.g., Russ et al., 2008). Cain et al. (2008) indicated that covert narcissistic individuals on the other hand are described as overtly shy, anxious and withdrawn, with a hypersensitivity to criticism and a propensity toward shame reactions. This surface manifestation, however, is believed to mask an underlying sense of self-importance, entitlement and grandiosity (e.g., Hunt, 1995). This description corresponds to a number of clinical profiles of narcissism (e.g., Kohut, 1971, 1977).

The following sections review the literature on the distinction between overt and covert narcissism. The first part reviews the theoretical literature supporting the idea of multiple forms of narcissism. Following this, the empirical literature focused on demarcating and elucidating the nature of the two distinct forms of narcissism is reviewed. A critique of the distinction between overt and covert narcissism is also presented. Following this, a discussion of the degree to which covert narcissism is compatible with argument that for some socially anxious individuals their social anxiety co-exists with narcissistic characteristics is presented.

### **Historical development of the concept of covert narcissism.**

*Theoretical developments.* The idea of multiple forms of narcissism had its genesis in early psychodynamic theories of narcissism. Possibly the earliest description similar to covert narcissism came from Jones (1923). In his discussion of extreme cases of narcissism which manifested in a type of god complex, Jones noted the tendency for these individuals to be characterised by both “excessive admiration for and confidence in one's own powers, knowledge, and qualities, both physical and mental.” (p. 207) while evidencing “excessive self-modesty, which at times is so pronounced as to be truly a self-effacement” (p. 208).

The next contribution came from Murray (1938). Murray indicated that he saw narcissism as being associated with a number of direct and indirect manifestations. One direct manifestation of narcissism was “superiority feelings and delusions of grandeur” (p. 180), and another was “hypersensitiveness, excessive shyness and delusions of persecution” (p. 180). However, Murray did not make it clear as to whether these manifestations co-occurred in the same individual, or whether they were two distinct types of narcissism.

*Kohut and covert narcissism.* A more comprehensive description of multiple forms of narcissism is offered within Kohut's (1966, 1971) theoretical model of narcissism. As discussed earlier, although Kohut saw narcissism as a single disorder, he did describe two different clinical pictures of narcissism. Specifically, Kohut indicated that the two different forms of splitting (horizontal and vertical) identified within his theory were associated with distinct clinical presentations.

Kohut (1971) did not associate narcissism with any particular behaviour, and did not diagnose narcissistic pathology on the presence or absence of manifest behaviours. He did indicate, however, that there were differences in the degree to which the grandiose self could be accessed by narcissistic individuals, and thus, the degree to which the vulnerable elements of narcissism (e.g., low self-worth, depression) were apparent. The primary difference between Kohut's two forms of narcissism was that while individuals with a vertical split sometimes displayed covert narcissistic characteristics, individuals with a horizontal split evidenced more stable, consistent covert narcissistic characteristics.

*Bach's extension of Kohut's work.* Following from Kohut's (1971) distinction between the development of the grandiose self and the omnipotent object, Bach (1975), suggested a tendency for narcissists to occupy one of two extreme positions and to see

themselves as existing *via* the self-object, with a masochistic relation to the other and a propensity for depression, or alternatively as existing as they are *mirrored* by the self-object. Bach suggested that when in this state, narcissists tend to relate to the object sadistically with a propensity for mania. He elaborated that one of the problems of treating narcissists is their tendency to adopt one of two positions in relation to the therapist and to either be excessively assertive (which Bach linked to the desire for dominance) or to be passive in relation to the therapist (which Bach tied to submissiveness, feelings of helplessness and powerlessness). Importantly, Bach argued that, for narcissists, the middle ground between these two extremes is often absent, and they tend to “oscillate between two unstable narcissistic positions” (p. 83). Although Bach described oscillations between these two positions, he did acknowledge the possibility that one position might be more characteristic of an individual, and that the other position might only become apparent over the course of therapy.

In a discussion of narcissistic states of consciousness, Bach (1977) further elaborated on the psychodynamics of the two manifestations of narcissism. Specifically, Bach extended on Kohut’s (1971) discussion of splitting and narcissism, positing that narcissistic patients had a split off self-representation which was a “mirror” of their clinical presentation. He argued that it was this factor which differentiated between the two broad clinical pictures of narcissism. For example, he suggested that “someone who feels physically weak and powerless may harbour a grandiose and dangerously powerful split-off image, while someone who presents with arrogance and grandiosity may be fearful of the dangerously vulnerable and dependent little child self” (p. 215).

In summary, Bach (1975, 1977) emphasised that narcissism could be potentially associated with two broadly different clinical pictures, and that although patients could oscillate between these two extremes, there was a tendency for one position to characterise the individual. He proposed that despite the two manifestations appearing superficially different, particularly in overt behaviours, the underlying characteristics of these two positions were the same, in that both positions were related to conflicts around feelings of superiority (e.g., overt grandiosity) and vulnerability (e.g., depression and anxiety). Thus, according to Bach, narcissists do not differ in vulnerability or grandiosity, but rather in the degree to which self-representations consonant with grandiosity and vulnerability are accessible to the individual.

*Bursten’s narcissistic types.* Bursten (1973) extended on existing work on narcissism, and on Kohut’s (1971) description of the two clinical pictures of narcissism.

Rather than focusing on differentiating two forms of narcissism on the basis of differences in types of splitting, Bursten proposed four distinct narcissistic personality types; the craving, the paranoid, the manipulative and the phallic. He argued that these types differed along a number of dimensions including mode of narcissistic repair (viz. regulation of the individual's sense of self), and degree of differentiation of self and others. Thus, while Bach's (1975, 1977) work represented an extension of Kohut's (1971) theory of narcissism, in that it explicitly referred to the importance of splitting in narcissism, Bursten's contribution represented a more dramatic departure.

Bursten (1973) saw the craving narcissist as characterised by clinginess, dependency and a need for the approval of others. He noted a tendency for these individuals to "cling" to one other person, or a small group of others in social situations and to derive support from this. The paranoid narcissists, on the other hand were sceptical, critical and suspicious, but not delusional as in more severe personality disorders. Bursten described the manipulative narcissists as characterised by intentional (or motivated) manipulateness, lack of guilt, and superficial object-relations. Lastly, the phallic narcissist, he described as arrogant, aggressive, manipulative and exhibitionistic, with a tendency to take risks.

Although Bursten (1973) saw similarities across the four types of narcissism (e.g., in propensity for aggression following narcissistic injury), it is evident in his work, although he did not explicitly state this, that he distinguished between narcissistic personality types associated with relatively more "overt" characteristics (e.g., overt aggression and exhibitionism) and narcissistic personality types associated with more covert narcissistic characteristics (e.g., dependency and clinginess). It could be argued, however, that the groups are not primarily different in these overt behaviours, but differ in their view of the self and view of others. These factors relate to differences in mode of narcissistic repair and regulation of grandiosity, with some types of narcissism (e.g., the phallic) more clearly focused on the grandiose self, and other types (e.g., the craving and paranoid) more clearly focused on the omnipotent object. In this regard, Bursten's work provides indirect support for the distinction between overt and covert narcissism, but the link is somewhat tenuous.

*Miller's perspective on narcissistic disturbance.* Following Bursten (1973), A. Miller (1979) indicated that narcissistic disturbances fell into two categories, those related to grandiosity, and those related to depression. For A. Miller, grandiosity is related to an insatiable desire for and dependence upon the admiration of others. These

individuals, she noted, base their self-regard on their qualities and achievements, which can suddenly fail, leading the individual to a dramatic loss of self-regard. When this grandiosity fails (because of aging, sickness, etc.), the individual tends to experience intense depression. However, some of these narcissistic individuals are able to briefly “recapture” the illusion of their narcissistic grandiosity which results in what A. Miller describes as “manic” phases embedded in a broader post-grandiose depressive phase. In addition A. Miller also described narcissistic individuals who experienced more intense and frequent fluctuations between these two positions, noting that for these individuals, their satisfactions of successes and achievements are often fleeting, quickly giving way to feelings of emptiness and futility, because current successes are unable to overcome vestiges of childhood frustrations.

A. Miller (1979) also described a form of narcissistic disturbance in which the narcissistic individual experienced constant and overt dejection, which appears superficially to be unrelated to any part of the grandiose self. A. Miller indicated, however, that despite seeming to be unrelated, that the repressed split off grandiose fantasies of these individuals are relatively easy for the analyst to discover, citing moral masochism as an example of a fusion of depression and grandiosity.

Although the surface presentation of the “grandiose” and “depressive” individuals is distinct, A. Miller (1979) noted that they share many similarities. To A. Miller, both individuals are driven to fulfil the expectations of critical introjected objects, and the difference lies in the fact that the “grandiose” individual views themselves as “successful” in winning the approval of these objects, whereas the “depressive” sees themselves as “failures” in this regard.

***Covert narcissism and DSM.*** Despite early work (Bach, 1975, 1977; Bursten, 1973; A. Miller, 1979) which elucidated different manifestations or forms of narcissism, the issue of different types of narcissism was not explored extensively again until after the publication of the DSM-III (APA, 1980).

With publication of the DSM-III (APA, 1980), it became apparent that the narrow and limited conceptualization of NPD in the DSM focused exclusively on one, very overt presentation of narcissism, at the expense of alternative more covert presentations (e.g., Gabbard, 1989). This led to a much greater effort to elucidate the more covert presentations of narcissism, in response to the incomplete view of narcissism presented in the DSM-III. Thus, it is likely that the emphasis on covert narcissism as a distinct form of narcissism arose not because prior theoretical literature

explicitly supported the idea of two qualitatively distinct forms of narcissism (as is implied by some later social-personality researchers; e.g., J.D. Miller & Campbell, 2008), but rather as a reaction to the perceived narrow interpretation of narcissism presented in the DSM.

***Post DSM-III work on covert narcissism.*** The first explicit post-DSM-III (APA, 1980) suggestion of two forms of narcissism which was compatible with the later overt/covert distinction came from Akhtar and Thomson (1982). In a review of NPD in the DSM, and of alternative theoretical models (focusing on Kernberg, 1975, and Kohut, 1971), Akhtar and Thompson proposed a revised set of diagnostic criteria, which they believed more fully captured the complexity of the condition than did the DSM. For Akhtar and Thompson, narcissism related to functional deficits in a number of areas; self-concept, interpersonal relationships, social adaptation, ethics, standards and ideals, relationships, and cognitive styles. They posited that rather than presenting in a single manner, as suggested in DSM, each of these deficits could present in relatively more overt and relatively more covert ways. They clarified that the term covert did not suggest “unconscious”, but simply that covert signs of deficits may be less apparent. While Akhtar and Thompson’s (1982) “overt” diagnostic indicators were in line with the diagnostic criteria of DSM III, their covert diagnostic indicators differed, focussing on hypersensitivity, feelings of inferiority, worthlessness and fragility and intense envy of others.

Following from Akhtar and Thompson’s (1982) differentiation of overt and covert manifestations of functional deficits, Adler (1986) suggested that theoretical differences between Kernberg (1975) and Kohut (1971) might be explained by the existence of two forms of narcissism. Adler argued that narcissists as described by Kernberg (1975) showed primarily what were later classified as overt characteristics, whereas Kohut’s (1971) descriptions focused on what were later classified as both overt and covert characteristics. Extending on Adler’s work, Gabbard (1989) proposed that narcissistic pathology differs along a continuum of interpersonal relatedness and that each pole of the continuum represents a prototypical form of narcissism. At one end of the continuum is the oblivious narcissist, characterised by unawareness of their impact on others, and at the other end, is the hypervigilant narcissist, characterised by sensitivity and preoccupation with their impact on others.

In line with NPD in the DSM (APA, 1980), Gabbard (1989) described the oblivious narcissist as being arrogant and self-absorbed, with a desire to be the centre of

attention. In contrast, Gabbard (1989) described the hypervigilant narcissist as sensitive to the reactions of others, inhibited and shy, with a hypersensitivity to criticism. In line with Adler's (1986) suggestion, Gabbard proposed that while the hypervigilant narcissist corresponded to Kohut's (1971) theoretical descriptions, the oblivious narcissist was closer to descriptions of narcissists in Kernberg's (1975) theory. He emphasised the importance of understanding both forms of narcissism in correctly diagnosing and treating narcissistic disorders, positing that hypervigilant narcissists would benefit from Kohut's treatment model and the oblivious narcissists from Kernberg's treatment model.

Akhtar (2003) later described a type of narcissism consistent with covert narcissism which he labelled *Shy Narcissism*. Akhtar focused on similarities between the shy narcissist and the overt narcissist (although he did not use this term). He indicated that both were characterised by intense ambition, were fixated on narcissistic fantasies involving personal fame and glory and sought omnipotence. Akhtar proposed that both narcissists saw themselves as unique, special and only able to be understood by "special or high status people" (p. 53). Interpersonally, he noted that both forms of narcissism were associated with a lack of empathy and a desire for acceptance and recognition by others. Thus, for Akhtar, the difference between the two forms of narcissism was purely in terms of presentation.

Akhtar (2003) describes the shy narcissist as more in control of their grandiose beliefs, with greater modesty and a perceived disinterest in material success. Akhtar noted that despite having the same deficits in empathy as the overt narcissist, the shy narcissist showed a propensity to display helping behaviours. Akhtar described this as due to their more strict conscience and more intensely experienced remorse over real or imagined transgressions.

### **Empirical research on covert narcissism.**

*Early empirical research on covert narcissism.* The empirical research on covert narcissism as a distinct form of narcissism was largely stimulated by empirical research employing the NPI (Raskin & Hall, 1979) rather than by the early theoretical literature. Following the development of the NPI a number of studies compared the NPI to existing narcissism measures. One of the first discussions of the difference between the NPI and older measures of narcissism (such as the NPDS; Ashby, 1978) was in Emmons (1984) analysis of the psychometric properties of the NPI. Emmons indicated that where previous narcissism scales had been developed to measure *pathological*

narcissism, that Raskin and Hall had developed the NPI as a measure of trait *normal* narcissism. In a follow up study, Emmons (1987) directly compared the NPI to alternative measures of narcissism, finding a complex relationship, with the NPI largely unrelated to the NPDS (with the exception of the Emmons' E/E subscale) and weakly related to the Millon Clinical Multiaxial Inventory (MCMI). Emmons (1987) suggested that whereas the NPI was measuring normal, non-clinical or adaptive narcissism and that the NPDS and MCMI were measuring clinical, pathological or maladaptive narcissism.

In a later study, Mullens and Kopelman (1988) conducted psychometric analyses of a number of narcissism scales, including the NPI, the NPDS, Serkownek's narcissistic-hypersensitivity scale (NHS; Schuerger, Foerstner, Serkownek, & Ritz, 1987) and the MT, an unpublished measure of normal and pathological narcissism. Their results showed that the NPI did not correlate with the other three scales. On the other hand, the other three scales were all strongly related to each other. Moreover, whereas the NPDS, NHS and MT were positively related to Machiavellianism and negatively related to social desirability, the NPI was not significantly related to either. In addition, the NPI was the only scale found to be significantly related to achievement motivation. Thus, taken together, there was a lack of convergence between the NPI and other narcissism scales.

In attempting to explain the lack of convergence between narcissism scales, Wink (1991) suggested that the scales might be measuring one of two qualitatively distinct *types* of narcissism. To explore this possibility, Wink (1991), factor analysed six MMPI based narcissism scales. His results indicated that the scales loaded onto two factors. The first factor included Raskin and Novacek's (1989) MMPI Narcissism scale, Morey, Waugh and Blashfield's (1985) Narcissistic Disorders scale designed to correspond with DSM-III NPD, and Wink and Goug's (1990) narcissism scale. Wink labelled this factor as "Grandiosity/Exhibitionism". The three MMPI scales which loaded on the grandiosity/exhibitionism factor were all developed based on the DSM-III (APA, 1980) definition of narcissism (Wink, 1996).

The second factor identified by Wink (1991) included the NPDS (Ashby, 1978), NHS (Schuerger et al., 1987) and the Ego-Sensitivity Scale, and was tentatively labelled "Vulnerability-Sensitivity". Whereas both factors were related to observer and clinician ratings of narcissism, only the "Grandiosity/Exhibitionism" factor was related to DSM-III (APA, 1980) ratings of narcissism.

In comparing the vulnerability-sensitivity and grandiose/exhibitionism dimensions to MMPI based scales, Wink (1991) found that both dimensions were negatively related to socialization and self-control. The dimensions also differed in that the vulnerability-sensitivity dimension was negatively related and the grandiose/exhibitionism positively related to dominance, sociability, social presence and self-acceptance. Furthermore, whereas the vulnerability-sensitivity dimension was moderately negatively related to wellbeing and personal adjustment, the grandiose/exhibitionism dimension was unrelated to wellbeing and weakly positively related to personal adjustment. The same pattern of results was evident when Wink (1991) compared the two dimensions on spouse rated adjectives. Results of this analysis indicated that both dimensions were similarly related to spousal ratings on adjectives related to being bossy, intolerant, cruel, argumentative, conceited and arrogant. However, the dimensions differed in that the vulnerability-sensitivity dimension was associated with spousal ratings of anxiety, tenseness and a propensity to worry, whereas the grandiosity-exhibitionism dimension was associated with spousal ratings of assertiveness, impulsivity, outspokenness and a lack of modesty. Thus, Wink's (1991) findings provide empirical support for two forms of narcissism which are largely consistent with the oblivious and hypervigilant prototypes which had been proposed earlier by Gabbard (1989).

In a later study, using the California Q set, however, Wink (1992a) found support for three rather than two types of narcissism. Wink labelled the three types of narcissism as *hypersensitive*, *wilful* and *autonomous*. Wink described hypersensitive narcissism in a similar manner to which he had earlier described the vulnerability-sensitivity dimension (e.g., Wink 1991) suggesting that it was related to overt inhibition, introversion, but with an underlying sense of grandiosity and self-importance. Results indicated that although hypersensitive narcissism was not predictive of DSM conceptualized NPD, it was strongly related to Ashby's (1978) NPDS and was more strongly related to pathology (e.g., MMPI scales measuring depression and social introversion) than wilful or autonomous narcissism.

In contrast to hypersensitive narcissism, Wink (1992a) argued that wilful narcissism was tapping in to a type of narcissism which was similar to that measured by the NPI. Results indicated that wilful narcissism was related to aggression, impulsivity and exhibitionism. Like hypersensitive narcissism, wilful narcissism was also found to be related to observer ratings of pathology.

Wink (1992a) found that autonomous narcissism was similar to wilful narcissism in terms of its association with exhibitionism, aggression and dominance. However, the primary difference between wilful narcissism and autonomous narcissism was that while wilful narcissism (like hypersensitive narcissism) was associated with various indicators of pathology, autonomous narcissism was not. Thus, Wink suggested whereas hypersensitive and wilful narcissism represented maladaptive forms of narcissism, autonomous narcissism represented healthy or adaptive narcissism. This was supported in some of the associations found for autonomous narcissism, with results indicating that autonomous narcissism was related to achievement, self-reliance, psychological mindedness, and empathy.

In analysing changes in these three types of narcissism over the lifespan in a sample of women, Wink (1992b) noted that women classified as either hypersensitive, wilful or autonomous narcissists at age 20 displayed different patterns of personality change at age 40. Vulnerable narcissists tended to fare worse, becoming more vulnerable, self-centred and pessimistic as they approached mid-life, whereas wilful narcissists tended to increase in confidence, self-efficacy and optimism, with a greater likelihood of starting a high-status career. Autonomous narcissists fared best and increased in creativity with better career success than either of the other two groups. What Wink demonstrated was that not only could narcissists be meaningfully differentiated, but that different types of narcissism were related differently to adjustment and maladjustment, which in turn had profound effects on the life of the individual.

The primary difference between Wink's (1991) original and later (Wink, 1992a, 1992b) studies, is that his first study focused solely on the difference between overt and covert narcissism, whereas his later studies implied that narcissism could be reliably differentiated on the basis of adaptive (autonomous) and maladaptive (wilful and hypersensitive) forms in addition to along overt (wilful and autonomous) and covert (hypersensitive) lines.

Subsequent researchers also found broad support for Wink's (1991) results. In a replication of Wink's (1991) original study, Rathvon and Holmstrom (1996) also found support for two narcissism factors, which they labelled *Grandiosity*, and *Depletion*. Rathvon and Holmstrom found that the grandiosity factor was positively related to MMPI measures of exhibitionism, and negatively related to MMPI measures of depression, anxiety, bodily concerns, and social discomfort. The depletion factor on the

other hand was related to most of the MMPI clinical scales and MMPI scales measuring maladjustment.

***Later empirical research on covert narcissism.*** In contrast to overt narcissism, research on covert narcissism was more restricted for several reasons. First, a number of covert narcissism scales have been used sporadically (Wink, 1996), and none had been widely accepted in the same way as the NPI had been. Second, covert narcissism tended to be measured using less well known MMPI scales (Hendin & Cheek, 1997). Although for a time there was a trend for the NPDS (Ashby, 1978) to be the “default” covert narcissism scale (Hibbard, 1992; Solomon, 1982; Wink & Donahue, 1997), this did not continue, largely for psychometric reasons. Despite acceptable validity (e.g., Solomon, 1982), the internal reliability of NPDS was problematic. While Ashby’s (1978) original study demonstrated that the NPDS had excellent internal consistency (with a reliability coefficient of .81), subsequent research showed lower reliabilities with scores ranging from around .40 (e.g., Mullins & Kopelman, 1988) to around .60 (e.g., Wink, 1991).

***Development of the Hypersensitive Narcissism Scale.*** In response to the lack of a standard scale to measure covert narcissism, Hendin and Cheek (1997) developed a new covert narcissism scale, the Hypersensitive Narcissism Scale (HSNS). Unlike previous covert narcissism scales, which were MMPI based, Hendin and Cheek wanted items to be face valid, and developed the scale by modifying Murray’s (1938) 20 item Narcism (sic) scale. As noted earlier, although Murray did not suggest more than one variety of narcissism, he did discuss some manifestations which were closer to later conceptualizations of overt narcissism (e.g., Cain et al., 2008) and some manifestations which were closer to later conceptualizations of covert narcissism. In line with this, Murray’s Narcism (sic) scale included items measuring both overt and covert manifestations. To identify the items which best represented covert narcissism, Hendin and Cheek selected items which correlated with a composite of existing MMPI based covert narcissism scales (including the NPDS and the NHS), and which did not correlate, or correlated only weakly with the NPI. This method identified 10 items. Content analysis indicated that these items were tapping into hypersensitive and vulnerable elements of narcissism.

Despite the promising nature of the HSNS (Hendin & Cheek, 1997), the scale has not been extensively employed. This is not necessarily a reflection on the scale, but more of the lack of interest in the concept of covert narcissism in contrast to that of overt narcissism. Nevertheless, results of subsequent studies employing the HSNS have

produced results confirming that it is an effective measure of maladaptive and covert narcissism.

*Overt narcissism, covert narcissism and approach-avoidance motivation.*

Subsequent research has examined differences between overt narcissism (usually measured using the NPI) and covert narcissism (usually measured using either the NPDS or the HSNS). Foster and Trimm (2008) suggested that core differences between overt and covert narcissism could be explained by approach and avoidance motivation. Using a non-clinical undergraduate sample, Foster and Trimm found that overt narcissism was related to high self-esteem and to high approach motivation and low avoidance motivation (measured using the Behavioural Activation System (BAS) and Behavioural Inhibition System (BIS) scales; Carver & White, 1994). Yet, in testing mediation models, they found that the relationship between overt narcissism and self-esteem was entirely mediated by approach and avoidance motivation. On the other hand, their analysis of covert narcissism (measured using the NPDS, NHS and HSNS) produced different results.

Foster and Trim (2008) found that covert narcissism was related to low self-esteem. Unlike overt narcissism, covert narcissism was related to high avoidance motivation, and was unrelated to approach motivation. The relationship between covert narcissism and self-esteem remained significant even when avoidance motivation was entered into the model. Foster and Trimm speculated that a difference between overt and covert narcissism was that whereas overt narcissists are driven to achieve success, covert narcissists are more inhibited and sensitive to punishment. They concluded that this supports the notion that covert narcissism is more maladjusted than overt narcissism.

In a follow-up study, Foster, Misra, and Reidy (2009) further explored the relationship between narcissism and motivation, and proposed that “unmitigated approach” is a central factor in narcissism. Their results once again indicated that overt (NPI measured) narcissism was related to strong approach-motivation and to weak avoidance motivation across a number of different contexts, including friendship and financial contexts. Similar results emerged in a study by Foster, Reidy, Misra, and Goff (2011), who found that the high approach and low avoidance motivation of narcissists translated into financial risk taking in hypothetical scenarios. A major limitation of these studies, however, was that unlike Foster and Trim (2008), Foster et al. did not include a measure of covert narcissism to allow for a comparison.

Ng, Tam and Shu (2011) further explored Foster and colleagues (Foster et al., 2009; Foster et al., 2011; Foster & Trimm, 2008) “unmitigated approach model” of narcissism within the context of money/financial attitudes. Ng et al. examined differences between overt and covert narcissism on attitudes to money (Yamauchi & Templer, 1982). This included “power and prestige”, the use of money for power or prestige in order to dominate others; “distrust”, the extent to which the individual is suspicious or doubtful when dealing with money; and “anxiety”, feelings of anxiety relating to money. Ng et al. found that both overt and covert narcissism were related to “power and prestige”. In contrast, only covert narcissism was associated with distrust and anxiety. Thus, both overt and covert narcissism were associated with grandiosity, and a desire to use power to dominate others.

To further explore the relationship of overt and covert narcissism to money related “power and prestige”, Ng et al. (2011) tested a number of potential mediators, including, approach and avoidance motivation, fear of negative evaluation (Leary, 1983a), and need for achievement and need for power (Liu, Liu, & Wu, 2010). Ng et al. observed that the only significant mediator between overt narcissism and money “power and prestige” was need for power. On the other hand, the relationship between covert narcissism and money “power and prestige” was mediated by both need for power and fear of negative evaluation. Thus, as with overt narcissism, need for power was a more important predictor of the attitudes of narcissists than was general approach and avoidance motivations.

The research described in the previous paragraphs is important for a number of reasons. First, it illustrates similarities between overt and covert narcissism, primarily that both forms of narcissism are related to a desire for dominance and a need for power. Results in relation to approach and avoidance motivation, on the other hand, illustrate an important difference, and indicate that despite both overt and covert narcissism being related to a desire for power and dominance, individuals high on overt narcissism employ different strategies in order to achieve this goal to individuals high on covert narcissism.

These results have parallels with Gilbert’s ethological model of Social Anxiety, discussed in Chapter 2, which differentiated between strategies employed by individuals seeking power and dominance. As discussed in Chapter 2, Trower and Gilbert (1989) differentiated several goals which individuals employ in relation to social rank. When these results are viewed in line with Trower and Gilbert’s theory, it can be speculated

that overt narcissists represent individuals who Trower and Gilbert suggest are motivated toward first level goals; that is, they see themselves as “dominant” and pursue strategies to maintain this dominance. On the other hand, these results suggest that covert narcissistic individuals might employ a mix of first level goals (seeking to be dominant) and second level goals (avoiding harm and rejection by others), with a greater focus on second level goals (showed through the high avoidance motivation of these individuals).

The second notable result was Ng et al.’s (2011) discovery that fear of negative evaluation mediated the relationship between covert narcissism and money related “power and prestige”. This finding is important because it illustrates that a significant and influential factor in determining a covert narcissists’ interest in appearing dominant and powerful is fear of negative evaluations, and more broadly, social anxieties. It is possible that for these individuals, a fear of being negatively evaluated is one factor (though not the sole factor) which drives their desire to appear powerful and to dominate others. This supports the prior assertion that covert narcissistic individuals might be motivated by both first and second level goals. From the perspective of second level goals, this result explains *why* dominance and power is important to covert narcissistic individuals (to wit. to avoid negative evaluation). From the perspective of third level goals, it can be argued that this strategy (seeking power/status) serves a defensive function in that covert narcissists employ it to avoid being negatively evaluated.

*Overt Narcissism, covert narcissism and aggression.* Recently, a number of studies have explored aggression in overt and covert narcissism. In a sample of 674 high school students, Fossati, Borroni, Eisenberg, and Maffei (2010) found that overt narcissism was associated with both proactive and reactive aggression, whereas covert narcissism was only related to reactive aggression. The relationship between narcissism and reactive aggression was stronger for overt narcissism than covert narcissism.

To clarify whether covert narcissist were more sensitive relative to others, Okada (2010) examined whether individuals high in covert narcissism were more likely to display aggression in response to social rejection than individuals low in covert narcissism. Relative to individuals low in covert narcissism, individuals high on covert narcissism reported greater aggression and aggressive cognitions in response to rejection in an experimental situation.

Fossati et al. (2010) and Okada's (2010) findings are also consistent with Trower and Gilbert's (1989) social rank related goals. The greater propensity for overt narcissists to express proactive aggression (Fossati et al.) and to express physical and verbal aggression (Okada) might be strategy to enhance their social status, or to appear dominant. These displays of aggression can be tied to Trower and Gilbert's first level goals (of becoming dominant or maintaining a position of dominance).

Alternatively, the lack of overt aggression of covert narcissists could represent second level goals (Trower & Gilbert, 1989) to avoid threat and social rejection. Although these individuals might have aggressive thoughts and feelings, that they might inhibit expression of aggression because of the negative social consequences of this expression. Thus, the relationship between overt and covert narcissism and aggression further supports the differentiation of overt and covert narcissism according to Gilbert's (1989) ethological theory.

*Development of the Pathological Narcissism Inventory.* Recently, a new scale, the Pathological Narcissism Inventory (PNI), has been constructed which allows simultaneous measurement of pathological-grandiose (as opposed to adaptive-overt) and covert narcissism (Pincus et al., 2009). As expected, factor analysis of the scale revealed that the two broader latent constructs of Grandiose Narcissism and Vulnerable Narcissism. In addition to the two broad latent factors of Grandiose and Vulnerable Narcissism, Pincus et al. found that the PNI could be further broken into seven subscales, with grandiose narcissism being comprised of the subscales of Entitlement Rage, Exploitativeness, Grandiose Fantasy, Self-sacrificing Self-enhancement and Vulnerable Narcissism being comprised of three subscales; Contingent Self-esteem, Hiding the Self, and Devaluing. Pincus et al. found that with the exception of a weak-moderate relationship between the NPI and the Exploitativeness factor, the NPI was only very weakly related, or unrelated to the remaining PNI subscales, further demonstrating that the NPI is a measure of normal/adaptive, rather than subclinical narcissism. Furthermore, unlike the NPI, which, in line with social-personality literature (e.g., J. D. Miller & Campbell, 2008) was found to be associated with intrapersonal adjustment, the PNI was found to be related to intrapersonal maladjustment.

Given the recency of the development of the scale, and the continued use of the NPI in the social-personality literature, the PNI has not yet been extensively employed, and only a small number of studies have employed it (Besser & Priel, 2010; Fetterman & Robinson, 2010; Zeigler-Hill & Besser, 2011). Many recent studies (e.g., Maples,

Collins, Miller, Fischer, & Seibert, 2011) still employ the NPI and HSNS in exploring differences between overt and covert narcissism.

### **Overview of Overt and Covert narcissism**

Given that the possibility of a relationship between overt narcissism and social anxiety has already been covered in the discussion on the social-personality perspective, this section focuses on the possibility of a relationship between covert narcissism and social anxiety.

Covert narcissism shares many similarities with social anxiety, with covert narcissistic individuals being described as shy, anxious, hypersensitive to criticism and more likely to experience shame (e.g., Cain et al., 2008). Thus, covert narcissism ought to be at least moderately correlated with social anxiety. While this certainly provides support for the core contention of the current thesis, the major argument of this thesis is not that covert narcissism will be linearly related to social anxiety, rather a subset of socially anxious individuals might be characterised by high levels of narcissism, and that such a subset of socially anxious individuals will be qualitatively distinct from socially anxious individuals who do not show high levels of narcissism.

Given the support for multiple forms of narcissism, and the suggestion that different subsets of socially anxious individuals might be able to be identified based on elevations on narcissism scales, it is possible that more than one narcissistic socially anxious group might be able to be identified, with distinct covert-narcissistic and overt-narcissistic socially anxious individuals being identifiable.

### **Attempting to Bridge Clinical, Social Personality and Overt/Covert Narcissism**

Recently, Russ et al., (2008) presented a review of narcissism which attempted to account for discrepancies between the clinical and social-personality theories of narcissism, and to account for theories describing two overt and one covert form of narcissism. Russ et al. conducted a Q-factor analysis of clinician reports of 1,201 patients, 255 of whom met DSM-IV (APA, 2000) criteria for NPD, and found support for three distinct narcissistic subtypes. Russ et al. labelled the three subtypes as *Grandiose/Malignant*, *Fragile*, and *High functioning/exhibitionistic*. The three narcissistic subtypes identified by Russ et al. correspond closely to the clinical (Grandiose/Malignant), covert (Fragile) and social-personality (High functioning/exhibitionistic) perspectives. Russ et al. describe the grandiose/malignant narcissist as being aggressive, exploitative, critical, controlling and lacking in empathy. They suggest that for this subtype, their grandiosity is “primary” rather than

compensatory. Validity analyses indicated that this subtype was associated with externalizing behaviours (e.g., being the perpetrator in abusive relationships) and a high comorbidity with Paranoid and Antisocial DSM –IV (APA, 2000) Axis II disorders.

Fragile narcissists on the other hand, are described in a similar way to covert narcissists, and Russ et al. (2008) indicate that they experience contradictory feelings with oscillations between feelings of grandiosity and superiority and feelings of inadequacy and inferiority. Russ et al.'s results also indicated a tendency for these narcissists to experience anxiety, intense envy and feelings of emptiness and to be preoccupied with possible abandonment. Russ et al. indicate that the grandiosity of these individuals is defensive, and that it frequently emerges under conditions of threat. Validity analyses indicated a high comorbidity between this narcissistic subtype and DSM–IV (APA, 2000) Avoidant and Borderline disorders.

Russ et al.'s (2008) description of high-functioning/exhibitionistic narcissist shares some similarities with the social-personality perspective, and they describe these narcissists as grandiose, competitive, and attention seeking. In line with the social-personality perspective, Russ et al. indicate that these narcissists are characterised by a number of adaptive characteristics, such as achievement orientation, ease in social situations and a tendency to be energetic and outgoing. Also consistent with the social-personality literature, this narcissistic subtype was found to have the lowest rate of psychiatric comorbidities, with comorbidity rates below 25% for all DSM–IV (APA, 2000) Axis I and II disorders assessed by Russ et al. Surprisingly, Russ et al. indicate that this subtype has received the least empirical attention, but that it has been described in the clinical literature. However, it is possible that Russ et al.'s review of the literature was confined solely to the clinical literature and they were unaware of this subtype being closely related to the narcissist described in the social/personality perspective and the many studies relating to this more adaptive variant of narcissism.

In addition to differences between the three subtypes, importantly, Russ et al.'s (2008) results indicate a number of areas of overlap, suggesting that although different, the three subtypes converge in the “core” of narcissism. All three subtypes were related to an exaggerated sense of self-importance, and a tendency to be critical of others

The reformulation of Russ et al. (2008) is important for a number of reasons, primarily because it better differentiates between adaptive overt (high-functioning exhibitionistic) and more maladaptive overt (grandiose-malignant) subtypes of narcissism. This distinction serves to highlight the core proposition of the current thesis,

that some socially anxious individuals will be characterised by elevated narcissism. It also adds weight to the earlier suggestion that there may be distinct overt and covert narcissistic social anxiety subtypes. Whereas an overt narcissistic social anxiety subtype would run counter to the social-personality literature, which has emphasised the lack of internalized negative emotions and adaptive nature of narcissism (e.g., J. D. Miller & Campbell, 2008) such relationship is more consistent with the grandiose-malignant subtype. Although Russ et al. did speculate that the grandiosity of this narcissistic subtype was not compensatory, this does not suggest that anxiety, depression and shame would be absent in this form of narcissism, simply that the individual's grandiosity is not a result of these factors. This is supported by the fact that, although lower than that for fragile narcissism, there were a number of these narcissists who showed comorbid DSM-IV (APA, 2000) Axis II Avoidant Personality Disorder (Russ et al. did not assess Social Anxiety Disorder in exploring DSM-IV Axis I comorbidities).

### **Current Work on Social Anxiety and Narcissism**

As noted, the idea of a relationship between narcissism and social anxiety has strong support in the historical social anxiety literature (Hartenberg, 1901; Janet, 1903; Janet & Raymond, 1903; Sandler et al., 1958) and recent reformulations of social anxiety (Hoffmann, 1999, 2002), and is consistent with theoretical models of narcissism. Despite this, to date, there has only been one attempt to empirically examine the relationship between narcissism and social anxiety directly. In a review of the literature, Schurman (2000) noted strong empirical support for a relationship between shame and narcissism and between shame and social anxiety, and proposed a possible relationship between narcissism and social anxiety on this basis. Thus, Schurman's argument was centred on the fact that both narcissism and social anxiety were related to shame. Although Schurman was interested in both overt and covert narcissism, she focused primarily on covert narcissism, proposing that there would be a strong linear relationship between covert narcissism (measured using the HSNS) and social anxiety, a weak linear relationship between Raskin and Terry's (Raskin & Terry, 1988) Exploitativeness and Entitlement subscales of the NPI and social anxiety, and no relationship between the full scale NPI and social anxiety.

In a non-clinical convenience sample of 91, Schurman (2000) found, as expected that the HSNS was moderately positively related to social anxiety. Contrary to her hypotheses, however, the NPI, and Raskin and Terry's (1988) Exploitativeness factor were significantly negatively related to social anxiety. Also contrary to her expectations,

Raskin and Terry's Entitlement factor was found to be unrelated to social anxiety. Schurman concluded that social failures (which result in social anxieties) result in or lead to narcissistic defences, specifically, to hypersensitive narcissistic characteristics. On the other hand, she suggested that the negative relationship between the NPI and social anxiety indicating that "outward displays of narcissism are antithetical to the shyness and social reticence of social phobics" (p. 93).

Although Schurman's (2000) interpretations fit with her results, it is possible to argue that she used the wrong kind of analysis, and thought about the relationship between narcissism and social anxiety in the wrong way. As has been indicated earlier, the literature reviewed in the previous chapters has strongly supported the idea that for some socially anxious individuals, their social anxieties co-exist with narcissistic characteristics, and that moreover, there may be distinct overt and covert narcissistic socially anxious individuals. On the other hand, there has not been strong support for a linear relationship between narcissism and social anxiety. Thus, rather than examining correlations, Schurman might have found a more meaningful relationship between narcissism and social anxiety through the use of cluster analysis. Such an analysis would allow the identification of unique clusters of individuals, and would possibly identify the unique overt and covert narcissistic social anxiety subgroups.

### **Summary of the Narcissism Chapters**

The previous two chapters have reviewed the three main perspectives on narcissism, namely, the clinical, the social-personality perspective, and the literature distinguishing between overt and covert narcissism. From within the narcissism literature, there is strong support for the argument introduced in Chapter 2 that for some socially anxious individuals their social anxiety co-exists with narcissistic characteristics. The following chapters report on the results of two empirical studies conducted in order to explore the possibility of narcissistic socially anxious individuals. In light of the limitations identified in Schurman's study, these studies use cluster analysis to attempt to identify these individuals.

## **Chapter 7: Study 1 Exploration of Narcissistic Social Anxiety Subgroups**

This chapter presents the results of Study 1. Given the scope of the study, it is presented in two sections. First, Study 1 Part A presents the initial cluster analysis and analysis of group differences in social anxiety, narcissism and anger. Study 1 Part B further illustrates the nature of the new subgroups by presenting analyses of group differences in a number of relevant variables. Following this, a general discussion of the results of Study 1 is presented.

### **Study 1 Part A**

**Aims and hypotheses.** Extensive reviews of both the social anxiety and narcissism literatures lead to the conclusion that there exist one or more subsets of socially anxious individuals whose social anxieties co-exist with narcissistic characteristics. Based upon this, the aim of current study was to explore the possibility of narcissistic social anxiety subgroups. The following sections describe the rationale for the current study in more detail.

The current study sought to extend upon the cluster analytic studies described in Chapter 4 (Kashdan et al., 2008; Kashdan & Hofmann, 2008), and explore the possibility of narcissistic social anxiety subtypes. The cluster analysis was performed using the same SPSS two-step cluster analysis method employed by Kashdan and colleagues (e.g., Kashdan et al., 2008; Kashdan & Hofmann, 2008; Kashdan et al., 2009). On the basis of the narcissism literature presented in Chapter 5, it was hypothesised that multiple narcissistic social anxiety subgroups would be identified, with one or more subgroups representing overt-narcissistic socially anxious individuals and one or more subgroups representing covert-narcissistic socially anxious individuals. The second aim was to explore group difference in social anxiety and narcissism to assist with labelling the new social anxiety subgroups.

### **Method**

#### ***Participants***

*Rationale for sample selection strategy.* As the current study was interested broadly in social anxieties, and not in the narrower Psychiatric conceptualization of Social Anxiety Disorder, or Avoidant Personality Disorder, as they appear in DSM-5 (APA, 2013), and given the exploratory nature of the study, the decision was made not to employ a clinical sample, but instead, to use an internet based sample. As such, there were no specific exclusion criteria used in the study, and the only inclusion criteria was that participants had experienced social anxiety. In this respect, Kashdan et al. (2008)

also used non-clinical samples to explore the *Avoidance-Motivated* and *Approach-Motivated* social anxiety subgroups. Kashdan et al. identified the same social anxiety subgroups in a non-clinical sample as Kashdan and colleagues did in clinical samples (Kashdan & Hofmann, 2008), and epidemiological studies (Kashdan et al., 2009). Thus, although clinical and non-clinical populations differ in severity of social anxieties, the same types of social anxiety are evident in both clinical and non-clinical populations.

However, it was not entirely clear that the internet sample would have low social anxiety, and it is possible the level of severity of social anxiety symptoms in the current internet sample would be equal or greater to clinical samples. This likelihood is supported by empirical research. Erwin, Turk, Heimberg, Fresco, and Hantula (2004) conducted a study to determine the characteristics of individuals who seek information online about social anxiety. These participants were compared to a treatment seeking sample of participants with Social Anxiety Disorder, and Erwin et al. found a greater proportion of the internet sample met diagnostic criteria for Generalised SAD, and the internet sample was more anxious, impaired and isolated in comparison to the treatment seeking sample.

Erwin et al. (2004) noted the impairment of the internet sample went beyond social anxiety symptoms. Although internet respondents were similar on some demographic metrics (e.g., age, sex and race) to socially anxious individuals identified in a National Comorbidity Survey (Kessler, McGonagle, Zhao, & Nelson, 1994), the internet sample was twice as likely to have never married. Erwin et al. speculated that the internet is especially attractive to individuals with severe social anxieties in that internet based communication allows them to form relationships while concealing physical appearance and overt (behavioural and physiological) manifestations of anxiety.

Finally, the primary reason not to employ a clinical sample, is that restricting the sample to individuals who met DSM (APA, 2013) diagnostic criteria for SAD, runs counter to the arguments presented in Chapters 2 and 4, which indicate that social anxieties are complex and multifaceted (Chapter 2), and that the current psychiatric diagnoses do not adequately cover all manifestations of the disorder (Chapter 4). Thus, the rationale to employ an internet sample is strong.

*Recruitment.* A similar recruitment strategy to Erwin et al. (2004) was used, with participants recruited via online flyers on social anxiety websites, web-forums, discussion boards and email lists (for example [www.socialphobiaworld.com](http://www.socialphobiaworld.com)). Given

that Erwin et al. posted links on a general anxiety website, online flyers were also posted on websites which dealt with broader psychological issues (e.g., depression, anxiety). The posting in depression forums is supported by research which has demonstrated a high degree of comorbidity between social anxiety and depression (Erwin, Heimberg, Juster, & Mindlin, 2002). The flyer also clarified that participation was sought from individuals who suffered from social anxiety and also those who did not. It was believed that such an approach might result in a small non-socially anxious (or low social anxiety) comparison group which could be compared to the new social anxiety groups identified.

### ***Characteristics of the final Sample***

Three hundred and forty-nine individuals completed the online questionnaire. Two hundred and four participants were female ( $MAge = 32.02$ ,  $SD = 11.34$ ), and 145 were male ( $MAge = 31.69$ ,  $SD = 10.71$ ). The age of the combined sample ranged from 15 to 74 ( $MAge = 31.88$ ,  $SD = 10.94$ ).

### ***Description of the sample.***

*Country of residence.* Use of the internet to recruit participants resulted in a multinational, heterogeneous sample. Four participants (1.4%) resided in Africa, 10 (2.9%) in Asia, 141 (40.4%) in Europe, three (.9%) in Israel, 150 (43%) in North America, and 40 (11.5%) in Oceania. A complete list of participants' countries of residence is presented in Table 7.1. One participant did not indicate their country of residence.

*Relationship status.* One hundred and twenty two participants (35%) indicated that they were single and had never been in an intimate relationship, 71 (20.3%) indicated that they were currently single but had previously been in an intimate relationship, 128 (36.7%) indicated that they were currently in an intimate relationship or married, 15 (4.3%) indicated that they were divorced or separated and currently single, 10 (2.9%) indicated that they had been divorced or separated but were currently in an intimate relationship and three participant's (.9%) indicated their relationship status as "other". The high number of participants who identified as single and indicated that they had not had previous relationships is expected on the basis of the age skew of the sample (with a greater proportion of younger participants), and the fact that participants were recruited from social anxiety forums, which would suggest lower numbers of offline interactions (Mazalin & Klein, 2008).

Table 7.1

*Participant's country of residence*

Country	Female	Male	Total
Australia	18	16	34
Canada	12	11	23
Croatia	1	1	2
Finland	1	0	1
Germany	0	1	1
Greece	1	1	2
Hungary	0	1	1
India	1	2	3
Indonesia	3	0	3
Israel	3	0	3
Italy	2	4	6
Japan	0	1	1
Malaysia	1	0	1
New Zealand	2	4	6
Norway	0	1	1
Singapore	1	1	2
Slovenia	1	0	1
South Africa	2	1	3
Spain	2	0	2
Sudan	1	0	1
Sweden	12	10	22
Switzerland	1	0	1
The Netherlands	9	2	11
The United Kingdom	46	44	90
The United States	84	43	127

Note.  $N = 348$ .

*Education status.* Twenty nine (8.3%) of participants had not completed high school, 126 (36.1%) had currently completed high school, 54 (15.5%) were current tertiary students, 72 (20.6%) had completed tertiary education, 35 (10%) were current post-graduate students, and 33 (9.5%) had completed post-graduate studies. Thus, taken

together, a high percentage of the sample were undertaking or had completed tertiary education (40.1%).

*Self-reported clinical history.* Although clinical assessments of anxiety and mood disorders were not used to determine if participants met clinical criteria for anxiety or mood disorders, participants were asked if they had ever been diagnosed with *Depression, Social Anxiety Disorder, Other Anxiety Disorders, or Other Mood Disorders* in the past 2 years. Participants were able to select more than one option.

One hundred and fifty seven participants (44.99%) indicated that they had received a diagnosis of Depression within the past 2 years and 146 participants (41.8%) a diagnosis of Social Anxiety/Social Phobia. Seventy participants (20.1%) indicated a diagnosis of another anxiety disorders, and 25 (7.2%) another mood disorder. Ninety four participants (26.9%) indicated that they had not been diagnosed with any of the aforementioned conditions within the last 12 months. Thus, although the data need to be interpreted with caution, almost half the sample reported being diagnosed with social anxiety within the past two years. Furthermore, only a quarter of the sample indicated that they had not been diagnosed with an anxiety or mood disorder. Thus, from a clinical perspective, it could be suggested that the current sample is characterised by individuals with a high level of impairment.

### ***Self-report measures of Social Anxiety and Narcissism***

*Measures of Social Anxiety.* Social anxiety was measured using the *Social Phobia Scale (SPS)* and *Social Interaction Anxiety Scale (SIAS)*. The SPS and SIAS were developed as companion measures by Mattick and Clarke (1998), with items derived from existing social anxiety scales, and from clinical interviews with socially anxious patients. The SPS was designed to measure fear of being scrutinised during routine activities (e.g., eating, drinking, writing, etc.), and the SIAS to measure social anxieties focused around fear of dyadic and group interactions. Mattick and Clarke's rationale for constructing two separate scales was that they were trying to capture the DSM-III-R (APA, 1987) distinction between Generalized Social Phobia and Social Phobia (circumscribed social phobia). They also reasoned that individuals could have scrutiny fears without interaction fears, or interaction fears without scrutiny fears.

The SIAS consists of 19 items and the SPS 20 items. Items are rated on a 5 point scale from 0 (*Not at all*) to 4 (*Extremely*) with higher scores indicative of greater social anxiety. Although the 20 SPS items are all scored in the same direction, the SIAS

includes two reverse scored items “I am at ease meeting people at parties et cetera” and “I find it easy to think of things to talk about”.

In their initial validation study Mattick and Clarke (1998) reported that the SPS and SIAS possessed good psychometric properties. Across a number of clinical and non-clinical samples, Cronbach’s alpha ranged from .89 to .94 for the SPS and between .88 and .94 for the SIAS. Additionally, Mattick and Clark reported retest-retest statistics of .91 for the SPS and .92 for the SIAS over a four-week period and .93 for the SPS and .92 for the SIAS over a 12 week period.

Mattick and Clark reported that both scales showed moderate to strong correlations with existing social anxiety scales, including the Social Phobia subscale of Marks and Matthews Fear Questionnaire (SPS:  $r = .69$ ; SIAS:  $r = .66$ ; Marks & Matthews, 1979) and the Fear of Negative Evaluation Scale (SPS:  $r = .60$ ; SIAS:  $r = .66$ ; D. Watson & Friend, 1969). In addition, both showed significant weak to moderate correlations with general measures of distress, including the Beck Depression Inventory (SPS:  $r = .54$ ; SIAS:  $r = .47$ ; Beck & Beck, 1972) and trait anxiety measured using the State Trait Anxiety Inventory (SPS  $r = .57$ , SIAS  $r = .58$ ; Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1983). The two scales were also found to be significantly positively related ( $r = .72$ ).

Importantly, given the sample used in the current study, Mattick and Clark performed reliability analysis of the scales using clinical samples (with a DSM diagnosis of Social Anxiety Disorder, Agoraphobia, and Simple Phobia), community sample, and undergraduate samples. They provided norms for each of these groups, and found that the Social Anxiety Disorder group showed higher scores (SPS  $M = 40$ , SIAS  $M = 34.6$ ) than the Agoraphobic sample (which could be seen to overlap with social anxiety; SPS  $M = 27.6$ , SIAS  $M = 15.4$ ), which was again higher than the Simple Phobia group (SPS  $M = 10.3$ , SIAS  $M = 11.5$ ), the Community sample (SPS  $M = 14.4$ , SIAS  $M = 11.2$ ) and the undergraduate sample (SPS  $M = 14.1$ , SIAS  $M = 10.2$ ).

Additional validation of the scales was undertaken by Brown, Turovsky, Heimberg, and Juster (1997). Brown et al. compared different clinical groups and found that individuals with DSM-diagnosed social anxiety scored significantly higher (SPS  $M = 36.9$ , SIAS  $M = 50.7$ ) than patients with Panic Disorder with (SPS  $M = 33.6$ , SIAS  $M = 40.2$ ) and without (SPS  $M = 23.9$ , SIAS  $M = 33.9$ ) Agoraphobia, Obsessive Compulsive Disorder (SPS  $M = 26.8$ , SIAS  $M = 34.6$ ), Generalized Anxiety Disorder (SPS  $M = 18$ , SIAS  $M = 32.7$ ), and non-clinical controls (SPS  $M = 6.3$ , SIAS  $M = 14.3$ )

on both the SPS and SIAS. Importantly, Brown et al. found no difference in SIAS and SPS scores for individuals with and without co-morbid mood disorders, indicating that the scales are measuring social anxiety, and scores are not being affected by general negative affect, or by a latent construct underling all (or many) mood and anxiety disorders. Brown et al. also found the SIAS was more strongly related to interactional fears (SPS  $r = .18$ , SIAS  $r = .53$ ), and the SPS more related to performance fears (SPS  $r = .53$ , SIAS  $r = .28$ ), thus providing further evidence that the two scales measure slightly different aspects of social anxiety.

Subsequent research confirmed that both scales possess excellent psychometric properties, with Cronbach's alpha ranging from .89 to .94 for the SPS and from .88 to .93 for the SIAS (Heimberg, Mueller, Holt, & Hope, 1992; Osman, Gutierrez, Barrios, Kopper, & Chiros, 1998). The scales were also found to have good convergent and discriminant validity, with the SIAS showing moderate to strong correlations with the social subscale of the Liebowitz Social Phobia Scale ( $r = .69$ ; [LSPS]; Liebowitz, 1987) and the Social Avoidance and Distress Scale ( $r = .74$ ; Watson & Friend, 1969), and the SPS being found to moderately correlate ( $r = .60$ ) with the Performance subscale of the LSPS (Heimberg et al., 1992). The pattern of correlations further supports the differentiation of the two scales with the SIAS measuring social anxiety around interactions and the SPS measuring performance based anxieties.

The scales have been used in a wide range of populations and have been used in clinical populations as measures of severity of social anxiety (Leung & Heimberg, 1996), in epidemiological research (Furmark et al., 1999) and as measures of "trait" social anxiety in non-clinical populations (Gore, Carter, & Parker, 2002). Additionally, the scales have been found to be cross-culturally valid, having been successfully used in Spain (Olivares, García-López, & Hidalgo, 2001), Italy (Sica et al., 2007), Germany (Heinrichs et al., 2002; Rabung, Jaeger, Streeck, & Leichsenring, 2006; Stangier, Heidenreich, Berardi, Golbs, & Hoyer, 1999), Sweden (Furmark et al., 1999), and China (Ye, Qian, Liu, & Chen, 2007).

Although a number of studies (Habke, Hewitt, Norton, & Asmundson, 1997; Safren, Turk, & Heimberg, 1998) have suggested that the SIAS and SPS are best represented by three factors, this is inconsistent with Mattick and Clarke's (1998) original conceptualization of the SIAS and SPS as two distinct scales, rather than a single scale with two factors. Additionally, a number of studies (e.g., Heinrichs et al.,

2002) on the factor structure have found evidence for the original two factors, rather than the proposed three factors.

In an item-response analysis of the SIAS, Rodebaugh, Woods, and Heimberg (2007) found that respondents tended to answer the reverse scored SIAS items differently to the forward scored items. They argued that the pattern of responses associated with the reverse scored items could lead to underestimation of the level of SIAS in non-clinical samples. On the basis of these results, Rodebaugh et al. suggested that the reverse scored items could be removed, and indicate that the reliability of the SIAS was substantially better when only standard items were considered. Although the arguments of Rodebaugh et al. are sound, the current study used the SIAS score with the two reverse scored items included. The rationale for this is that many studies which have presented norms for various clinical and non-clinical populations (E. J. Brown et al., 1997; Mattick & Clarke, 1998) have used the full SIAS (with the reverse scored items included) and meaningful comparisons between the SIAS scores of the current sample, and SIAS norms could not be made if the items were removed.

*Measures of Narcissism.* As noted in Chapter 4, narcissism is an enigmatic construct, and is conceptualized differently across clinical, psychodynamic and social-personality psychology perspectives. To fully capture the construct of narcissism, three narcissism scales were employed; the *Narcissistic Personality Inventory* (NPI; Raskin & Hall, 1979), the MMPI based *Narcissistic Personality Disorder Scale* (NPDS; Ashby, 1978), and the *Hypersensitive Narcissism Scale* (HSNS; Hendin & Cheek, 1997).

*Narcissistic Personality Inventory.* The Narcissistic Personality Inventory (NPI; Raskin & Hall, 1979) was developed based on the preliminary diagnostic criteria for Narcissistic Personality Disorder from DSM-III (APA, 1980). Rather than being conceptualized as a clinical scale, Raskin and Hall initially suggested that the scale measured individual differences in *trait* narcissism. The current study used the 40 item version of the NPI, which has become the most frequently used version of the scale (e.g., Buffardi & Campbell, 2008; Campbell et al., 2005; Campbell & Sedikides, 1999; Rhodewalt & Morf, 1998; Rhodewalt, Tragakis, & Finnerty, 2006; Twenge, Konrath, Foster, Keith Campbell, & Bushman, 2008).

Psychometric analyses of the NPI have demonstrated that the scale possesses excellent psychometric properties. Reliability of the scale has been found to be good, with Emmons (1984, 1987) reporting Cronbach's alpha statistics of .86 and .87 and Raskin and Terry (1988) a Guttman Lambda (Guttman, 1945) statistic of .83 for the

scale. The scale has also been shown to be stable over time, with del Rosario and White (2005) reporting a test-retest reliability figure of .81 over a 13 week period.

The factor structure of the NPI presents a difficult problem, as several factor structures have been proposed, including seven (Raskin & Terry, 1988), four (Emmons, 1984), three (Ackerman et al., 2011) and two (Ackerman et al., 2012; Corry, Merritt, Mrug, & Pamp, 2008; del Rosario & White, 2005; Kubarych et al., 2004) factor solutions. Despite evidence that the NPI is not measuring a unidimensional construct, the lack of agreement as to the number of factors which underlie the NPI, and the lower reliability for the subscales in comparison to the full NPI score (e.g., Emmons, 1984) has meant that the majority of empirical research using the NPI has used the full scale score, rather than the subscales (Atlas & Them, 2008; Buffardi & Campbell, 2008). Given the lack of consensus around the factor structure of the NPI (e.g., Kubarych et al., 2004), and in line with the bulk of the social-personality literature (J. D. Miller & Campbell, 2008), the current study used the full scale NPI.

*Narcissistic Personality Disorder Scale (NPDS)*. The NPDS (Ashby, 1978; Ashby, Lee, & Duke, 1979) is an 19 item scale derived from the MMPI. Participants rate the 19 items true or false (e.g., "I worry quite a bit over possible misfortunes"). One NPDS item was excluded (I used to like drop-the-handkerchief) because it has been suggested that the item is anarchistic and not well understood by contemporary respondents (Hendin & Cheek, 1997). This left a total of 18 items in the current study.

The NPDS, in contrast to the NPI which was first validated in an undergraduate sample, was first validated using a clinical sample of patients with a diagnosis of narcissistic personality by an experienced clinician (with verification from a second clinician), and who were currently in therapy. Ashby (1978) noted that the requirement that the sample were currently in therapy was important, because Kohut (1971) had suggested that narcissistic pathology could only be reliably diagnosed from patterns of transference and countertransference within the therapeutic situation.

Ashby (1978) used three groups as controls: a historical cohort of 50,000 patients who had completed MMPI data, 50 undergraduate students, and 20 patients in therapy who did not have a narcissistic disorder. The items for the NPDS were selected on the basis of how well they differentiated between these groups and the narcissistic patients. Ashby found that the final NPDS scores were significantly higher for the narcissistic patients than for the non-narcissistic patients and the non-clinical controls.

The NPDS was found by Ashby and later researchers to possess acceptable psychometric properties (Ashby, 1978; Solomon, 1982). Although the reliability of the NPDS has not been extensively examined, Ashby et al. (1979) did find the scale to possess acceptable internal consistency, reporting a Kuder-Richardson (Kuder & Richardson, 1937) statistic of .81. In a subsequent study using the NPDS, Wink (1991) reported a reliability statistic of .60 for the scale, which while lower, is still acceptable (see J. C. Nunnally, 1974).

Consistent with clinical theories of narcissism, Solomon (1982) found high, moderate and low scorers on the NPDS could be differentiated on self-esteem and satisfaction with relationships. Higher levels of NPDS measured narcissism was associated with lower self-esteem and less relationship satisfaction.

*The Hypersensitive Narcissism Scale (HSNS).* The HSNS (Hendin & Cheek, 1997) is a 10 item scale derived from Murray's (1938) narcissism scale (MNS). Like the NPDS, Murray's scale was not initially conceptualized as a measure of any particular variant of narcissism (overt or covert), and like clinical theorists (e.g., Kernberg, 1975; Kohut, 1971) Murray saw narcissism as not associated with any particular behavioural characteristics. Hendin and Cheek developed the HSNS to create a scale to measure covert narcissism which did not rely on the MMPI. To achieve this, they correlated items from Murray's narcissism scale with two MMPI based narcissism scales, the NPDS, and Serkownek's Narcissism-Hypersensitivity Scale (NHS; Solomon, 1982) which they classified as "covert" narcissism scales, and the NPI, to identify items which best represented "covert" narcissism.

Hendin and Cheek (1997) assumed that those MNS items which positively correlated with the NPDS and NHS and were unrelated or correlated negatively with the NPI were items reflecting "covert" narcissism. There are, however, problems with the method they employed to create the scale. Given that the NPDS was not conceptualized as a measure of covert narcissism, suggesting that MNS items which correlated with the NPDS represented covert narcissism is erroneous. This is not to say that the scale is not valid. If the NPDS is considered a scale of clinical narcissism rather than covert narcissism, and if one considers the overlap between some NPI items and normal high self-esteem, then it is possible that rather than representing "covert" or hypersensitive narcissism, the scale measures clinical or pathological narcissism.

The 10 HSNS items measure manifestations of narcissism such as self-absorption, hypersensitivity to criticism, and a desire for recognition. Items are rated

between 1 *Very uncharacteristic or untrue; strongly disagree* and 5 *Very characteristic or true; strongly agree*. Higher HSNS scores indicate a higher degree of hypersensitive narcissism. Psychometric studies indicate that the HSNS possesses good psychometric properties (Gleason, Jarudi, & Cheek, 2003; Smolewska & Dion, 2005). In their initial validation study, Hendin and Cheek reported Cronbach's alpha statistics between .62 and .72. Similarly, Gleason et al. (2003) reported a Cronbach's alpha of .76.

Correlations between the three narcissism scales indicated a significant negative correlation between the NPDS and the NPI  $r = .15, p = .006$ , a significant positive correlation between the NPDS and the HSNS  $r = .49, p < .001$ , but no significant correlation between the HNSN and the NPI  $r = -.02, p = .588$ . This indicates that each of the three scales is measuring a slightly different aspect of narcissism, thus further justifying the inclusion of all three scales.

### **Results**

The following sections present the results of Study 1 part A. Initially, preliminary analyses of the scales are presented, then age and gender differences on the measures are assessed. Following this, results of the cluster analysis are presented. Finally, additional analyses are presented which explore the nature of the new clusters.

***Preliminary analyses of the scales.*** Preliminary analyses of the scales had two objectives. First, scale scores are compared to scores published in previous literature. In the case of the social anxiety scales, comparison is made with clinical studies using the SIAS and SPS. For the narcissism scales, comparison is made with non-clinical populations for the NPI and HSNS, due to the lack of clinical studies, with the NPDS compared to a clinical sample. Second, the univariate normality of each of the scales is discussed. An overall discussion of the suitability of data for the use of inferential statistics is presented later.

***Preliminary analyses of social anxiety scales.*** Means and standard deviations for the social anxiety measures are reported in

Table 7.2. Comparison with means reported in Brown et al.'s (1997) clinical sample which meet criteria for DSM-III diagnosed social anxiety disorder (SIAS:  $M = 50.7, SD = 17$ , SPS:  $M = 36.9, SD = 17.5$ ; Brown et al., 1997) indicated that the current sample reported more severe social anxieties (SIAS and SPS) than the clinical sample.

A series of one sample *t*-tests revealed that scores on the SIAS  $t(349) = 4.64, p < .001$  were significantly higher in the current sample than in Brown et al.'s clinical sample, but that the SPS scores of the current sample did not differ significantly from

Brown et al.'s clinical sample  $t(349) = 1.54, p = .12$ . Thus, while not a clinical sample, the current sample was substantially impaired.

*Univariate normality of the Social Anxiety Scales.* As shown in Table 7.2, both the SPS and SIAS showed deviations from univariate normality. Skewness statistics for the SIAS indicated that participants in the current sample tended to rate SIAS items at the higher end of the scale, with skewness significant (Tabachnick & Fidell, 2007). In contrast the skewness statistic for the SPS was low, and the scale was not significantly skewed. Given the assumption of normality of distribution for the statistical tests to be employed, the SIAS was transformed<sup>7</sup>. Transformations were guided by suggestions in Tabachnick and Fidell (2007). After transformation, reassessment of the skewness statistic revealed that the SIAS was not significantly skewed.

Table 7.2

*Descriptive Statistics for the total sample*

Variable	<i>M</i>	<i>SD</i>	Range	Theoretical Range	Skewness	Reliability
SPS	38.41	18.28	1 – 78	0 – 80	-0.09	.94
SIAS	54.48	15.22	1 – 76	0 – 76	-1.07	.93
NPI	10.44	6.65	0 – 36	0 – 40	1.00	.86
NPDS	10.74	3.30	2 – 17	0 – 18	-0.55	.71
HSNS	34.87	6.75	13 – 50	10 – 50	-0.30	.77

*Note.* SPS = Social Phobia Scale. SIAS = Social Interaction Anxiety Scale. NPI = Narcissistic Personality Inventory. NPDS = Narcissistic Personality Disorder Scale. HSNS = Hypersensitive Narcissism Scale.  $N = 349$ .

Assessment of kurtosis values for the variables indicated that although the revised SIAS scale was mesokurtic, the SPS scale showed a platykurtic distribution. Examination of a histogram of the SPS, however, indicated that the variable approximated normal distribution. Given this, and considering that with large samples that minor deviations from normality can result in high kurtosis values (see Tabachnick & Fidell, 2007) the decision was made to proceed with the analysis, despite the platykurtic distribution of the SPS scale. Examination of box-plots revealed no univariate outliers for either the SPS or the revised SIAS.

<sup>7</sup> SIAS was transformed using the equation  $-\sqrt{MAX - SIAS}$ , where Max = the maximum value for the SIAS

*Preliminary analyses of the narcissism scales.* Comparison of the mean NPI score of the sample with mean NPI scores of samples over the past 20 years (Twenge et al., 2008) revealed that the current sample had lower NPI scores than those found in previous research using the NPI (Twenge et al. reported a range of mean NPI scores from 15.47 to 20.02). A one sample *t*-test indicated that the NPI scores of the current sample were significantly lower than the lowest NPI ( $M = 15.47$ ) score reported by Twenge et al.  $t(348) = -14.14, p < .001$ . In addition, one sample *t*-tests comparing the mean NPI score of the current sample with that reported by Schurman (2000;  $M = 12.42$ ), the only study to date exploring narcissism and social anxiety, also revealed significantly lower NPI scores in the current sample  $t(348) = -1.98, p < .001$ .

The results for the NPDS and HSNS were different. The mean NPDS score of the current sample was significantly higher than the NPDS score of a group of clinically diagnosed narcissistic patients (Mean = 4; Ashby, 1978)  $t(349) = 38.12, p < .001$ . Similarly, the mean HSNS scale of the current sample was higher than those reported by Hendin and Cheek (1997;  $M = 29.7$ ), and a one sample *t*-test revealed that this difference was significant  $t(348) = 14.31, p < .001$ . Similarly, one sample *t*-tests revealed that the mean HSNS score of the current sample was significantly higher than that reported by Schurman (2000;  $M = 29.05$ ) in her study on narcissism and social anxiety  $t(348) = 5.82, p < .001$ . Thus, the current sample had higher NPDS scores than a sample of clinically diagnosed narcissistic patients, and higher HSNS scores than undergraduate and community samples.

Taken together, the scores of the current sample on the NPI, the NPDS and HSNS make it difficult to ascertain the level of narcissism of the sample. Focusing solely on the NPI indicates a low level of narcissism. The NPDS and HSNS, on the other hand, indicate a high level of narcissistic pathology. It is possible that, in line with previous suggestions (Rose, 2002), the NPDS is actually measuring a construct closer to covert narcissism, and therefore, the current sample has high levels of covert narcissism (NPDS & HSNS), but low levels of overt narcissism (NPI). The second possibility is that the NPI is measuring a more adaptive variant of narcissism, and the NPDS and HSNS less adaptive variants, and that therefore the current sample has high levels of maladaptive narcissism, and low levels of adaptive narcissism.

*Univariate normality of the narcissism scales.* Examination of boxplots for the narcissism scales revealed that all three narcissism scales had a number of univariate outliers. As shown in

Table 7.2, the narcissism scales the NDPS and HSNS were both close to normal distribution, yet, comparison of the skewness statistic with the critical value of chi-square (Tabachnick & Fidell, 2007) indicated that both were significantly negatively skewed. Given that the skewness statistics for NPDS and HSNS were relatively low, and there were only a small number of univariate outliers, the cases classified as univariate outliers were removed. This resulted in the removal of four cases due to extreme (low) scores on the HSNS, and five cases due to extreme (low) cases on the NDPS. Once the outliers were removed, the skewness statistics were reassessed. The HSNS was found to be normally distributed, however the NPDS and NPI were still found to be significantly skewed. To correct for this, the NPDS<sup>8</sup> and NPI were transformed<sup>9</sup>. Transformations were guided by Tabachnick and Fidell (2007). After transformation, the skewness statistics for the transformed NPDS and NPI were assessed and compared to the critical value of chi-square (Tabachnick & Fidell, 2007, and were found to be normally distributed.

Assessment of kurtosis values for the narcissism scales revealed that the HSNS and revised NPDS and NPI scales all showed mesokurtic distributions.

*Overview of univariate normality.* Although some of the variables were found to be significantly non-normally distributed, after univariate outliers were removed, and the variables transformed all of the variables were found to be normally distributed. It was decided therefore, that the current data was appropriate for the use of inferential multivariate statistics.

*Overview of multivariate normality.* To assess for multivariate normality of the data, the Mahalanobis was requested. Results indicated no significant multivariate outliers ( $p < .001$ ).

*Overview of scale reliability.* The Cronbach's alpha measure of internal consistency was requested for each of the scales and subscales used in the current study. As seen in

Table 7.2, all the scales had acceptable reliability values with most scales showing moderate to high internal consistency ( $\alpha = .71 - .94$ ). Given that all of the scales had at least minimally acceptable internal consistency, it was decided that the use of the current scales was acceptable.

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<sup>8</sup> NPDS was transformed using the equation  $-\sqrt{MAX - NPDS}$ , where Max = the maximum value for the SIAS

<sup>9</sup> NPI was transformed using the equation  $\sqrt{NPI}$

***Age and gender differences in the scales.***

*Age differences.* To analyse age differences in the variables of interest, a bivariate correlation was run on the data. Results revealed weak negative correlations between age and the SPS ( $r = -.16, p = .002$ ), the SIAS ( $r = -.26, p < .001$ ), the NPDS ( $r = -.15, p < .001$ ), and the HSNS ( $r = -.13, p = .016$ ). There was also a weak positive correlation between the NPI and age ( $r = .10, p < .05$ ). Thus, in the current sample, older participants were found to have lower social anxiety and HSNS and NPDS measured narcissism and higher NPI measured narcissism.

*Gender differences.* To assess gender differences in the variables of interest a Multivariate Analysis of Variance (MANOVA) was run with gender entered as the independent variable (IV) and all the scales of interest entered as dependent variables (DVs) (SIAS, SPS, NPI, NPDS, and HSNS). In the case of the SIAS, NPI and NPDS, the normalised versions of the variables were used to meet the MANOVA assumption of normality. There were no violations of any assumptions of MANOVA.

Initial results indicated a significant gender difference Wilks'  $\Lambda = .94, F(6,333) = 3.56, p < .01$ , partial  $\eta^2 = .06$ . Follow up ANOVA results are presented in Table 7.3.

Table 7.3

*Gender Differences in the variables of interest*

Scale	Female $n = 200$ $M(SD)$	Male $n = 140$ $M(SD)$	$F(1,338)$	$p$ value	Partial $\eta^2$
SPS	39.43 (18.69)	37.05 (17.09)	1.43	.23	.004
SIAS <sup>1</sup>	-4.31 (1.65)	-4.33 (1.59)	0.01	.92	<.001
NPI <sup>1</sup>	3.01 (1.03)	3.14 (1.04)	1.28	.26	.004
NPDS <sup>1</sup>	-2.47 (0.63)	-2.36 (0.66)	2.58	.11	.008
HSNS	34.47 (6.61)	35.90 (6.08)	4.11	.04	.012

*Note.* SPS = Social Phobia Scale. SIAS = Social Interaction Anxiety Scale. NPI = Narcissistic Personality Inventory. NPDS = Narcissistic Personality Disorder Scale. HSNS = Hypersensitive Narcissism Scale. <sup>1</sup>Due to significantly skewed data, transformed versions of these variables were used.

Due to the number of IVs, a Bonferroni adjustment was applied to adjust for Type I error, with a significance level of  $p < .008$  used. As can be seen from Table 7.3, there were no significant gender differences in any of the IVs.

**Cluster Analysis.** The following sections describe the cluster analysis of the current data. First, a description and rationale of the technique chosen is given. Following this, the results of the cluster analysis are presented. MANOVA was then conducted to assist with labelling the new clusters.

*Choice and justification of cluster analytic method.* The possibility of narcissistic social anxiety subgroups was explored using a two-step cluster analytic method suggested by Steinley (2006b). Further support for the use of this cluster analytic technique comes from its use in the cluster analytic studies of Kashdan and colleagues (Kashdan & Hofmann, 2008; Kashdan et al., 2009) which explored *Avoidant-Motivated* and *Approach-Motivated* social anxiety subtypes. The use of this technique is justified given that these studies successfully used this statistical technique, and given that the primary aim of the current study is to extend upon the cluster analytic studies of Kashdan and colleagues.

*Cluster Analysis.* As the purpose of the analysis was the exploration of possible narcissistic socially anxious subgroups, the SIAS, NPI, NPDS and HSNS were entered into the cluster analysis. The SIAS, rather than the SPS was chosen in line with Kashdan et al. (2008). All of the narcissism scales were included in the cluster analysis to ensure that both overt and covert forms of narcissism were covered. In the case of the SIAS, NPI and NPDS, the transformed variables were used to correct for the earlier reported significant skew in these variables.

Similar to the previous cluster analytic studies of Kashdan and colleagues (e.g., Kashdan & Hofmann, 2008), the Bayesian Information Criterion (BIC) was used to objectively determine the optimal number of clusters. This was chosen as an alternative to more subjective methods of selecting the appropriate number of clusters (e.g., use of the dendrogram). On the basis of the Schwarz's BIC, a five cluster solution was deemed to be optimal (BIC = 714.97; four cluster solution BIC = 720.82, six cluster solution BIC = 724.28). The five clusters were found to comprise 61 (cluster one), 84 (cluster two), 55 (cluster three), 56 (cluster four) and 84 (cluster five) participants.

**Section 4: Labelling of the new subgroups.** To facilitate labelling of clusters, a MANCOVA was conducted with the new cluster variable entered as the IV and the SIAS, SPS and narcissism scales (NPI, NPDS and HSNS) entered as DVs. Given that

age was found to be significantly, though weakly, related to all of the DVs, it was entered as a covariate. The transformed versions of the SIAS, NPI and NPDS, described earlier, were used to meet the assumptions of MANOVA.

Examination of Box's Test of Equality of Covariance Matrices indicated that the data did not meet the assumption of Homogeneity of Covariances, Box'  $M = 120.90 F(60, 181052.89), p < .001$ . While this is undesirable, Box's  $M$  is highly sensitive to unequal group numbers. Due to the high number of dependant variables, the Bonferroni correction was applied, and a more conservative  $p$  value ( $p < .0005$ ) employed. Levine's test of Equality of Error variance indicated violation of the assumption of the NPI, and NPDS. However, MANCOVA is robust to minor violations of this assumption with large samples, and the use of a more conservative  $p$  value in the current analysis further prevents problems related to violation of this assumption. However, due to a number of assumptions not having been met, the Pillai's criterion is reported, rather than the more frequently used Wilk's Lambda, because the Pillai's criterion is considered more robust to violations of assumptions of homogeneity (Tabachnick & Fidell, 2007).

The MANCOVA results revealed that the new clusters differed significantly on social anxiety and narcissism (Pillai's Trace = 1.49  $F(20, 1332) = 39.32, p < .0005, \eta^2 = .37$ ). Age was not found to be a significant covariate (Pillai's Trace = .20  $F(5, 330) = 1.32, p = .25$ ). Given that age was not a significant covariate, it was removed from the analysis, and a MANOVA was run, to allow post-hoc tests to be performed.

Follow up univariate analyses showed significant group differences on all variables (all  $p$  values  $< .0005$ ). Post hoc tests are displayed in Table 7.4. Although the transformed versions of the SIAS, NPI and NPDS were used in the MANOVA, statistics for the untransformed variables are presented in Table 7.4 to aid interpretability.

Overall, the cluster analysis revealed the existence of four socially anxious groups, and one non-socially anxious group. The following sections describe each of the subgroups in detail. An overview of the differences between the subgroups is displayed in Table 7.4. In addition group differences in social anxiety are displayed graphically in Figure 1. Group differences in narcissism are displayed in Figure 2. Values in Figure 1 and 2 have been converted to z-scores to allow comparisons between scales.

As shown in Table 7.4 and Figure 2, three of the new subgroups were defined by high scores on multiple narcissism scales and one of the subgroups was defined by a high score on a single narcissism scale. Two subgroups (Cluster one and two) were

characterised by high SIAS and SPS measured social anxiety, low NPI and high scores on the NPDS and HSNS. The pattern of results, especially the combination of a higher score on the HSNS and lower scores on the NPI indicates that these groups seemed to represent covert narcissistic social anxiety groups. These groups were labelled Covert Narcissistic Social Anxiety One (CNSA1; Cluster one) and Covert Narcissistic Social Anxiety Two (CNSA2; Cluster Two).

Table 7.4

*Analysis of group differences in narcissism and social anxiety*

Scale	Cluster 1 (CNSA1) <i>n</i> = 61	Cluster 2 (CNSA2) <i>n</i> = 84	Cluster 3 (NSA) <i>n</i> = 55	Cluster 4 (LSA) <i>n</i> = 56	Cluster 5 (GSA) <i>n</i> = 84	<i>F</i> (4, 355)	$\eta^2$
SIAS						137.25*	.62
<i>M</i>	68.13 <sub>a</sub>	63.93 <sub>b</sub>	51.76 <sub>c</sub>	32.86 <sub>d</sub>	52.31 <sub>c</sub>		
<i>SD</i>	5.24	6.35	9.6	13.25	10.47		
Range	54-76	49-75	22-69	1-61	23-68		
SPS						45.08*	.35
<i>M</i>	51.66 <sub>a</sub>	45.27 <sub>b</sub>	41.15 <sub>b</sub>	18.84 <sub>c</sub>	33.35 <sub>d</sub>		
<i>SD</i>	14.95	15.07	14.15	14.24	14.57		
Range	11-77	13-78	13-67	1-54	1-67		
NPI						89.70*	.52
<i>M</i>	8.84 <sub>a</sub>	4.95 <sub>b</sub>	18.35 <sub>c</sub>	15.29 <sub>d</sub>	8.64 <sub>a</sub>		
<i>SD</i>	5.02	2.67	6.68	5.35	3.86		
Range	1-21	0-11	7-36	4-31	2-18		
NPDS						120.95*	.59
<i>M</i>	14.3 <sub>a</sub>	11.25 <sub>b</sub>	11.29 <sub>b</sub>	6.18 <sub>c</sub>	10.2 <sub>d</sub>		
<i>SD</i>	1.04	1.84	2.49	2.17	2.44		
Range	12-16	3-14	5-16	2-11	2-15		
HSNS						123.25*	.60
<i>M</i>	40.97 <sub>a</sub>	37.2 <sub>b</sub>	39.71 <sub>a</sub>	28.29 <sub>c</sub>	30.1 <sub>d</sub>		
<i>SD</i>	4.63	3.8	3.92	4.51	3.86		
Range	29-50	28-46	33-48	18-38	20-36		

*Note.* Means not sharing a common subscript differ significantly.

NSA = Angry Covert Narcissistic Social Anxiety. CNSA = Covert Narcissistic Social Anxiety. NSA = Narcissistic Social Anxiety. LSA = Low Social Anxiety. GSA = General Social Anxiety. SIAS = Social Interaction Anxiety Scale, SPS = Social Phobia Scale, NPI = Narcissistic Personality Inventory, NPDS = Narcissistic Personality Disorder Scale, HSNS = Hypersensitive Narcissism Scale.

\* = significant at  $p < .0005$ .

Cluster three was characterised by high social anxiety and elevations on all narcissism scales. Given that this subgroup had high narcissism scores on all measures, including the NPI, this group seemed to represent a group high on both overt narcissism (NPI), covert narcissism (HSNS) and narcissistic pathology (NPDS). Thus, this group was labelled Narcissistic Social Anxiety (NSA) group to reflect the fact that individuals in this group were characterised by both overt and covert narcissism.

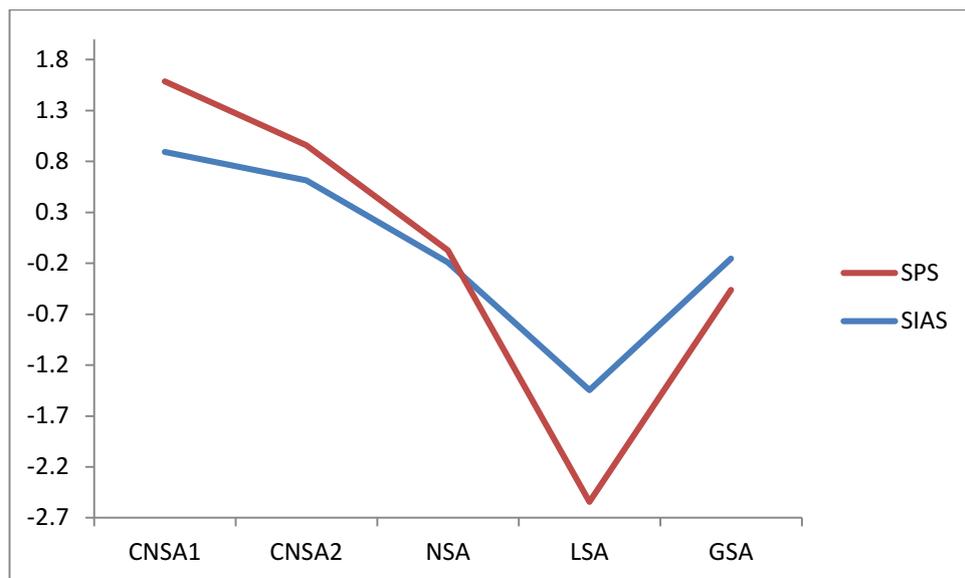


Figure 1. Group differences in social anxiety

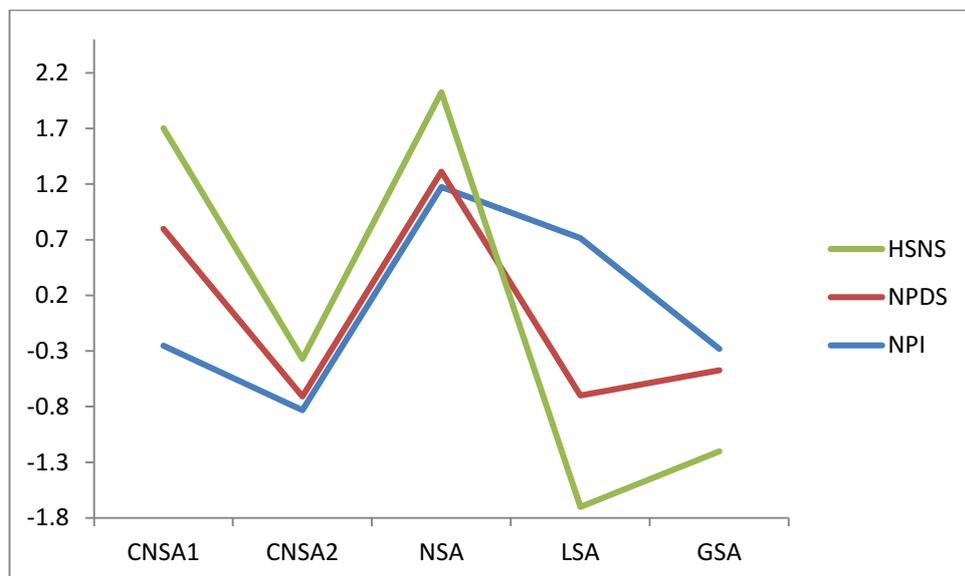


Figure 2. Group differences in narcissism.

The description of the NPI scores of this group as “high” is supported by comparison of the mean NPI score for this group ( $M = 18.35$ ) with 83 mean values from published and unpublished literature compiled by Twenge et al. (2008). Comparison

reveals that the mean NPI score of the narcissistic group was higher than 78 (93.98%) of the mean (published and unpublished) NPI values reported. Furthermore, one-sample  $t$ -tests revealed that of the five higher mean NPI scores reported, only one ( $M = 21.54$ ; Krusemark, 2006 cited in Twenge et al., 2008) was significantly higher than the mean NPI of the narcissistic group  $t(54) = -3.55, p = .001$ . However, this value was taken from unpublished data. Restricting the comparison to the published studies ( $N = 72$ ) reported by Twenge et al. reveals that the mean NPI value of the narcissistic group was higher than 71 (98.61%) of the mean NPI scores from published studies. The mean NPI score of the narcissistic group did not differ from the one study ( $M = 19.37$ ) which reported a higher mean score  $t(54) = -1.14, p = .26$ .

Further support for the suggestion that the narcissistic group has high overt narcissism comes from the mean NPI score of the group, which is above the mean of 18 used by Campbell (1999) to demarcate a “high” narcissistic group. Although he doesn’t use categories (e.g., J. D. Miller & Campbell, 2008), Campbell refers to individuals scoring above 18 as “narcissists” (comparing them to those scoring less than 11).

Cluster five showed high SIAS and SPS measured social anxiety, low scores on the NPI and NPDS and a low to moderate HSNS score. Given the low scores on the narcissism measures, this group seemed to represent a non-narcissistic social anxiety subgroup. The group was thus labelled *General Social Anxiety* (GSA). However, despite low scores on the NPI and NPDS, the general social anxiety group had a low to moderate HSNS score indicating the presence of at least some narcissistic characteristics. Nevertheless, the classification of this group as non-narcissistic was deemed appropriate owing to low scores on two of the three narcissism scales (e.g., the NPI, and the NPDS), and owing to the fact that this group had significantly lower HSNS scores than the three social anxiety subgroups classified as narcissistic (e.g., narcissistic group, covert narcissism group 1 and covert narcissism group 2).

Further support for the decision to classify the general social anxiety group as a non-narcissistic group comes from comparison of the mean HSNS score of the non-clinical undergraduate sample ( $M = 29.7$ ) reported by Hendin and Cheek (1997) with the current mean scores. One sample  $t$ -tests reveal that the mean scores of the narcissistic ( $t(54) = 18.94, p < .0001$ ), covert narcissistic one ( $t(60) = 18.99, p < .0001$ ) and covert narcissistic two ( $t(83) = 18.12, p < .0001$ ), groups were all significantly higher than that of Hendin and Cheek’s sample. In comparison, there was no significant difference between the mean HSNS score of the GSA group and Hendin and Cheek’s

undergraduate sample  $t(83) = .938, p = .35$ . Thus, while the GSA group showed some covert narcissistic characteristics, the level of covert narcissism was not significantly higher than that of a normal undergraduate population.

Last, Cluster four was defined by low social anxiety, moderate NPI and low NPDS and HSNS. Thus, cluster five seemed to represent a higher functioning group with low social anxiety and this group was labelled Low Social Anxiety (LSA).

The distinction between the four socially anxious (general social anxiety, narcissistic social anxiety, covert narcissism one and covert narcissism two) and the low social anxiety group is supported by comparison of the mean SPS and SIAS values of the groups with the mean values of a clinical sample diagnosed with DSM IV-TR (APA, 2000) SAD (E. J. Brown et al., 1997). One sample  $t$ -tests reveal that the covert narcissism one ( $t(60) = 26, p < .0001$ ) and covert narcissism two ( $t(83) = 19.11, p < .0001$ ) groups showed significantly higher SIAS scores than a Brown et al.'s clinical sample, whereas there was no significant difference between the clinical sample's scores and the scores of the narcissistic ( $t(54) = .822, p = .42$ ) and general social anxiety ( $t(83) = 1.41, p = .193$ ) groups. On the other hand, the low social anxiety group showed significantly lower SIAS scores than the clinical sample ( $t(55) = -10.08, p < .0001$ ).

Comparisons with the SPS scores reported by Brown et al. (1997) yielded similar results, with the covert narcissism one ( $t(60) = 7.71, p < .0001$ ), covert narcissism two ( $t(83) = 5.09, p < .0001$ ) and narcissistic ( $t(54) = 2.23, p < .05$ ) groups all significantly higher than the clinical sample. On the other hand, the low social anxiety ( $t(55) = -9.50, p < .0001$ ) and general social anxiety groups ( $t(84) = -2.24, p < .05$ ) both showed significantly lower scores than the clinical sample. Therefore, there is strong support for the classification of the general social anxiety (given high SIAS measured social anxiety), covert narcissism one, covert narcissism two, and narcissistic groups as "socially anxious" groups, and the low social anxiety group as a "non-socially anxious" group (given low scores on the SPS and SIAS).

### ***Section 5: Additional exploration of the new clusters.***

*Correlations between social anxiety and narcissism.* Although the core argument of the current thesis was not that social anxiety would correlate with narcissism, but rather that a subset of socially anxious individuals would also be characterised by narcissistic characteristics, correlations between narcissism and social anxiety were explored, both for the sample as a whole, and individually for each of the subgroups. The purpose of this analysis was to determine whether narcissism and social

anxiety was correlated for the narcissistic social anxiety subgroups, or, in line with the predictions of this thesis, whether there would not be consistent correlations between narcissism and social anxiety. Correlations are presented in Table 7.5.

As shown in Table 7.5, the results for the total sample are similar to those of Schurman (2000), with both social anxiety scales being significantly positively related to narcissistic pathology (NPDS) and covert narcissism (HSNS) and negatively related to overt narcissism (NPI). However, the pattern of correlations between narcissism and social anxiety is different for each of the subgroups. There was no significant correlation between either of the social anxiety scales and any of the narcissism scales for the first covert and general social anxiety groups. There was a weak to moderate significant negative relationship between the NPDS and the SIAS for the second covert narcissistic group. There was no relationship between the SPS and any of the narcissism scales for the two covert groups, or general social anxiety groups.

Table 7.5  
*Correlations between narcissism and social anxiety*

	SPS	SIAS	NPI	NPDS
Total Sample ( $N = 340$ )				
SPS	-			
SIAS	.66***	-		
NPI	-.20***	-.41***	-	
NPDS	.45***	.49***	-.15***	-
HSNS	.51***	.51***	-.03	.50***
CNSA1 ( $n = 61$ )				
SPS	-			
SIAS	.24*	-		
NPI	.04	.01	-	
NPDS	-.01	-.18	-.22	-
HSNS	.27*	.04	-.08	-.12
CNSA2 ( $n = 84$ )				
SPS	-			
SIAS	.37**	-		
NPI	.06	.04	-	
NPDS	.06	-.37**	.04	-
HSNS	.18	-.15	.22*	.04
NSA ( $n = 55$ )				
SPS	-			
SIAS	.30*	-		
NPI	.05	-.04	-	
NPDS	-.03	.01	.08	-
HSNS	.16	.20	.14	.01
LSA ( $n = 56$ )				
SPS	-			
SIAS	.53***	-		
NPI	-.12	-.20	-	
NPDS	.15	-.09	.08	-
HSNS	.39**	.51***	.09	.09
GSA ( $n = 84$ )				
SPS	-			
SIAS	.62***	-		
NPI	.03	-.12	-	
NPDS	.04	-.18	.42***	-
HSNS	.03	.01	.19	-.09

*Note.* CNSA = Covert Narcissistic SA (social anxiety). NSA = Narcissistic SA. LSA = Low SA. GSA = General SA. SIAS = Social Interaction Anxiety Scale, SPS = Social Phobia Scale, NPI = Narcissistic Personality Inventory, NPDS = Narcissistic Personality Disorder Scale, HSNS = Hypersensitive Narcissism Scale.

\*  $p < .05$ , \*\*  $p < .01$ , \*\*\*  $p < .001$ .

*Analysis of NPI item endorsements of the LSA and NSA groups.*

Two groups, the narcissistic social anxiety and low social anxiety groups showed high NPI scores, with the narcissistic group having the highest mean NPI score of the five groups. In addition, as noted previously, the narcissistic group had a higher mean NPI score than 93.98% of published and unpublished mean NPI values reported by Twenge et al. (2008). The high NPI score of the narcissistic group is interesting, because, as noted in Chapter 5, many studies have found that the NPI is positively predictive of psychological health, and negatively related to internalized negative emotions. From a social-personality perspective (e.g., J. D. Miller & Campbell, 2008) it would be expected that a group with a high mean NPI score should have low levels of social anxiety, and moreover, that there ought to be a significant negative relationship between narcissism and social anxiety. In contrast to this assumption, however, the mean SPS score of the narcissistic group were significantly higher than Brown et al.'s (1997) clinical sample and the mean SIAS score was not significantly different from Brown et al.'s clinical sample. Additionally, there was no correlation between the NPI and social anxiety for the narcissistic group.

Whereas the narcissistic group is different to what would be expected on the basis of social-personality theory, the low social anxiety group, which was characterised by a moderate mean NPI score was more in line with what would be expected on the basis of this theory. Whereas the narcissistic group was characterised by high scores on both the SPS and SIAS, the low social anxiety group was characterised by low scores on both of these scales. However, as with the narcissistic group, there was no significant correlation between the NPI and either the SPS or SIAS for this group either.

Thus, results revealed the presence of two groups characterised by moderate to high NPI scores. One, the narcissistic group, which runs counter to the expectations of social-personality theory with a combination of a high mean NPI score and high SPS/SIAS scores, and the other, more in line with social-personality theory showing a moderate mean NPI score and low scores on the SPS/SIAS. A possible explanation for finding two different groups which both have moderate to high mean NPI scores might lie in item endorsement.

It has been previously noted that the NPI is not unidimensional (Donnellan, Trzesniewski, & Robins, 2009), and efforts have been made to identify NPI items which are reflective of normal self-esteem and remove them (Rosenthal & Hooley, 2010). This supports the idea that not all NPI items are equally representative of maladaptive narcissism. Furthermore, Twenge, et al.'s (2008) cross temporal meta-analysis reported that high mean NPI scores ranged between 14.56 and 19.37 (e.g., Exline, Baumeister, Bushman, Campbell, & Finkel, 2004 study four and study five). Considering that the theoretical range of the NPI is between 0 and 40, the range of mean NPI scores reported by Twenge et al. illustrates a problem with NPI scores, to wit, that high NPI scores tend to fall around the middle of the theoretical range of the scale. Considering this, it is possible that two different samples with "high" mean NPI scores might be endorsing different NPI items, with some samples achieving high mean NPI scores due to endorsing relative more "adaptive" NPI items, and some samples achieving high mean NPI scores by endorsing relatively more "maladaptive" items.

To determine if the narcissistic and low social anxiety groups endorsed different NPI items, an analysis was performed to determine the total number of endorsements of each NPI item by participants in the narcissistic and low social anxiety groups. NPI items endorsed by over 50% of the narcissistic group, the low social anxiety group and both groups are presented in Table 7.6.

As shown in Table 7.6, eight NPI items were endorsed by over 50% of participants in both the narcissistic and low social anxiety groups. NPI items endorsed by over 50% of both groups tapped desire for recognition (e.g., "I like to be complimented"), feelings of uniqueness (e.g., "I am a special person") and personal efficacy (e.g., "I am more capable than other people").

In addition to the items endorsed by over 50% of both groups, four NPI items were endorsed by over 50% of the low social anxiety group and by fewer than 50% of the narcissistic group (see Table 7.6). Examination of the four NPI items endorsed by the low social anxiety revealed that they tapped in to leadership (e.g., "I see myself as a good leader") and assertiveness (e.g., "I like to take responsibility for making decisions", "I am assertive").

Table 7.6

*NPI item endorsements for the NSA and LSA groups.*

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NPI items endorsed by >50% of NSA and LSA groups	
	I will be a success
	I like to be complimented
	I think I am a special person
	I want to amount to something in the eyes of the world
	I am more capable than other people
	I have a natural talent for influencing people
	I can live my life if any way I want
	I am going to be a great person
NPI items endorsed by >50% of the NSA group only	
	I can read people like a book
	I am an extraordinary person
	I expect a great deal from other people
	If I ruled the world, it would be a better place
	I will never be satisfied until I get all that I deserve
	I wish somebody would someday write my biography
	I can usually talk my way out of anything
	I insist on getting the respect which is due me
NPI items endorsed by >50% of the LSA group only	
	I like to take responsibility for making decisions
	I am assertive
	I see myself as a good leader
	I rarely depend on anyone else to get things done

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Eight NPI items were endorsed by over 50% of the narcissistic group and by fewer than 50% of the low social anxiety group. Examination of these NPI items indicated that they appeared to be tapping into a broader number of narcissistic aspects, with the narcissistic group endorsing NPI items tapping in to tendency to manipulate/exploit others (e.g., “I can usually talk my way out of anything”, “I can read people like a book”), entitlement (e.g., “I will never be satisfied until I get all that I deserve”), desire for power (e.g., “If I ruled the world it would be a better place) and a

sense of uniqueness (e.g., “I insist on getting the respect that is due me”). Thus, there is evidence that individuals in the NSA group endorse more maladaptive NPI items (i.e., exploitativeness), and the LSA more adaptive NPI items (i.e., Leadership).

### **Study 1 Part B**

**Aims and hypotheses.** The aim of the second part of Study 1 was to extend upon results of the cluster analysis presented in Study 1 part A, and further explore the nature of the new social anxiety groups. Group differences in anger, psychological adjustment, alexithymia and personality organisation are explored. The following sections elaborate on the rationale and hypotheses for these analyses.

***Exploration of group differences in anger.*** The first aim was to examine group differences in anger. Given that both social anxiety and narcissism have been associated with elevated anger, no specific directional hypotheses were proposed.

***Exploration of group differences in depression, anxiety, stress and shame.*** To clarify differences in psychological adjustment among the groups, group differences in depression, anxiety, stress and shame were explored.

***Hypothesis one.*** Given their higher impairment related to social anxiety, it was hypothesised that the narcissistic social anxiety subgroups (narcissistic, covert 1 and covert 2) will show higher depression, anxiety, stress and shame than the non-narcissistic socially anxious group (general social anxiety group).

The second purpose of this analysis was to further clarify the nature of narcissism in the four subgroups with elevated narcissism. Initial analyses of the subgroups revealed three of the four groups with elevated narcissism scores (narcissistic, covert 1 and covert 2) were also characterised by high self-reported social anxiety and thus, presented a similar profile to what would be expected on the basis of clinical theories of narcissism. One of the four groups with elevated narcissism (low social anxiety group) was characterised by a moderate to high NPI score and low scores on the social anxiety scales. It was suggested that this group was similar to what would be expected on the basis of social-personality theories of narcissism.

***Hypothesis two.*** On the basis of the group differences in social anxiety and narcissism, it was hypothesised that the three narcissistic socially anxious groups (narcissistic, covert 1 and covert 2) will show higher depression, anxiety, stress, and shame scores than the non-socially anxious high narcissism (low social anxiety) group.

***Exploration of group differences in Personality Organisation.*** The purpose of this analysis was to further clarify group differences in maladjustment. Importantly, this

analysis used a measure of maladjustment derived from object-relations theory, and reflective of a core component of Kernberg's (1985) object-relations theory and an important part of his clinical theory of narcissism (Kernberg, 1975). According to Kernberg's theory, narcissists and borderlines have similar psychostructural defects, although narcissists are believed to have more intact reality testing than borderlines, and to be generally less severe across other indicators of maladjustment. Therefore, it would be expected that a narcissistic social anxiety subgroup should show relatively higher scores on most of the IPO scores in comparison to a non-narcissistic social anxiety group.

*Hypothesis three.* On the basis of clinical theories of narcissism it was hypothesised that the narcissistic social anxiety subgroups (narcissistic, covert 1 and covert 2) will show lower levels of personality organisation than the non-narcissistic general socially anxious group.

Additionally, the second purpose of this analysis was to further clarify whether the narcissism associated with the narcissistic social anxiety groups (narcissistic, covert 1 and covert 2) is associated with a lower level of personality organisation, as would be expected on the basis of clinical theories of narcissism (e.g., Kernberg, 1975), or a higher level of personality organisation, as would be expected on the basis of social-personality Psychology theories of narcissism (e.g., Campbell, 2001).

*Hypothesis four.* On the basis of the results of Study 1 part A, it was hypothesised that the narcissistic social anxiety subgroups (narcissistic, covert 1 and covert 2) will show lower personality organisation and would reflect a type of narcissism consistent with clinical theories, than the low social anxiety group (with high narcissism and low social anxiety).

***Exploration of group differences in alexithymia.*** This analysis had two purposes. First, it was conducted to explore group differences in emotion regulation. Second, clinical studies (e.g., Lawson, Waller, Sines, & Meyer, 2008) have suggested that narcissism is related to emotional instability, such as difficulty identifying feelings, and difficulty describing emotional states. Therefore, it is expected that narcissistic social anxiety subgroups would report higher levels of alexithymia than non-narcissistic social anxiety subgroups.

*Hypothesis five.* On the basis of research linking narcissism to difficulties in emotion regulation (e.g., Lawson, et al., 2008) it was hypothesised that the narcissistic

social anxiety groups (narcissistic, covert 1 and covert 2) will be higher in self-reported alexithymia than non-narcissistic general social anxiety subgroup.

## **Method**

### ***Materials***

The following sections describe the scales relevant to the analyses conducted in Study 1 part B.

*Anger.* The *Dimensions of Anger Reactions Scale* (DAR; Forbes et al., 2004) was included as a measure of anger. Forbes et al. note that although anger can have adaptive value, anger can be deemed to be maladjusted based on frequency and intensity of anger reactions. The DAR is a seven item scale which is a trait measure of dimensions of anger reactions. Each of the items is intended to measure a different aspect of anger, including anger frequency, duration, intensity and expression. Responses are rated on a 9 point scale from 0 (not at all) to 8 (exactly so), with higher scores indicative of higher levels of anger. All items are weighted equally. Forbes et al. found that the DAR possessed excellent psychometric properties, with Cronbach's alpha statistics between .91 and .94. Additionally, the scale was highly correlated with alternative anger measures, such as the *STAXI Trait Anger* ( $r = .79$ ) and *Anger Out* ( $r = .73$ ) subscales.

*Psychological Adjustment.* Two measures of psychological adjustment were included, the Depression, Anxiety and Stress Scale (DASS), and the Experience of Shame Scale (ESS). The following sections review the rationale for the use of these scales, and present details of their psychometric properties.

*Depression Anxiety Stress Scales (DASS).* The DASS (P.F. Lovibond & Lovibond, 1995) was included to measure Depression, Anxiety and Stress. The DASS is a 21 item scale measuring depression, anxiety and stress. Items are scored on four point scale from 0 *Did not apply to me at all* to 3 *Applied to me very much, or most of the time*. The scale allows calculation of separate scores for depression, anxiety and stress. Higher scores on the DASS indicate higher levels of depression, anxiety or stress. There are two versions of the DASS, a 42 and a 21 item version (Henry & Crawford, 2005). The current study employed the 21 item version.

T. A. Brown, Chorpita, Korotitsch, and Barlow (1997) noted that although the DASS was developed prior to Clark and Watson's (1991) tripartite model of depression

and anxiety, that the three factors of the DASS are consistent with three components of the tripartite model. Consistent with the tripartite model, T. A. Brown et al. noted that the DASS Depression scale was related to absence of positive affect (e.g., loss of self-esteem and incentive and a sense of helplessness), the anxiety scale to physiological hyper-arousal (e.g., autonomic arousal, fearfulness), and the stress scale, to negative affect, tension, irritability and a tendency to become upset.

The advantage of using the DASS is that it allows a fuller understanding of the level of psychological adjustment of each of the new social anxiety subgroups. The fact that the DASS depression scale has been found to be distinct from the DASS anxiety scale is important, because it means that if the social anxiety groups are found to have high levels of depression, it could be more confidently asserted that this is not simply the result of a general negative affectivity associated with social anxiety. Moreover, the three scales provide a rich way of differentiating the new social anxiety subgroups on the basis of the dimensions of Clark and Watson's model, viz. lack of positive affect, negative affect and physiological hyper-arousal.

Analysis of the DASS has revealed that the scales possess excellent psychometric properties. Internal consistency for the individual subscales has been found to be high, with Cronbach's values for depression ranging from .89 to .96, values for anxiety ranging from .81 to .92 and values for stress ranging from .89 to .95 (Akin & Çetin, 2007; Lovibond & Lovibond, 1995; Page, Hooke, & Morrison, 2007). In an analysis of the temporal stability of the DASS over a three-week period, Akin and Çetin reported test-retest scores of .98 for all three subscales and .99 for the full scale.

Analysis of the structure of the scale has established that the three factor model is a better fit than one or two factor models (Crawford & Henry, 2003; Lovibond & Lovibond, 1995). The scale has been used in both non-clinical (Szabó, 2010, 2011) and clinical populations (T. A. Brown et al., 1997). Additionally, the scale has been used in internet based studies, with the psychometric properties of the online version of the scale similar to that reported in literature using the scale in the traditional paper-pencil method (Zlomke, 2009). Importantly, given the use of the cross national nature of the sample, the DASS has been used cross-culturally, including in Iran (Sahebi, Asghari, & Salari, 2004) Portugal (Apóstolo, Mendes, & Azeredo, 2006) and Turkey (Akin & Çetin, 2007; Bilgel & Bayram, 2010)

*The Experience of Shame Scale.* (ESS; Andrews, Qian, & Valentine, 2002) was included to measure shame proneness. The ESS is a 25 item scale developed from an

interview based measure (Andrews, 1995; Andrews & Hunter, 1997). The ESS measures eight aspects of shame (shame surrounding personal habits, one's manner with others, the sort of person one is, one's personal abilities, shame about the possibility of doing something wrong, saying something stupid, failing competitively, and body shame) which are subsumed within three superordinate latent categories; characterological shame, behavioural shame and bodily shame.

Andrews et al. suggest that the ESS has the advantage of measuring a disposition to experience shame, rather than a transient (nonspecific) experience of negative affect (or to put it another way, the ESS measures trait shame rather than a transient negative emotional state). The ESS was chosen because it measures aspects of shame relating to self (characterological shame) and social performance (behavioural shame) and thus taps dimensions of shame particularly pertinent to socially anxious individuals.

Each of the ESS items is measured on a scale of 1 *Not at all* to 4 *Very much*, with higher ESS scores indicating greater shame proneness. Scores can be calculated for each of the individual components of shame (characterological, behavioural, and bodily shame) as well as producing an overall "general" shame score. The current study examined scores for the three components of shame, and the overall shame score.

The ESS has been successfully used in non-clinical (Andrews et al., 2002) and clinical populations (Harman & Lee, 2010; Sweetingham & Waller, 2008). Additionally, the scale has previously been used in social anxiety studies (e.g., Zhong et al., 2008), further supporting the selection of this scale in the current study.

The ESS possesses good psychometric properties (Andrews et al., 2002). Andrews et al. reported that the reliability for the full scale was .92, with Cronbach's alpha for the three subscales ranging from .86 to .90. Andrews et al. also reported that the scale possessed good temporal stability. Over an 11 week period, test-test statistics were .83 for the full scale and ranged from .74 to .82 for the three subscales.

*Personality Organisation.* The *Inventory of Personality Organisation* (IPO; Lenzenweger, Clarkin, Kernberg, & Foelsch, 2001) was used to assess Personality Organisation. The IPO is a 57 item scale measuring three dimensions of Kernberg's (1975) model of personality organisation: Primitive Defences, Reality Testing and Identity Diffusion.

According to Kernberg (Kernberg, 1985; Lenzenweger et al., 2001), an individual's level of personality organisation (viz. healthy, neurotic, borderline or

psychotic) can be determined by assessing three components; primitive psychological defences, reality testing and identity diffusion. The *Primitive Psychological Defences* scale measures the tendency to rely on psychological defences, seen to be developmentally less mature, such as projection, denial and splitting (in contrast to more healthy defence mechanisms such as repression, reaction formation, suppression) Within psychodynamic models, it is assumed that greater use of primitive (or immature) defence mechanisms is associated with lower psychological adjustment and indicative of more severe psychopathology. The *Reality Testing* Scale measures the capacity to differentiate self and objects and empathy. It also measures more severe psychotic disorganisation of thought and behaviour. The *Identity Diffusion* Scale measures indications of the level of integration of concepts of self and others.

Although conceptualized as clinical scales designed to measure severe psychostructural defects associated with a borderline level of functioning, the scales have been shown to be appropriate for use in non-clinical samples. Lenzenweger et al. (2001) tested the scales with a non-clinical population. In their initial validation study of the IPO, they found that although the non-clinical sample did not show severe psychostructural defects, higher IPO scores were associated with lower levels of positive affect and higher levels of aggressive dyscontrol and dysphoria.

Lenzenweger et al. (2001) reported that the IPO possessed good psychometric properties with internal consistencies of the subscales ranging from .81 for the Primitive Defences scale to .88 for the Identity Diffusion scale. Reliability was confirmed by subsequent studies, with Berghuis, Kamphuis, and Boedijn (2009) reporting Cronbach's alpha values ranging between .78 to .93 for the IPO in clinical samples. Test-retest statistics were moderate ranging from .72 for the Primitive Defences scale to .78 for the Identity Diffusion scale. The IPO has been employed cross culturally, having been used in Japan (Igarashi et al., 2009) and the Netherlands (Berghuis et al., 2009).

*Alexithymia.* The 20 item Toronto Alexithymia Scale (TAS; Bagby, Parker, & Taylor, 1994) was used as a measure of Alexithymia. The TAS measures three core elements of Alexithymia: difficulty identifying feelings, difficulty describing feelings and externally oriented thinking. It involves answering questions on a five point scale, with higher scores on the scale reflecting higher levels of alexithymia.

The TAS is the most widely used measure of Alexithymia (G. J. Taylor & Bagby, 2004), and possesses adequate psychometric properties (Bagby et al., 1994; J. D. A. Parker, Bagby, Taylor, Endler, & Schmitz, 1993). In a cross national sample, J. D.

A. Parker et al. (1993) reported that Cronbach's alpha statistics for the TAS subscales ranged from .60 to .80. Bagby et al. reported that the scales also possess acceptable temporal stability with a test-retest statistics over a three-week period of .77 for the full TAS-20.

The scale has been used with both clinical (Lawson et al., 2008), and non-clinical populations (J. D. A. Parker, Taylor, & Bagby, 2003). Additionally, the scale is valid cross-culturally (G. J. Taylor, Bagby, & Parker, 2003), having been used in China (Zhu et al., 2007), Germany (J. D. A. Parker et al., 1993), India (Pandey, Mandal, Taylor, & Parker, 1996) and Sweden (Simonsson-Sarnecki et al., 2000)

### **Results.**

The following sections present the results of Study 1 part B. First, preliminary analyses of the scales are presented. Following this, age and gender differences in the scales are described. Finally, analyses exploring the nature of the new social anxiety groups are presented.

*Preliminary analyses of the scales.* Preliminary analyses of the scales had two objectives. First, scale scores are compared to scores published in previous literature to allow comparisons to be made. Second, the univariate normality of each of the scales is discussed. An overall discussion of the suitability of data for the use of inferential statistics is presented later. Descriptive statistics for the sample are presented in Table 7.7.

*Preliminary analyses of the DAR.* Examination of the mean DAR score (see Table 7.7) indicates that the current sample scored toward the low end of the theoretical range. Comparison of the DAR scores reported by Forbes et al. (2004; Mean = 34.72) supports this assumption. A one sample *t*-test revealed that the DAR scores of the current sample were significantly lower than the scores of the clinical sample of Posttraumatic Stress Disorder patients of Forbes et al.'s study  $t(339) = -26.65, p < .001$ . This score is interesting, and is lower than would have been expected on the basis of the historical literature reviewed in Chapter 2, which suggested a relationship between social anxiety and anger. The result is, however, consistent with the clinical outcome study of Erwin et al. (2004) which suggested that anger was a characteristic of some, but not all socially anxious individuals, and that the presence of anger in socially anxious individuals predicted poorer response to treatment (greater severity of social anxiety).

Table 7.7  
*Descriptive Statistics for the total sample*

Variable	Mean	SD	Range	Theoretical Range	Skewness	Reliability
DAR	17.52	11.90	0-53	0 – 56	0.79	.87
DASS						
Depression	11.29	5.78	0-21	0 – 21	-0.14	.91
Anxiety	7.18	4.71	0-20	0 – 21	0.56*	.83
Stress	10.09	4.68	0-21	0 – 21	0.27	.84
ESS	75.56	16.61	26-100	4 – 16	-0.56*	.95
Characterological	35.26	9.19	12-48	12-48	-0.50*	.92
Behavioural	28.57	6.26	10-36	9-36	-0.65*	.91
Bodily	11.72	3.55	4-16	4-16	-0.50*	.87
IPO						
Primitive Defences	40.03	11.43	16-72	16-80	0.44*	.87
Identity Diffusion	59.87	15.67	22-105	21-105	0.26	.90
Reality Testing	40.91	14.11	20-91	20-100	1.02*	.92
TAS						
DIF	18.77	6.98	7-35	7 – 35	0.21	.85
DDF	16.80	5.10	5-25	5 – 25	-0.44*	.85
EOR	19.56	5.02	8-32	8 – 40	0.01	.60

Note: \* = Significantly skewed. DAR = Dimensions of Anger Reactions. DASS = Depression, Anxiety, Stress Scale. ESS = Experience of Shame Scale. IPO = Inventory of Personality Organisation. TAS = Toronto Alexithymia Scale. DIF = Difficulty Identifying feelings. DDF = Difficulty Describing Feelings. EOR = Externally Oriented Thinking.

*Univariate normality of the DAR.* As presented in Table 7.7, the DAR showed some skewness. Comparison of the skewness statistic with the critical value of chi-square (Tabachnick & Fidell, 2007) revealed that the DAR was significantly positively skewed. Given the subsequent analyses assume normality of distribution, the DAR was transformed<sup>10</sup>. Transformation of the data was guided by Tabachnick and Fidell (2007).

<sup>10</sup> DAR was transformed using equation  $\log(DAR)$ . Given that log transformations cannot work with values of 0, the DAR variables were recoded, so that the range of each

After the transformation, skewness statistic for the transformed DAR variable was compared to the critical value of chi-square, and was found to be normally distributed. Assessment of the kurtosis of the revised DAR indicated that the variable showed a mesokurtic distribution. Examination of box plots for the transformed DAR, revealed no univariate outliers.

*Preliminary analysis of the Depression, Anxiety and Stress Scale.* The mean scores for the Depression, Anxiety and Stress Scale were around the middle of the theoretical range (see Table 7.7). A series of one sample *t*-tests comparing the DASS scores of the current sample to those of the large non-clinical sample employed by Henry and Crawford (2005) revealed that the current sample showed significantly higher scores on all DASS scales (Depression = 3.87,  $t(339) = 23.65$ ,  $p < .001$ ; Anxiety = 2.95,  $t(339) = 16.55$ ,  $p < .001$ ; Stress = 4.20;  $t(339) = 23.21$ ,  $p < .001$ ).

Although the current's scores on all DASS subscales were higher than a non-clinical sample, their scores were all significantly lower than those of a clinical outpatient sample employed by Antony, Bieling, Cox, Enns, and Swinson (1998) who had received a diagnosis of DSM-IV (APA, 2000) SAD (Depression  $M = 13.19$ ,  $t(339) = -6.06$ ,  $p < .001$ ; Anxiety  $M = 12.22$ ,  $t(339) = -19.73$ ,  $p < .001$ ; Stress  $M = 16.57$ ,  $t(339) = -25.57$ ,  $p < .001$ ). Thus, in terms of depression, anxiety and stress, the current sample showed a moderate level of impairment, with results indicating that on average they were more impaired than a general community sample, but less impaired than a clinical sample.

*Univariate normality of the Depression, Anxiety, Stress Scales.* Comparison of the skewness statistics for the DASS subscales displayed in Table 7.7 with the critical value of chi-square indicated that the DASS Anxiety scale was significantly positively skewed. To meet the requirements of MANOVA, an attempt was made to transform the scale. Transformations were guided by suggestions in Tabachnick and Fidell (2007). The first attempt at transformation was unsuccessful. A second attempt to transform the scale was made after converting the DASS Anxiety scores to standardised *Z* scores<sup>11</sup>. Comparison of the transformed DASS Anxiety Subscale with the critical value of chi-square indicated that the scale was normally distributed.

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value was 1 to 9, rather than 0 to 8. A new total was calculated with a revised of 7-60. This enabled the data to be transformed using a log transformation.

<sup>11</sup> DASS Anxiety subscale was transformed using the equation  $\sqrt{\text{DASS Anxiety} + 2}$ . A constant of 2 was added because square root transformations do not work with negative numbers.

Assessment of the kurtosis values of the DASS subscales indicated that all of the DASS subscales showed mesokurtic distributions. Examination of box-plots for the three DASS subscales indicated that there were no univariate outliers.

*Preliminary analysis of the Experience of Shame Scale.* As shown in Table 7.7, the mean total ESS score was toward the high end of the theoretical range. Similarly, the three ESS subscales were all at the higher end of the theoretical range. A series of one sample *t*-tests revealed that the current sample had higher scores on the full scale ESS score and all subscales than the undergraduate sample employed by Andrews et al. (2002; ESS = 55.58,  $t(339) = 22.17, p < .001$ ; characterological shame = 24.43,  $t(339) = 21.72, p < .001$ ; behavioural shame = 21.25,  $t(339) = 21.58, p < .001$ ; bodily shame = 9.82,  $t(339) = 9.89, p < .001$ ).

The current sample also had significantly higher scores on all shame scales than Harmen and Lee's (2011) clinical sample of PTSD patients (ESS = 68.86,  $t(339) = 7.26, p < .001$ ; characterological Shame = 31.73,  $t(339) = 7.08, p < .001$ ; behavioural shame = 26.11,  $t(339) = 7.26, p < .001$ , bodily shame = 11.01;  $t(348) = 3.71, p < .001$ ). Thus, the current sample was characterised by high levels of shame proneness, and moreover, their shame proneness was not restricted to one particular form (e.g., bodily shame). A clinical social anxiety sample employing the ESS could not be located for comparison.

*Univariate normality of the Experience of Shame Scales.* Comparison of the skewness statistic for the total ESS and ESS subscales (see Table 7.7) with the critical value of chi-square revealed that all of the ESS scores were significantly negatively skewed (Tabachnick & Fidell, 2007). To meet requirements of MANOVA, an attempt was made to transform the scales following suggestions in Tabachnick and Fidell (2007). The first attempt at transformation was unsuccessful for the ESS and all subscales. A second attempt to transform the scales was made after converting the scores to standardised *Z* scores<sup>12</sup>. Comparison of the skewness statistics of the scales with the critical value of chi-square indicated that all scales were normally distributed.

Assessment of the Kurtosis values for the ESS and ESS subscales indicated that all variables showed platykurtic distribution. Although undesirable, it has been suggested that with large samples that minor deviations from normality can result in

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<sup>12</sup> All ESS scales were transformed using the equation  $-\log(1 + \text{Max} - \text{ESS Scale})$  Where Max = the maximum value for the variable in question, and ESS Scale = the ESS Total Scale or ESS subscale (e.g., characterological shame, behavioural shame or bodily shame) in question

high kurtosis values (see Tabachnick & Fidell, 2007). Considering this, and the fact that the scales were not significantly skewed, the decision was made to continue with the analysis, despite the platykurtic distribution of the ESS scales. Examination of box plots for the ESS total and ESS subscales indicated that there were no univariate outliers.

*Preliminary analyses of the Inventory of Personality Organisation.* As evident in Table 7.7, mean scores for the three IPO scales were around the middle of the theoretical range. The mean scores of all IPO scales were higher than those of an undergraduate sample reported by Lenzenweger et al. (2001; Primitive defences = 39.91; Reality Testing = 38.46; Identity Diffusion = 51.68). One sample *t*-tests revealed that the mean Primitive Defences score was not significantly different to the mean reported by Lenzenweger et al.  $t(339) = .193, p = .84$ . On the other hand, the mean scores for reality testing  $t(339) = 3.20, p < .01$  and identity diffusion  $t(339) = 9.64, p < .001$  were both significantly higher for the current sample than those reported by Lenzenweger et al.

Comparison of the current IPO values to those of a heterogeneous Dutch clinical sample reported by Berghuis et al. (2009; Primitive Defences = 38.33, Reality Testing = 38.43, Identity Diffusion = 54.21) reveal that the current sample showed higher scores on all subscales. One sample *t*-tests revealed that the current sample had significantly higher scores on Primitive Defences  $t(339) = 2.74, p = .006$ , Reality Testing  $t(339) = 3.24, p = .001$  and Identity Diffusion  $t(339) = 6.66, p < .001$ . Interestingly, the mean scores for Primitive Defences and Reality Testing were lower in the Dutch clinical sample than they were in Lenzenweger et al.'s undergraduate sample. It is not clear why this is the case. As the Dutch non-clinical sample reported lower values for all subscales of the IPO than Lenzenweger et al.'s sample, the difference might be culturally based.

*Univariate normality of the Inventory of Personality Organisation.* Comparison of the skewness values of the IPO subscales (see Table 7.10) with the critical value of chi-square revealed that two of the IPO subscales (Primitive defences and Reality Testing) were significantly positively skewed (see Table 7.10). To meet the requirements of MANOVA, Primitive Defences and Reality Testing scales were transformed<sup>13</sup>. Transformations were guided by suggestions in Tabachnick and Fidell (2007). After transformation, the revised skewness statistics for the scales were compared to the critical value of chi-square and found to be normally distributed.

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<sup>13</sup> IPO subscales were transformed using the equation  $\sqrt{IPO\ Reality\ Testing}$  and  $\sqrt{IPO\ Primitive\ Defences}$

Assessment of the kurtosis values of the IPO scales indicated that all three IPO scales showed mesokurtic distributions (Tabachnick & Fidell, 2007). Examination of box-plots revealed that no univariate outliers for any of the three IPO subscales.

*Preliminary analyses of the Toronto Alexithymia Scale.* As shown in Table 7.7, scores for all TAS subscales were around the middle of the theoretical range. Given that a clinical social anxiety sample employing the TAS could not be located for comparison, a series of one sample *t*-tests were conducted to compare the TAS scores of the current sample with mean scores of a clinical sample of eating disordered patients (Lawson et al., 2008). Results revealed that the current sample showed lower scores on Difficulty Identifying Feelings ( $M = 21.5$ ;  $t(339) = -7.21$ ,  $p < .001$ ), and Externally Oriented Thinking ( $M = 21.1$ ;  $t(339) = -5.64$ ,  $p < .001$ ) and significantly higher scores on Difficulty Defining Feelings ( $M = 15.5$ ,  $t(339) = 4.69$ ,  $p < .001$ ). Thus, relative to a clinical sample, the current sample had greater difficulty describing their emotional state to others. This is consistent with a suggestion that the TAS *Difficulty Defining Feelings* subscale is closely related to shame (Suslow, Donges, Kersting, & Arolt, 2000), which was found to be elevated in the current sample.

*Univariate normality of the Toronto Alexithymia Scale.* Comparison of the skewness statistics for the TAS subscales (see Table 7.10) with the critical value of chi-square (Tabachnick & Fidell, 2007) indicated that the Difficulty Identifying Feelings and Externally Oriented Thinking scales were both normally distributed, but that the Difficulty Defining Feelings scale showed a significant negative skew. To meet the requirements of MANOVA, an attempt was made to transform the scale guided by suggestions in Tabachnick and Fidell (2007). The first attempt at transformation of the scale was unsuccessful. A second attempt to transform the scale was made after converting the Difficulty Defining Feelings scores to a standardised *Z* score<sup>14</sup>. Comparison of the transformed Difficulty Defining Feelings with the critical value of chi-square indicated that the scale now positively skewed. The scale was retransformed<sup>15</sup>, and comparison of the retransformed scale with the critical value of chi-square revealed that the scale was normally distributed.

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<sup>14</sup> TAS Difficulty Defining Feelings was transformed using the equation  $-\sqrt{\text{MAX} - \text{TAS Difficulty Defining Feelings}}$ , where MAX = the highest value recorded for the variable Difficulty Defining Feelings

<sup>15</sup> Transformed TAS Difficulty Defining Feelings Scale was re-transformed using the formula  $\log(\text{Revised TAS Difficulty Defining Feelings Scale} + 10)$ . A constant

Assessment of the kurtosis values for the TAS subscales indicated that all of the TAS subscales showed mesokurtic distribution. Examination of box-plots for the three TAS subscales indicated that there were no univariate outliers.

*Normality of the data and suitability for inferential statistics.* The previous sections assessed the univariate properties of the scales used in the current study. Although some scales were significantly skewed, after transformation all scales were normally distributed. Problematically, the ESS total and all three ESS subscales (characterological shame, behavioural shame and bodily shame) showed platykurtic distributions. However, owing to the sensitiveness of the test with large sample, and the fact that the scales were not significantly skewed, the decision was made to proceed with the analyses. Thus, on the basis of the preceding analyses, it was decided that the current data were appropriate for the use of inferential multivariate statistics. Multivariate normality of the data was assessed using Mahalanobis distance. Results indicated no significant multivariate outliers ( $p < .001$ ).

*Overview of scale reliability.* Cronbach's alpha measure of internal consistency was calculated for all scales and subscales (see Table 7.7). With the exception of the TAS Externally Oriented Thinking subscale, all scales demonstrated excellent reliability (all  $\alpha > .80$ ). Furthermore, although the Externally Oriented Thinking Scale was low ( $\alpha = .60$ ), given that the current thesis is theoretical and represents a preliminary analysis of new subtypes (see J.C. Nunnally, 1978 for a discussion of the importance of context in considering reliability cut-offs), the decision was made to use the subscale but to interpret the results with caution.

#### ***Age and gender differences on the measures.***

*Age differences.* Bivariate correlations were run to explore age differences. There were significant weak negative correlations between age and the IPO Identity diffusion  $r = -.15$   $p < .01$ , IPO Reality Testing,  $r = -.11$ ,  $p < .05$ , TAS Difficulty Defining Feelings  $r = -.18$   $p < .001$ , the total ESS scale  $r = -.15$   $p < .01$ , the ESS characterological Shame subscale  $r = -.21$ ,  $p < .001$  and the ESS behavioural shame subscale  $r = -.12$ ,  $p < .05$ .

*Gender differences in the variables of interest.* To assess gender differences a Multivariate Analysis of Variance (MANOVA) was run with gender as the independent variable and all the scales entered as dependent variables (DVs) (for a list of variables,

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was added to the equation because log transformations do not work with negative numbers

see Table 7.11). In the case of the ESS scales, the DASS Anxiety scale, the IPO Primitive Defences and Reality Testing scales and the TAS difficulty defining feelings scale, the normalised versions of the variables were used to meet the MANOVA assumption of normality. The assumption of Homogeneity of Covariances was met, Box' M = 89.87  $F(78, 35121.28) = 1.03, p = .41$ . Levene's tests indicated that the data met the assumption of equality of group variances. Inspection of the intercorrelations among the dependant variables indicated high correlations between the total ESS scale, and the ESS characterological shame scale, and between the total ESS scale and the ESS behavioural shame scale. Although this is to be expected given that the total ESS scale incorporates items which comprise both of the subscales, to avoid the problem of multicollinearity, the ESS total was removed from the MANOVA and subjected to separate one-way ANOVA. Results indicated a significant gender differences Wilks'  $\Lambda = .81, F(12,113) = 2.21, p < .05, \text{partial } \eta^2 = .19$ . Univariate results are presented in Table 7.8.

Due to the number of IVs, a Bonferroni adjustment was applied to adjust for Type I error, with a significance level of  $p < .004$ . As shown in Table 7.8, there were no significant gender differences on any of the IVs. To explore gender differences in the full scale ESS, a one way between subjects ANOVA was conducted. Due to the non-normal distribution of the original scale, the transformed version of the scale was used. Levene's test indicated that the assumption of homogeneity was met. Results revealed no significant difference in full scale ESS between men and women  $F(1, 339) = .20, p = .66$ . As there were no gender differences all subsequent analyses were conducted without controlling for gender.

Table 7.8

*Gender Differences in the variables of psychological adjustment and alexithymia*

Scale	Female <i>n</i> = 200 <i>M</i> ( <i>SD</i> )	Male <i>n</i> = 140 <i>M</i> ( <i>SD</i> )	<i>F</i> (1,338)	<i>p</i>	Partial $\eta^2$
DAR <sup>1</sup>	1.35 (0.21)	1.32 (0.22)	2.52	.11	.007
DASS Depression	10.78 (5.88)	12.02 (5.73)	3.86	.05	.011
DASS Anxiety <sup>1</sup>	7.45 (4.83)	6.79 (4.52)	1.57	.21	.005
DASS Stress	10.34 (4.76)	9.72 (4.54)	1.44	.23	.004
IPO Primitive Defences <sup>1</sup>	39.71 (12.01)	40.49 (10.75)	0.66	.42	.002
IPO Reality Testing <sup>1</sup>	40.91 (15.19)	40.92 (12.45)	0.59	.44	.002
IPO Identity Diffusion	60.14 (16.59)	59.50 (14.31)	.13	.71	<.001
TAS Difficulty Identifying Feelings	19.30 (7.18)	18.02 (6.63)	2.76	.10	.008
TAS Difficulty Defining Feelings <sup>1</sup>	16.76 (5.27)	16.85 (4.86)	0.07	.78	<.001
TAS Externally Oriented Thinking	19.19 (4.98)	20.10 (5.10)	2.72	.10	.008
ESS Characterological Shame <sup>1</sup>	34.72 (9.37)	30.02 (8.92)	1.55	.21	.005
ESS Behavioural Shame <sup>1</sup>	29.05 (6.21)	27.89 (6.27)	3.33	.07	.010
ESS Bodily Shame <sup>1</sup>	12.08 (3.53)	11.21 (3.52)	5.97	.02	.017

*Note.* DASS = Depression, Anxiety, Stress Scale. IPO = Inventory of Personality Organisation

<sup>1</sup>Due to significantly skewed data, transformed versions of these variables were used

**Further analysis of the new subgroups.** A series of ANOVAs and MANOVAs were conducted to further explore the differences among the new social anxiety groups, and to determine group differences in the additional variables of interest (anger, depression, anxiety, stress, shame, the IPO and the TAS). Multiple MANOVAs were used due to the large number of DVs being explored. In the case of the ESS scales, due to the high correlations between the total ESS score, and the ESS subscales, an individual ANOVA was used to explore group differences in total ESS to avoid complications arising from multicollinearity. The following sections report the results of each analysis separately.

*Group differences in Anger.* To explore group differences in anger, a between subjects ANOVA was conducted with the new social anxiety subgroups entered as the IV and the DAR entered as the DV. To meet the ANOVA requirement that the DV be normally distributed, the transformed version of the DAR, was used. Examination of

Levene's Test of Equality of Error Variances indicated that this assumption was met  $F(4, 335) = .633, p = .64$ .

Descriptive statistics for the DAR across the groups are presented in Table 7.9. Although the transformed version of the DAR variable was used in the analysis, descriptive statistics are presented for the non-transformed version to aid interpretability.

Table 7.9

*Analysis of group differences in anger*

Scale	Cluster 1 AnCNSA <i>n</i> = 61	Cluster 2 CNSA <i>n</i> = 84	Cluster 3 NSA <i>n</i> = 55	Cluster 4 LSA <i>n</i> = 56	Cluster 5 GSA <i>n</i> = 84
DAR					
<i>M</i>	24.70 <sub>a</sub>	17.08 <sub>b</sub>	21.73 <sub>a</sub>	12.23 <sub>b</sub>	13.51 <sub>b</sub>
<i>SD</i>	13.63	11.84	12.19	7.73	9.40
Range	2-53	0-47	3-47	1-40	0-44

*Note.* To aid interpretability, untransformed, rather than transformed scores were included in the Table. Means not sharing a common subscript differ significantly.

DAR = Dimensions of Anger Reactions. AnCNSA = Angry Covert Narcissistic Social Anxiety Group, CNSA = Covert Narcissistic Social Anxiety Group, NSA = Narcissistic Social Anxiety Group, LSA = Low Social Anxiety Group, GSA = General Social Anxiety Group.

\* = significant at  $p < .0005$ .

Results of the ANOVA revealed a significant difference in anger across the new social anxiety groups  $F(4, 335) = 12.60, p < .0001$ , partial  $\eta^2 = .13$ . Post-hoc analysis<sup>16</sup> (see Table 7.9) revealed that two clusters, covert narcissism one (Cluster one) and narcissistic group (Cluster three) showed significantly higher scores on the DAR than the remaining three clusters. Thus, in addition to anger being a characteristic of the narcissistic group, anger also differentiated the two covert narcissism groups (CNSA1 and CNSA2). On the basis of this difference, the two groups were relabelled as Angry Covert Narcissistic Social Anxiety (CNSA1; AnCNSA), and Covert Narcissistic Social Anxiety (CNSA2; CNSA).

*Group differences in Depression, Anxiety and Stress.* To explore group differences in Depression, Anxiety and Stress, a between subjects MANOVA was conducted with the new social anxiety subgroups entered as the IV, and the three DASS

<sup>16</sup> While the current thesis makes predictions about specific differences among the groups, given the exploratory nature of this thesis, post-hoc tests rather than contrasts were used in order to allow the consideration of group differences which had not been hypothesised.

scales (Depression, Anxiety, and Stress) entered as DVs. Examination of Box's Test of Equality of Covariance Matrices indicated that the data met the assumption of Homogeneity of Covariances, Box'  $M = 89.87$   $F(24, 243566.83) = 19.97, p = .72$ .

Levene's test of equality of error variance indicated no violations of this assumption.

Initial results indicated a significant group difference on the DASS for the new social anxiety subgroups Wilks'  $\Lambda = .44$   $F(12, 881.33) = 15.95, p < .001$ , partial  $\eta^2 = .16$ . Univariate results revealed significant differences in each subscale: depression  $F(4, 335) = 38.79, p < .001$ , partial  $\eta^2 = .32$ , anxiety  $F(4, 335) = 26.57, p < .001$ , partial  $\eta^2 = .24$  and stress  $F(4, 335) = 21.00, p < .001$ , partial  $\eta^2 = .20$ . Post hoc tests are displayed in Table 7.10. To aid interpretability, although the transformed version of the DASS Anxiety scale was used in the MANOVA analysis, statistics for the untransformed DASS Anxiety scale are presented in Table 7.10.

Table 7.10

*Analysis of group differences in Depression, Anxiety and Stress*

Scale	AnCNSA <i>n</i> = 61	CNSA <i>n</i> = 84	NSA <i>n</i> = 55	GSA <i>n</i> = 84	LSA <i>n</i> = 56
DASS					
Depression					
<i>M</i>	15.33 <sub>a</sub>	13.48 <sub>b</sub>	11.51 <sub>c</sub>	10.07 <sub>c</sub>	5.21 <sub>d</sub>
<i>SD</i>	4.35	4.90	5.17	5.13	4.28
Range	6 – 21	1 – 21	0 – 21	0 – 21	0 – 16
DASS					
Anxiety					
<i>M</i>	10.54 <sub>a</sub>	6.92 <sub>b</sub>	8.36 <sub>c</sub>	6.48 <sub>b</sub>	3.80 <sub>d</sub>
<i>SD</i>	4.92	4.24	4.30	4.20	3.50
Range	0 – 20	0 – 18	1 – 19	0 – 19	0 – 13
DASS					
Stress					
<i>M</i>	13.84 <sub>a</sub>	10.02 <sub>b,c</sub>	11.53 <sub>c</sub>	8.79 <sub>d</sub>	6.62 <sub>b</sub>
<i>SD</i>	3.71	4.45	4.31	4.14	3.65
Range	6 – 21	2 – 20	4 – 20	1 – 19	0 – 17

*Note.* Means not sharing a common subscript differ significantly.

DASS = Depression, Anxiety, Stress Scale. AnCNSA = Angry Covert Narcissistic Social Anxiety. CNSA = Covert Narcissistic Social Anxiety. NSA = Narcissistic Social Anxiety. GSA = General Social Anxiety. LSA = Low Social Anxiety

As shown in Table 7.10, for all DASS subscales, the low social anxiety group showed significantly lower scores than all social anxiety groups. For anxiety and stress, all the narcissistic social anxiety groups (narcissistic, covert and angry covert) had higher scores than the non-narcissistic general social anxiety group. For depression, the narcissistic group did not significantly differ from the general social anxiety group, however both of these groups had significantly lower scores than the two covert narcissistic social anxiety subgroups. Therefore, taken together, overall, all of the narcissistic social anxiety subgroups were more impaired than the non-narcissistic social anxiety subgroups, with the exception of depression. However while all social anxiety groups reported high levels of depression, the covert narcissistic social anxiety groups (covert and angry covert) were significantly more depressed.

*Group differences in Personality Organisation.* To explore group differences in personality organisation, a between subjects MANCOVA was conducted with the new social anxiety subgroups entered as the IV, and the three IPO scales (Identity Diffusion, Primitive Defences and Reality Testing) entered as DVs. Given that age was significantly, although weakly correlated with the IPO variables Identity Diffusion and Reality Testing, it was entered as a covariate. Examination of Box's Test of Equality of Covariance Matrices indicated that the data did not meet the assumption of Homogeneity of Covariances, Box'  $M = 40.23$   $F(24, 243566.83) = 1.642, p = .02$ . Levene's test of equality of error variance indicated that while the Primitive Defences and Reality Testing scales met this assumption, the Identity Diffusion scale did not. Given that a number of assumptions were not met, a more conservative  $p$  value of  $p < .001$  was employed, and the Pillai's Trace was reported.

Initial results indicated a significant group difference in the IPO subscales Pillai's Trace = .41,  $F(12, 1002) = 13.21, p < .001$ , partial  $\eta^2 = .14$ . Age was not found to be a significant covariate Pillai's Trace = .03,  $F(3, 332) = 3.72, p = .01$ , partial  $\eta^2 = .03$ , and was removed from the analysis. MANOVA was run to allow post-hoc tests to be performed.

Univariate results revealed significant group differences in Identity Diffusion  $F(4,335) = 45.94, p < .001$ , partial  $\eta^2 = .35$ , Primitive Defences  $F(4,335) = 33.32, p < .001$ , partial  $\eta^2 = .29$  and Reality Testing  $F(4,335) = 30.67, p < .001$ , partial  $\eta^2 = .27$ . Post hoc tests are displayed in Table 7.11. Although the transformed version of the IPO Primitive Defences and IPO Reality Testing scales were used in the MANOVA

analysis, statistics for the untransformed scales are presented in Table 7.11 to aid interpretability.

As can be seen in Table 7.11, the pattern of group differences was the same for all the IPO subscales. Across all IPO subscales, the low social anxiety group had significantly lower scores than all of the social anxiety subgroups (general, narcissistic, covert and angry covert social anxiety subgroups). The non-narcissistic general social anxiety group had significantly lower scores than all the narcissistic social anxiety groups. Examining differences between the narcissistic social anxiety subgroups, the narcissistic and angry covert narcissistic subgroups were significantly higher on all IPO subscales than the covert narcissistic subgroup. Thus, interestingly, the two narcissistic social anxiety subgroups with elevated anger (narcissistic and angry covert subgroups) were most impaired according to the IPO subscales.

Table 7.11

*Analysis of group differences in Personality Organisation*

Scale	AnCNSA <i>n</i> = 61	CNSA <i>n</i> = 84	NSA <i>n</i> = 55	GSA <i>n</i> = 84	LSA <i>n</i> = 56
<b>IPO ID</b>					
<i>M</i>	71.74 <sub>a</sub>	61.43 <sub>b</sub>	69.90 <sub>a</sub>	52.81 <sub>c</sub>	45.66 <sub>d</sub>
<i>SD</i>	13.40	14.57	14.16	10.29	10.25
Range	38 – 97	29 – 95	38 – 105	34 – 77	22 – 69
<b>IPO PD</b>					
<i>M</i>	49.93 <sub>a</sub>	39.35 <sub>b</sub>	46.89 <sub>a</sub>	34.44 <sub>c</sub>	33.00 <sub>c</sub>
<i>SD</i>	10.78	10.55	11.06	7.81	8.02
Range	26 – 69	21 – 65	24 – 72	16 – 56	16 – 51
<b>IPO RT</b>					
<i>M</i>	50.84 <sub>a</sub>	40.64 <sub>b</sub>	47.96 <sub>a</sub>	35.88 <sub>c</sub>	31.13 <sub>d</sub>
<i>SD</i>	14.30	13.59	15.02	9.45	8.56
Range	24 – 82	22 – 77	25 – 91	21 – 71	20 – 59

*Note.* Means not sharing a common subscript differ significantly.

IPO = Inventory of Personality Organisation. IPO ID = IPO Identity Diffusion. IPO PD = IPO Primitive Defences. IPO RT = IPO Reality Testing. AnCNSA = Angry Covert Narcissistic Social Anxiety. CNSA = Covert Narcissistic Social Anxiety. NSA = Narcissistic Social Anxiety. GSA = General Social Anxiety. LSA = Low Social Anxiety

*Group differences in Alexithymia.* A between subjects MANCOVA was conducted to explore group differences in alexithymia, with the new social anxiety

subgroups entered as the IV, and the three TAS scales (Difficulty Identifying Feelings, Difficulty Defining Feelings and Externally Oriented Thinking) entered as DVs. Given that Difficulty Defining Feelings was found to be significantly, though weakly correlated with age, age was entered as a covariate. Examination of Box's Test of Equality of Covariance Matrices indicated that the data met the assumption, Box'  $M = 27.13$   $F(24, 243566.83) = 1.10$ ,  $p = .324$ . Levene's test of equality of error variance indicated that this assumption was met for all scales.

Initial results indicated a significant group difference in the TAS subscales Wilks Lambda = .67,  $F(12, 878.68) = 11.60$ ,  $p < .001$ , partial  $\eta^2 = .12$ . Age was not found to be a significant covariate Wilks Lambda = .98,  $F(3, 332) = 2.43$ ,  $p = .065$  and it was removed from the analysis. MANOVA was run, to allow post-hoc tests to be performed.

Univariate results revealed significant group differences in Difficulty Identifying Feelings  $F(4,335) = 25.72$ ,  $p < .001$ , partial  $\eta^2 = .24$ , Difficulty Defining Feelings  $F(4,335) = 19.85$ ,  $p < .001$ , partial  $\eta^2 = .19$  and Externally Oriented Thinking  $F(4,335) = 9.05$ ,  $p < .001$ , partial  $\eta^2 = .10$ . Post hoc tests are displayed in Table 7.12. Although the transformed version of the TAS Difficulty Defining Feelings scale was used in the MANOVA, statistics for the untransformed scales are presented in Table 7.12 to aid interpretability.

As shown in Table 7.12, there was not a consistent pattern of group differences for the TAS subscales. The only consistency was that across all TAS subscales, the low social anxiety group had significantly lower scores than all of the social anxiety groups. For difficulty identify feelings, the non-narcissistic general social anxiety group had lower scores than the three narcissistic groups. Comparing the narcissistic subgroups, the narcissistic and angry covert subgroups had significantly higher scores than the covert narcissistic group. Thus, as was the case with the IPO, the two angry narcissistic social anxiety groups (narcissistic and angry covert) were more impaired than the covert narcissistic subgroup in relation to difficulty identifying feelings.

For difficulty defining feelings, the angry covert narcissistic group was significantly more impaired than the general and narcissistic groups, but there were no significant difference between the covert group and the other social anxiety groups. For externally oriented thinking, the narcissistic group had significantly lower scores than the angry covert group. There were no other significant differences among the social anxiety groups in externally oriented thinking. Thus, taken together, all social anxiety

groups reported impairment according to the TAS subscales, but there was not a consistent pattern of differences between the social anxiety subgroups.

Table 7.12

*Analysis of group differences in Alexithymia*

Scale	AnCNSA <i>n</i> = 61	CNSA <i>n</i> = 84	NSA <i>n</i> = 55	GSA <i>n</i> = 84	LSA <i>n</i> = 56
TAS ID					
<i>M</i>	24.11 <sub>a</sub>	18.83 <sub>b</sub>	21.22 <sub>c</sub>	16.55 <sub>d</sub>	13.79 <sub>e</sub>
<i>SD</i>	6.19	6.28	6.87	6.12	5.03
Range	8 – 35	7 – 33	8 – 34	7 – 35	7 – 26
TAS DEF					
<i>M</i>	19.57 <sub>a</sub>	18.12 <sub>a,b</sub>	16.93 <sub>b</sub>	16.37 <sub>b</sub>	12.25 <sub>c</sub>
<i>SD</i>	3.67	4.33	4.88	5.17	4.57
Range	9 – 25	5 – 25	5 – 25	5 – 25	5 – 23
TAS EXT					
<i>M</i>	21.48 <sub>a</sub>	20.64 <sub>a,b</sub>	18.71 <sub>b</sub>	19.60 <sub>a,b</sub>	16.66 <sub>c</sub>
<i>SD</i>	4.48	4.9	5.32	4.96	4.14
Range	11 – 30	9 – 30	9 – 30	8 – 32	9 – 27

*Note.* Means not sharing a common subscript differ significantly.

TAS = Toronto Alexithymia Scale. ID = Difficulty Identifying Feelings. DEF = Difficulty Defining Feelings. EXT = Externally Oriented Thinking. AnCNSA = Angry Covert Narcissistic Social Anxiety. CNSA = Covert Narcissistic Social Anxiety. NSA = Narcissistic Social Anxiety. GSA = General Social Anxiety. LSA = Low Social Anxiety

*Group differences in ESS measured shame.* A one-way between subjects ANCOVA was conducted to explore group differences in total ESS measured shame. The new social anxiety subgroups were entered as the IV, and the total ESS scale entered as the DV. As age was significantly correlated with total ESS, age was entered as a covariate. Levene's test of homogeneity of variance indicated that this assumption was met ( $p = .37$ ). ANOVA indicated a significant difference in total ESS measured shame among the new social anxiety groups  $F(4,334) = 35.20, p < .001$ . Age was not found to be a significant covariate  $F(1,334) = .18, p = .68$  and was removed from the analysis. An ANOVA was conducted to allow for post-hoc tests to be performed.

Post hoc tests are displayed in Table 7.13. Although the transformed versions of the scales were used in the ANOVA, statistics for the untransformed scales are presented in Table 7.13 to aid interpretability.

Table 7.13

*Analysis of group differences in ESS measured shame*

Scale	AnCNSA <i>n</i> = 61	CNSA <i>n</i> = 84	NSA <i>n</i> = 55	GSA <i>n</i> = 84	LSA <i>n</i> = 56
ESS					
<i>M</i>	89.33 <sub>a</sub>	82.62 <sub>b</sub>	77.31 <sub>c</sub>	70.06 <sub>d</sub>	56.48 <sub>e</sub>
<i>SD</i>	10.39	11.37	12.66	13.97	15.16
Range	48 – 100	44 – 100	52 – 99	31 – 100	26 – 100

*Note.* Means not sharing a common subscript differ significantly.

ESS = Experience of Shame Scale. AnCNSA = Angry Covert Narcissistic Social Anxiety. CNSA = Covert Narcissistic Social Anxiety. NSA = Narcissistic Social Anxiety. GSA = General Social Anxiety. LSA = Low Social Anxiety

As can be seen in Table 7.13, the low social anxiety group had significantly lower shame than the social anxiety groups (general, narcissistic, angry covert and covert). The non-narcissistic general social anxiety subgroup had lower shame than the three narcissistic subgroups. Among the narcissistic social anxiety subgroups, the covert narcissistic social anxiety subgroups reported more shame than the narcissistic group. Thus, taken together, all social anxiety subgroups reported high levels of shame, but shame was higher among narcissistic than non-narcissistic socially anxious individuals, with covert narcissistic socially anxious the most shame prone.

*Group differences in ESS subscales.* A between subjects MANCOVA was conducted to explore group differences in the three ESS subscales. The new social anxiety subgroups were entered as the IV, and the three ESS scales (characterological shame, behavioural shame and bodily shame) entered as DVs. Given that age was found to be significantly related to characterological and behavioural shame, age was entered as a covariate. Examination of Box's Test of Equality of Covariance Matrices indicated that the data met the assumption of Homogeneity of Covariances, Box'  $M = 20.37 F(24, 243566.83) = 0.83, p = .70$ . Levene's test of equality of error variance indicated that this assumption was met for all scales.

MANCOVA indicated significant group differences on ESS scores Wilks Lambda = .57,  $F(12, 878.68) = 16.92, p < .001$ , partial  $\eta^2 = .17$ . Age was a significant covariate Wilks Lambda = .94,  $F(3, 332) = 6.15, p < .001$ , partial  $\eta^2 = .05$ . Descriptive statistics are displayed in Table 7.14. Although the transformed versions of the scales were used in the MANCOVA, statistics for the untransformed scales are presented in Table 7.14 to aid interpretability.

Univariate analyses revealed significant group differences in characterological  $F(4,334) = 46.20, p < .001$ , partial  $\eta^2 = .36$ , behavioural  $F(4,334) = 37.93, p < .001$ , partial  $\eta^2 = .32$  and bodily shame  $F(4,335) = 15.70, p < .001$ , partial  $\eta^2 = .16$ . Age was a significant covariate for bodily  $F(1,334) = 11.29, p = .001$ , partial  $\eta^2 = .03$ , but not characterological  $F(1,334) = 1.66, p = .19$  or behavioural shame  $F(1,334) = .38, p = .54$ .

Table 7.14

*Descriptive statistics for ESS subscales*

Scale	AnCNSA <i>n</i> = 61	CNSA <i>n</i> = 84	NSA <i>n</i> = 55	GSA <i>n</i> = 84	LSA <i>n</i> = 56
ESS Char					
<i>M</i>	42.97 <sub>a</sub>	38.61 <sub>b</sub>	36.27 <sub>c</sub>	32.44 <sub>d</sub>	25.07 <sub>e</sub>
<i>SD</i>	6.07	6.85	6.98	8.12	7.75
Range	25 – 48	13 – 48	22 – 48	12 - 48	12 - 48
ESS Beh					
<i>M</i>	33.13 <sub>a</sub>	30.79 <sub>b</sub>	29.78 <sub>b</sub>	26.38 <sub>c</sub>	22.39 <sub>d</sub>
<i>SD</i>	4.24	4.39	5.27	5.58	6.34
Range	14 – 36	20 – 36	16 – 36	13 - 36	10 – 36
ESS Bod					
<i>M</i>	13.23 <sub>a</sub>	13.23 <sub>a</sub>	11.25 <sub>b</sub>	11.24 <sub>b</sub>	9.02 <sub>c</sub>
<i>SD</i>	2.97	2.68	3.57	3.36	3.7
Range	4 – 16	5 – 16	4 – 16	4 – 16	4 – 16

*Note.* ESS = Experience of Shame Scale. Char = Characterological Shame. Beh = Behavioural Shame. Bod = Bodily Shame.

Examination of Table 7.14 reveals that the pattern of group differences was generally consistent across the three ESS subscales. The low social anxiety group reported significantly less shame across all ESS subscales than the social anxiety groups (general, narcissistic, angry covert and covert). For characterological shame and behavioural shame, the general social anxiety subgroup reported significantly less shame than the narcissistic social anxiety subgroups, however, for bodily shame, there was no significant difference between the general and narcissistic groups.

Examining the narcissistic groups more closely, for bodily shame and characterological shame, the two covert groups reported significantly higher shame than

the narcissistic group. For behavioural shame, however, there was no significant difference between the covert and narcissistic groups. Thus, taken together, while all social anxiety subgroups reported high shame, the narcissistic social anxiety groups (narcissistic, angry covert and covert) generally reported greater shame.

*Group differences in demographic characteristics.* To further clarify group differences, a series of chi-square analyses were performed to explore group differences in demographic characteristics.

*Relationship status.* A cross-tabs analysis conducted to explore group differences in relationship status (see Table 7.15) was significant  $\chi^2(20) = 61.90, p < .001$ . As shown in Table 7.15, more angry covert and covert narcissistic participants individuals reported being “single, have never been in an intimate relationship” and more participants in the low social anxiety group reported being “Currently in an intimate relationship or married” than would have been expected. Although numbers were low, individuals in the narcissistic social anxiety group were more likely to select “separated and currently single” than would be expected.

Table 7.15

*Group differences in relationship status.*

	AnCNSA <i>n</i> = 61	CNSA <i>n</i> = 84	NSA <i>n</i> = 55	LSA <i>n</i> = 56	GSA <i>n</i> = 84
Single (never)					
Actual	32	41	16	5	27
Predicted	21.71	29.89	19.57	19.93	29.89
Single (prev)					
Actual	16	14	10	7	20
Predicted	12.02	16.55	10.84	11.04	16.55
Current					
Actual	10	27	23	37	28
Predicted	22.43	30.88	20.22	20.59	30.88
Separated – S					
Actual	2	0	4	2	7
Predicted	2.69	3.71	2.43	2.47	3.71
Separated – R					
Actual	1	1	1	4	2
Predicted	1.61	2.22	1.46	1.48	2.22
Other					
Actual	0	1	1	1	3
Predicted	0.54	0.74	0.49	0.49	0.74

*Note.* Single (never) = Single, never been in an intimate relationship, Single (prev) = Single, have been in intimate relationships, Current = Currently in an intimate relationship or married, Separated (S) = Divorced or separated and currently single, Separated (relationship) = Divorced or separated and currently in an intimate relations.

*Education status.* A cross-tabs analysis conducted to explore group differences in education status (see Table 7.16) was significant  $\chi^2(20) = 74.32, p < .001$ . As shown in Table 7.16, the narcissistic and low social anxiety groups reported being more educated, with fewer participants than would have been expected having selected ‘no secondary’ or ‘secondary’ as their highest level of education completed and more participants than would have been expected reporting that they were current or past post-graduate students. The reverse was true for the angry covert and covert narcissistic social anxiety groups.

Table 7.16

*Group differences in education status.*

	AnCNSA <i>n</i> = 61	CNSA <i>n</i> = 84	NSA <i>n</i> = 55	LSA <i>n</i> = 56	GSA <i>n</i> = 84
<b>No Secondary</b>					
Actual	6	9	7	0	6
Predicted	5.0	6.9	4.5	4.6	6.9
<b>Secondary</b>					
Actual	38	32	13	9	31
Predicted	22.1	30.4	19.9	20.3	30.4
<b>Tertiary – C</b>					
Actual	5	11	12	9	15
Predicted	9.3	12.8	8.4	8.6	12.8
<b>Tertiary – F</b>					
Actual	8	23	5	13	21
Predicted	12.6	17.3	11.3	11.5	17.3
<b>PostGrad – C</b>					
Actual	2	4	10	11	7
Predicted	6.1	8.4	5.5	5.6	8.4
<b>PostGrad – F</b>					
Actual	2	5	8	14	4
Predicted	5.9	8.2	5.3	5.4	8.2

*Note.* No Secondary = Less than secondary education, Secondary = Completed Secondary education, Tertiary – C = Current tertiary student, Tertiary – F = Completed tertiary education, PostGrad – C = Current post-graduate student, PostGrad – F = Completed post-graduate studies.

## **Discussion of the results of Study 1**

The key contribution of this study was to show that narcissistic social anxiety subgroups could be identified in a general community sample of socially anxious individuals on the basis of cluster analysis. Results indicated the presence of five distinct social anxiety subgroups, a Low Social Anxiety Group (LSA), a General Social Anxiety Group (GSA), a Covert Narcissistic Social Anxiety Group (CNSA), an Angry Covert Narcissistic Social Anxiety Group (AnCNSA) and a Narcissistic Social Anxiety Group (NSA). Therefore, the groups could be said to comprise one non-socially anxious and four socially anxious groups. Of the four socially anxious groups, three were characterised by elevated narcissism across at least two of the narcissism measures, providing strong support for the idea that some socially anxious individuals are characterised by elevated narcissism.

Consistent with the argument presented in Chapter 5 and 6, the results revealed different types of narcissistic socially anxious subgroups. Specifically, the results showed support for distinct overt (narcissistic social anxiety; NSA) and covert (angry covert [AnCNSA] and covert [CNSA]) narcissistic socially anxious individuals. In addition, the narcissistic socially anxious groups were also found to differ in anger expression, with the three groups being differentiated into angry (i.e., the narcissistic and angry covert social anxiety groups) and non-angry narcissistic socially anxious groups (the covert narcissistic social anxiety group). The following sections first describe the characteristics of the total sample, before addressing the specific hypotheses proposed in Study 1B (i.e., group differences in depression, anxiety, stress and shame (Study 1B hypothesis one and two), personality organisation (Study 1B hypothesis three and four) and alexithymia Study 1B hypothesis five). Finally, directions for Study 2 are outlined.

### **Characteristics of the sample.**

***Social Anxiety.*** The current sample was characterised by exceptionally high levels of social anxiety, which provided justification for the decision to use a well-targeted internet based sample for the current study. Although no direct comparison was made in the current sample between an internet and offline population, the comparison of mean scores on the SIAS and SPS with those reported by clinical studies does suggest that the most severely disordered socially anxious individuals may not be presenting to treatment. Although treatment of social anxiety is not the focus of the

current study, this result suggests that greater focus might need to be placed on developing internet based social anxiety treatments.

**Narcissism.** Levels of narcissism for the entire sample was less consistent than were levels of social anxiety, with the total sample evincing significantly lower NPI scores than those reported in social-personality literature (employing non-clinical samples) and significantly higher NPDS scores than clinical populations and significantly higher HSNS scores than non-clinical populations (owing to no clinical data being available for comparison). However, given that level of narcissism differed between the groups, these results suggest that the overreliance on the NPI alone may not be warranted. Specifically, had the current sample only employed the NPI, it would not have produced an accurate picture of the narcissism of the sample.

**Anger.** Overall, the sample showed low levels of anger, which as noted was unexpected given that much of the historical literature presented in Chapter 2 suggested a strong relationship between social anxiety and anger. However, while anger was not elevated across the whole sample, anger was found to be important for specific social anxiety subgroups.

Two of the narcissistic social anxiety groups (the narcissistic and angry covert groups) reported greater frequency of anger expression than the covert narcissistic, the general (non-narcissistic) and the low social anxiety groups. Thus, anger provided a way to differentiate between the two covert narcissistic social anxiety groups. There are two possible explanations for this difference. The first is that the difference between the angry covert and covert groups accurately reflects group differences in anger expression. That is to say, that a subset of covert narcissists are characterised by more frequent expressions of anger and aggression, and another subset is not. A second possibility is that both groups experience anger, but that the way that anger is experienced differs between the two groups. It is possible that the explanation may lie in the type of anger measured by the DAR. Given the overt nature of the questions in the DAR (e.g., “*When I get angry at someone, I want to hit or clobber the person*”), and the fact that the scale dealt largely with anger directed at others, the scale may not be subtle enough to detect the type of anger experienced by the covert narcissistic group. Rather than externally directed anger, the covert narcissistic group might be more inclined to direct anger at the self, that is to say, to be angry at oneself for social failures. Although an interesting possibility, unfortunately, no self-report scale of self-directed anger exists, and thus, it is only possible to speculate about such an association.

### **Group differences in depression, anxiety, stress and shame.**

It was hypothesised that the narcissistic social anxiety subgroups (narcissistic, angry covert and covert groups) would show higher depression, anxiety, stress and shame than the non-narcissistic socially anxious group (general social anxiety) subgroup (Study 1B hypothesis one). Overall, there was partial support for this hypothesis. For DASS anxiety, total ESS shame, and characterological shame and behavioural shame, the narcissistic social anxiety groups were significantly higher than the non-narcissistic general social anxiety group. Contrary to the hypothesis, there was no significant difference between the narcissistic social anxiety group and the general (non-narcissistic) group on DASS depression and bodily shame. In addition, there was no significant difference between the covert narcissistic and general (non-narcissistic) groups on DASS anxiety. Nevertheless, apart from these results, the narcissistic social anxiety subgroups were more impaired on these variables than the non-narcissistic social anxiety group. Thus, taken together, there was evidence that the narcissistic social anxiety subgroups were more impaired than the non-narcissistic (general social anxiety group).

It was also hypothesised that the three narcissistic socially anxious groups (narcissistic, angry covert and covert groups) would have higher depression, anxiety, stress, and shame scores than the non-socially anxious high narcissism (low social anxiety) group (Study 1B hypothesis two). This hypothesis was supported, with the narcissistic socially anxious groups having elevated scores on all measures relative to the low social anxiety group. This result supports the idea that the narcissistic social anxiety subgroups correspond to profiles of narcissists presented in the clinical literature and that the low social anxiety group corresponds to narcissists presented in the social-personality psychology literature.

**Group differences in Personality Organisation.** It was hypothesised that the narcissistic social anxiety subgroups (narcissistic, angry covert and covert groups) would have lower levels of personality organisation than the non-narcissistic general socially anxious group (Study 1B hypothesis three) and that the narcissistic social anxiety subgroups (narcissistic, angry covert and covert groups) would show lower personality organisation and would reflect a type of narcissism consistent with clinical theories, in contrast to the low social anxiety group (with high narcissism and low social anxiety; Study 1B hypothesis four). Results revealed support for both of these hypotheses. The narcissistic social anxiety subgroups were found to be more impaired

than the general (non-narcissistic) social anxiety group, and the narcissistic social anxiety subgroups were more impaired than the non-socially anxious high narcissism group (low social anxiety group).

These results further reinforce that the narcissistic social anxiety groups are similar to narcissists presented in the clinical literature, whereas the low social anxiety group is capturing narcissists similar to those identified in the social-personality literature.

**Group differences in alexithymia.** It was hypothesised that the narcissistic social anxiety groups (narcissistic, angry covert and covert groups) would be higher in self-reported alexithymia than non-narcissistic general social anxiety subgroup (Study 1B hypothesis five). Results revealed mixed support for this hypothesis. As expected, for *difficulty defining feelings*, the narcissistic subgroups (narcissistic, angry covert and covert) reported higher scores than the general (non-narcissistic) socially anxious subgroup. Contrary to the hypothesis, however, in relation to *difficulty defining feelings*, the narcissistic group did not significantly differ from the general (non-narcissistic) group. In relation to *externally oriented thinking*, the narcissistic and covert narcissistic social anxiety groups did not significantly differ from the general (non-narcissistic) group. Thus, although regulation of emotional states was a difficulty for all socially anxious individuals, it was not consistently found to be a greater difficulty for narcissistic socially anxious individuals compared to non-narcissistic socially anxious individuals. Despite this, the angry covert group was significantly more impaired than the non-narcissistic group on all aspects of alexithymia. Overall, it is possible that narcissists' difficulties with emotion regulation apply only to specific facets (i.e., identifying feelings) rather than to emotion regulation more generally.

#### **Further discussion of the nature of the social anxiety groups**

**Low Social Anxiety Group.** The low social anxiety (LSA) group is one which is associated with low social anxiety, moderate NPI measured narcissism, low HSNS and NPDS measured narcissism, and low psychological maladjustment. This group was also better educated and more likely to report being in a relationship. These results suggest that individuals in this group are similar to narcissists described in the social-personality literature (J. D. Miller & Campbell, 2008), to wit; high narcissism and low levels of intrapersonal maladjustment.

Despite these similarities, the low social anxiety group is not entirely consistent with the profile of social-personality 'narcissists'. As J. D. Miller and Campbell (2010)

noted, within the social-personality paradigm, narcissism is often associated with aggression and externalising behaviours. In contrast to this, the low social anxiety group reported lower anger than the other groups, suggesting that in relation to anger, individuals in the low social anxiety group are better adjusted than narcissists identified in the social-personality literature. One possibility is that while the anger scores of this group were lower than the other groups, they may be higher than a non-narcissistic (i.e., low NPI) non clinical sample. In the absence of a non-socially anxious control group with low levels of NPI measured narcissism, however, it is not possible to test this explanation.

***General Social Anxiety Group.*** The general social anxiety group was characterised by high scores on the SIAS and SPS, low scores on the NPI, and NPDS and moderate scores on the HSNS. Thus, although, as noted, the decision was made to label this group as a non-narcissistic social anxiety group owing to the fact that the group had low scores on two of the three narcissism measures, it would be wrong to suggest that the group was not associated with any narcissism. The group did show the lowest narcissism scores of any of the social anxiety groups and only showed moderate scores on a single scale.

The GSA was also better adjusted than the narcissistic social anxiety groups reporting lower levels of shame proneness, depression, anxiety and stress. Thus, taken together, this group comprises socially anxious individuals who have substantial fears about dyadic and group interactions (high SPS and SIAS), but despite this, have reasonable psychological functioning (e.g., lower depression, anxiety and stress).

***The Narcissistic Social Anxiety Subgroups.*** In examining the pattern of differences between the narcissistic social anxiety subgroups, a number of consistencies emerged. First, across most variables, the angry covert group was significantly more impaired, reporting greater impairment in social anxiety, more characterological and behavioural shame, greater difficulty identifying feelings and more severe depression, anxiety and stress. On many measures, the covert narcissistic group seemed to represent an intermediate group in terms of impairment, being less impaired than the angry covert group, but often more impaired than the narcissistic group.

The pattern of results for the IPO, however, was different, with both the angry covert and the narcissistic groups evincing more impairment than the covert narcissistic group on all IPO subscales. Thus, while on some measures, the covert group represented an intermediate group between the angry covert and narcissistic groups, this

was not true for all measures, indicating that the narcissistic groups do not simply reflect an alternative way of presenting levels of impairment among socially anxious individuals. The similarity between the angry covert and narcissistic subgroups on the IPO also indicate that type of narcissism alone is not an indicator of level of impairment, but that anger may also be important in relation to IPO related impairment, considering that the angry covert and narcissistic groups reported greater anger than the other groups.

**Narcissism and the social anxiety subgroups: theoretical considerations.** As noted in Chapter 5, two of the main theoretical perspectives on narcissism, viz. clinical and social-personality psychology predict different portraits of narcissism. Where the clinical literature on narcissism suggested that narcissism should be related to internalized negative emotions and greater levels of intrapersonal maladjustment, the social-personality psychology perspective would suggest that although narcissism would be related to interpersonal maladjustment (e.g., lack of empathy, exploitativeness, failed relationships, etc.) that narcissism should be related to higher levels of psychological adjustment (or related inversely to psychological maladjustment). The new social anxiety groups revealed support for both theoretical perspectives. In particular, the LSA and NSA groups represent the social-personality psychology and clinical perspectives on narcissism respectively. As noted, the LSA group had elevated scores on the NPI, but lower scores on measures of psychological maladjustment, consistent with the social-personality psychology perspective. On the other hand, the NSA group was associated with high social anxiety, and high scores on measures of psychological maladjustment. However, while, both groups were characterised by high scores on the NPI, the NSA group had significantly higher scores than the LSA, and thus represented a “more” narcissistic group.

A more nuanced understanding of the narcissism of the LSA and NSA groups was gained through an analysis of item endorsement rates, with this comparison indicating that although both the LSA and NSA groups endorsed NPI items tapping uniqueness and leadership, the NSA group also had a high endorsement rate for items tapping manipulativensness and entitlement (whereas the LSA group has lower levels of endorsement of these items). Therefore, for the LSA group, the high NPI scores were tapping in to aspects of narcissism (e.g., leadership) which have been described as relatively more adaptive (e.g., Emmons, 1984), whereas the NSA group endorsed a mix

of relatively more adaptive (e.g., Leadership), and relatively less adaptive (e.g., entitlement, exploitativeness) features of narcissism (see Emmons, 1984).

Given that both groups had moderate to high NPI scores, this suggests that NPI scores are not meaningful when considered alone. Indeed, the current results suggest that to know what a high score on the NPI means, one must consider not just the sample (e.g., high NPI scores in clinical or subclinical samples might mean something different to high NPI scores in non-clinical samples), but also the pattern of associations with other variables (e.g., scores on other narcissism measures, and scores on measures of psychological maladjustment). Thus, it is possible that rather than focusing on the population (e.g., clinical vs. non-clinical), that researchers should focus on subsets of individuals within these populations (using cluster analysis). It is possible that the different types of high NPI scoring individuals might be evident in both clinical and non-clinical populations.

Overall, the current study provides preliminary evidence for the existence of several unique narcissistic social anxiety subgroups. At the broadest level, the narcissistic social anxiety subgroups were more impaired than the non-narcissistic social anxiety subgroup, and the angry covert subgroup in particular represented a particularly poorly functioning group of socially anxious individuals.

**Directions for Study 2.** The aim of this first study was to establish the existence of distinct narcissistic social anxiety groups and to begin to identify the nature of these groups. The next study attempts to replicate these preliminary results, specifically with a goal to identifying the same social anxiety subgroups. The second study extends on the first by including variables which allow a more comprehensive understanding of the nature of the new social anxiety subgroups.

As noted in Chapter 3, there is a growing acknowledgement that conceptualizations of social anxiety are limited due to an emphasis on Western interpretations of the disorder. Specifically, it was suggested in Chapter 3 that a more comprehensive understanding of social anxiety might be possible by incorporating elements specific to Taijin-Kyofusho (TKS) into descriptions and definitions of social anxiety. Thus, while this study identified important differences between the groups in social anxiety, if TKS represents a unique aspect of social anxieties not well represented in Western conceptualizations of the disorder (and hence, in social anxiety scales stemming from these conceptualizations) then a better understanding of the nature of the groups could be gained by analysing group differences in TKS.

As noted in Chapter 2, social rank is central to Gilbert's (2001) ethological theory of social anxiety. Although generally, social anxiety is thought to be related to low perceived social rank, he suggested that in some instances, social anxiety might be related to high perceived social rank, and that some dominant individuals might be vulnerable to social anxiety if weaknesses in their perceived social dominance are revealed. While it could be argued that narcissism is related to higher perceived social rank (or social dominance), it is not a direct measure of social rank, and examination of group differences in perceptions of social rank would allow a more comprehensive understanding of the new social anxiety subgroups. Analysis of group differences in social rank would also allow for additional comparisons to be made between the current subgroups and the hostile/dominant and friendly/submissive subgroups identified by Kachin et al. (2001).

## **Chapter 8: Study 2: Further explorations of the new social anxiety subgroups.**

This chapter describes the aims, participants, methods and results of Study 2. The primary contribution of Studies 1A and 1B was the identification via cluster analysis of five new social anxiety subgroups. Results revealed that three of the new social anxiety subgroups were characterised by elevations on multiple narcissism scales. One was characterised by elevations on overt and covert narcissism scales (NSA), and two were characterised by elevations on covert narcissism scales only (AnCNSA/CNSA). In addition a non-narcissistic social anxiety subgroup (GSA) and a low/non-socially anxious subgroup (LSA) were identified.

**Aims and hypotheses.** On the basis of the results of Study 1, Study 2 had three aims. The first was to replicate the results of Study 1 and re-identify the same social anxiety subgroups. The second was to further explore the nature of the new social anxiety subgroups by exploring group differences in *Taijin-Kyofusho* (TKS) and social rank. The third was to examine group differences in psychological adjustment.

### ***Re-analysis of social anxiety subgroups.***

*Hypothesis one.* It was hypothesised that cluster analysis would result in the same five social anxiety groups identified in Study 1 being identified in the current study.

***Re-examination of group differences in psychological adjustment and personality organisation.*** Study 2 also re-explored group differences in psychological adjustment (depression, anxiety and stress) and personality organisation to compare the social anxiety subgroups identified in Study 1 with subgroups identified in the current study and to make more definitive statements about the nature of the groups.

*Hypothesis two.* It was hypothesised that the pattern of differences between the narcissistic social anxiety subgroups (NSA, AnCNSA and CNSA) and the non-narcissistic social anxiety subgroup (GSA) on depression, anxiety, and stress would be the same as the patterns identified in Study 1. Specifically, (a) all of the narcissistic socially anxious subgroups would show higher anxiety than the GSA group, (b) the AnCNSA and CNSA (but not the NSA) would show higher depression than the GSA group, and (c) the NSA and AnCNSA (but not the CNSA) would show higher stress than the GSA group.

*Hypothesis three.* On the basis of the results of Study 1, it was hypothesised that all of the narcissistic social anxiety subgroups (NSA, AnCNSA and CNSA) would report lower levels of personality organisation (higher IPO scores) than the non-narcissistic social anxiety group (GSA).

**Examination of group differences in TKS.** As noted in the discussion of Study 1, a full understanding of the nature of the social anxiety of the subgroups is not possible unless the focus extends beyond Western conceptualizations of social anxiety. Thus, extending on the results of Study 1, the next aim of the current study was to explore group differences in TKS.

*Hypothesis four.* On the basis of the results of Study 1, it was hypothesised that the four socially anxious subgroups (GSA, NSA, AnCNSA and CNSA) would show higher TKS than the non-socially anxious subgroup (LSA). It was further hypothesised that consistent with the results for social anxiety in study one that the angry covert group would show significantly higher TKS than the other socially anxious groups. However, there is no a priori expectation about how the other socially anxious groups might differ, given that the pattern of differences between the covert, narcissistic and general groups was not consistent across the SIAS and SPS.

**Examination of group differences in perceived social rank.** As noted in the discussion of Study 1, it is possible that the narcissistic social anxiety subgroups represent relatively more dominant individuals, in line with Gilbert's (1994) theory. However, as social rank was not explicitly measured in Study 1, this was speculative. Thus, the next aim of Study 2 was to explore group differences in perceptions of social rank, to further understand the nature of the narcissistic social anxiety subgroups.

*Hypotheses five.* On the basis of descriptions of narcissism presented in Chapter 5, it was hypothesised that the narcissistic social anxiety subgroup would show higher social rank than the covert narcissistic and general narcissistic groups.

## **Method**

### **Participants**

*Rationale for sample selection strategy.* In support of Erwin et al.'s (2004) research, Study 1 found that the internet based sample employed showed significantly higher levels of social anxiety than treatment seeking clinical samples. In view of this, and considering that Study 1 was successful in identifying subgroups of socially anxious individuals not well described in the DSM-5 (APA, 2013) the decision was made to employ an internet based sample in the current study also. This decision is further reinforced since a primary aim of the current study is to replicate the results of Study 1.

*Recruitment.* The current study used a similar recruitment strategy to Study 1, which was based on that employed by Erwin et al. (2004). Participants were recruited

by posting online flyers to various social anxiety websites, web forums, discussion boards, social media sites and email lists. Again, the strategy employed in Study 1 of targeting general anxiety websites as well as websites dealing with broader psychological issues (e.g., depression and anxiety) was used. Given the number of international participants in Study 1, the online flyer was posted on a number of international anxiety forums. Participants were informed that the survey was in English and were advised to be aware of any potential formal government restrictions on participating in foreign research. As in Study 1, the flyer indicated that participation was sought from individuals who suffered from social anxiety, as well as those who do not. The use of this strategy in Study 1 contributed to the identification of the LSA group, which allowed for comparison between high (GSA, NSA, AnCNSA and CNSA) and low (LSA) social anxiety groups and also allowed for comparison between narcissistic social anxiety groups (NSA, AnCNSA and CNSA) and the non-socially anxious high narcissism LSA group.

***Final sample.*** Six hundred and twelve individuals completed an online questionnaire. Three hundred and eighty participants were female ( $MAge = 26.27$ ,  $SD = 9.30$ ) and 232 were male ( $MAge = 26.92$ ,  $SD = 9.14$ ). The age of the combined sample ranged from 15 to 82 ( $MAge = 26.51$ ,  $SD = 9.24$ ). Comparison of skewness and kurtosis values for age revealed with the critical value of chi-square (Tabachnick & Fidell, 2007) indicated that the distribution of age was significantly different from normal, with more participants clustered at the younger end of the age range. Although normality of variables is desirable, the age range identified in the current study is similar to that identified in Study 1, and it is possible that the age range of the current sample is a reflection of the method used to recruit participants (e.g., web-based methods). Given that age was not used as an IV or DV in any analysis which requires variables to be normally distributed, the decision was made to proceed with subsequent analysis regardless of the significant skew.

#### ***Description of sample***

***Country of birth.*** A complete list of participants' country of birth and country of residence is presented in Table 8.1. As in Study 1, use of the internet to recruit participants resulted in a multinational, heterogeneous sample. Six participants (1%) were born in Africa, 23 (3.8%) in Asia, two (.3%) in Central America, 198 (32.4%) in Europe, 308 (50.3%) in North America, 66 (10.8%) in Oceania, four (.7%) in South

America and three (.5%) in other regions. Two participants did not state their country of birth.

Examining participants country of residence revealed a similar pattern, with four participants (.7%) currently residing in Africa, 16 (2.6%) in Asia, one (.2%) in Central America, 197 (32.2%) in Europe, 315 (51.5%) in North America, 69 (11.3%) in Oceania, four (.7%) in South America and four (.7%) in other regions. Two participants did not state their country of residence.

***Relationship status.*** Two hundred and sixty six (43.5%) participants indicated that they were single and had never been in an intimate relationship, 130 (21.2%) indicated that they were currently single but had previously been in an intimate relationship, 190 (31%) indicated that they were currently in an intimate relationship or married, 17 (2.8%) indicated that they were divorced or separated and six participant's (.9%) indicated their relationship status as "other".

***Education status.*** One hundred and two (16.7%) participants had not completed high school, 131 (21.4%) had currently completed high school, 218 (35.6%) were current tertiary students, 81(13.2%) had completed tertiary education, 39 (6.4%) were current post-graduate students, and 39 (6.4%) had completed post-graduate studies. Thus, taken together, a high percentage of the sample were undertaking or had completed tertiary education (61.60%).

***Self-reported clinical history.*** Three hundred and thirteen (51.1%) participants reported having received a diagnosis of depression at some point during their life and 126 (20.6%) reported having been diagnosed within the past two years. Three hundred and seventeen (51.8%) participants reported having received a diagnosis of social anxiety/social phobia at some point during their life and 243 participants (39.7%) reported having been diagnosed within the past two years. One hundred and twenty-six (20.6%) participants reported having received a diagnosis of another anxiety disorder at some point during their life and 98 participants (16%) reported having been diagnosed within the past two years. Sixty-three participants (10.3%) reported having received a diagnosis of another mood disorder at some point during their life and 45 (7.4%) reported having been diagnosed within the past two years. Given that diagnostic data was self-reported, these results need to be interpreted with caution.

Table 8.1

*Participant's country of birth and country of residence.*

Country	Female		Male		Total	
	Birth	Residence	Birth	Residence	Birth	Residence
Australia	35	40	19	21	54	61
Bangladesh	1	0	0	0	1	0
Belgium	0	0	2	0	2	0
Brazil	2	2	0	0	2	2
Canada	34	34	16	17	50	51
China	1	0	1	0	2	0
Costa Rica	0	0	1	1	1	1
Denmark	1	1	5	7	6	8
Egypt	0	0	1	1	1	1
Finland	5	4	2	2	7	6
France	2	2	0	0	2	2
Germany	3	2	0	1	3	3
Guam	1	0	0	0	1	0
Honduras	0	0	1	0	1	0
India	3	3	3	2	6	5
Ireland	4	5	2	3	6	8
Italy	0	1	4	4	4	5
Jordan	0	0	1	1	1	1
Lithuania	0	0	1	1	1	1
Malaysia	2	2	0	0	2	2
Malta	0	0	1	0	1	0
Mexico	1	0	0	0	1	0
Norway	0	0	1	1	1	1
NZ	6	3	3	3	9	6
Pakistan	0	0	1	1	1	1
Peru	1	1	0	0	1	1
Philippines	3	2	0	0	3	2
Poland	0	0	1	0	1	0
Puerto Rico	1	1	0	0	1	1
Republic of Macedonia	1	1	0	0	1	1
Russia	0	0	1	0	1	0
Singapore	2	2	0	0	2	2
Somalia	0	0	1	0	1	0
South Africa	1	1	3	2	4	3
South Korea	2	0	0	0	2	0
Spain	0	0	1	1	1	1
Sweden	27	27	9	9	36	36
Syria	0	0	0	0	0	0
Thailand	0	0	1	0	1	0
The Netherlands	5	6	1	2	6	8
UK	68	68	49	47	117	115
USA	160	161	93	99	253	260
Venezuela	1	1	0	0	1	1
Vietnam	0	0	2	0	2	0

Of the 243 participants who indicated they had received a diagnosis of social anxiety/social phobia within the past two years, 57 (23.5%) participants indicated that they were currently receiving treatment from a Psychologist for their condition, 55 (22.6%) from a Psychiatrist, 40 (16.5%) from a GP and 36 (14.8%) from a counsellor. Eleven (4.5%) of participants reported that they were managed by their GP and a Psychologist, 10 (4.1%) by their GP and a Psychiatrist and seven (2.9%) by their GP, a Psychologist and a Psychiatrist. One hundred and ten (45.3%) participants who reported having received a diagnosis of social anxiety/social phobia within the past two years indicated that they were not currently receiving any form of treatment for their condition.

### **Materials**

**Social Anxiety.** Social anxiety was measured using the Social Phobia Scale (SPS) and Social Interaction Anxiety Scale (SIAS; Mattick & Clarke, 1998). The scales are described in detail in Study 1 part A.

**Narcissism.** Given that narcissism is complex multifaceted construct, three scales were used to measure narcissism; the Narcissistic Personality Inventory (NPI; Raskin & Hall, 1979), the MMPI based Narcissistic Personality Disorder Scale (NPDS; Ashby, 1978), and the Hypersensitive Narcissism Scale (HSNS; Hendin & Cheek, 1997). This decision was further supported by the results of Study 1, which indicated that the pattern of scores for the three narcissism scales different between the five new social anxiety groups identified. The scales are described in detail in Study 1 part A.

**Anger.** Anger was measured using the Dimensions of Anger Reactions Scale (DAR; Forbes et al., 2004). The scale is described in detail in Study 1 part B.

### **Psychological Adjustment**

**Depression Anxiety Stress Scales (DASS).** To measure psychological adjustment, the Depression, Anxiety, Stress Scales were included. The scale is described in detail in Study 1 part B.

**Personality Organisation.** The Inventory of Personality Organisation (IPO; Lenzenweger, Clarkin, Kernberg, & Foelsch, 2001) was used to assess Personality Organisation. The scale is described in detail in Study 1 part B.

**Social Rank.** Social rank was assessed using the Social Comparison Scale (SCS; Allan & Gilbert, 1995). The SCS was developed based on evolutionary theory, and measures judgements of social rank, judgements of perceived attractiveness and judgements of group fit. The scale involves presenting participants with 11 sentence

stems “In relation to others, I feel” and asking them to make global comparisons of themselves with others by placing a mark on a 10 point scale, with contrasting options at either pole (e.g., Superior vs. Inferior). In addition, for each set of contrasting options, participants were given a forced choice question in which they had to choose one of the two options.

Allan and Gilbert’s (1995) validation study found inconsistent support for the factor structure of the SC scale, with a two factor model being found to fit for the non-clinical sample, and a three factor model found to fit for the clinical sample. Given the lack of consistency in relation to the factor structure, and the lack of any subsequent attempts to factor analyse the scale, subsequent studies employing the SCS have treated the scale as a unidimensional measure (e.g., Gilbert et al., 2010; McEwan, Gilbert, & Duarte, 2012; Sturman, 2011).

Allan and Gilbert reported the scale had good internal consistency ( $\alpha = .88$ ) and test-retest reliability ( $\alpha = .84$ ). The scale has been used in non-clinical (e.g., Gilbert et al., 2009) and clinical populations (Gilbert et al., 2010; McLeod, Coertze, & Moore, 2009). The scale has been shown to be cross-culturally valid (e.g., Israel; Aderka, Weisman, Shahar, & Gilboa-Schechtman, 2009; Turkey; Berber Çelik & Odacı, 2012), Additionally, the scale has been previously used in social anxiety studies (Gilbert, Boxall, Cheung, & Irons, 2005; Weeks, Jakatdar, & Heimberg, 2010; Weisman, Aderka, Marom, Hermesh, & Gilboa-Schechtman, 2011) further supporting the use of the scale in the current study.

**Taijin-Kyofusho.** Taijin-Kyofusho was measured using the Taijin-Kyofusho Scale (TKS; Kleinknecht et al., 1997; Kleinknecht et al., 1994). The first version of the TKS was a ten item scale developed by Kleinknecht et al. (1994) on the basis of descriptions of TKS provided by Takahashi (1989), in his discussion of social anxiety in Japan. Later, Kleinknecht et al. (1997) revised the scale, increasing the number of items to 31. The revised scale was comprised of items which had been found to best differentiate individuals with and without TKS (as diagnosed by Japanese Psychiatrists) and items based on definitions in the literature. The items measure concerns that an individual’s appearance or self-presentation might offend or embarrass others. Higher scores on the TKS indicate higher levels of TKS related symptoms.

Kleinknecht et al. (1997) initially factor analysed the scale in combination with the SIAS and SPS. Results supported a three factor solution, with the SIAS, SPS and TKS items loading on to separate factors. Following this, Tarumi, Ichimiya, Yamada,

Umesue, and Kuroki, (2004) factor analysed the scale alone and found support for a five factor solution; appearance anxiety, ‘part specific’ anxiety, blushing/trembling anxiety, scrutiny anxiety and odour/emission anxiety. Several of the factors overlapped with Suzuki, Takei, Kawai, Minabe, and Mori’s (2003) four subtypes of TKS; sekimen-kyofu (the phobia of blushing), shubo-kyofu (the phobia of a deformed body), jikoshisen-kyofu (the phobia of eye-to-eye contact), and jikoshu-kyofu (the phobia of one’s own foul body odour). Neither of the factor solutions has yet been replicated, and all studies employing the TKS have used a total score, rather than subscale scores.

Although the TKS has not been extensively utilized, initial psychometric analyses indicate that the scale possesses desirable psychometric properties, with Kleinknecht et al. (1997) reporting Cronbach’s alphas above .9 for both their US and Japanese samples.

**Neurotic and offensive (delusional) TKS.** To provide a measure of cognitions associated with the two broad subtypes of TKS, neurotic and offensive/delusional (Kleinknecht et al., 1994; Nakamura et al., 2002), the *Other offending and Avoidance by others Cognition scales* (OACS) (Sasaki & Tanno, 2006) was used. The OACS provides a list of 14 aspects of the self which may offend others (e.g., expression of the eyes), and asks participants to rate, on a five point scale “To what degree do you think that this aspect of you makes others uncomfortable?” and “To what degree do you think you are avoided due to this aspect of yourself?”. In the current study, items corresponding *other offending cognitions* (OC) and *avoidance-by-other cognitions* (AO) were summed to create two subscale scores. Higher scores on both subscales indicate a greater belief that one offends or is avoided by others because of perceived defects. Although the scale has not yet been extensively employed, initial analyses indicate the scale has acceptable psychometric properties, with Sasaki and Tanno reporting a Cronbach’s  $\alpha$  of .89 for the OC, and .93 for the AC.

## Results

The following sections present the results of Study 2. First, preliminary analyses are presented. Following this, possible covariates, specifically, gender, age, a current diagnosis of social anxiety, and current treatment for social anxiety are explored. The final section replicates and extends upon the cluster analysis conducted in Study 1. The subgroups identified were explored on a number of variables to further elucidate the nature of the group under investigation.

**Preliminary analyses.** The following section presents the descriptive statistics for the scales which form part of the current study. First, univariate normality of the scales was addressed. The mean values of the current sample were then compared to the mean values of other samples. Descriptive statistics for the sample are presented in Table 8.2.

Table 8.2

*Descriptive statistics for the total sample*

Variable	Mean	SD	Range	Theoretical Range	Skewness	Reliability
SPS	41.01	15.86	2-77	0-80	-0.19	.92
SIAS	54.27	13.24	4-76	0-76	-0.94*	.91
NPI	9.69	6.54	0-30	0-40	0.83*	.87
NPDS	11.99	2.67	2-18	0-18	-0.51*	.56
HSNS	36.42	5.90	12-50	10-50	-0.71*	.68
DAR	21.25	13.57	0-56	0-56	0.46*	.88
DASS						
Depression	13.24	5.46	0-21	0-21	-0.46*	.90
Anxiety	8.56	5.29	0-21	0-21	0.28*	.84
Stress	11.14	4.93	0-21	0-21	-0.14	.84
IPO						
Primitive Defences	42.60	10.75	16-71	16-80	0.11	.85
Identity Diffusion	63.77	14.57	21-100	21-105	-0.17	.89
Reality Testing	42.45	13.86	20-96	20-100	0.84*	.91
TKS	127.78	40.38	33-214	31-217	-0.17	.95
Other Offend	39.96	13.80	14-70	14-70	-0.08	.92
Other Avoid	37.03	14.30	14-70	14-70	0.14	.92
SC	40.89	19.62	11-110	11-110	0.84*	.90

*Note.* DASS = SPS = Social Phobia Scale. SIAS = Social Interaction Anxiety Scale. NPI = Narcissistic Personality Inventory. NPDS = Narcissistic Personality Disorder Scale. HSNS = Hypersensitive Narcissism Scale. DAR = Dimensions of Anger Reactions. DASS = Depression, Anxiety, Stress Scale. IPO = Inventory of Personality Organisation. TKS = Taijin-Kyofusho Scale. SC = Social Comparison Scale.

\* = Skewness significant at  $p < .05$

**Preliminary analyses of the social anxiety scales.** Mean social anxiety scores (see Table 8.2) were in the upper end of the theoretical range. Comparison of the mean values with those reported in Study 1 (see Table 7.2) revealed that the mean social anxiety scores of the current sample were similar to those found in Study 1. One sample  $t$ -test revealed that the SPS scores were significantly higher in the current sample than in Study 1  $t(611) = 4.06, p < .001$ , but that the SIAS scores did not significantly differ between the current study and Study 1  $t(611) = -.38, p = .70$ . Thus, compared with

Study 1, the participants in the current study had similar interaction anxieties, but greater fear of being scrutinised during routine activities.

Similar to Study 1, a series of one sample  $t$ -tests was performed to compare the mean values of the current sample with the mean values reported by Brown et al. (1997) identified in a clinical population of individuals who had been diagnosed with Social Anxiety Disorder according to DSM-III criteria. Results revealed that the current sample showed significantly higher levels of both SIAS  $t(611) = 6.68, p < .001$  and SPS  $t(349) = 6.42, p < .001$  than Brown et al.'s clinical sample. Thus, unlike the sample identified in Study 1 which was found to have similar SPS scores, but significantly higher SIAS than Brown et al.'s clinical sample, the current sample showed higher scores on both social anxiety scales.

***Univariate normality of the Social Anxiety Scales.*** As evident in Table 8.2, both the SPS and SIAS showed some deviations from univariate normality. Comparison of the skewness statistics with the critical value of chi-square (Tabachnick & Fidell, 2007) revealed that the SPS was normally distributed, and the SIAS significantly negatively skewed. Given the assumption of normality of distribution for the statistical tests to be employed, the SIAS variable was transformed<sup>17</sup>. Transformation was guided by suggestions in Tabachnick and Fidell (2007). After transformation, reassessment of the skewness statistic revealed that the SIAS was not significantly skewed.

Assessment of kurtosis values for the variables indicated that although the revised SIAS scale was mesokurtic, the SPS scale showed a platykurtic distribution. Examination of a histogram of the SPS, however, indicated that the variable approximated normal distribution. Given this, considering that with large samples that minor deviations from normality can result in high kurtosis values (see Tabachnick & Fidell, 2007), and considering that the same pattern of results was identified in Study 1, the decision was made to proceed with the analysis, despite the platykurtic distribution of the SPS scale. Examination of box-plots revealed no extreme univariate outliers for either the SPS or the revised SIAS.

***Preliminary analyses of the narcissism scales.*** Comparison of the mean narcissism scores of the current sample with those identified in Study 1 (see Table 7.2) revealed that the current sample showed similar scores on the narcissism scales as the sample in Study 1. One sample  $t$ -tests revealed that the current sample showed

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<sup>17</sup> SIAS was transformed using the equation  $-\sqrt{MAX - SIAS}$ , where Max = the maximum value for the SIAS

significantly lower scores on the NPI  $t(611) = -2.84, p < .001$ , and significantly higher scores on the NPDS  $t(611) = 11.57, p < .001$  and HSNS  $t(611) = 6.48, p < .001$ . Thus, compared to the sample identified in Study 1, the current sample showed higher levels of covert narcissism (HSNS) and narcissistic pathology (NPDS) and lower levels of overt narcissism (NPI).

***Univariate normality of the narcissism scales.*** As shown in Table 8.2, the NPI showed a positive skew and the NPDS and HSNS negative skews. Comparison of the skewness statistics with the critical value of chi-square (Tabachnick & Fidell, 2007) revealed that the NPI was significantly positively skewed, and the NPDS and HSNS significantly negatively skewed. Given the assumption of normality of distribution for the statistical tests to be employed, the NPI variable was transformed<sup>18</sup>. Transformations of all narcissism scales were guided by suggestions in Tabachnick and Fidell (2007). Reassessment of the skewness statistic of the NPI after transformation revealed that the NPI was no longer significantly skewed. The NPDS was also transformed<sup>19</sup>. Reassessment of the skewness statistic revealed that the NPDS was still significantly skewed after transformation. Analysis of box-plots revealed that the revised NPDS variable had two outliers. The outliers were removed, and the skewness statistic reassessed. After transformation and removal of the outliers, the revised NPDS variable was no longer significantly skewed. Finally, the HSNS was transformed<sup>20</sup>. Reassessment of the skewness statistic revealed that the HSNS was still significantly skewed after transformation. Analysis of box-plots revealed that the revised HSNS variable had two extreme outliers. The outliers were removed, and the skewness statistic reassessed. After transformation and removal of the outliers, the revised HSNS variable was no longer significantly skewed.

Analysis of the kurtosis values of the narcissism scales revealed that the NPI and the NPDS showed mesokurtic distribution. Comparison of the kurtosis value with the critical value of chi-square revealed that the HSNS had significant leptokurtic distribution. Examination of a histogram of the revised HSNS, however, indicated that the variable approximated normal distribution. Given this, and considering that with

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<sup>18</sup> NPI was transformed using the equation  $-\sqrt{MAX - NPI}$ , where Max = the maximum value for the NPI

<sup>19</sup> NPDS was transformed using the equation  $-\sqrt{MAX - NPDS}$ , where Max = the maximum value for the NPDS

<sup>20</sup> HSNS was transformed using the equation  $-\sqrt{MAX - HSNS}$ , where Max = the maximum value for the HSNS

large samples that minor deviations from normality can result in high kurtosis values (see Tabachnick & Fidell, 2007) the decision was made to proceed with the analysis, despite the leptokurtic distribution of the HSNS scale.

***Preliminary analyses of the DAR.*** Examination of the mean DAR score (see Table 8.2) indicates that the current sample scored toward the low end of the theoretical range. Comparison of the mean DAR value of the current sample with that reported in Study 1 (see Table 7.2) revealed that the current sample reported higher levels of anger than the sample in Study 1. A one sample *t*-test indicated that this difference was significant  $t(607) = 6.54, p < .001$ . Despite reporting higher levels of anger, than participants in Study 1, however, as was the case in Study 1, a one sample *t*-test revealed that the mean anger scores for the current sample were still significantly lower than those reported by Forbes et al. (2004)  $t(607) = -24.94, p < .001$ . Thus, the current anger scores of the current sample were significantly lower than those reported by a clinical sample.

***Univariate normality of the DAR.*** As can be seen in Table 8.2, the DAR showed some skewness. Comparison of the skewness statistic with the critical value of chi-square (Tabachnick & Fidell, 2007) revealed that the DAR was significantly positively skewed. Given the assumption of normality of distribution for the statistical tests to be employed, the DAR variable was transformed<sup>21</sup>. Transformation of the DAR was guided by suggestions in Tabachnick and Fidell (2007). After the transformation, skewness statistic for the transformed DAR variable was compared to the critical value of chi-square, and was found to be normally distributed.

Analysis of the kurtosis value of the DAR revealed that the scale showed a platykurtic distribution. Comparison of the kurtosis value with the critical value of chi-square revealed that this deviation was significant. Examination of a histogram of the revised DAR, however, indicated that the variable approximated normal distribution. Given this, and considering that with large samples that minor deviations from normality can result in high kurtosis values (see Tabachnick & Fidell, 2007) the decision was made to proceed with the analysis, despite the platykurtic distribution of the DAR scale.

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<sup>21</sup> DAR was transformed using equation  $\sqrt{DAR}$ . Consistent with Study 1 part A, the DAR variables were first recoded, so that the range of each value was 1 to 9, rather than 0 to 8.

**Preliminary analyses of the Depression, Anxiety and Stress Scale.** As evident in Table 8.2, mean scores for the Depression, Anxiety and Stress Scale were around the middle of the theoretical range and were similar to those reported in Study 1 (see Table 7.10). One sample *t*-tests revealed that the depression  $t(607) = 8.67, p < .001$ , anxiety  $t(607) = 6.30, p < .001$  and stress  $t(607) = 5.05, p < .001$  scores were all significantly higher in the current sample than in Study 1. Given that the current sample showed higher scores on all DASS scales, as was the case in Study 1, a series of one sample *t*-tests were conducted to compare the mean values of the current sample with those of clinical sample (Antony, Bieling, et al., 1998). Similar to Study 1, the current sample had significantly lower levels of anxiety  $t(607) = -17.25, p < .001$  and stress  $t(607) = -27.45, p < .001$  than Antony et al.'s clinical sample. Unlike participants in Study 1, however, who reported significantly lower levels of depression in comparison to Antony et al.'s clinical sample, the mean depression score of the current sample did not differ from that reported by Antony et al.  $t(607) = .09, p = .93$ . Thus, compared to a clinical sample, the current sample had similar levels of depression, but lower levels of anxiety and stress.

**Univariate normality of the Depression, Anxiety, Stress Scale.** Comparison of the skewness statistics for the DASS subscales displayed in Table 8.2 with the critical value of chi-square (Tabachnick & Fidell, 2007) indicated that the DASS Depression scale was significantly negatively skewed, and the DASS Anxiety scale significantly positively skewed. In contrast, the DASS Stress scale was not significantly skewed. Given the assumption of normality of distribution for the statistical tests to be employed the DASS Depression<sup>22</sup> and Anxiety<sup>23</sup> scales were transformed. Transformation was guided by suggestions in Tabachnick and Fidell (2007). After transformation, the DASS Depression and Anxiety scales were reassessed and found to be still significantly skewed. The transformed DASS Depression score was retransformed<sup>24</sup>. After transformation, the skewness statistics of the transformed DASS Depression scale was compared to the critical value of chi-square and was found to be not significantly

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<sup>22</sup> DASS Depression was transformed using the equation  $-\sqrt{MAX - DASS\ Depression}$ , where Max = the maximum value for the DASS Depression Subscale

<sup>23</sup> DASS Anxiety was transformed using equation  $\sqrt{DASS\ Anxiety}$ .

<sup>24</sup> DASS Depression was transformed using equation  $\sqrt{DASS\ Depression\ (Revised) + 4}$ .

skewed. The DASS Anxiety score was converted to a Z-score and retransformed<sup>25</sup>. The retransformed DASS Anxiety score was found to be not significantly skewed.

Analysis of the kurtosis value of the three DASS subscales revealed that all three scales showed platykurtic distributions. Comparison of the kurtosis values with the critical value of chi-square revealed that these deviations were significant. Examination of a histogram of the DASS Stress Scale and revised DASS Depression and Anxiety scales, however, indicated that the variables approximated normal distribution. Given this, and considering that with large samples that minor deviations from normality can result in high kurtosis values (see Tabachnick & Fidell, 2007) the decision was made to continue with the analysis, despite the platykurtic distribution of the DASS subscales.

***Preliminary analyses of the Inventory of Personality Organisation.***

Examination of the mean values of the IPO scales revealed that the mean scale scores were around the middle of the theoretical range. The scores were all higher than those reported in Study 1 (see Table 7.10). One sample *t*-tests revealed that the current sample was significantly higher on all IPO subscales (Primitive defences  $t(607) = 5.68, p < .001$ , Identity Diffusion  $t(607) = 6.38, p < .001$ , Reality Testing  $t(607) = 2.49, p < .001$ ).

Additionally, the mean values of the current sample were all significantly higher than those reported by Lenzenweger et al. (2001) (Primitive defences  $t(607) = 5.96, p < .001$ , Identity Diffusion  $t(607) = 20.33, p < .001$ , Reality Testing  $t(607) = 6.90, p < .001$ ).

***Univariate normality of the Inventory of Personality Organisation.***

Comparison of the skewness statistics for the IPO subscales displayed in Table 8.2 with the critical value of chi-square (Tabachnick & Fidell, 2007) revealed that the IPO Identity Diffusion and Primitive Defences subscales were not significantly skewed, but that the IPO Reality Testing subscale was significantly positively skewed. Given the assumption of normality of distribution for the statistical tests to be employed the IPO Reality Testing Subscale was transformed<sup>26</sup>. Transformation was guided by suggestions in Tabachnick and Fidell (2007). After transformation, the skewness statistic of the IPO Reality Testing Scale was reassessed, and was found to be not significantly skewed.

Comparison of the kurtosis values for the IPO subscales with the critical value of chi-square revealed that the IPO Primitive Defences subscales was not significantly kurtotic, and the Identity Diffusion and Reality Testing subscales both showed significant platykurtic distributions. Examination of histograms of the Identity Diffusion

<sup>25</sup> DASS Anxiety was transformed using equation  $\sqrt{DASS\ Anxiety\ (Z) + 2}$ .

<sup>26</sup> IPO Reality Testing was transformed using the equation  $\log(IPO\ Reality\ Testing)$

and Reality Testing subscales, however, indicated that the variables approximated normal distribution. Given this, and considering that with large samples that minor deviations from normality can result in high kurtosis values (see Tabachnick & Fidell, 2007) the decision was made to continue with the analysis, despite the platykurtic distribution of the IPO subscales.

***Preliminary analyses of the Taijin-Kyofusho Scale and subscales.*** The mean of the TKS (see Table 8.2) was at the lower end of the theoretical range. This is in contrast with the mean social anxiety scores which were at the upper end of the theoretical range. One sample *t*-tests revealed that the current TKS score was significantly higher than that reported by Kleinknecht, et al. (1997; Mean = 80.86)  $t(607) = 28.55, p < .001$  and Tarumi, et al. (2004; Mean = 109.1)  $t(607) = 11.24, p < .001$ . Although both samples were non-clinical, the sample employed by Tarumi were screened using two questions which were thought to indicate the potential for problematic TKS and were excluded if they met criteria (assessed using the Japanese version of the Mini International Version of the Neuropsychiatric Interview) for any other condition which might account for tension and nervousness in social situations (e.g., affective or psychotic disorders). Thus, the sample could be argued to be a sub-clinical sample, which indicates that although the mean value of the total TKS score is only at the lower end of the theoretical range, that the current participants have substantial impairments in domains relevant to TKS.

***Univariate normality of the Taijin-Kyofusho Scale and subscales.*** Comparison of the skewness statistics of the TKS scale with the critical value of chi-square (Tabachnick & Fidell, 2007) revealed that the TKS scale was not significantly skewed. Examination of the kurtosis value of the TKS scale indicated that it showed significant platykurtic distribution. Examination of histograms of the TKS, however, indicated that the variable approximated normal distribution. Given this, and considering that with large samples that minor deviations from normality can result in high kurtosis values (see Tabachnick & Fidell, 2007) the decision was made to proceed with the analysis, despite the platykurtic distribution of the TKS.

***Preliminary analyses of the Other Offending and Avoidance by Others Cognition scales.*** As can be seen in Table 8.2, the mean values for the Other Offending (OO) and Avoidance by Others (AO) scales were around the middle of the theoretical range. One sample *t*-tests comparing the mean OO and AO scores with those of a

sample of Japanese undergraduates reported by Sasaki and Tanno (2006)<sup>27</sup> revealed that the current sample reported stronger belief that they offended others  $t(607) = 24.80$ ,  $p < .001$  and were avoided by others  $t(607) = 25.41$ ,  $p < .001$  because of perceived defects.

***Univariate normality of the Other offending and Avoidance by others***

***Cognition scales*** Comparison of the skewness statistic with the critical value of chi-square revealed that the OO and AO were not significantly skewed. Examination of the kurtosis value of the OO and OA scales indicated that they both showed significant platykurtic distributions. Examination of histograms of the TKS, however, indicated that the variables approximated normal distribution. Given this, and considering that with large samples minor deviations from normality can result in high kurtosis values (see Tabachnick & Fidell, 2007), the decision was made to proceed with the analysis, despite the platykurtic distribution of the scales.

***Preliminary analyses of the Social Comparison Scale.*** Examination of the mean values of the SC displayed in Table 8.2 revealed that the current sample showed scores at the lower end of the theoretical range. Individuals in the current sample, therefore, had a tendency to view themselves as being low in social rank. Comparison of the total SC score with that reported in previous studies revealed that the current sample reported significantly lower perceived social rank than a sample of treatment seeking socially anxious individuals with co-morbid depression (Mean = 46.27; Weisman et al., 2011)  $t(607) = -6.63$ ,  $p < .001$ , and significantly higher from the SC scores reported in a more general clinical sample comprising individuals at a day hospital with diagnoses of anxiety or depression (Mean = 38.90; Allan & Gilbert, 1995)  $t(607) = 2.62$ ,  $p = .009$ . (e.g., McLeod et al., 2009),

***Univariate normality of the Social Comparison Scale.*** The skewness statistics (see Table 8.2) for the SC total, was found to be significant (Tabachnick & Fidell, 2007). Given the assumption of normality of distribution for the statistical tests to be employed the SC was transformed<sup>28</sup>. Transformation was guided by suggestions in Tabachnick and Fidell (2007). After transformation, the skewness statistic was found to

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<sup>27</sup> Although Sasaki and Tanno (2006) did not report overall mean scores for the OO and OA subscales, they did report mean scores for individual items, which was used to calculate the overall subscale means. OO Mean = 26. OA Mean = 22.2.

<sup>28</sup> SC was transformed using the equation  $\sqrt{SC}$ .

be only slightly higher than the critical value of chi-square. Examination of the kurtosis value for the SC scale revealed that the scale showed mesokurtic distribution.

**Overview of univariate normality.** After univariate outliers were removed and the variables transformed, all variables were normally distributed. On this basis, the data were deemed appropriate for the use of inferential multivariate statistics. Multivariate normality of the data, was assessed using Mahalanobis distance. Results indicated the presence of five multivariate outliers. These cases were deleted before proceeding with the remaining analyses.

**Overview of scale reliability.** Cronbach's alpha measure of internal consistency was calculated for all scales and subscales (see Table 8.2). With the exception of the HSNS and NPDS, all scales showed excellent reliability (all  $\alpha > .80$ ). Furthermore, although the HSNS was low, it was still at an acceptable level (see J. C. Nunnally, 1974). The NPDS on the other hand, was lower than would be desired ( $<.60$ ), however it is possible that this lower than desirable reliability was a result of the nature of the NPDS items (i.e., MMPI derived items). It was decided therefore, to retain the NPDS in the current analysis, but to interpret results of analyses employing the NPDS with caution.

#### **Age, gender, current diagnosis and current treatment**

**Age differences in the variables of interest.** Bivariate correlations were run to analyse age differences in the variables. Results revealed weak negative correlations between age and the SPS, SIAS, NPDS, HSNS, DASS Depression, DASS Anxiety, IPO Primitive Defences, IPO Identity Diffusion, IPO Reality Testing, TKS, Other-offending cognition and Other-avoiding cognitions ( $r$  values ranged from  $= -.21$  to  $-.13$ , all  $p$  values  $<.01$ ). Results also revealed a weak positive correlation between age and SC ( $r = .21$ ,  $p <.001$ ).

**Gender differences in the variables of interest.** To assess gender differences in the variables of interest a Multivariate Analysis of Variance (MANOVA) was run with gender entered as the IV and all scales entered as DVs (for a list of variables, see Table 8.3). The assumption of Homogeneity of Covariances was met, Box'  $M = 158.48$   $F(136, 735175.128) = 1.42$ ,  $p = .14$ . Levene's tests indicated that the data met the assumption of equality of group variances. Inspection of the intercorrelations among the dependant variables indicated a high correlation between Other-avoid cognitions and Other-offend cognitions, but not other problems with Multicollinearity. Given that there

was only one high correlation among the DVs, the decision was made to proceed with the MANOVA but to interpret the results for the OA and OO with caution.

Results indicated a significant gender difference Wilks'  $\Lambda = .93$ ,  $F(16, 586) = 2.61$ ,  $p < .05$ , partial  $\eta^2 = .07$ . Univariate results are presented in Table 8.3. Due to the number of IVs, a Bonferroni adjustment was applied to adjust for Type I error, with a significance level of  $p < .003$  used. As shown in Table 8.3, there were significant gender differences in both SPS, and DASS Anxiety, with women reporting significantly higher levels of SPS measured social anxiety, and anxiety. Despite the significant findings, however, the effect sizes were small. Therefore, all subsequent analyses were conducted without controlling for gender.

Table 8.3

*Gender Differences in the variables of interest*

Scale	Female <i>n</i> = 374 <i>M</i> ( <i>SD</i> )	Male <i>n</i> = 229 <i>M</i> ( <i>SD</i> )	<i>F</i> (1, 601)	<i>p</i> value	Partial $\eta^2$
SPS	42.35 (15.48)	38.34 (16.15)	9.21	<.001	0.02
SIAS <sup>1</sup>	-4.44 (1.47)	-4.45 (1.37)	0.00	.96	0.00
NPI <sup>1</sup>	2.81 (1.10)	3.07 (1.09)	7.64	.01	0.01
NPDS <sup>1</sup>	-2.41 (0.55)	-2.37 (0.57)	0.75	.39	0.00
HSNS <sup>1</sup>	-3.58 (0.80)	-3.64 (0.81)	0.77	.38	0.00
DAR <sup>1</sup>	5.16 (1.30)	5.10 (1.31)	0.22	.64	0.00
DASS Depression <sup>1</sup>	1.54 (0.38)	1.51 (0.37)	0.89	.35	0.00
DASS Anxiety <sup>1</sup>	1.41 (0.37)	1.30 (0.37)	12.27	<.001	0.02
DASS Stress	11.49 (4.88)	10.42 (4.91)	6.74	.01	0.01
IPO PD	43.11 (10.95)	41.58 (10.19)	2.92	.09	0.00
IPO ID	64.46 (14.27)	62.25 (14.47)	3.37	.07	0.01
IPO RT <sup>1</sup>	1.61 (0.14)	1.59 (0.13)	2.86	.09	0.00
TKS	129.49 (40.72)	123.68 (39.37)	2.97	.09	0.00
Other-Offend	40.85 (13.72)	38.08 (13.68)	5.80	.02	0.01
Other-Avoid	37.88 (14.24)	35.38 (14.17)	4.39	.04	0.01
SC <sup>1</sup>	6.13 (1.56)	6.37 (1.40)	3.62	.06	0.01

*Note.* DASS = Depression, Anxiety, Stress Scale. IPO = Inventory of Personality Organisation. IPO PD = Primitive Defences. IPO ID = Identity Diffusion. IPO RT = Reality Testing.

<sup>1</sup>Due to significantly skewed data, transformed versions of these variables were used

***The influence of a current diagnosis of social anxiety on the variables of interest.*** Bivariate correlations revealed that no significant correlation between Social Anxiety Diagnosis (within the past 2 years) and any of the variables of interest.

***The influence of currently receiving treatment for Social Anxiety on the variables of interest.*** Bivariate correlations revealed that no significant correlation between social anxiety treatment status and the variables of interest.

### **Replication of the social anxiety subgroups.**

***Cluster analysis of the data.*** To replicate Study 1, a cluster analysis was run on the data. As in Study 1, the SIAS, NPI, NPDS and HSNS were entered in to the analysis. Given that all variables were found to be non-normally distributed, the transformed versions of the variables were used. As the purpose of the current study was to investigate whether the results of Study 1 could be replicated, a five cluster solution was requested, using the Bayesian Information Criterion (BIC) to determine cluster membership<sup>29</sup>. The five clusters were found to comprise 59 (cluster one), 161 (cluster two), 89 (cluster three), 181 (cluster four) and 113 (cluster five) participants.

***Clarifying the nature of the groups.*** To determine if the groups identified in the current study were consistent with those identified in Study 1, a MANCOVA was conducted. The new social anxiety subgroups were entered as the IV, and the social anxiety (SPS, SIAS), narcissism (NPI, NPDS, HSNS) and anger (DAR) scales entered as DVs. Given that the weak significant correlation between age and the SPS, SIAS, NPDS and HSNS was found, age was entered into the analysis as a covariate. Examination of Box's Test of Equality of Covariance Matrices indicated that the data did not meet the assumption of Homogeneity of Covariances, Box'  $M = 225.32 F(84, 270542), p < .001$ . While this is undesirable, Box's  $M$  is highly sensitive to unequal group numbers. Due to the high number of dependant variables, the Bonferroni correction was applied, and a more conservative  $p$  value ( $p < .005$ ) was employed. The Levine's test of Equality of Error variance indicated violation of the assumption of homogeneity for the SIAS, NPI, HSNS and DAR. However, MANOVA is robust to minor violations of this assumption with large samples, and the use of a more conservative  $p$  value in the current analysis further prevents problems related to violation of this assumption. However, due to a number of assumptions not having been met, the Pillai's criterion is reported, rather than the more frequently used Wilk's

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<sup>29</sup> As of version 18, which was used for analysis of the current study, SPSS no longer produces a Table of BIC values.

Lambda, because the Pillai's criterion being more robust to violations of assumptions of homogeneity (Tabachnick & Fidell, 2007).

Initial results revealed that the new clusters differed significantly on social anxiety, narcissism and anger, Pillai's Trace = 1.46  $F(24, 2372) = 56.04, p < .0005, \eta^2 = .36$ . Age was not found to be a significant covariate Pillai's Trace = .03  $F(6, 590) = 2.76, p = .012, \eta^2 = .03$  and so it was removed from the analysis. A MANOVA was run to allow post-hoc tests to be performed.

Follow up univariate analyses showed significant group differences on all variables (all  $p$  values  $< .005$ ). Post hoc tests are displayed in Table 8.4. Although the transformed versions of the SIAS, NPI, NPDS, HSNS and DAR were used in the MANOVA analysis, statistics for the untransformed variables are presented in Table 8.4 to aid interpretability.

As can be seen in Table 8.4, four of the five groups (Groups 2, 3, 4 & 5) were associated with elevated scores on both social anxiety scales, and one with lower scores on both social anxiety scales (Group 1). Group 2 showed high scores on both social anxiety scales and the NPI and moderate scores on the HSNS and DAR, and low scores on the NPDS, and was consistent with the NSA group identified in Study 1. Group 3 was associated with high social anxiety and lower scores on all measures of narcissism and anger, and was consistent with the GSA group. Groups 4 and 5 were found to be similar to the covert narcissistic (CNSA & AnCNSA) groups identified in Study 1, with high social anxiety, and high NPDS and HSNS measured narcissism. Interestingly, in the current study, the angry covert group (AnCNSA) showed a moderate score on the NPI in addition to high scores on the NPDS and HSNS, indicating a greater level of narcissism in this group in the current sample. In addition, the CNSA group showed moderate scores on the DAR, indicating some anger, although still significantly less than the AnCNSA group. Thus, taken together, the current study identified five social anxiety subgroups which were equivalent to those identified in Study 1.

Table 8.4

*Analysis of group differences in social anxiety, narcissism and anger*

Scale	Cluster 1 (AnCNSA) <i>n</i> = 59	Cluster 2 (CNSA) <i>n</i> = 161	Cluster 3 (NSA) <i>n</i> = 89	Cluster 4 (GSA) <i>n</i> = 181	Cluster 5 (LSA) <i>n</i> = 113	<i>F</i> (4, 598)	$\eta^2$
SIAS						129.78*	.46
<i>M</i>	58.31 <sub>a</sub>	63.40 <sub>b</sub>	50.03 <sub>c</sub>	53.45 <sub>d</sub>	30.51 <sub>e</sub>		
<i>SD</i>	10.08	7.07	10.05	9.44	11.39		
Range	20 – 74	37 – 76	17 – 69	27 – 71	4 – 55		
SPS						66.98*	.31
<i>M</i>	46.58 <sub>a</sub>	49.77 <sub>a</sub>	36.07 <sub>b</sub>	37.28 <sub>b</sub>	20.75 <sub>c</sub>		
<i>SD</i>	13.24	13.19	13.17	13.67	12.62		
Range	15 – 72	8 – 77	7 – 70	10 – 70	2 – 54		
NPI						173.14*	.54
<i>M</i>	11.95 <sub>a</sub>	4.71 <sub>b</sub>	14.50 <sub>c</sub>	4.48 <sub>b</sub>	15.15 <sub>c</sub>		
<i>SD</i>	6.1	2.75	5.43	2.32	5.54		
Range	1 – 29	0 – 13	5 – 30	0 – 10	5 – 30		
NPDS						127.42*	.46
<i>M</i>	14.81 <sub>a</sub>	12.76 <sub>b</sub>	10.66 <sub>c</sub>	10.91 <sub>c</sub>	9.25 <sub>d</sub>		
<i>SD</i>	1.34	1.86	2.19	2	2.9		
Range	11 – 17	8 – 17	3 – 14	6 – 15	2 – 16		
HSNS						225.45*	.60
<i>M</i>	41.77 <sub>a</sub>	38.87 <sub>b</sub>	36.61 <sub>c</sub>	30.60 <sub>d</sub>	26.66 <sub>e</sub>		
<i>SD</i>	3.78	2.77	3.25	3.39	5.43		
Range	33 – 49	32 – 46	29 – 46	21 – 37	12 – 35		
DAR						21.64*	.13
<i>M</i>	28.41 <sub>a</sub>	23.72 <sub>b</sub>	19.18 <sub>c</sub>	14.88 <sub>d</sub>	13.39 <sub>d</sub>		
<i>SD</i>	14.89	13.44	11.56	11.24	9.42		
Range	0 – 56	0 – 56	0 – 49	0 – 47	0 – 50		

*Note.* Means not sharing a common subscript differ significantly.

SIAS = Social Interaction Anxiety Scale, NPI = Narcissistic Personality Inventory, NPDS = Narcissistic Personality Disorder Scale, HSNS = Hypersensitive Narcissism Scale. LSA = Low Social Anxiety Group, NSA = Narcissistic Social Anxiety Group, GSA = General Social Anxiety Group, CNSA = Covert Narcissistic Social Anxiety Group, AnCNSA = Angry Covert Narcissistic Social Anxiety Group. \* = significant at  $p < .0005$ .

**Comparison of groups identified in Study 1 and Study 2.** To compare the proportion of participants who were classified into each of the new social anxiety subgroups between Study 1 and the current study, a chi-square analysis was conducted. Results revealed that although the current study identified the same groups as those identified in Study 1, the proportion of participants classified into each of the groups differed significantly  $\chi^2(4) = 32.46, p < .001$ . Results of the analysis are displayed in Table 8.5.

Table 8.5

*Differences in proportions of respondents in the new social anxiety subgroups between Study 1 and Study 2*

	AnCNSA	CNSA	NSA	GSA	LSA
Study 1					
Actual	61	84	55	84	56
Predicted	63	96	78	62	41
Study 2					
Actual	113	181	161	89	59
Predicted	111	169	138	111	74

*Note.* LSA = Low Social Anxiety Group, GSA = General Social Anxiety Group, CNSA = Covert Narcissistic Social Anxiety Group, AnCNSA = Angry Covert Narcissistic Social Anxiety Group. NSA = Narcissistic Social Anxiety Group.

As shown in Table 8.5, compared with Study 1, there were fewer participants in the LSA and GSA groups and more participants in the NSA and CNSA groups than would have been expected. Proportions of participants in the AnCNSA group were similar between Study 1 and the current study. Thus, compared with Study 1, the current study had fewer non-socially anxious and general (non-narcissistic) socially anxious participants, and more narcissistic socially anxious participants. The largest discrepancy between observed and predicted values for the current study occurred for the narcissistic social anxiety group.

#### **Further exploration of the nature of the groups.**

**Group differences in demographic characteristics.** A series of chi-square analyses was performed to see if the social anxiety groups differed according to demographic characteristics.

*Relationship status.* A cross-tabs analysis was conducted to explore group differences in relationship status (see Table 8.6). Results revealed a subsequent group difference in relationship status  $\chi^2(20) = 48.01, p < .001$ . As shown in Table 8.6, people in the CNSA and AnCNSA groups were more likely to be currently single, and have never been in an intimate relationship. AnCNSA participants were also less likely to be currently in a relationship. NSA and LSA participants were both less likely to report being single, and having never been in an intimate relationship and were more likely to report being single, but having previously been in intimate relationships. More LSA individuals reported being separated than expected.

Table 8.6

*Group differences in relationship status.*

	AnCNSA <i>n</i> = 59	CNSA <i>n</i> = 161	NSA <i>n</i> = 89	GSA <i>n</i> = 181	LSA <i>n</i> = 113
Single (never)					
Actual	58	92	65	37	11
Predicted	49.3	78.9	70.2	38.8	25.7
Single (prev)					
Actual	25	29	39	17	19
Predicted	24.2	38.7	34.4	19.0	12.6
Current					
Actual	27	57	50	30	22
Predicted	34.9	55.8	49.7	27.5	18.2
Separated					
Actual	2	3	4	3	5
Predicted	3.2	5.1	4.5	2.5	1.7
Other					
Actual	1	0	0	2	2
Predicted	.9	1.5	1.3	.7	.5

*Note.* Single (never) = Single, never been in an intimate relationship, Single (prev) = Single, have been in intimate relationships, Current = Currently in an intimate relationship or married, Separated = Divorced or separated. LSA = Low Social Anxiety Group, GSA = General Social Anxiety Group, CNSA = Covert Narcissistic Social Anxiety Group, AnCNSA = Angry Covert Narcissistic Social Anxiety Group. NSA = Narcissistic Social Anxiety Group.

*Education status.* Cross-tabs analyses on education status revealed that the groups were significantly different in education status  $\chi^2(20) = 41.74, p < .05$  (see Table

8.7). There was a tendency for the CNSA and AnCNSA groups to report less education (e.g., more participants indicating secondary or incomplete secondary as their highest level of education and less participants indicating that they were past or current post-graduate students than would have been expected).

Table 8.7

*Group differences in education status.*

	AnCNSA <i>n</i> = 59	CNSA <i>n</i> = 161	NSA <i>n</i> = 89	GSA <i>n</i> = 181	LSA <i>n</i> = 113
Incomplete					
Secondary					
Actual	24	35	24	11	5
Predicted	18.6	29.7	26.4	14.6	9.7
Secondary					
Actual	27	44	33	17	9
Predicted	24.4	39.0	34.7	19.2	12.7
Tertiary – C					
Actual	41	70	49	33	24
Predicted	40.7	65.1	57.9	32.0	21.2
Tertiary – F					
Actual	14	20	27	11	8
Predicted	15.0	24.0	21.4	11.8	7.8
PostGrad - C					
Actual	4	7	16	8	4
Predicted	7.3	11.7	10.4	5.8	3.8
PostGrad - F					
Actual	3	5	10	9	9
Predicted	6.7	10.8	9.6	5.3	3.5

*Note.* Tertiary C = Current tertiary student. Tertiary F = Finished tertiary studies. PostGrad – C = Current PostGrad student. PostGrad F = Finished PostGrad studies. LSA = Low Social Anxiety Group, GSA = General Social Anxiety Group, CNSA = Covert Narcissistic Social Anxiety Group, AnCNSA = Angry Covert Narcissistic Social Anxiety Group. NSA = Narcissistic Social Anxiety Group.

1: Two NSA participants did not indicate their current education status.

***Group differences in psychological adjustment and personality organisation.***

A MANCOVA was conducted with the Social Anxiety subgroups entered as the IV, and DASS (Depression, Anxiety and Stress) and IPO (Primitive Defences, Identity

Diffusion and Reality Testing) subscales entered as DVs. Given that a weak significant correlation between age and DASS Depression and Anxiety subscales, and all of the IPO subscales was found, age was entered into the analysis as a covariate. Examination of Box's Test of Equality of Covariance Matrices indicated that the data met the assumption of Homogeneity of Covariances, Box'  $M = 88.03 F(84, 270542) = 1.02, p = .43$ . Levene's test of equality of error variance indicated that this assumption was met for all scales. Given the high number of DVs, the Bonferroni adjustment was applied, and significance was set at  $p < .008$ .

The results of MANOVA revealed that the new clusters differed significantly on psychological adjustment and personality organisation (Wilk's Lambda =  $.58 F(24, 2059.47) = 14.46, p < .008, \eta^2 = .13$ ). Age was not a significant covariate Wilk's Lambda =  $.99 F(6, 590) = 1.06, p = .386, \eta^2 = .01$  and so it was removed from the analysis. A MANOVA was run to allow post-hoc tests to be performed.

Follow up univariate analyses showed significant group differences on all variables (all  $p$  values  $< .008$ ). Post hoc tests are displayed in Table 8.8. Although the transformed versions of the DASS Depression and Anxiety subscales and the IPO Reality Testing scale were used in the MANOVA analysis, statistics for the untransformed variables are presented in Table 8.8 to aid interpretability.

The pattern of results for most variables was similar, with the LSA group evincing the lowest levels of adjustment across all IVs, the NSA and GSA groups moderate levels, and the two covert narcissistic groups (CNSA/AnCNSA) the lowest levels of adjustment (see Table 8.8). Although there were minor differences between the current results and those reported in Study 1, the general pattern of results remained consistent; namely, that the narcissistic social anxiety subgroups were found to be significantly more impaired than the non-narcissistic social anxiety (GSA) and the non-socially anxious (LSA) subgroups.

Table 8.8

*Analysis of group differences in psychological adjustment*

Scale	AnCNSA <i>n</i> = 59	CNSA <i>n</i> = 161	NSA <i>n</i> = 89	GSA <i>n</i> = 181	LSA <i>n</i> = 113	<i>F</i> (4, 598)	$\eta^2$
DASS D						54.69*	.27
<i>M</i>	15.85 <sub>c</sub>	15.95 <sub>c</sub>	11.53 <sub>b</sub>	11.52 <sub>b</sub>	7.42 <sub>a</sub>		
<i>SD</i>	4.28	4.21	5.12	4.80	5.13		
Range	5-21	3-21	0-21	2-20	0-20		
DASS A						23.70*	.14
<i>M</i>	10.65 <sub>c</sub>	10.36 <sub>c</sub>	7.25 <sub>b</sub>	6.69 <sub>b</sub>	5.32 <sub>a</sub>		
<i>SD</i>	4.89	5.21	4.58	4.85	4.99		
Range	1-20	0-21	0-21	0-18	0-18		
DASS S						34.77*	.19
<i>M</i>	13.87 <sub>e</sub>	12.48 <sub>d</sub>	10.37 <sub>b</sub>	8.54 <sub>c</sub>	7.27 <sub>a</sub>		
<i>SD</i>	4.36	4.42	4.38	4.46	4.80		
Range	0-21	0-21	1-21	0-19	0-18		
IPO ID						57.58*	.28
<i>M</i>	71.85 <sub>e</sub>	68.60 <sub>d</sub>	62.99 <sub>b</sub>	55.10 <sub>c</sub>	47.19 <sub>a</sub>		
<i>SD</i>	11.75	12.71	12.50	12.12	11.26		
Range	44-98	29-99	22-90	21-90	23-72		
IPO PD						53.12*	.26
<i>M</i>	48.96 <sub>d</sub>	45.87 <sub>d</sub>	42.19 <sub>b</sub>	35.03 <sub>c</sub>	32.19 <sub>a</sub>		
<i>SD</i>	9.54	9.63	9.03	8.62	8.52		
Range	27-71	21-69	19-64	19-59	16-65		
IPO RT						40.59*	.21
<i>M</i>	50.45 <sub>e</sub>	45.30 <sub>d</sub>	40.89 <sub>b</sub>	35.27 <sub>c</sub>	31.31 <sub>a</sub>		
<i>SD</i>	13.28	13.70	11.81	11.18	7.88		
Range	25-96	23-83	21-81	20-76	20-50		

*Note.* Means not sharing a common subscript differ significantly.

DASS = Depression, Anxiety, Stress Scale. DASS D = DASS Depression. DASS A = DASS Anxiety. DASS S = DASS Stress. IPO = Inventory of Personality Organisation. IPO ID = IPO Identity Diffusion. IPO PD = IPO Primitive Defences. IPO RT = IPO Reality Testing. LSA = Low Social Anxiety Group, NSA = Narcissistic Social Anxiety Group, GSA = General Social Anxiety Group, CNSA = Covert Narcissistic Social Anxiety Group, AnCNSA = Angry Covert Narcissistic Social Anxiety Group  
\* = significant at  $p < .0005$ .

**Group differences in social rank.** To explore group differences in social rank, a between subjects ANCOVA was conducted with the social anxiety subgroups entered as the IV and the SC entered as the DV. Given that a significant relationship was found

between age and SC, age was entered as a covariate. To meet the ANOVA requirement that the DV be normally distributed, the transformed version of the SC was used. Examination of Levene's Test of Equality of Error Variances indicated that this assumption was violated  $F(4, 596) = 4.14, p = .003$ . Although not desirable, it was decided to proceed with the analysis and adopt a more conservative  $p$  value of  $<.001$ , and interpret the results with caution. Results of the ANOVA revealed a significant difference in Social Rank between the social anxiety groups  $F(4, 595) = 39.94, p < .001$ , partial  $\eta^2 = .21$ . Age was a significant covariate  $F(1, 595) = 24.90, p < .001$ .

Descriptive statistics are displayed in Table 8.9. Although the transformed version of the SC was used in the ANCOVA, the untransformed version is presented in Table 8.9 to aid interpretability. Planned comparisons are displayed in Table 8.9

Table 8.9

*Analysis of group differences in social rank*

Scale	AnCNSA <i>n</i> = 59	CNSA <i>n</i> = 161	NSA <i>n</i> = 89	GSA <i>n</i> = 181	LSA <i>n</i> = 113
SC					
<i>M</i>	39.80 <sub>a</sub>	30.34 <sub>b</sub>	46.98 <sub>c</sub>	40.75 <sub>a</sub>	59.44 <sub>d</sub>
<i>SD</i>	19.56	17.13	14.86	20.50	15.23
Range	11 – 99	11 – 101	13 – 94	11 – 106	21 – 97

*Note.* To aid interpretability, untransformed, rather than transformed scores were included in the Table. SC = Social Comparison Scale. LSA = Low Social Anxiety Group, NSA = Narcissistic Social Anxiety Group, GSA = General Social Anxiety Group, CNSA = Covert Narcissistic Social Anxiety Group, AnCNSA = Angry Covert Narcissistic Social Anxiety Group. \* = significant at  $p < .0005$ .

As evident in Table 8.9, all but one of the planned comparisons was significant. The LSA group reported the highest social rank, followed by the NSA group. There was no significant difference between the AnCNSA and GSA groups. The CNSA group reported significantly lower perceived social rank than all of the other groups.

To further explore differences in perceived social rank between the social anxiety groups, a series of crosstabs analyses were performed, with the social anxiety subgroups and the forced choice responses to the SC. Chi-square statistics were calculated, and all analyses were found to be significant at a level of at least  $p = .001$ . Results are displayed in Table 8.10.

Table 8.10

*Forced choice social rank evaluations by social anxiety group*

		AnCNSA	CNSA	NSA	GSA	LSA
Inferior	A.	78 (69%)	172 (95%)	99 (61%)	77 (87%)	28 (47%)
	P.	85.1	136.3	121.2	67.0	44.4
Superior	A.	35 (31%)	9 (5%)	62 (39%)	12 (13%)	31 (53%)
	P.	27.9	44.7	39.8	22.0	14.6
Competent	A.	43 (38%)	37 (20%)	83 (52%)	23 (26%)	47 (80%)
	P.	43.7	69.9	62.2	34.4	22.8
Incompetent	A.	70 (62%)	144 (80%)	78 (48%)	66 (74%)	12 (20%)
	P.	69.3	111.1	98.8	54.6	36.2
Likeable	A.	26 (23%)	17 (9%)	61 (38%)	18 (20%)	43 (73%)
	P.	30.9	49.5	44.1	24.4	16.1
Unlikeable	A.	87 (77%)	164 (91%)	100 (62%)	71 (80%)	16 (27%)
	P.	82.1	131.5	116.9	64.6	42.9
Accepted	A.	3 (3%)	4 (2%)	26 (16%)	5 (6%)	22 (37%)
	P.	11.2	18.0	16.0	8.9	5.9
Left out	A.	110 (97%)	177 (98%)	135 (84%)	84 (94%)	37 (63%)
	P.	101.8	163.0	145.0	80.1	53.1
Different	A.	109 (96%)	180 (99%)	151 (94%)	83 (93%)	51 (86%)
	P.	107.6	172.3	153.3	84.7	56.2
Same	A.	4 (4%)	1 (1%)	10 (6%)	6 (7%)	8 (14%)
	P.	5.4	8.7	7.7	4.3	2.8
More talented	A.	48 (42%)	41 (23%)	91 (57%)	17 (19%)	43 (73%)
	P.	45.0	72.0	64.1	35.4	23.5
Untalented	A.	65 (58%)	140 (77%)	70 (43%)	72 (81%)	16 (27%)
	P.	68.0	109.0	96.9	53.6	35.5
Stronger	A.	20 (18%)	15 (8%)	58 (36%)	12 (13%)	36 (61%)
	P.	26.4	42.3	37.6	20.8	13.8
Weaker	A.	93 (82%)	166 (92%)	103 (64%)	77 (87%)	23 (39%)
	P.	86.6	138.7	123.4	68.2	45.2
More confident	A.	6 (5%)	0 (0%)	11 (7%)	0 (0%)	18 (31%)
	P.	6.6	10.5	9.3	5.2	3.4
Unconfident	A.	107 (95%)	181 (100%)	150 (93%)	89 (100%)	41 (69%)
	P.	106.4	170.5	151.7	83.8	55.6
More desirable	A.	10 (9%)	4 (2%)	25 (16%)	1 (1%)	21 (36%)
	P.	11.4	18.3	16.3	9.0	6.0
Undesirable	A.	103 (91%)	177 (98%)	136 (84%)	88 (99%)	38 (64%)
	P.	101.6	162.7	144.7	80.0	53.0
More attractive	A.	19 (17%)	10 (6%)	43 (27%)	7 (8%)	26 (44%)
	P.	19.7	31.5	28.0	15.5	10.3
Less attractive	A.	94 (83%)	171 (94%)	118 (73%)	82 (92%)	33 (56%)
	P.	93.3	149.5	133.0	73.5	48.7
Insider	A.	4 (4%)	4 (2%)	7 (4%)	3 (3%)	12 (20%)
	P.	5.6	9.0	8.0	4.4	2.9
Outsider	A.	109 (96%)	177 (98%)	154 (96%)	86 (97%)	47 (80%)
	P.	107.4	172.0	153.0	84.6	56.1

*Note.* A. = Actual scores. P. = Predicted scores. LSA = Low Social Anxiety Group, NSA = Narcissistic Social Anxiety Group, GSA = General Social Anxiety Group, CNSA = Covert Narcissistic Social Anxiety Group, AnCNSA = Angry Covert Narcissistic Social Anxiety Group

As shown in Table 8.10, more participants than would have been expected in the LSA and NSA groups selected the “high rank” option, with the reverse being true for the GSA, CNSA and AnCNSA groups. For the NSA group, this trend was not apparent for the comparisons of “Different” vs. “Same”, “More confident” vs. “unconfident”, and “Insider” vs. “Outsider”. Thus, although the NSA participants were more likely to indicate that they saw themselves as “Superior”, “Competent”, “Likeable”, “Accepted”, “More talented”, “Stronger”, “More desirable” and “More attractive”, they rated themselves as “Different”, “Less confident”, and saw themselves as “Outsiders” to a similar degree as did the remaining Social Anxiety groups. Thus, the tendency of NSA individuals to see themselves as higher in social rank than other socially anxious individuals was not universal and that they only judged themselves more positively in some areas.

**Group differences in TKS.** Differences in TKS, were examined with a between subjects ANCOVA with the social anxiety subgroups entered as the IV and the total TKS score entered as the DV. Given that a weak significant relationship was identified between age and TKS, age was entered as a covariate. Examination of Levene's Test of Equality of Error Variances indicated that this assumption was violated  $F(4, 596) = 2.54, p = .04$ . Although this is not desirable, it was decided to proceed with the analysis, but to adopt a more conservative  $p$  value of  $<.0001$ , and interpret the results for the TKS scale with caution. The results of the ANCOVA revealed a significant difference in TKS between the social anxiety groups  $F(4, 595) = 101.49, p < .0001$ , partial  $\eta^2 = .41$ . Age was not found to be a significant covariate  $F(1, 595) = 5.62, p = .02$  and so was removed from the analysis. An ANOVA was run to allow post-hoc tests to be performed.

Post-hoc analysis (see Table 8.11) revealed that the distribution of scores for the TKS was the same as that found for the SPS, with the LSA group evincing the lowest scores, and the two covert narcissistic groups (CNSA and AnCNSA) evincing the highest scores.

Table 8.11

*Analysis of group differences in TKS*

Scale	AnCNSA <i>n</i> = 59	CNSA <i>n</i> = 161	NSA <i>n</i> = 89	GSA <i>n</i> = 181	LSA <i>n</i> = 113
TKS					
<i>M</i>	146.02 <sub>a</sub>	152.23 <sub>a</sub>	114.06 <sub>b</sub>	118.39 <sub>b</sub>	65.20 <sub>c</sub>
<i>SD</i>	31.59	31.00	29.16	33.92	25.68
Range	66 – 201	77 – 209	39 – 177	48 – 214	33 – 165

*Note.* To aid interpretability, untransformed, rather than transformed scores were included in the Table. Means not sharing a common subscript differ significantly.

TKS = Taijin-Kyofusho. LSA = Low Social Anxiety Group, NSA = Narcissistic Social Anxiety Group, GSA = General Social Anxiety Group, CNSA = Covert Narcissistic Social Anxiety Group, AnCNSA = Angry Covert Narcissistic Social Anxiety Group. \* = significant at  $p < .0005$ .

**Group differences in other offend/other avoid.** Group differences in the two cognitions associated with TKS; other offending (OO) and other avoiding (OA) cognitions were explored with a MANCOVA. Social anxiety subgroups were entered as the IV, and OO and OA entered as DVs. Age was significantly, albeit weakly related to both OO and OA, and was entered as a covariate.

Examination of Box's Test of Equality of Covariance Matrices indicated that the data violated the assumption of Homogeneity of Covariances, Box'  $M = 42.64 F(12, 653189) = 3.52, p < .001$ . Levene's test of equality of error variance was also violated for both scales. While these results are undesirable, these tests are highly sensitive to unequal group numbers. Given that both assumptions were violated, it was decided to proceed with subsequent analysis, but to apply a more stringent  $p$  value of  $< .001$  and to use the Pillai's  $F$  given that it is more robust to violations of assumptions of homogeneity (Tabachnick & Fidell, 2007).

The MANCOVA revealed a significant group difference across the social anxiety groups on self-reported TKS cognitions Pillai's Trace = .28  $F(8, 1190) = 23.79, p < .0001, \eta^2 = .14$ . Age was not a significant covariate Pillai's Trace = .01  $F(2, 594) = 3.90, p = .02, \eta^2 = .01$  and so it was removed from the analysis. A MANOVA was run to allow post-hoc tests to be performed.

Follow up univariate analyses showed significant group differences on both variables (both  $p$  values  $< .001$ ). Post hoc tests are displayed in Table 8.12. As displayed in Table 8.12, the pattern of results for both other offending and other avoiding cognitions was the same as that identified for the SPS and TKS scales, with the LSA

group significantly lower on both types of cognition, and the two covert narcissistic socially anxious groups significantly higher.

Table 8.12

*Analysis of group differences in Other-offending and Other-avoiding cognitions*

Scale	AnCNSA <i>n</i> = 59	CNSA <i>n</i> = 161	NSA <i>n</i> = 89	GSA <i>n</i> = 181	LSA <i>n</i> = 113	<i>F</i> (4, 598)	$\eta^2$
OO						55.61	.27
<i>M</i>	46.27 <sub>c</sub>	46.08 <sub>c</sub>	36.11 <sub>b</sub>	36.34 <sub>b</sub>	23.46 <sub>a</sub>		
<i>SD</i>	11.75	12.62	11.96	11.37	8.94		
Range	17 – 70	14 – 70	14 – 63	14 – 64	14 – 51		
OA						51.90	.26
<i>M</i>	42.77 <sub>c</sub>	44.12 <sub>c</sub>	32.49 <sub>b</sub>	33.09 <sub>b</sub>	21.61 <sub>a</sub>		
<i>SD</i>	13.07	13.55	11.85	11.56	8.68		
Range	17 – 67	14 – 70	14 – 60	14 – 59	14 – 52		

*Note.* Means not sharing a common subscript differ significantly.

OO = Other-offending cognitions, OA = Other-avoiding cognitions. LSA = Low Social Anxiety Group, NSA = Narcissistic Social Anxiety Group, GSA = General Social Anxiety Group, CNSA = Covert Narcissistic Social Anxiety Group, AnCNSA = Angry Covert Narcissistic Social Anxiety Group.\* = significant at  $p < .0005$ .

## Discussion of the Results of Study 2

The current study sought to replicate and extend on the results of Study 1. As hypothesised, the same five subgroups identified in Study 1 were again identified in the current study. In relation to hypothesised group differences, there was mixed support. The following sections review each of the hypotheses in detail.

**Re-analysis of social anxiety subgroups.** As hypothesised, consistent with Study 1, five social anxiety subgroups were identified which were similar to the subgroups identified in Study 1. Despite identifying similar subgroups, analysis of differences in the proportion of participants classified in each group between Study 1 and the current study indicated some differences in proportion of individuals in each group. Specifically, there were significantly fewer non-socially anxious and non-narcissistic socially anxious participants and significantly more narcissistic socially anxious participants in the current study than would have been expected based on distributions identified in Study 1.

Consequently, it seems that those in Study 2 represent a more severe group in terms of maladjustment. Supporting this conclusion is that those in Study 2 had

significantly higher scores than Brown et al.'s (1997) clinical sample on both the SPS and SIAS, whereas Study 1 participants only scored higher on the SIAS. Thus, the Study 2 sample had greater social anxiety related impairment than Study 1 sample.

Additionally, although the profiles of the groups in relation to social anxiety and narcissism scores were similar to what was found in Study 1, there were nevertheless differences in the groups between the two studies. There was less difference in NPI scores between the groups in the current sample, with the NPI score of the narcissistic social anxiety group lower than what was found in Study 1, resulting in no significant difference in NPI score between the narcissistic social anxiety and low social anxiety groups. Additionally, although the NPI score of the angry covert group in the current study was still low, it was higher than that identified in Study 1, suggesting that the angry covert participants in the current study were slightly more narcissistic than those identified in Study 1.

While the general pattern of scores for the NPDS was similar, the non-narcissistic group had a slightly higher score than was found in Study 1, and no longer significantly differed from the narcissistic group on this measure. Nevertheless, the GSA group was still consistent with a non-narcissistic social anxiety subgroup, at least relative to the three identified narcissistic social anxiety subgroups (NSA, AnCNSA and CNSA) owing to low scores on the HSNS and NPI. Notably, the reliability of the NPDS was lower in the current study, and therefore as discussed, results of the NPDS should be interpreted with caution.

#### **Psychological maladjustment and personality organisation.**

*Group differences in psychological maladjustment.* The hypothesis concerning group differences in psychological maladjustment was only partially supported. Across all DASS scales, both covert narcissistic social anxiety groups (AnCNSA and CNSA) were higher than the non-narcissistic social anxiety group (GSA). Thus, contrary to the hypothesis that there would be no difference between the CNSA and GSA groups on stress, the CNSA group was found to be more impaired.

As expected, the narcissistic social anxiety group was significantly higher than the non-narcissistic group on stress and did not differ significantly from it in depression. Contrary to expectation, however, there was also no significant difference between the narcissistic and non-narcissistic groups on anxiety. It should be noted, however, that both groups reported high levels of anxiety.

***Group differences in personality organisation.*** As hypothesised, the narcissistic socially anxious subgroups (NSA, AnCNSA and CNSA) were significantly higher than the non-narcissistic social anxiety subgroup (GSA) on all IPO scales. This is broadly consistent with the results of Study 1, and indicates that the IPO provides a better method of differentiating narcissistic and non-narcissistic socially anxious individuals than does the DASS. This is not unexpected considering Kernberg's suggestion that narcissists have similar psychostructural defects to borderline individuals (albeit less severe).

While the differences between the narcissistic and non-narcissistic groups was consistent with Study 1, the difference between the three narcissistic subgroups was not, with the narcissistic group not more impaired than the covert narcissistic social anxiety group in Study 2.

***Summary of psychological adjustment and personality organisation.*** Although the trend identified in Study 1 for the narcissistic social anxiety subgroups to be more impaired was found in the current study, examination of differences between the narcissistic social anxiety subgroups revealed greater consistency in the current study. The current results indicated that the covert narcissistic subgroups showed greater maladjustment than all of the other groups on all indices. Unlike in Study 1, there was no measure on which the NSA group was found to be more maladjusted than the other groups.

Additionally, whereas in Study 1, the angry covert group was consistently more impaired than the covert group, this was not always the case in the current study and there was no difference between the two groups on depression, anxiety or IPO measured primitive defences. Thus, in the current study, the two covert narcissistic subgroups appeared to be less distinct than they were in Study 1 (although it should be noted that there were still significant differences between the groups on Stress and IPO measured identity diffusion and reality testing). Interestingly, in opposition to the trend expected, the covert group reported higher SIAS scores than the angry covert group. One possible explanation lies in the level of anger reported by the three subgroups. Relative to Study 1, the covert group in Study 2 reported more anger and the narcissistic group (NSA) less anger. Thus, finding that there were no indices on which the NSA group was more severe, and finding that the covert narcissistic group was more maladjusted than they had been in Study 1 might be a function of different levels of anger. This further reinforces the argument that anger, in addition to narcissism plays an important role in

determining the level of impairment of socially anxious individuals and supports the use of anger as a method of differentiating the two covert narcissistic subgroups.

Although there were some differences in the pattern of results between the current study and Study 1, it should be noted that the overall trend of the results, namely that the narcissistic social anxiety subgroups are more impaired than the non-narcissistic socially anxious subgroup, and that the angry covert narcissistic subgroup (AnCNSA) is the most impaired of the narcissistic subgroups was confirmed in the current study. An explanation for the few discrepancies identified might lie in the severity of the current sample. It is possible that all subgroups were more maladjusted and that ceiling effects meant that differences between the groups became less pronounced.

#### **Group differences in TKS and TKS cognitions.**

As hypothesised, the social anxiety subgroups showed significantly higher TKS, other offend, and other avoid cognition scores than the non-socially anxious group (LSA). This is consistent with the pattern of group differences for social anxiety across the current study and Study 1.

Results revealed that the pattern of group differences was the same for all three TKS related variables, with the low social anxiety group significantly lower than all other groups, and the two covert groups (CNSA/AnCNSA) significantly higher. There was no significant difference between the narcissistic (NSA) and non-narcissistic (GSA) groups. The pattern of results was the same as that identified for the SPS. One interpretation of this is that there is little distinction between social anxiety symptoms and TKS symptoms and that the two overlap. Although as noted in Chapter 3, preliminary research examining TKS in a Western country found that only a small number of cases met diagnostic criteria (e.g., Jinkwan et al., 2008) the present results support that suggestion in Chapter 3 that the diagnostic thresholds employed in that study were too restrictive, and that less restrictive thresholds would have revealed a more substantial overlap.

More broadly, given that the current sample was demographically heterogeneous, it supports the argument presented in Chapter 4 that it would be beneficial for the DSM to incorporate specific criteria related to TKS and to focus on both belief that others are offended up aspects of the individual as well as the belief that the individual is avoided because of an aspect of themselves. Importantly, the present results indicate that TKS related concerns; at least those assessed by the current scale are not culture bound.

A possible explanation for the higher TKS scores in the covert narcissistic subgroups relative to the other social anxiety subgroups lies in the level of shame reported by the covert narcissistic groups in Study 1. With the exception of behavioural shame, the two covert narcissistic subgroups reported significantly higher shame than the narcissistic and general subgroups. Therefore, the higher degree to which the two covert subgroups are concerned about offending others might be tied to their greater shame proneness. More broadly, the shame proneness and propensity of the covert groups to be concerned with offending others represents compelling evidence that the two covert narcissistic groups represent unique subtypes of socially anxious individuals who are more impaired than the DSM-5 (APA, 2013) profile of SAD would suggest. The two subgroups are also very closely aligned with Kohut's horizontal split narcissists, with these individuals having less conscious access to the grandiose self, with a tendency to distance themselves from others.

Despite the interesting results however, it should be borne in mind that the current study only assessed more mild forms of TKS, namely fear of offending others and fear of being avoided by others. As noted in Chapter 4, at the more extreme end of the continuum, individuals with TKS have been noted to report beliefs that a part of themselves could harm another person, with some of the individuals acknowledging that this fear is unreasonable and some being convinced that this is likely to happen. Thus, it is possible to argue that even though the pattern of results across the new social anxiety subgroups was the same for social anxiety and TKS, that if fear of harming others and conviction of this belief had been measured, the pattern of results might have been distinct from that identified. Moreover, it could be argued that while the less severe forms of TKS are similar to social anxiety that the difference between the two disorders lies primarily in the more severe manifestations of TKS, which could be argued are distinct to social anxiety. Currently, there is no known scale measuring these more extreme aspects of TKS, so it is not yet possible to answer this question definitively.

A second possible explanation for the current result is that the relatively severe impairment in the current sample meant that ceiling effects resulted in relatively high scores on both social anxiety and TKS. It is possible that with a less severe sample, that the difference between the social anxiety and TKS scales might have been more pronounced.

**Group differences in social rank.** The hypothesis that the narcissistic social anxiety subgroup (NSA) would show higher social rank than the covert narcissistic and

non-narcissistic social anxiety subgroups (GSA) was supported, with the NSA group reporting significantly higher social rank. The hypothesis that the narcissistic socially anxious subgroups would not significantly differ in perceived social rank from the non-socially anxious narcissistic group (LSA) was not supported, with the LSA group reporting significantly higher social rank than all of the other groups. Thus, as expected, rather than being related to narcissism generally, higher social rank was only associated with NPI measured overt narcissism.

Group differences in social rank identified in the current study are important in that they reinforce the fact that the new social anxiety subgroups cannot be subsumed within a severity based model and are not better represented dimensionally. Consistent with group differences on indices of maladjustment described earlier, the low social anxiety group showed higher self-reported social rank than any of the social anxiety subgroups. However the pattern of differences between the social anxiety subgroups was not consistent with the pattern of differences identified on the other indices of maladjustment.

Whereas the angry covert group was more impaired than the covert group on DASS stress and IPO measured identity diffusion and reality testing, unexpectedly, the angry covert group reported higher social rank than the covert group. Thus, despite evincing more severe maladjustment on a number of indices, the angry covert group reported seeing themselves as higher in social rank. A possible explanation for this is that although the angry covert group was more impaired, they did report significantly higher NPI scores than the covert group, which would further support the argument that NPI measured narcissism is important in relation to social rank. Also interesting, is that whereas on all indices of maladjustment, the angry covert group was consistently significantly higher than the non-narcissistic social anxiety group, there was no significant difference between these two groups on self-reported social rank. While the NPI explanation holds for the angry covert group, it should be noted that the general social anxiety group had similar social rank to the angry covert group, but significantly lower NPI measured narcissism. A possible explanation for this is that covert narcissism, on its own is associated with lower social rank but that as NPI measured narcissism increases, the impact of covert narcissism on social rank reduces. However, it is not possible to test this proposition with cross-sectional data.

Results also revealed interesting differences between the non-narcissistic (GSA) and narcissistic (NSA) social anxiety group groups. Although as noted earlier, the NSA

group showed more severe maladjustment on a number of indices than the GSA group (e.g., stress), the NSA group reported significantly higher self-reported social rank. Thus, consistent with the angry covert group, the NSA group reported high levels of social anxiety, showed high levels of maladjustment, but reported higher perceived social rank.

Taken together, the finding that general impairment was not an indicator of perceived social rank further reinforces the usefulness of distinguishing between the three narcissistic social anxiety groups, and importantly, serves to illustrate that there are meaningful differences between the higher-maladjustment/high social rank angry covert group and the lower maladjustment/lower social rank covert group.

*Comparison of the LSA and NSA groups on forced choice SC items.* Analysis of the forced choice responses for social comparison items of the two groups with higher self-reported social rank (LSA and NSA) yields interesting information on the nature of the high social rank of the narcissistic social anxiety group (NSA) relative to the non-socially anxious narcissistic group (LSA). In the non-socially anxious high rank subgroup (LSA), over 50% of people chose the high social rank option for five items, reporting that relative to others they felt superior, more competent, more likeable, more talented and stronger. In comparison, in the narcissistic social anxiety group with high social rank, over 50% of people chose the high rank option for only two items, reporting that relative to others, they felt more competent and more talented.

Consideration of the high social rank options for SC items endorsed by both groups reveals interesting differences. For the low social anxiety group, there was high endorsement of one SC item tapping into the individuals perception of how others see them (e.g., “more likeable”) and high endorsement of a number of items measuring the individuals perception of their own competence/efficacy relative to others (e.g., “more competent”). Both of the high social rank options with high endorsement in the narcissistic social anxiety group tend to fall into the latter category and represent competence/efficacy items. Thus, it could be argued that the high social rank of the narcissistic social anxiety group was more related to perceived superiority of the self over others across a broad range of domains (e.g., the terms “more competent”, “more talented” can be applied fairly widely) rather than a perception of the self as being socially accepted and of the self and “fitting” socially.

This interpretation is further supported by examining the two low social rank options which received the highest endorsement (over 90%) by the narcissistic social

anxiety group; namely “outsider” and “different”. These items seem to directly refer to perceived social “fit” and indicate that the majority of the individuals in the narcissistic social anxiety group see themselves as distinct from others. Thus, within the narcissistic social anxiety group it could be argued that there was a tendency for individuals to see themselves simultaneously as isolated and distinct from, but “better” than others.

***Comparison of the social anxiety groups on specific SC items.*** The major difference between the social anxiety groups in forced choice SC items lay in the tendency for endorsement of the high social rank option to be higher in the NSA group than all of the other social anxiety groups. Interestingly, whereas the selections of the non-narcissistic (GSA) and covert (CNSA) groups were generally consistent (e.g., a high percentage of participants in both groups choose the low rank alternative for almost all items), in the angry covert group a higher number of participants choose the high rank option for some items, although this number was always lower than the number of participants who chose the same option in the narcissistic group. Thus, in terms of perceived social rank, the angry covert group seemed to represent an intermediate group, located between the narcissistic group with high perceived social rank and the covert and non-narcissistic groups with low perceived social rank.

An analysis of similarities between the groups on responses to forced choice items revealed that the greatest degree of consistency between all four social anxiety subgroups was found for the items “different” and “outsider”, in which greater than 90% of participants in all social anxiety groups selected the low rank option. Interestingly, these items appear to relate directly to how the individual sees themselves in relation to other people or the perceived degree of social “fit” with others. Given the consistency among the social anxiety groups, it is possible that these are the social rank items most relevant to social anxiety.

Overall, among all socially anxious groups there was a tendency for individuals to perceive themselves as distinct or distant from others (e.g., “different” and “outsider”), but that the groups differed in terms of broader competency/efficacy related comparisons between the self and others with some socially anxious individuals (e.g., GSA and CNSA) making negative comparisons with between the self and others (e.g., more likely to report seeing themselves as “less talented” and “less competent” compared to others) and some socially anxious individuals (e.g., NSA and AnCNSA) making positive comparisons between the self and others (e.g., more likely to see themselves as “more talented” and “more competent” compared to others). As would be

expected, the social anxiety group with the highest endorsement of competency/efficacy items was the NSA group, which, with higher levels of overt narcissism would be expected to have relatively greater access to the grandiose self (see Chapter 4).

The current chapter reported on the second study of the current thesis. The following chapter provides a broad overview of the current thesis, and discusses the theoretical and applied implications of the results of study 1 and 2.

## Chapter 9: General Discussion

The key contribution of this thesis was the identification via cluster analysis of new social anxiety subgroups. The subgroups were found to be distinct from those identified in previous cluster analytic studies. Support for the new subgroups was strengthened, with similar subgroups being identified in two distinct samples. Of the subgroups identified, four were classified as socially anxious and one was classified as non-socially anxious. Of the four socially anxious subgroups, three were associated with elevations on multiple narcissism scales. One of the narcissistic social anxiety subgroups was associated with elevations on overt and covert narcissism scales and two were associated with elevations on covert, but not overt narcissism scales. The two covert narcissistic social anxiety subgroups were differentiated on the basis of anger, with angry covert narcissistic and non-angry covert narcissistic social anxiety subgroups identified.

The new subgroups were found to differ on a number of characteristics. The narcissistic social anxiety subgroups were more impaired on most indices than the non-narcissistic social anxiety subgroup. However, the pattern of group differences between the narcissistic social anxiety subgroups varied, indicating that the new subgroups could not be subsumed within a symptom severity model of social anxiety. The following sections discuss the significance of the current thesis and the theoretical and applied implications of the results. Following this, limitations and directions for future research are presented.

### **Significance of the current results.**

The current research is important for several reasons. First, this thesis identified unique narcissistic socially anxious subgroups and demonstrated differences between the three narcissistic social anxiety subgroups. The narcissistic social anxiety subgroup, with high social rank importantly demonstrated that Gilbert and Trower's (1990) argument that some dominant individuals might be high in social anxiety is correct. The high social rank of this group, however, did not indicate this group of individuals was better functioning. Indeed, relative to the general (non-narcissistic) group with lower perceived social rank, the narcissistic group was more maladjusted on many indices, reporting greater stress, worse personality organisation, and greater difficulty identifying emotions. This indicates that while superficially high social rank might be seen to confer a psychological advantage (in terms of positive self views), in the case of the narcissistic social anxiety group, this did not translate into better functioning.

Rather, these individuals seem to be highly consistent with Kohut's vertical split narcissistic individuals. They seem to have better access to the grandiose self, shown through both the types of NPI items they endorse and their higher perceived social rank, but this grandiose sense of self is fragile, as shown by elevated shame concerning personal self-efficacy (behavioural shame). This suggests that while these individuals report higher social rank than other social anxiety groups, this must be considered alongside their intense shame at the thought of others seeing them as lacking in personal efficacy.

Examining the demographic variables further complicates the picture, with results showing that, relative to the other social anxiety groups, the narcissistic social anxiety group were somewhat better functioning. Specifically, they were more likely to be in a current relationship, and less likely to have never been in a relationship than the covert and general social anxiety groups. They were also over-represented in participants reporting having undertaken post-graduate study. These patterns are also evident in the low social anxiety group. Thus, on some indices, specifically social rank, educational attainment, and relationship status, the narcissistic social anxiety group look as well functioning as the low social anxiety group. However, on other indices, specifically, social anxiety, personality organisation and psychological distress, the narcissistic social anxiety group is impaired. Therefore, the group cannot easily be considered to be either high functioning or low functioning social anxious individuals.

Therefore, the narcissistic social anxiety subgroup represents a highly complex group of individuals, who, despite being somewhat more successful (e.g., academically and interpersonally) show high maladjustment. Clinically, the contradictory characteristics of these individuals, namely, high social rank and high social anxiety and worse personality organisation, is not well represented in either clinical portraits of social anxiety (i.e., APA, 2013) or in many contemporary models of social anxiety.

While the narcissistic social anxiety group was demonstrated to be significantly impaired, on many of the indices, the two covert narcissistic groups showed significantly worse functioning. In particular, the identification of the angry covert narcissistic subgroup represents an important finding of this thesis. Specially, the profile of the angry covert subgroup, with impaired functioning on all indices, suggests that they represent a subgroup of social anxious individuals that is severely impaired. Yet beyond simply focussing on impairment broadly, the importance of this subgroup is enhanced when their profile is examined in more detail. Specifically, in addition to high

social anxiety, these individuals scored high on TKS related anxieties and cognitions, and shame. They also showed the worst impairments in relation to identifying and defining emotion. Thus, the angry covert group represents a group of individuals who have intense shame, fear of offending others, and difficulties with identifying and defining their emotions. If one considers this alongside the fact that they showed high impairment in personality organisation, it is possible that this subgroup represents a uniquely maladjusted subgroup of socially anxious individuals.

With the strong emphasis on fear of offending others, and the shame proneness of the angry covert individuals, it is possible that their experience of social anxiety might be distinct to that of other socially anxious individuals. Moreover, the importance of fear of offending others in this subgroup provides justification for the inclusion of fear of offending others in the revised DSM-5 SAD criteria (APA, 2013). It does, however, suggest that the descriptive text of DSM-5 noting that fear of offending others may be the predominant fear among individuals from cultures with strong collectivist backgrounds is unnecessary, given that in the current sample of individuals who, largely were not from cultures with strong collectivist backgrounds, there was a very strong emphasis on fear of offending others.

Yet, there are some interesting contradictory aspects to the angry covert subgroup which paints an increasingly complex picture of these individuals. On the one hand, their low scores on the overt narcissism measures, high scores on the covert narcissism measures, high shame, and higher psychological distress (e.g., anxiety and depression) suggests that they are quite similar to Kohut's (1971) horizontal split narcissists, that is, narcissistic individuals whose grandiose self is largely repressed and inaccessible. Kohut's suggestion that these patients are emotionally cold is also consistent with the higher alexithymia scores for these individuals identified in Study 1, and suggests that underlying this emotional coldness is a lack of ability to process emotions (i.e., difficulty identifying and defining emotions). Certainly the elevated depression and shame of this group is consistent with Kohut's description of symptoms of narcissistic deficiency. However, in contradiction to the idea that the grandiose self of these individuals is inaccessible, while they reported lower social rank than the more dominant narcissistic group, they reported higher social rank than the covert narcissistic group. This suggests that while their grandiose self is largely inaccessible, it is not entirely inaccessible. On a broader theoretical level, the perceived social rank of these individuals does provide evidence of some sense of grandiosity.

From a developmental perspective, the covert narcissistic subgroups might represent individuals who experienced less than optimal developmental origins. Indeed, in particular, the angry covert group are highly consistent with individuals Kohut described as having experienced mirroring failures, in which the parents did not respond to the child's narcissistic displays, resulting in repression of the grandiose self, and the experience of shame in relation to narcissistic strivings. This less optimal development might explain some of the demographic differences identified. Specifically, relative to the other groups, the two covert narcissistic social anxiety groups were found to be more likely to be single, and less likely to be in a current relationship. These poorer outcomes were also reflected in educational attainment, with both covert narcissistic groups overrepresented among individuals whose highest level of educational achievement was secondary, and underrepresented among participants undertaking postgraduate study. Therefore, taken together, the covert groups, but particularly the angry covert group represents a highly shame prone group of individuals who have significant concern around offending others, and being avoided by others.

The identification of these narcissistic social anxiety subtypes has implications for treatment. In particular, the covert narcissistic subgroups, with their shame proneness, concern about offending others, difficulties with emotion regulation and high levels of psychological distress (e.g., depression and anxiety), present a complex clinical picture. While a full discussion of treatment is beyond the scope of this thesis, the findings suggest that optimal treatment of this severely maladjusted group of individuals would need to take into account their narcissistic wounds (e.g., see Kohut, 1971) and difficulties with emotional regulation (e.g., addressing alexithymia). Given the high concern with offending others, which is a concept better developed in Eastern literatures, it is possible that an analysis of differences in treatment approaches between Western and Eastern clinicians might result in useful additions to Western treatment models which might allow for more effective treatment of the fear of offending others which was demonstrated to be highly problematic in the covert groups.

Taken together, this thesis is significant for having identified important new social anxiety groups. The following sections compare the subgroups identified with social anxiety subgroups identified by previous studies. Following this, the broader theoretical implications of the current thesis are discussed.

### **Comparison of the Results with the Studies of Sandler and Colleagues**

Consistent with Sandler and Colleagues (Dixon et al., 1957a; Sandler et al., 1958), who found narcissistic characteristics in some, but not all of their four social anxiety groups, the current thesis found that while most socially anxious individuals showed narcissistic characteristics, not all did. The following sections compare the narcissistic social anxiety subtypes identified in the current thesis with those subgroups identified by Sandler et al..

**Comparison with social anxiety type C.** Sandler et al. (1958) described the social anxiety type C individual as someone who believes others look critically upon them, who has excessive hostility, narcissistic characteristics (e.g., believes that other's do not appreciate what an important person they are), and are hypersensitive, with a tendency for phobic anxieties. Considering this, the angry covert group identified in the current research shares similarities with the type C individual. Consistent with the type C individuals, the angry covert group was characterised by high anger, and high levels of narcissism, with high scores on both the NPDS and HSNS narcissism scales.

**Comparison with social anxiety type D.** In contrast to type C, none of the groups identified in the current research exactly matched Sandler et al.'s (1958) social anxiety type D. Sandler et al. described type D individuals as being characterised by bitterness, a tendency toward depression, with contrasting grandiose and persecutory fantasies. Focusing on depression, both the covert and angry covert groups were characterised by elevated depression. While the current research did not measure irrationality, the IPO Reality Testing subscale does tap into disorganisation of thought and ideas, and more extreme variants of irrationality (e.g., "I believe that things will happen simply by thinking about them"). Examining group differences on this variable indicates that the narcissistic and angry covert groups had significantly higher scores than the other groups in Study 1. However, this was not the case in Study 2, with both covert groups showing higher scores than the narcissistic group.

Thus, the current research does broadly support the findings of Sandler and colleagues (1958) that narcissistic characteristics are present in many socially anxious individuals, but provide a more comprehensive understanding of the different types (e.g., overt/covert, angry/non-angry) of narcissistic social anxious individuals. Comparison of the results with the Kachin, et al. and Kashdan and colleagues. As noted in Chapter 3, both Kachin et al. (2001) and Kashdan and colleagues (Kashdan et al., 2008; Kashdan & Hofmann, 2008) identified two distinct social anxiety

subgroups. In addition to finding individuals who met the typical DSM (APA, 2013) picture of social anxiety (e.g., friendly-submissive/avoidance motivated), both Kachin et al. and Kashdan and colleagues described a second subgroup of socially anxious individuals who were characterised by anger, aggression and hostility (e.g., hostile-dominant/approach-motivated).

There are two possible methods of comparing the subgroups identified in this thesis to those identified by Kachin et al. (2001) and Kashdan and colleagues (Kashdan et al., 2008; Kashdan & Hofmann, 2008). First, it is possible to suggest that the social anxiety groups with elevated anger scores most closely correspond to the hostile-dominant/approach-motivated groups, whereas the non-angry groups correspond more closely to the friendly-submissive/avoidance-motivated groups. This interpretation is supported by a number of factors. First, the elevated anger scores of these subgroups is consistent with descriptions of the hostile-dominant and approach-motivated groups. Second, in Study two, level of anger seemed to be tied with social rank in the narcissistic subgroups, which is consistent with social dominance.

A second possible interpretation is that the narcissistic social anxiety group (NSA), but not the angry covert (AnCNSA) group is reflective of the hostile-dominant/approach-motivated groups identified by Kachin et al. (2001) and Kashdan and colleagues (Kashdan et al., 2008; Kashdan & Hofmann, 2008). Rather than placing an emphasis on the role of anger, this explanation would place equal emphasis on group differences in narcissism, anger and social rank.

There are a number of reasons to suggest that the NSA group is similar to the hostile-dominant/approach-motivated groups. First, the high anger and narcissism scores of this subgroup support this argument. As noted in Chapter 5, the NPI taps into forms of narcissism which are reflective of the hostile-dominant/approach-motivated groups, such as desire for power, sense of uniqueness and entitlement, and tendency to be exploitative. Indeed, consideration of NPI item endorsements within the NSA group (see Study 1) supports this interpretation, with the NSA group evincing high endorsement of items measuring need for power, sense of entitlement and tendency to manipulate. Secondly, the NSA group also showed the highest self-reported social rank among the social anxiety groups. Moreover, in several of the forced choice social comparison items, more NSA individuals than would have been expected chose the high social rank option.

Overall, although there are similarities between the current subgroups and those identified by Kashdan and colleagues (Kashdan et al., 2008; Kashdan & Hofmann, 2008) and Kachin et al. (2001), there was not a complete overlap between the hostile-dominant/approach motivated and friendly-submissive/avoidance-motivated groups and the groups identified in the current study, reinforcing the uniqueness and usefulness of the current results.

### **Theoretical Discussion of the Current Results**

**Contemporary psychodynamic theory of social anxiety.** As outlined in Chapter 2, contemporary Psychodynamic theories of social anxiety suggest that narcissism is a core component of social anxiety, and that social anxiety is related to a compensatory inflated self-view (Hoffmann, 1999, 2002). For Hoffmann, it is the unconscious grandiose self of the socially anxious individual which contributes to social anxiety symptoms. Hoffman suggested that this was because the expectations that socially anxious individuals have of how social interactions ought to unfold, and how others ought to react to them are based on their grandiose self. Thus, for Hoffmann, rather than being a characteristic of a subset of socially anxious individuals, narcissism is assumed to be a core characteristic of social anxiety, and elevated narcissism would be expected in all socially anxious individuals.

The current thesis provides partial support for Hoffmann's theory. As noted, Hoffmann would have suggested that all of the socially anxious participants would have been classified within one of the narcissistic socially anxious groups. Although not all socially anxious individuals were characterised by elevated narcissism, three of the four social anxiety groups identified were classified as narcissistic groups on the basis of elevated scores on multiple narcissism measures. Therefore, across Study 1 and Study 2, the *majority* of socially anxious participants showed narcissistic characteristics.

When considering narcissism in socially anxious individuals, it is necessary to take into account the complications associated with measuring narcissism. As noted in Chapter 5, there are many different manifestation of narcissism, and different theories present narcissism in subtly different ways. Therefore, considering this, it is possible that a more comprehensive narcissism scale might have identified narcissistic characteristics in a larger number of socially anxious participants and may have identified narcissistic characteristics in what the current thesis classed the non-narcissistic social anxiety group. This possibility needs to be addressed with a more comprehensive narcissism scale.

A second possible explanation as to why narcissistic characteristics might not have been identified in all socially anxious individuals centres on *when* rather than *how* narcissistic characteristics might be expressed. It is possible that consistent with clinical theories of narcissism, that rather than being absent, narcissistic characteristics in the non-narcissistic social anxiety subgroup might only become evident in a limited range of situations, and thus, might not be evident at all times. For example, one possibility is that unless the individual was “challenged” (for example, either by others or in the context of therapy) that their narcissistic characteristics may not be apparent. Thus, if Hoffmann is correct, and narcissism is present in all socially anxious individuals, it might not be possible to measure this quantitatively, but instead, might require the use of in-depth qualitative clinical interviews. Alternatively, for these individuals, narcissistic characteristics may only be evident during the process of therapy, which would be consistent with Kohut’s (1971) theory of narcissism.

A second aspect of Hoffmann’s (1999, 2002) model which was supported in the current thesis was Hoffmann’s suggestion that shame is a central and important affect in the experience of social anxiety. Although Hoffmann’s model is not the only one to link shame to social anxiety (see Chapter 2), his is the most relevant to the results of the current thesis because of the manner in which he explains the shame of socially anxious individuals. As noted in Chapter 2, for Hoffmann, the shame experienced by socially anxious individuals is a result of the narcissistic characteristics he postulated are central to social anxiety. Thus Hoffmann explicitly linked shame and narcissism in social anxiety, and suggested that it was the tendency of socially anxious individuals to view themselves as “damaged” (to wit. the difference between their “actual” selves and grandiose self-images) that led to their shame.

In line with Hoffmann’s suggestion that the shame of socially anxious individuals is related to their narcissism, and considering that not all of the current groups were classified as narcissistic, Hoffmann’s (1999, 2002) model would predict that the individuals classified into one of the three narcissistic socially anxious subgroups would show higher shame than the non-narcissistic socially anxious individuals. There was partial support for this aspect of Hoffmann’s model in the current thesis. The results for total ESS measured shame and ESS behavioural shame were consistent with predictions made based on Hoffmann’s model. For these variables, all of the narcissistic socially anxious subgroups reported significantly higher shame than the non-narcissistic social anxiety subgroup.

Examination of Andrews et al.'s (2002) behavioural shame subscale reveals that behavioural shame is comprised of items tapping shame surrounding *doing something wrong, saying something stupid* and *failing competitively*. Thus, a large part of behavioural shame is shame surrounding lack of personal efficacy. Given the importance of social rank for narcissistic socially anxious individuals, in particular, the narcissistic social anxiety (NSA) group, the finding in relation to behavioural shame is to be expected. Moreover, considering that Study 1 found that NSA individuals frequently endorsed NPI items which tapped personal efficacy (e.g., "*I am more capable than other people*", and "*I will be a success*"), the fact that the NSA group was higher than the non-narcissistic group on this type of shame is to be expected.

Further examining behavioural shame, the finding that both the covert and narcissistic groups reported similar behavioural shame, but were significantly different in perceived social rank suggests that behavioural shame, while focused on fear of personal efficacy may not be directly related to one's perception of oneself relative to others. A related possibility is that regardless of how the person views themselves relative to others, that is, somewhat more positively in the case of the narcissistic group, and less positively in the case of the covert group, that the shame around the potential of being seen to lack personal efficacy is the same for both groups.

The pattern of results for ESS characterological shame was similar to that for behavioural shame, except that both covert groups were significantly higher than the narcissistic group. However, all of the narcissistic social anxiety subgroups were significantly higher than the general (non-narcissistic) subgroup. In contrast to the results for total ESS shame, behavioural shame and characterological shame, for ESS bodily shame the results were not consistent with predictions made of the basis of Hoffmann's model. Although the two covert narcissistic social anxiety subgroups had significantly higher scores than the non-narcissistic social anxiety subgroup, the shame reported by the narcissistic social anxiety group (NSA) was not significantly different to that reported by the non-narcissistic social anxiety group (GSA). This result is unexpected considering that according to Hoffmann's model, the NSA group, with elevations on all of the narcissism scales ought to be expected to show the highest shame. Looking at the items which form bodily shame (e.g., "*Have you worried about what other people think of your appearance*") the finding that the two covert groups scored higher than the narcissistic is not unexpected, especially considering that these groups scored significantly higher than the narcissistic group on TKS, and the fear of

offending, and being avoided by others. Thus, while this form of shame was broadly an issue for all socially anxious individuals compared to the non-socially anxious (low social anxiety) group, it was a bigger issue for the two groups which reported the greatest concern that some aspect of themselves (e.g., part of their body) might offend others. Thus, the finding that the two covert groups are higher than the narcissistic group further reinforces that these two groups represent particularly maladjusted individuals.

Taken together, despite the unexpected results for ESS bodily shame the results are generally consistent with Hoffmann's (1999, 2002) theory. Although Hoffmann indicated that shame is central to social anxiety and is a result of narcissistic characteristics of socially anxious individuals, Hoffmann did not specify the *type* of shame. As noted, some forms of shame appear to be more problematic for specific narcissistic socially anxious individuals (i.e., the covert narcissistic groups). In explaining the shame proneness of the covert groups, these results are consistent with Russ et al.'s (2008) descriptions of narcissism, which suggested that covert (fragile) narcissistic individuals had a greater tendency toward experiencing internalized negative emotions (e.g., "*tends to be unhappy, depressed, despondent*", "*tends to be anxious*") relative to other narcissistic individuals, which might explain why on all shame scales except behavioural shame, the covert groups were significantly higher than the narcissistic group.

Taken together, the results of this thesis support a number of predictions made on the basis of Hoffmann's (1999, 2002) model. This suggests that his model can make useful contributions to further understanding the disorder. Despite this, it should be noted that there were a number of aspects of Hoffmann's model which could not be tested in the current thesis. For example, it was not possible to test the idea of an unconscious grandiose self-image; therefore, no comment can be made as to the usefulness of these aspects of the model.

**Attachment theory.** As noted in Chapter 2, the attachment model of social (Vertue, 2003) is less clear about the presence of contradictory personality characteristics in socially anxious individuals than other theoretical models. On the basis of Vertue's model specifically, one would not predict the presence of narcissistic characteristics in socially anxious individuals.

However, despite the lack of support for the presence of contradictory characteristics in socially anxious individuals in Vertue's model, it was noted in Chapter

2 that if one consider more complex interpretations of attachment theory, the presence of contradictory characteristics in socially anxious individuals is more likely. Although not emphasised by Vertue, it was noted that Bowlby (1973/1991, 1980/1991) postulated that, an individual has multiple (not a single) working models of attachment. This incorporates multiple representations of the self and others, and of the self-in-relation to others. It was suggested in Chapter 2, that using Bowlby's more complex view of internal working models of attachment, that socially anxious individuals might have an overall negative view of the self in social domains, but might have more positive views of the self (or grandiose self-views) in either non-social domains, or in specific relationships (i.e., self with partner vs self with stranger).

Given that the current thesis empirically demonstrated that some socially anxious individuals are characterised by contradictory personality characteristics (i.e., social reticence and narcissism), suggests that Vertue's (2003) attachment theory model of social anxiety needs to be revised to more explicitly address the possibility of multiple representations of the self and of others, and to address the possibility that where some of a socially anxious individual's self-representations might be negative, others may be more positive, or, as was demonstrated in the current thesis, excessively positive (e.g., representing a "*grandiose*" self-representation).

Although the current thesis supported the presence of contradictory characteristics in socially anxious individuals, the current results do not allow specific comments to be made about what this means from the point of view of an expanded attachment theory model of social anxiety. Specifically, it is not clear if narcissistic socially anxious individuals have positive self-views in some domains (e.g., in non-social domains), whether they have positive self-views in relation to specific relationships (e.g., self-in relation to partner) or a combination of both.

While the results of the current thesis do not allow for speculation on whether self-views of narcissistic socially anxious individuals differ for different relationships (e.g., self-in relation to partner, vs. self-in relation to superiors), the results of Study 2 allow for some speculation on the suggestion that narcissistic socially anxious individual's might have more positive self-views in non-social domains. However, that possibility would appear more likely for the narcissistic social anxiety (NSA) group than for the two covert narcissistic social anxiety groups, given that their perceived social rank was higher than the covert narcissistic and general (non-narcissistic) groups.

The results of Study 2 provide some preliminary indications of the nature of the contradictions within the narcissistic social anxiety group (NSA). In Study two, a large number of NSA individuals chose the “high social rank” alternative. These items tended to involve comparison of the self with others in broad rather than specifically social domains (e.g., in relation to mastery and efficacy generally). In contrast, for the NSA group, and also all other social anxiety subgroups, the items for which the “low social rank” alternative was consistently chosen involved perceived social fit. For example, individuals in the NSA group more frequently chose “outsider” and “different” than “insider” or “same”. Thus, the NSA group did seem to represent a group of socially anxious individuals who had relatively negative views of the self in social domains and relatively more positive views of the self in non-social domains. This provides additional support for the broader attachment theory of social anxiety posited based upon the results of this thesis.

Overall, the current thesis suggests current attachment theory models of social anxiety require modification. Specifically, it suggests that attachment theory models of social anxiety need to be cognisant of Bowlby’s (1973/1991, 1980/1991) indication that there exist multiple internal working models of attachment, and thus, multiple representations of self, others and self-in-relation to others.

**Ethological model of social anxiety.** The results of the current thesis are broadly consistent with Gilbert’s ethological model of social anxiety (Gilbert, 2000a; Gilbert & Trower, 1990; Trower & Gilbert, 1989; Trower et al., 1990). As noted in Chapter 2 for Gilbert, an important component of the agonic mode is social rank. Gilbert (Trower & Gilbert, 1989) demarcated three levels of goals related to social rank, positing that first level goals were related to a desire for dominance, second level goals to a desire to avoid harm (de-escalation behaviours like submissiveness), and third level goals which comprised responses to failures of second level goals such as escape, freeze or faint. Although social anxieties are often related to second level goals, and socially anxious individuals are often characterised by lower perceived social rank, Trower and Gilbert (1989) suggested that in some instances, dominant individuals might be vulnerable to social anxiety.

The results of Study 2 support Trower and Gilbert’s (1989) suggestion that relatively more dominant individuals can be vulnerable to social anxieties. The narcissistic social anxiety (NSA) group, with high social anxiety showed high self-reported social rank. On this basis, it could be speculated that the NSA group represents

a relatively more “dominant” social anxiety group. Using Gilbert’s model, one characterisation of this group is that they represent social anxious individuals who are pursuing first level goals, and who have a desire for dominance. However, when considering first level goals, it is important to note that pursuing first level goals does not assume that an individual *is* dominant, rather, just that they are pursuing strategies in an attempt to be dominant. Thus, these results cannot be taken as evidence that the NSA group is socially dominant.

Trower and Gilbert (1989), however, are somewhat reserved in their speculation that dominant individuals might be prone to social anxiety, specifically noting “dominant (“confident”) types might be vulnerable to specific social phobias, where specific weaknesses in their dominance repertoires may be exposed or anticipated in specific situations” (p. 27). While the results of the current thesis do not allow comment on the types of situations feared by each of the social anxiety groups, the fact that the NSA group showed high scores on both the SIAS (e.g., fear of dyadic and group interactions) and the SPS (e.g., fear of being scrutinised during routine activities) makes it unlikely that this subgroup represents a group of individuals who have problems with specific social anxieties or whose social anxieties are only present in specific situations.

It is possible, to reconcile the present results with the suggestion made by Trower and Gilbert (1989) that dominant individuals experience social anxiety in specific situations, and that dominant individuals are likely to experience specific, rather than “general” social anxieties. The NSA individuals may represent a group of individuals who *wish to be* dominant, not a group of socially anxious individuals who would be objectively rated by observers as *being dominant*. Thus, it might be that individuals who have achieved dominance might only be vulnerable to specific social anxieties or only be vulnerable to social anxieties in specific situations (e.g., when they are challenged) but that individuals who *desire* dominance but who may not be in a dominant position or, alternatively, who may be in a dominant position in only a few of their relationships (e.g., self-in-relation to partner, vs. self-in-relation to peers), might be more vulnerable to general social anxieties.

Whereas the NSA group is the best representation of socially anxious individuals who are pursuing first level goals (e.g., seeking dominance), the covert narcissistic (CNSA) group, with high social anxiety and the low perceived social rank, could be argued to be the most representative example of individuals pursuing second level goals (e.g., submissive strategies). Interestingly, the CNSA group reported lower

perceived social rank than the non-narcissistic social anxiety group. This was unexpected, because, Trower and Gilbert (1989), linked narcissism to higher social rank. Thus, it would have been expected that all narcissistic socially anxious groups would be more dominant than the non-narcissistic social anxiety groups. The most likely explanation is that while Trower and Gilbert's model fits for individuals with high levels of overt narcissistic characteristics, it does not apply to individuals with purely high levels of covert narcissistic characteristics. When one considers the broader results of the two covert groups, specifically that they have greater shame on most indices, and that they have more concern about offending others and being avoided by others, the lower perceived social rank of these individuals is consistent with the broader trend for these subgroups to represent more maladjusted socially anxious individuals.

Although the NSA (first level goals) and CNSA (second level goals) groups fit well within Trower and Gilbert's (1989) model, it is less clear where the angry covert (AnCNSA) group fits in relation to the social rank aspect of Trower and Gilbert's model. This difficulty is largely because Study 2's results indicated the AnCNSA group reported higher perceived social rank than the CNSA group, but lower perceived social rank than the NSA group. One explanation is that the angry covert group is distinct from both the narcissistic and covert groups. To clarify, the angry covert group might represent an intermediate position in between level one and level two goals (e.g., level 1.5 goals), with a greater desire for dominance than the more submissive covert (CNSA) group, but less desire for dominance than the more dominant narcissistic social anxiety (NSA) group. However, Trower and Gilbert (1989) are not explicit about whether an individual's goals can occupy a position between two levels (i.e., between first and second level goals), so this explanation is speculative.

A slightly different explanation for the angry covert group comes from examining Trower and Gilbert's (1989) suggestion that when there is a large discrepancy between the expected outcome of a dominance challenge and the desired outcome of a dominance challenge, that the individual experiences heightened anxiety. Trower and Gilbert suggest that given sufficient anxiety, to wit, a sufficient number of situations in which there is a discrepancy between expected and desired outcomes, that an individual is likely to disengage from the goals they are currently pursuing and instead attempt different (lower level) goals. In the case of the angry covert individuals, it could be argued that individuals in this group were initially pursuing first level goals,

but that awareness that they would likely not achieve their goals and concomitant anxiety that accompanied this resulted in the abandonment of first level goals, and a focus instead on second level goals. This could explain why the angry covert had higher perceived social rank than the covert (CNSA) group, but lower perceived social rank than the narcissistic social anxiety (NSA) group.

Whereas both the covert and angry covert groups likely represent individuals who pursue second level goals, it is suggested that the way these second level goals came to be pursued differs. The covert group may represent individuals who pursue second level goals but who have no desire to pursue first level goals and the angry covert group might represent individuals who pursue second level goals only after having disengaged from the pursuit of first level goals. This explanation is supported by examining the relative maladjustment of the two groups.

Across both Study 1 and Study 2, the angry covert group was often significantly higher than the covert group in self-reported maladjustment (i.e., depression, anxiety, stress, shame and personality organisation). It could be argued that for the AnCNSA group, the need to alter their goals based on awareness of the discrepancy between the expected outcome and the desired outcome of their goals led to greater maladjustment (e.g., depression, shame). This would be consistent with Price et al.'s assertion that when individuals perceive themselves to be lower in social rank, but have a *desire* for higher social rank (i.e., the angry covert group), they will have greater maladjustment than individuals lower in social rank who have less (or no) desire for higher social rank (i.e., CNSA group).

The fact the narcissistic social anxiety subgroups did not consistently differ from the non-narcissistic social anxiety subgroup in perceived social rank, to wit, that the narcissistic social anxiety and angry covert groups were higher and the covert group was lower suggests consideration of group differences in narcissism are important and that the groups cannot be better explained by using perceived social rank alone.

**Cognitive-behavioural models of social anxiety.** As with the attachment model of social anxiety, the contradictory characteristics of social anxious individuals is less apparent in the cognitive-behavioural models of social anxiety than in other models. Nevertheless, Clark and Wells (1995) suggested that socially anxious individuals might have negative self-views in social domains, but more positive self-views in non-social domains. This was strongly supported in the case of the narcissistic social anxiety (NSA) group, given their significantly higher social rank.

Although the current results identify types of socially anxious individual not readily apparent in cognitive behavioural models, the findings are broadly consistent with those models. Thus, rather than necessitating revisions to the model, it is possible narcissistic and non-narcissistic socially anxious individuals might simply differ in relation to aspects of the model. For example, when socially anxious individuals enter a social situation, they are considered to activate assumptions (what Clark & Wells 1995 refer to as dysfunctional beliefs). It is possible the specific types of dysfunctional beliefs activated by narcissistic versus non-narcissistic socially anxious individuals might be different. For example, considering the high level of behavioural shame reported by narcissistic socially anxious individuals in Study 1, the dysfunctional beliefs of narcissistic socially anxious individuals might centre on fear surrounding personal efficacy. Furthermore, given the importance of social rank to some narcissistic socially anxious individuals, it is possible dysfunctional beliefs might centre on social rank related comparisons between the narcissistic socially anxious individual and others.

If there are differences in dysfunctional beliefs activated in social situations, it is also possible the types of safety behaviours (e.g., eye gaze avoidance, talking quickly, or holding a cup tightly to avoid their hands visibly shaking) adopted by narcissistic socially anxious individuals might be different to those employed by non-narcissistic socially anxious individuals and may be tied to specific dysfunctional beliefs of these individuals. It is possible, in line with Kashdan and colleagues (e.g., Kashdan & Hofmann, 2008) that individuals with high narcissism, high anger and high social anxiety are more likely to utilize different coping strategies to cope with social anxiety, such as abusing alcohol or other drugs.

Another result with implications for cognitive behavioural models of social anxiety was the finding many socially anxious individuals also report high shame, high TKS, and indicate concerns with offending others. This suggests many socially anxious individuals experience TKS related dysfunctional beliefs, and that thought needs to be given to how to incorporate TKS related dysfunctional beliefs into the cognitive behavioural model.

**Theories of narcissism.** Although the preceding discussion has focused on interpreting the results through the lens of social anxiety theories, the results also have implications for understanding narcissism. As noted in Chapter 5, there are three major traditions in the narcissism literature, the clinical approach, the social-personality

approach and the literature which focuses on the distinction between covert narcissism and overt narcissism.

Based on the review of clinical theories of narcissism, it was suggested there was strong evidence for a relationship between narcissism and social anxiety. Specifically, it was noted several clinical theories of narcissism (e.g., Kohut, 1966) would predict the presence of several, rather than a single narcissistic social anxiety subgroup. Extending on this, the review of literature distinguishing covert and overt narcissism concluded this research tradition also strongly supported a relationship between narcissism and social anxiety. The suggestion was made that distinct overt and covert narcissistic social anxiety subgroups might be identified.

The current results strongly support the arguments presented in Chapter 5, with several narcissistic social anxiety subgroups being identified in the current studies. However, despite finding two covert narcissistic social anxiety subgroups, a purely “overt” narcissistic social anxiety subgroup was not identified, with the narcissistic social anxiety (NSA) group having elevated scores on both “overt” and “covert” narcissism measures. Despite this, it can be argued their elevated levels of overt narcissism does qualitatively distinguish them from the two covert narcissistic groups.

Whereas the review of clinical narcissism and the covert/overt narcissism literature led to much stronger support for the relationship between narcissism and social anxiety, the review of the social-personality perspective was less clear. On the basis of research on the NPI, the dominant social-personality measure of narcissism (J. D. Miller & Campbell, 2008) a narcissistic social anxiety subgroup seemed unlikely, and it would have been expected high scores on the NPI would have been related to low levels of social anxiety. Despite this, the present results still support a social-personality perspective. Specifically, the identification of the LSA group, with moderate to high levels of NPI measured narcissism, low levels of covert narcissism and low levels of social anxiety represents the profile of an individual predicted on the basis of the social-personality perspective.

In summary, the current thesis identified individuals with characteristics consistent with both the clinical and overt/covert narcissism literature and the social-personality perspective. This lends strong support to Russ et al.’s (2008) efforts to link the three perspectives. Indeed, it is possible most of the subgroups identified in the current research fit within Russ et al.’s proposed subtypes of narcissism, with the narcissistic social anxiety (NSA) group representing Russ et al.’s Grandiose/malignant

narcissists, the two covert (AnCNSA/CNSA) groups Russ et al.'s Fragile narcissists and the low social anxiety group Russ et al.'s high-functioning/exhibitionistic narcissists.

### **Implications for the diagnosis of Social Anxiety Disorder.**

The current thesis was focused on social anxieties broadly, rather than the narrower conceptualization of SAD as it appears in the DSM-5 (APA, 2013). Nevertheless, the current results have implications for the way social anxiety is represented in the DSM.

As noted in Chapter 4, the DSM does not cover all manifestations of social anxiety. Specifically, it does not include diagnostic criteria based on TKS, possibly due to an assumption that TKS is specific to East Asian cultures. In Study 2, the pattern of differences between the social anxiety groups was found to be similar for TKS as for social anxiety. In particular, the pattern of group differences for the TKS scale and the TKS cognitions scales were identical to that found for the SPS. Additionally, although the TKS scores were around the middle of the theoretical range, they were higher than those reported in previous studies. Given the cross-national nature of the sample, and the large numbers of North American participants, the idea that TKS is distinct from social anxiety or that TKS is unique to East Asian cultures seems to be erroneous. Instead, the results suggest that the current diagnostic criteria in the DSM may need to be broadened to incorporate TKS specific criteria. However, it should be noted that these suggestions are tentative, owing to the fact that the current thesis utilized a non-clinical sample.

### **Caveats and limitations of the findings.**

Although the results of the current thesis are promising, they need to be considered in light of some caveats. First, a possible objection to the interpretation of the results presented in this thesis is that a more parsimonious explanation would be to suggest that narcissism is simply another measure of maladjustment, and as such, groups high on narcissism and social anxiety are more maladjusted than groups which are just high on social anxiety. However, this interpretation overlooks the fact that the relationship between narcissism and maladjustment was not as straightforward as this, and the group with the highest narcissism (combining overt/covert narcissism) scores (NSA group) was not the most maladjusted in both Study 1 and Study 2.

Overall, the findings suggest that the unique pattern of scores on narcissism, social anxiety and anger resulted in groups which could not be subsumed within dimensional models of social anxiety based on symptom severity. Nevertheless, for

definitive statements to be made about the relative levels of adjustment of each of the groups, it would be necessary to examine the groups in a longitudinal study and to track the relationship between changes in social anxiety, narcissism and anger and determine if changes in these variables led to differences in levels of adjustment.

The second caveat to consider is the nature of the sample. It is possible internet populations have substantially more severe social anxieties than treatment seeking samples (e.g., Erwin, et al. 2004). Therefore, a criticism of the current study might be that the current results are an artefact of the current sample, and are reflective of the characteristics of a particularly severe socially anxious sample. As such, the findings might not hold true for broader socially anxious samples. While this is plausible, this explanation would need to be viewed in light of several counter arguments.

This criticism need to be considered in light of both the size of the current samples, and the fact that rather than representing homogeneous groups, the current samples were cross-national heterogeneous samples. The diversity of the sample thus makes the potential that the current results are an artefact of the current sample less likely. Moreover, the method chosen to identify the factors in the samples was statistically robust. The two stage cluster analytic technique employed in this research is believed to result in more robust cluster solutions (Milligan & Cooper, 1987; Steinley, 2006a). Additionally, this specific SPSS two-step technique employed has been previously used to good effect by other studies exploring social anxiety subgroups.

A related caveat is that it is not clear if the type of participants who respond to internet surveys differ from the general population in systematic ways. For example, it is possible that the anonymous nature of the internet may lead to greater dissembling by participants than if they met face to face with the researcher. To test for this possibility, future researchers may wish to attempt to replicate this study by collecting data using interview based rather than self-report based measures.

A final caveat related to the sample is that it was not clear whether participants in this thesis met diagnostic criteria for any other psychiatric conditions which were not assessed (e.g., psychosis, eating disorders, etc). While it was not possible to comprehensively screen participants in this thesis, future interview based replications of this study may wish to use more comprehensive clinical assessment tools to explore this possibility. Related to this, it is possible that controlling for other psychiatric conditions (e.g., depression) might change the nature of the group differences.

An additional limitation concerns the data analytic method used to determine the number of clusters. Although cluster analysis was selected on the basis that it had been used by Kashdan et al. (2009), future research should attempt to replicate the same clusters using alternative statistical methods, such as Latent Class Analysis (LCA).

Moreover, while study two found the same clusters as study one, it is possible that future research using exploratory rather than confirmatory methods might find a different number of clusters. Replication of these results across different samples, using different techniques is an important next step in demonstrating the validity of the clusters.

A final limitation concerned the psychometric properties of two of the scales employed in this thesis, specifically the NPDS and TKS. While they were on the border of being acceptable, future research may wish to find alternative measures of these constructs with more robust psychometric properties.

### **Directions for future research**

While the results of this thesis are promising, there are a number of aspects of the new social anxiety subgroups which need to be further clarified. First, this thesis did not explore the *types* of social situation feared. It was not possible, therefore to definitively address Trower and Gilbert's (1989) suggestion that the social anxieties of dominant individuals are more likely to be situation specific. Although, the high SPS and SIAS scores of the narcissistic social anxiety group makes this unlikely, examination of differences in types of feared social situations across the groups would provide stronger evidence that the social anxiety of the NSA group is not situation specific.

In this thesis, it has been argued that the social anxiety subgroups identified would not have been predicted on the basis of DSM-5 (APA, 2013) diagnostic criteria. This implies that some individuals in the current study with high levels of social anxiety might not have been identified using current DSM-5 criteria. However, while plausible, this assertion can only be tested by inclusion of clinical interviews for a subset of socially anxious individuals from each subgroup. These interviews would help to determine if these individuals do, or do not meet DSM criteria for SAD. This information could potentially lead to a better understanding of how DSM criteria could be modified to more effectively capture a higher number of socially anxious individuals.

While consideration of treatment of social anxiety is beyond the scope of this thesis, future research could also explore if the new narcissistic social anxiety subtypes

differ in response to treatment, or whether specific types of treatment may differ in effectiveness for each of the narcissistic social anxiety subtypes. Given that treatment dropout rates from social anxiety remain problematic, with some meta-analyses reporting dropout rates of nearly 20% (S. Taylor, 1996), it is possible understanding how each of the new subtypes responds to treatment, coupled with an understanding of the nature of each of the subtypes elucidated in this thesis might lead to modifications to treatment that reduce dropout rates. For example, it is possible that individuals in the narcissistic social anxiety group (NSA) might respond differently in group therapy settings as a result of higher (overt) narcissism, and higher perceived social rank.

There are also implications for dealing with treatment non-response. The current results support recent arguments that socially anxious individuals with severe comorbidities are less likely to respond to treatment than individuals without severe comorbidities (Tillfors, Furmark, Carlbring, & Andersson, 2015). While Tillfors et al. focused on social anxiety and depressive symptoms, this thesis indicates the most severely maladjusted socially anxious individuals are also characterised by high covert narcissism, shame, TKS symptoms and alexithymia. Measuring these variables in treatment outcome studies would allow researchers to determine which characteristic of severely maladjusted socially anxious individuals leads to treatment non-response. For example, if TKS was found to be important, then a more explicit focus on TKS related anxiety could improve response rates to treatment. Similarly, if the level of covert narcissism was related to treatment non-response, then incorporation of interventions to treat narcissistic pathology in conjunction with treatment for social anxiety might improve response rates.

The current results also have implications for manualised self-guided social anxiety treatments, such as Rapee's (1998) *Overcoming Shyness and Social Phobia: A Step-by-Step Guide*. Given that levels of TKS related anxiety were high in the current sample, this suggests that manualised self-guided treatments need to incorporate specific references to TKS related anxieties.

Although the current thesis is important, both studies were cross-sectional investigations. It is not possible, therefore, to determine if the social anxiety subtypes identified in the current study are stable, or if an individual's social anxiety subtype changes over time. Longitudinal studies of socially anxious individuals would allow determination of the stability of the newly identified subgroups. Longitudinal studies

would also help determine if the natural course of the disorder was different for each of the social anxiety subtypes.

Finally, considering that both studies in this thesis utilized internet based samples, it would be beneficial for future studies to explore narcissistic social anxiety subgroups in other samples of socially anxious individuals. Clinical samples would be of particular value to explore, especially in relation to clinical outcomes after treatment. The use of internet based samples also meant that this thesis relied on self-report measures. In addition, future research could measure the social anxiety, narcissism and psychological adjustment of narcissistic socially anxious individuals using methods other than self-report. Clinical interviews and observational methods would provide data to extend the current data.

### **Summary**

In conclusion, the main contribution of this thesis has been to identify four distinct social anxiety subgroups. While these subgroups were consistent with subgroups identified in previous research, they were meaningfully distinct. More importantly, this thesis illustrated the importance of considering narcissism in socially anxious individuals. This opens the way for more detailed research on these subgroups. There are also implications for future empirical and clinical work on social anxiety that considers the role of elevated narcissistic characteristics in the aetiology and maintenance of Social Anxiety Disorder and Avoidant Personality Disorder.

## References

- Abbott, M. J., & Rapee, R. M. (2004). Post-Event rumination and negative self-appraisal in social phobia before and after treatment. *Journal of Abnormal Psychology, 113*, 136-144. doi:10.1037/0021-843X.113.1.136
- Ackerman, R. A., Donnellan, M. B., & Robins, R. W. (2012). An Item Response Theory analysis of the Narcissistic Personality Inventory. *Journal of Personality Assessment, 94*, 141-155. doi:10.1080/00223891.2011.645934
- Ackerman, R. A., Witt, E. A., Donnellan, M. B., Trzesniewski, K. H., Robins, R. W., & Kashy, D. A. (2011). What does the Narcissistic Personality Inventory really measure? *Assessment, 18*, 67-87. doi:10.1177/1073191110382845
- Aderka, I. M., Weisman, O., Shahar, G., & Gilboa-Schechtman, E. (2009). The roles of the social rank and attachment systems in social anxiety. *Personality and Individual Differences, 47*, 284-288. doi:10.1016/j.paid.2009.03.014
- Adler, G. (1986). Psychotherapy of the narcissistic personality disorder patient: Two contrasting approaches. *American Journal of Psychiatry, 143*, 430-436. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1986-22393-001&site=ehost-live>
- Akhtar, S. (2003). *New clinical realms: Pushing the envelope of theory and technique*. Lanham, MD US: Jason Aronson.
- Akhtar, S., & Thomson, J. A. (1982). Overview: Narcissistic Personality Disorder. *American Journal of Psychiatry, 139*, 12-20. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1982-09945-001&site=ehost-live>
- Akin, A., & Çetin, B. (2007). The Depression Anxiety and Stress Scale (DASS): The study of validity and reliability. *Kuram ve Uygulamada Eğitim Bilimleri, 7*, 260-268. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2007-06487-008&site=ehost-live&scope=site>
- Alden, L. E. (2005). Interpersonal Perspectives on Social Phobia. In W. R. Crozier & L. E. Alden (Eds.), *The essential handbook of social anxiety for clinicians*. (pp. 167-192). New York, NY US: John Wiley & Sons Ltd.
- Alden, L. E., Ryder, A. G., & Mellings, T. M. B. (2002). Perfectionism in the context of social fears: Toward a two-component model. In G. L. Flett & P. L. Hewitt (Eds.), *Perfectionism: Theory, research, and treatment*. (pp. 373-391). Washington, DC US: American Psychological Association.
- Alden, L. E., Wiggins, J. S., & Pincus, A. L. (1990). Construction of Circumplex Scales for the Inventory of Interpersonal Problems. *Journal of Personality Assessment, 55*, 521-536. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=6392170&site=ehost-live>
- Allan, S., & Gilbert, P. (1995). A social comparison scale: Psychometric properties and relationship to psychopathology. *Personality and Individual Differences, 19*, 293-299. doi:10.1016/0191-8869(95)00086-L
- American Psychiatric Association. (1952). *Diagnostic & Statistical Manual of Mental Disorders*. Washington, D.C.: American Psychiatric Association.
- American Psychiatric Association. (1968). *Diagnostic & Statistical Manual of Mental Disorders* (2nd ed.). Washington, D.C.: American Psychiatric Association.
- American Psychiatric Association. (1980). *Diagnostic & Statistical Manual of Mental Disorders* (3rd ed.). Washington, D.C.: American Psychiatric Association.

- American Psychiatric Association. (1987). *Diagnostic & Statistical Manual of Mental Disorders*. (3rd ed. revised). Washington, D.C.: American Psychiatric Association.
- American Psychiatric Association. (1994). *Diagnostic & Statistical Manual of Mental Disorders* (4th ed.). Washington, D.C.: American Psychiatric Association.
- American Psychiatric Association. (2000). *Diagnostic & Statistical Manual of Mental Disorders: DSM-IV-TR*. (4th ed., text revision). Washington, D.C.: American Psychiatric Association.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders : DSM-5*. Arlington, Va: American Psychiatric Association.
- Ames, D. R., Rose, P., & Anderson, C. P. (2006). The NPI-16 as a short measure of narcissism. *Journal of Research in Personality, 40*, 440-450. Retrieved from <http://www.scopus.com/inward/record.url?eid=2-s2.0-33646888013&partnerID=40&md5=8259a1a18affaec2ddbee538fcebcb9>
- Andrews, B. (1995). Bodily shame as a mediator between abusive experiences and depression. *Journal of Abnormal Psychology, 104*, 277-285. doi:10.1037/0021-843X.104.2.277
- Andrews, B., & Hunter, E. (1997). Shame, early abuse, and course of depression in a clinical sample: Preliminary study. *Cognition and Emotion, 11*, 373-381. doi:10.1080/026999397379845
- Andrews, B., Qian, M., & Valentine, J. D. (2002). Predicting depressive symptoms with a new measure of shame: The Experience of Shame Scale. *British Journal of Clinical Psychology, 41*, 29. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=6708363&site=ehost-live>
- Antony, M. M., Bieling, P. J., Cox, B. J., Enns, M. W., & Swinson, R. P. (1998). Psychometric properties of the 42-item and 21-item versions of the Depression Anxiety Stress Scales in clinical groups and a community sample. *Psychological Assessment, 10*, 176-181. doi:10.1037/1040-3590.10.2.176
- Antony, M. M., Purdon, C. L., Huta, V., & Swinson, R. P. (1998). Dimensions of perfectionism across the anxiety disorders. *Behaviour Research and Therapy, 36*, 1143-1154. doi:10.1016/S0005-7967(98)00083-7
- Apóstolo, J. L. A., Mendes, A. C., & Azeredo, Z. A. (2006). Adaptation to Portuguese of the Depression, Anxiety and Stress Scales (DASS). *Revista Latino-Americana de Enfermagem, 14*, 863-871. doi:10.1590/s0104-11692006000600006
- Ashbaugh, A., Antony, M. M., Liss, A., Summerfeldt, L. J., McCabe, R. E., & Swinson, R. P. (2007). Changes in perfectionism following cognitive-behavioral treatment for social phobia. *Depression & Anxiety, 24*, 169-177. doi:10.1002/da.20219
- Ashby, H. U. (1978). *An MMPI scale for narcissistic personality disorder*. (PhD Thesis), Northwestern University, Evanston, Illinois.
- Ashby, H. U., Lee, R. R., & Duke, E. H. (1979). *A Narcissistic Personality Disorder MMPI Scale*. Paper presented at the A.P.A. National Convention, New York.
- Atlas, G. D., & Them, M. A. (2008). Narcissism and Sensitivity to Criticism: A Preliminary Investigation. *Current Psychology, 27*, 62-76. doi:10.1007/s12144-008-9023-0
- Auerbach, J. S. (1984). Validation of two scales for Narcissistic Personality Disorder. *Journal of Personality Assessment, 48*, 649. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=6386415&site=ehost-live>

- Bach, S. (1975). Narcissism, continuity and the uncanny. *International Journal of Psycho-Analysis*, 56, 77-86. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1977-23442-001&site=ehost-live>
- Bach, S. (1977). On the narcissistic state of consciousness. *International Journal of Psycho-Analysis*, 58, 209-233. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1981-10541-001&site=ehost-live>
- Bagby, R. M., Parker, J. D. A., & Taylor, G. J. (1994). The twenty-item Toronto Alexithymia Scale: I. Item selection and cross-validation of the factor structure. *Journal of Psychosomatic Research*, 38, 23-32. doi:10.1016/0022-3999(94)90005-1
- Baldwin, M. W. (1992). Relational schemas and the processing of social information. *Psychological Bulletin*, 112, 461-484. doi:10.1037/0033-2909.112.3.461
- Baldwin, M. W., & Main, K. J. (2001). Social Anxiety and the cued activation of relational knowledge. *Personality and Social Psychology Bulletin*, 27, 1637-1647. Retrieved from <http://psp.sagepub.com/cgi/content/abstract/27/12/1637>
- Banai, E., Mikulincer, M., & Shaver, P. R. (2005). 'Selfobject' needs in Kohut's Self Psychology: Links with attachment, self-cohesion, affect regulation, and adjustment. *Psychoanalytic Psychology*, 22, 224-260.
- Bander, K. W., Steinke, G. V., Allen, G. J., & Mosher, D. L. (1975). Evaluation of three dating-specific treatment approaches for heterosexual dating anxiety. *Journal of Consulting and Clinical Psychology*, 43, 259-265. doi:10.1037/h0076528
- Bartholomew, K., & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology*, 61, 226-244. doi:10.1037/0022-3514.61.2.226
- Beck, A. T., & Beck, R. W. (1972). Screening depressed patients in family practice: A rapid technique. *Postgraduate Medicine*, 52, 81-85.
- Beck, A. T., Freeman, A. M., & Davis, D. D. (2004). *Cognitive therapy of personality disorders* (2nd ed.). New York: Guilford Press.
- Berber Çelik, Ç., & Odacı, H. (2012). The effect of experience of childhood abuse among university students on self-perception and submissive behavior. *Children and Youth Services Review*, 34, 200-204. doi:10.1016/j.childyouth.2011.09.017
- Berghuis, H., Kamphuis, J. H., & Boedijn, G. R. (2009). Psychometric properties and validity of the Dutch Inventory of Personality Organization (IPO-NL). *Bulletin of the Menninger Clinic*, 73, 44-60. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=40520694&site=ehost-live&scope=site>
- Berrios, G. (1999). Anxiety disorders: A conceptual history. *Journal of Affective Disorders*, 56, 83-94. doi:10.1016/S0165-0327(99)00036-1
- Besser, A., & Priel, B. (2010). Grandiose narcissism versus vulnerable narcissism in threatening situations: Emotional reactions to achievement failure and interpersonal rejection. *Journal of Social and Clinical Psychology*, 29, 874-902. doi:10.1521/jscp.2010.29.8.874
- Bilgel, N., & Bayram, N. (2010). Turkish version of the Depression Anxiety Stress Scale (DASS-42): Psychometric properties. *Nöropsikiyatri Arşivi/Archives of Neuropsychiatry*, 47, 118-126. doi:10.4274/npa.5344
- Binet, A. (1896). Dugas La timidité. *L'année psychologique*, 3, 609-610.

- Bing, J. F., McLaughlin, F., & Marburg, R. (1959). The metapsychology of narcissism. *The Psychoanalytic Study of the Child, 14*, 9-28. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1960-08025-001&site=ehost-live&scope=site>
- Bloch, I. (1902). *Beiträge zur Aetiologie der Psychopathia Sexualis*. Dresden: Verlag von H.R. Dohrn.
- Bogart, L. M., Benotsch, E. G., & Pavlovic, J. D. P. (2004). Feeling superior but threatened: The relation of narcissism to social comparison. *Basic & Applied Social Psychology, 26*, 35-44. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=18331801&site=ehost-live>
- Bögels, S. M., Alden, L., Beidel, D. C., Clark, L. A., Pine, D. S., Stein, M. B., & Voncken, M. (2010). Social anxiety disorder: questions and answers for the DSM-V. *Depression and Anxiety, 27*, 168-189. doi:10.1002/da.20670
- Bowlby, J. (1953). Some pathological processes set in train by early mother-child separation. *Journal of Mental Science, 99*, 265-272. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1954-00604-001&site=ehost-live>
- Bowlby, J. (1958). The nature of the child's tie to his mother. *The International Journal of Psychoanalysis, 39*, 350-373. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1960-02815-001&site=ehost-live&scope=site>
- Bowlby, J. (1969). Disruption of affectional bonds and its effects on behavior. *Canada's Mental Health Supplement, 59*, 12-12. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1970-06805-001&site=ehost-live&scope=site>
- Bowlby, J. (1969/1991). *Attachment and loss. Volume 1: Attachment*. London: Penguin
- Bowlby, J. (1973/1991). *Attachment and loss. Volume 2: Separation: anxiety and anger*. London: Penguin
- Bowlby, J. (1980/1991). *Attachment and loss: Volume 3: Sadness and depression*. London: Penguin
- Brill, A. A. (1912). *Psychanalysis: Its theories and practical application*. Philadelphia: W.B. Saunders Co.
- Broucek, F. J. (1982). Shame and its relationship to early narcissistic developments. *International Journal of Psycho-Analysis, 63*, 369-378. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1983-10213-001&site=ehost-live>
- Brown, E. J., Heimberg, R. G., & Juster, H. R. (1995). Social phobia subtype and avoidant personality disorder: Effect on severity of social phobia, impairment, and outcome of cognitive behavioral treatment. *Behavior Therapy, 26*, 467-486. doi:10.1016/S0005-7894(05)80095-4
- Brown, E. J., Turovsky, J., Heimberg, R. G., & Juster, H. R. (1997). Validation of the Social Interaction Anxiety Scale and the Social Phobia Scale across the anxiety disorders. *Psychological Assessment, 9*, 21-27. doi:10.1037/1040-3590.9.1.21
- Brown, T. A., Chorpita, B. F., Korotitsch, W., & Barlow, D. H. (1997). Psychometric properties of the Depression Anxiety Stress Scales (DASS) in clinical samples. *Behaviour Research and Therapy, 35*, 79-89. doi:10.1016/S0005-7967(96)00068-X

- Brunello, N., den Boer, J. A., Judd, L. L., Kasper, S., Kelsey, J. E., Lader, M., . . . Wittchen, H. U. (2000). Social phobia: Diagnosis and epidemiology, neurobiology and pharmacology, comorbidity and treatment. *Journal of Affective Disorders, 60*, 61-74. doi:10.1016/S0165-0327(99)00140-8
- Bucknill, J. C., & Tuke, D. H. (1862). *A manual of psychological medicine: containing the history, nosology, description, statistics, diagnosis, pathology, and treatment of insanity. With an appendix of cases*. London: J. Churchill.
- Buffardi, L. E., & Campbell, W. K. (2008). Narcissism and social networking web sites. *Personality and Social Psychology Bulletin, 34*, 1303-1314.
- Bursten, B. (1973). Some narcissistic personality types. *International Journal of Psycho-Analysis, 54*, 287-300. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1974-22989-001&site=ehost-live>
- Bursten, B. (1982). Narcissistic personalities in DSM III: I. Personality classification. *Comprehensive Psychiatry, 23*, 409-420. doi:10.1016/0010-440X(82)90154-7
- Bushman, B. J., & Baumeister, R. F. (1998). Threatened egotism, narcissism, self-esteem, and direct and displaced aggression: Does self-love or self-hate lead to violence? *Journal of Personality and Social Psychology, 75*, 219-229. doi:10.1037/0022-3514.75.1.219
- Cain, N. M., Pincus, A. L., & Ansell, E. B. (2008). Narcissism at the crossroads: Phenotypic description of pathological narcissism across clinical theory, social/personality psychology, and psychiatric diagnosis. *Clinical Psychology Review, 28*, 638-656.
- Campbell, W. K. (1999). Narcissism and romantic attraction. *Journal of Personality and Social Psychology, 77*, 1254-1270. doi:10.1037/0022-3514.77.6.1254
- Campbell, W. K. (2001). Is narcissism really so bad? *Psychological Inquiry, 12*, 214-216.
- Campbell, W. K., Bush, C. P., Brunell, A. B., & Shelton, J. (2005). Understanding the social costs of narcissism: The case of the tragedy of the commons. *Personality and Social Psychology Bulletin, 31*, 1358-1368. doi:10.1177/0146167205274855
- Campbell, W. K., & Sedikides, C. (1999). Self-threat magnifies the self-serving bias: A meta-analytic integration. *Review of General Psychology, 3*, 23-43. doi:10.1037/1089-2680.3.1.23
- Carter, S. A., & Wu, K. D. (2010). Relations among symptoms of social phobia subtypes, avoidant personality disorder, panic, and depression. *Behavior Therapy, 41*, 2-13. doi:10.1016/j.beth.2008.10.002
- Carver, C. S., & White, T. L. (1994). Behavioral Inhibition, Behavioral Activation, and Affective Responses to Impending Reward and Punishment: The BIS/BAS Scales. *Journal of Personality and Social Psychology, 67*, 319-333. Retrieved from <http://www.scopus.com/inward/record.url?eid=2-s2.0-38549137059&partnerID=40&md5=de6659a02420fe8c7ae434f77e38776f>
- Casper, J. L. (1901). Biographie d'une idée fixe [Biography of a fixed idea]. *Arch, de Neurologie [Archives of Neurology]*, 270-287.
- Chambless, D. L., Fydrich, T., & Rodebaugh, T. L. (2008). Generalized social phobia and avoidant personality disorder: meaningful distinction or useless duplication? *Depression & Anxiety (1091-4269), 25*, 8-19. doi:10.1002/da.20266

- Chance, M. R. (1984). Biological systems synthesis of mentality and the nature of the two modes of mental operation: Hedonic and agonic. *Man-Environment Systems, 14*, 143-157. Retrieved from <http://psycnet.apa.org/psycinfo/1985-24635-001>
- Chance, M. R. (1988a). Introduction. In M. R. A. Chance (Ed.), *Social Fabrics of the Mind* (pp. 1-29). London: Lawrence Erlbaum.
- Chance, M. R. (1988b). A systems synthesis of mentality. In M. R. A. Chance (Ed.), *Social Fabrics of the Mind* (pp. 37-45). London: Lawrence Erlbaum.
- Chen, C. P. (2010). Morita therapy and its counseling implications for social anxiety. *Counselling Psychology Quarterly, 23*, 67-82. doi:10.1080/09515071003629805
- Chomsky, N. (1959). Review: Verbal behavior by B. F. Skinner. *Language, 35*, 26-58. Retrieved from <http://www.jstor.org/stable/411334>
- Clark, D. M., & Wells, A. (1995). A cognitive model of social phobia. In R. G. Heimberg, M. R. Liebowitz, D. A. Hope, & F. R. Schneier (Eds.), *Social phobia: Diagnosis, assessment, and treatment*. (pp. 69-93). New York, NY US: Guilford Press.
- Clark, L. A., & Watson, D. (1991). Tripartite model of anxiety and depression: Psychometric evidence and taxonomic implications. *Journal of Abnormal Psychology, 100*, 316-336. doi:10.1037/0021-843x.100.3.316
- Clarvit, S. R., Schneier, F. R., & Liebowitz, M. R. (1996). The offensive subtype of Taijin-Kyofu-Sho in New York City: The phenomenology and treatment of a social anxiety disorder. *Journal of Clinical Psychiatry, 57*, 523-527. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1996-06961-004&site=ehost-live>
- Compton, A. (1972). A study of the psychoanalytic theory of anxiety: I. The development of Freud's theory of anxiety. *Journal of the American Psychoanalytic Association, 20*, 3-44. doi:10.1177/000306517202000101
- Cooper, A. M. (1986). Narcissism. In A. P. Morrison (Ed.), *Essential papers on Narcissism* (pp. 112-143). New York: New York University Press.
- Cooper, A. M. (1989). Narcissism and masochism: The narcissistic-masochistic character. *Psychiatric Clinics of North America, 12*, 541-552. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1990-07573-001&site=ehost-live>
- Cooper, A. M. (2004a). The narcissistic-masochistic character. In E. L. Auchincloss (Ed.), *Quiet Revolution in American Psychoanalysis : Selected Papers of Arnold M. Cooper* (pp. 121-139). London: Brunner-Routledge.
- Cooper, A. M. (2004b). The unusually painful analysis. A group of narcissistic-masochistic characters. In E. L. Auchincloss (Ed.), *Quiet Revolution in American Psychoanalysis : Selected Papers of Arnold M. Cooper* (pp. 140-149). London: Brunner-Routledge.
- Corry, N., Merritt, R. D., Mrug, S., & Pamp, B. (2008). The Factor Structure of the Narcissistic Personality Inventory. *Journal of Personality Assessment, 90*, 593-600. doi:10.1080/00223890802388590
- Crawford, J. R., & Henry, J. D. (2003). The Depression Anxiety Stress Scales (DASS): Normative data and latent structure in a large non-clinical sample. *British Journal of Clinical Psychology, 42*, 111. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=10100708&site=ehost-live&scope=site>
- Crockatt, P. (2006). Freud's 'On narcissism: an introduction'. *Journal of Child Psychotherapy, 32*, 4-20. doi:10.1080/00754170600563638

- Darwin, C. (1878). *On the origin of species by means of natural selection*. New York: D. Appleton & Company.
- Darwin, C. (1896). *The expression of the emotions in man and animals*. New York: D. Appleton & Company.
- Davis, J. M., Janicak, P. G., & Ayd, F. J. (1995). Psychopharmacotherapy of the personality-disordered patient. *Psychiatric Annals*, 25, 614-620. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1996-15192-001&site=ehost-live&scope=site>
- Dawkins, R. (1976). *The Selfish Gene*. Oxford: Oxford University Press.
- del Rosario, P. M., & White, R. M. (2005). The Narcissistic Personality Inventory: Test-retest stability and internal consistency. *Personality and Individual Differences*, 39, 1075-1081.
- Dixon, J. J., De Monchaux, C., & Sandler, J. (1957a). Patterns of anxiety: An analysis of social anxieties. *British Journal of Medical Psychology*, 30, 107-112. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1959-01677-001&site=ehost-live>
- Dixon, J. J., De Monchaux, C., & Sandler, J. (1957b). Patterns of anxiety: The phobias. *British Journal of Medical Psychology*, 30, 34-40. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1958-04323-001&site=ehost-live>
- Donley, J. E. (1911). Freud's anxiety neurosis. *The Journal of Abnormal Psychology*, 6, 126-134. doi:10.1037/h0073533
- Donnellan, M. B., Trzesniewski, K. H., & Robins, R. W. (2009). An emerging epidemic of narcissism or much ado about nothing? *Journal of Research in Personality*, 43, 498-501. Retrieved from <http://www.sciencedirect.com/science/article/B6WM0-4V7MSF8-3/2/452ecab2427b8ea06f01368e3e7ababa>
- Eagle, M. (1997). Attachment and psychoanalysis. *British Journal of Medical Psychology*, 70, 217-229. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1997-30172-002&site=ehost-live&scope=site>
- El-Gabalawy, R., Cox, B., Clara, I., & Mackenzie, C. (2010). Assessing the validity of social anxiety disorder subtypes using a nationally representative sample. *Journal of Anxiety Disorders*, 24, 244-249. Retrieved from <http://www.sciencedirect.com/science/article/B6VDK-4XR5N39-2/2/4340490971653e0d962ee59fd9b1a6a9>
- Ellis, H. (1898). Auto-Erotism: A Psychological Study. *Alienist and Neurologist*, 19, 260-299. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1898-10004-002&site=ehost-live&scope=site>
- Ellis, H. (1905). *Studies in the Psychology of Sex: The Evolution of Modesty; The Phenomena of Sexual Periodicity; Auto-Erotism* (Vol. 1). Philadelphia: F. A. Davis Company Publishers.
- Ellis, H. (1914). *Studies in the Psychology of Sex: Sexual Selection in Man*. (Vol. 4). Philadelphia: F. A. Davis Company Publishers.
- Ellis, H. (1927). *Studies in the Psychology of Sex: The Evolution of Modesty; The Phenomena of Sexual Periodicity; Auto-Erotism* (3rd ed. Vol. 1). Philadelphia: F. A. Davis Company Publishers.

- Emmons, R. A. (1984). Factor analysis and construct validity of the Narcissistic Personality Inventory. *Journal of Personality Assessment*, 48, 291. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=6385814&site=ehost-live>
- Emmons, R. A. (1987). Narcissism: Theory and measurement. *Journal of Personality and Social Psychology*, 52, 11-17. doi:10.1037/0022-3514.52.1.11
- Erwin, B. A., Heimberg, R. G., Juster, H., & Mindlin, M. (2002). Comorbid anxiety and mood disorders among persons with social anxiety disorder. *Behaviour Research and Therapy*, 40, 19-35.
- Erwin, B. A., Turk, C. L., Heimberg, R. G., Fresco, D. M., & Hantula, D. A. (2004). The Internet: Home to a severe population of individuals with social anxiety disorder? *Journal of Anxiety Disorders*, 18, 629-646.
- Esquirol, E. (1838). *Des maladies mentales considérées sous les rapports médical, hygiénique et médico-légal*. Paris: Meline, Cans.
- Exline, J. J., Baumeister, R. F., Bushman, B. J., Campbell, W. K., & Finkel, E. J. (2004). Too Proud to Let Go: Narcissistic Entitlement as a Barrier to Forgiveness. *Journal of Personality and Social Psychology*, 87, 894-912. doi:10.1037/0022-3514.87.6.894
- Fairbrother, N. (2002). The treatment of social phobia--100 years ago. *Behaviour Research and Therapy*, 40, 1291-1304.
- Feighner, J. P., Robins, E., Guze, S. B., Woodruff, R. A., Jr., Winokur, G., & Munoz, R. (1972). Diagnostic Criteria for Use in Psychiatric Research. *Arch Gen Psychiatry*, 26, 57-63. doi:10.1001/archpsyc.1972.01750190059011
- Fenichel, O. (1939). *The Outline of Clinical Psychoanalysis* (B. D. Lewin & G. Zilboorg, Trans.). New York: The Psychoanalytic Quarterly Press and W.W. Norton & Co.
- Fenichel, O. (1945). *The Psychoanalytic Theory of Neurosis*. New York: W.W. Norton & Co.
- Fetterman, A. K., & Robinson, M. D. (2010). Contingent self-importance among pathological narcissists: Evidence from an implicit task. *Journal of Research in Personality*, 44, 691-697. doi:10.1016/j.jrp.2010.09.002
- Forbes, D., Hawthorne, G., Elliott, P., McHugh, T., Biddle, D., Creamer, M., & Novaco, R. W. (2004). A concise measure of anger in combat-related Posttraumatic Stress Disorder. *Journal of Traumatic Stress*, 17, 249-256. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=13233253&site=ehost-live>
- Fossati, A., Borroni, S., Eisenberg, N., & Maffei, C. (2010). Relations of proactive and reactive dimensions of aggression to overt and covert narcissism in nonclinical adolescents. *Aggressive Behavior*, 36, 21-27. doi:10.1002/ab.20332
- Foster, J. D., Misra, T. A., & Reidy, D. E. (2009). Narcissists are approach-oriented toward their money and their friends. *Journal of Research in Personality*, 43, 764-769. doi:10.1016/j.jrp.2009.05.005
- Foster, J. D., Reidy, D. E., Misra, T. A., & Goff, J. S. (2011). Narcissism and stock market investing: Correlates and consequences of cocksure investing. *Personality and Individual Differences*, 50, 816-821. doi:10.1016/j.paid.2011.01.002

- Foster, J. D., & Trimm, R. F. (2008). On being eager and uninhibited: Narcissism and approach-avoidance motivation. *Personality and Social Psychology Bulletin*, 34, 1004-1017.
- Freud, A. (1966). *The ego and the mechanisms of defense* (2nd ed.). New York: International Universities Press
- Freud, S. (1893/1953). Draft B (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 1, pp. 179-184). London: Hogarth Press.
- Freud, S. (1894/1953). On the grounds for detaching a particular syndrome from neurasthenia under the description of anxiety neurosis (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 3, pp. 85-117). London: Hogarth Press.
- Freud, S. (1895/1953). Obsessions and phobias. Their psychical mechanisms and their aetiology (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 3, pp. 70-84). London: Hogarth Press.
- Freud, S. (1896/1953). Further remarks on the neuro-psychoses of defence (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 3, pp. 159-185). London: Hogarth Press.
- Freud, S. (1898/1953). Sexuality in the aetiology of the neuroses (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 3, pp. 261-286). London: Hogarth Press.
- Freud, S. (1900/1953a). The Interpretation of Dreams (Part 1) (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 4, pp. 1-310). London: Hogarth Press.
- Freud, S. (1900/1953b). The Interpretation of Dreams (Part 2) (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 5, pp. 339-626). London: Hogarth Press.
- Freud, S. (1905/1953). Three Essays on the Theory of Sexuality (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 7, pp. 123-246). London: Hogarth Press.
- Freud, S. (1909/1953). Analysis of a Phobia in a Five-Year-Old Boy. (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 10, pp. 3-149). London: Hogarth Press.
- Freud, S. (1910/1953). Leonardo da Vinci and a Memory of his Childhood. (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 11, pp. 59-137). London: Hogarth Press.
- Freud, S. (1911/1953). Psycho-Analytic Notes on an Autobiographical Account of a Case of Paranoia (Dementia Paranoides). (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 12, pp. 3-82). London: Hogarth Press.
- Freud, S. (1913/1953). Totem and Taboo (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 13, pp. 1-161). London: Hogarth Press.
- Freud, S. (1914/1953). On Narcissism: An Introduction (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 14, pp. 67-102). London: Hogarth Press.

- Freud, S. (1915/1953a). Instincts and their Vicissitudes. (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 14, pp. 111-140). London: Hogarth Press.
- Freud, S. (1915/1953b). Repression (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 14, pp. 141-158). London: Hogarth Press.
- Freud, S. (1915/1953c). Thoughts For The Times On War And Death. (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 14, pp. 273-300). London: Hogarth Press.
- Freud, S. (1917/1953). Introductory Lectures on Psycho-Analysis. Part III. General Theory of the Neuroses (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 16, pp. 243-496). London: Hogarth Press.
- Freud, S. (1919/1953). A child is being beaten (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 17, pp. 179-204). London: Hogarth Press.
- Freud, S. (1921/1953). Group Psychology and the Analysis of the Ego. (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 18, pp. 65-144). London: Hogarth Press.
- Freud, S. (1923/1953). The Ego and the Id (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 19, pp. 19-27). London: Hogarth Press.
- Freud, S. (1924/1953). The economic problem of masochism (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 19, pp. 159-170). London: Hogarth Press.
- Freud, S. (1926/1953). Inhibitions, Symptoms and Anxiety (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 20, pp. 76-181). London: Hogarth Press.
- Freud, S. (1930/1953). Civilization and its Discontents (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 21, pp. 57-146). London: Hogarth Press.
- Freud, S. (1938/1953). An Outline of Psycho-Analysis. (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 23, pp. 141-207). London: Hogarth Press.
- Freud, S. (1951). A letter from Freud. *The American Journal of Psychiatry*, 107, 786-787. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1952-00050-001&site=ehost-live&scope=site>
- Furmark, T. (2002). Social phobia: overview of community surveys. *Acta Psychiatrica Scandinavica*, 105, 84-93. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=6444968&site=ehost-live>
- Furmark, T., Tillfors, M., Everz, P. O., Marteinsdottir, I., Gefvert, O., & Fredrikson, M. (1999). Social phobia in the general population: prevalence and sociodemographic profile. *Social Psychiatry & Psychiatric Epidemiology*, 34, 416. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=4684541&site=ehost-live>

- Gabbard, G. O. (1979). Stage fright. *International Journal of Psycho-Analysis*, 60, 383-392. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1991-57539-001&site=ehost-live>
- Gabbard, G. O. (1989). Two subtypes of narcissistic personality disorder. *Bulletin of the Menninger Clinic*, 53, 527-532. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1990-31089-001&site=ehost-live>
- Gabbard, G. O. (1992). Psychodynamics of panic disorder and social phobia. *Bulletin of the Menninger Clinic*, 56, 3-13. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1992-39396-001&site=ehost-live>
- Gabriel, M. T., Critelli, J. W., & Ee, J. S. (1994). Narcissistic Illusions in Self-Evaluations of Intelligence and Attractiveness. *Journal of Personality*, 62, 143-155. doi:10.1111/1467-6494.ep9406221282
- Galatzer-Levy, I. R., & Galatzer-Levy, R. M. (2007). The revolution in psychiatric diagnosis: problems at the foundations. *Perspectives in Biology and Medicine*, 50, 161(120). doi:10.1353/pbm.2007.0016
- Gélineau, J. B. É. (1880). *De la kénophobie ou peur des espaces, (agoraphobie des Allemands) [Kénophobie or fear of spaces (agoraphobia of Germans)]*. Paris: Tessier.
- Gentile, B., Miller, J. D., Hoffman, B. J., Reidy, D. E., Zeichner, A., & Keith Campbell, W. (2013). A test of two brief measures of grandiose narcissism: The narcissistic personality inventory-13 and the narcissistic personality inventory-16. *Psychological Assessment*, 25, 1120-1136. doi:10.1037/a0033192  
10.1080/00223891.2011.645934
- Gilbert, P. (1989). *Human Nature and Suffering*. N.J.: Hillsdale.
- Gilbert, P. (1998). Shame and humiliation in the treatment of complex cases. In N. Tarrier, A. Wells, & G. Haddock (Eds.), *Treating complex cases: The cognitive behavioural therapy approach*. (pp. 241-271). New York, NY US: John Wiley & Sons Ltd.
- Gilbert, P. (2000a). The relationship of shame, social anxiety and depression: the role of the evaluation of social rank. *Clinical Psychology & Psychotherapy*, 7, 174-189. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=11820321&site=ehost-live>
- Gilbert, P. (2000b). Varieties of submissive behavior as forms of social defense: Their evolution and role in depression. In P. Gilbert & L. Sloman (Eds.), *Subordination and defeat: An evolutionary approach to mood disorders and their therapy*. (pp. 3-45). Mahwah, NJ US: Lawrence Erlbaum Associates Publishers.
- Gilbert, P. (2001). Evolution and social anxiety: The role of attraction, social competition, and social hierarchies. *Psychiatric Clinics of North America*, 24, 723-751.
- Gilbert, P. (2003). Evolution, social Roles, and the difference in shame and guilt. *Social Research*, 70, 1205-1230. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=12012741&site=ehost-live>

- Gilbert, P. (2004). Evolution, attractiveness, and the emergence of shame and guilt in a self-aware mind: A reflection on Tracy and Robins. *Psychological Inquiry, 15*, 132-135.
- Gilbert, P. (2006). Evolution and depression: Issues and implications. *Psychological Medicine, 36*, 287-297.
- Gilbert, P., Boxall, M., Cheung, M., & Irons, C. (2005). The relation of paranoid ideation and social anxiety in a mixed clinical population. *Clinical Psychology & Psychotherapy, 12*, 124-133. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=16854986&site=ehost-live>
- Gilbert, P., McEwan, K., Irons, C., Bhundia, R., Christie, R., Broomhead, C., & Rockliff, H. (2010). Self-harm in a mixed clinical population: The roles of self-criticism, shame, and social rank. *British Journal of Clinical Psychology, 49*, 563-576. doi:10.1348/014466509x479771
- Gilbert, P., McEwan, K., Mitra, R., Richter, A., Franks, L., Mills, A., . . . Gale, C. (2009). An exploration of different types of positive affect in students and patients with a bipolar disorder. *Clinical Neuropsychiatry, 6*, 135-143. Retrieved from <http://www.scopus.com/inward/record.url?eid=2-s2.0-74849085259&partnerID=40&md5=dce5464a1a091569ebd6c0ce8dbdca61>
- Gilbert, P., McGuire, M. T., & Andrews, B. (1998). Shame, status, and social roles: Psychobiology and evolution. In P. Gilbert & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology, and culture*. (pp. 99-125). New York, NY US: Oxford University Press.
- Gilbert, P., & Trower, P. (1990). The evolution and manifestation of social anxiety. In W. R. Crozier (Ed.), *Shyness and embarrassment: Perspectives from social psychology*. (pp. 144-177). New York, NY US: Cambridge University Press.
- Gleason, T. R., Jarudi, R. N., & Cheek, J. M. (2003). Imagination, personality, and imaginary companions. *Social Behavior & Personality: An International Journal, 31*, 721-737. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=11763489&site=ehost-live>
- Glick, R. A., & Meyers, D. I. (1988). Introduction. In R. A. Glick & D. I. Meyers (Eds.), *Masochism: Current psychoanalytic perspectives*. (pp. 1-25). Hillsdale, NJ England: Analytic Press, Inc.
- Glover, E. (1931). Sublimation, substitution and social anxiety. *International Journal of Psycho-Analysis, 12*, 263-297. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1931-04783-001&site=ehost-live>
- Glover, E. (1939). *Psycho-Analysis*. London: John Bale Medical Publications Ltd.
- Gordon, R. M. (2009). Reactions to the Psychodynamic Diagnostic Manual (PDM) by psychodynamic, CBT and other non-psychodynamic psychologists. *Issues in Psychoanalytic Psychology, 31*, 53-59.
- Gore, K. L., Carter, M. M., & Parker, S. (2002). Predicting anxious response to a social challenge: The predictive utility of the Social Interaction Anxiety Scale and the Social Phobia Scale in a college population. *Behaviour Research and Therapy, 40*, 689-700. doi:10.1016/s0005-7967(01)00029-8
- Gramzow, R., & Tangney, J. P. (1992). Proneness to shame and the narcissistic personality. *Personality and Social Psychology Bulletin, 18*, 369-376. doi:10.1177/0146167292183014

- Gullestad, S. E. (2001). Attachment theory and psychoanalysis: Controversial issues. *Scandinavian Psychoanalytic Review*, *24*, 3-16.
- Guttman, L. (1945). A basis for analyzing test-retest reliability. *Psychometrika*, *10*, 255-282. doi:10.1007/BF02288892
- Habke, A. M., Hewitt, P. L., Norton, G. R., & Asmundson, G. (1997). The social phobia and social interaction anxiety scales: An exploration of the dimensions of social anxiety and sex differences in structure and relations with pathology. *Journal of Psychopathology and Behavioral Assessment*, *19*, 21-39. doi:10.1007/bf02263227
- Halasz, G. (2008). Psychodynamic diagnostic manual. *Australasian Psychiatry*, *16*, 289-291. doi:10.1080/10398560802056699
- Hampton, F. A. (1927). Shyness. *The Journal of Neurology and Psychopathology*, *8*, 124-131.
- Harman, R., & Lee, D. (2010). The role of shame and self-critical thinking in the development and maintenance of current threat in post-traumatic stress disorder. *Clinical Psychology and Psychotherapy*, *17*, 13-24. doi:10.1002/cpp.636
- Hartenberg, P. (1901). *Les Timides et la Timidité [The Timid and Shyness]*. Paris: F. Alcan.
- Hartmann, H. (1949). Comments on the psychoanalytic theory of the ego *The psychoanalytic study of the child*. Vol. 3/4. (pp. 74-96). Oxford, England: International Universities Press.
- Heimberg, R. G., Hofmann, S. G., Liebowitz, M. R., Schneier, F. R., Smits, J. A. J., Stein, M. B., . . . Craske, M. G. (2014). Social Anxiety Disorder in DSM-5. *Depression and Anxiety*, n/a-n/a. doi:10.1002/da.22231
- Heimberg, R. G., Holt, C. S., Schneier, F. R., & Spitzer, R. L. (1993). The issue of subtypes in the diagnosis of social phobia. *Journal of Anxiety Disorders*, *7*, 249-269. doi:10.1016/0887-6185(93)90006-7
- Heimberg, R. G., Mueller, G. P., Holt, C. S., & Hope, D. A. (1992). Assessment of anxiety in social interaction and being observed by others: The Social Interaction Anxiety Scale and the Social Phobia Scale. *Behavior Therapy*, *23*, 53-73. doi:10.1016/s0005-7894(05)80308-9
- Heinrichs, N., Hahlweg, K., Fiegenbaum, W., Frank, M., Schroeder, B., & von Wittleben, I. (2002). Validität und Reliabilität der Social Interaction Anxiety Scale (SIAS) und der Social Phobia Scale (SPS). *Verhaltenstherapie*, *12*, 26-35. doi:10.1159/000056690
- Heiserman, A., & Cook, H. (1998). Narcissism, affect, and gender: An empirical examination of Kernberg's and Kohut's theories of narcissism. *Psychoanalytic Psychology*, *15*, 74-92. doi:10.1037/0736-9735.15.1.74
- Hendin, H. M., & Cheek, J. M. (1997). Assessing hypersensitive narcissism: A reexamination of Murray's Narcism Scale. *Journal of Research in Personality*, *31*, 588-599. doi:10.1006/jrpe.1997.2204
- Henry, J. D., & Crawford, J. R. (2005). The short-form version of the Depression Anxiety Stress Scales (DASS-21): Construct validity and normative data in a large non-clinical sample. *British Journal of Clinical Psychology*, *44*, 227-239. doi:10.1348/014466505x29657
- Herbert, J. D., Hope, D. A., & Bellack, A. S. (1992). Validity of the distinction between generalized social phobia and avoidant personality disorder. *Journal of Abnormal Psychology*, *101*, 332-339. doi:10.1037/0021-843X.101.2.332

- Hibbard, S. (1992). Narcissism, shame, masochism, and object relations: An exploratory correlational study. *Psychoanalytic Psychology, 9*, 489-508. doi:10.1037/h0079392
- Hickman, S. E., Watson, P. J., & Morris, R. J. (1996). Optimism, pessimism, and the complexity of narcissism. *Personality and Individual Differences, 20*, 521-525. doi:10.1016/0191-8869(95)00223-5
- Higgins, E. T. (1987). Self-discrepancy: A theory relating self and affect. *Psychological Review, 94*, 319-340. doi:10.1037/0033-295x.94.3.319
- Hill, P. L., & Roberts, B. W. (2012). Narcissism, well-being, and observer-rated personality across the lifespan. *Social Psychological and Personality Science, 3*, 216-223. Retrieved from <http://www.scopus.com/inward/record.url?eid=2-s2.0-84856507147&partnerID=40&md5=88786efd2ef8f9ffdf51d62a961d2720>
- Hirsch, C. R. M. T. D. M. (2004). Negative self-imagery in social anxiety contaminates social interactions. *Memory, 12*, 496-506. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=13310595&site=ehost-live&scope=site>
- Hoffmann, S. O. (1999). Die phobischen störungen (phobien). Eine übersicht zum gegenwärtigen verständnis ihrer psychodynamik und hinweise zur therapie. [The phobic disturbances (phobias). A survey of the actual state of psychodynamic concepts and remarks on therapy.]. *Forum der Psychoanalyse: Zeitschrift für klinische Theorie & Praxis, 15*, 237-252. doi:10.1007/s004510050064
- Hoffmann, S. O. (2002). Die Psychodynamik der Sozialen Phobien: Eine Åbersicht mit einem ersen 'Leitfaden' zur psychoanalytisch orientierten Psychotherapie [The psychodynamics of the social anxiety disorder: An overview with a first "guide" for psychoanalytically oriented psychotherapy]. *Forum der Psychoanalyse: Zeitschrift für klinische Theorie & Praxis, 18*, 51-71. doi:10.1007/s00451-002-0115-4
- Hofmann, S. G., Heinrichs, N., & Moscovitch, D. A. (2004). The nature and expression of social phobia: Toward a new classification. *Clinical Psychology Review, 24*, 769-797.
- Holmes, J. (1993). *John Bowlby and attachment theory*. London: Routledge.
- Holmes, J. (1994). The clinical implications of attachment theory. *British Journal of Psychotherapy, 11*, 62-76. doi:10.1111/j.1752-0118.1994.tb00702.x
- Holt, C. S., Heimberg, R. G., & Hope, D. A. (1992). Avoidant personality disorder and the generalized subtype of social phobia. *Journal of Abnormal Psychology, 101*, 318-325. doi:10.1037/0021-843X.101.2.318
- Horney, K. (1939). *New ways in psychoanalysis*. Oxford England: Norton & Co.
- Horney, K. (1945). *Our inner conflicts*. Oxford England: Norton & Co.
- Horney, K. (1950). *Neurosis and Human Growth*. Oxford England: Norton & Co.
- Hummelen, B., Wilberg, T., Pedersen, G., & Karterud, S. (2007). The relationship between avoidant personality disorder and social phobia. *Comprehensive Psychiatry, 48*, 348-356. doi:10.1016/j.comppsy.2007.03.004
- Hunt, W. (1995). The diffident narcissist: A character-type illustrated in The Beast in the Jungle by Henry James. *International Journal of Psycho-Analysis, 76*, 1257-1267. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1996-00716-014&site=ehost-live>

- Huppert, J. D., Strunk, D. R., Ledley, D. R., Davidson, J. R. T., & Foa, E. B. (2008). Generalized social anxiety disorder and avoidant personality disorder: structural analysis and treatment outcome. *Depression & Anxiety (1091-4269)*, *25*, 441-448. doi:10.1002/da.20349
- Igarashi, H., Kikuchi, H., Kano, R., Mitoma, H., Shono, M., Hasui, C., & Kitamura, T. (2009). The Inventory of Personality Organisation: Its psychometric properties among student and clinical populations in Japan. *Annals of General Psychiatry*, *8*. doi:10.1186/1744-859x-8-9
- Izgiç, F., Akyüz, G., Doğan, O., & Kuğu, N. (2004). Social Phobia Among University Students and Its Relation to Self-Esteem and Body Image. *Canadian Journal of Psychiatry*, *49*, 630-634. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=14576892&site=ehost-live&scope=site>
- Jacobs, M. (2010). *Psychodynamic Counselling in Action*: SAGE Publications.
- Jacobson, E. (1954). The self and the object world: Vicissitudes of their infantile cathexes and their influence on ideational and affective development. *The Psychoanalytic Study of the Child*, *9*, 75-127. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1955-07001-001&site=ehost-live>
- Jacoby, M. (1981). Reflections on Heinz Kohut's concept of narcissism. *Journal of Analytical Psychology*, *26*, 19-32. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=12200998&site=ehost-live>
- Jacoby, M. (1990). *Individuation and Narcissism: The Psychology of the Self in Jung and Kohut* (M. Gubitz & F. O'Kane, Trans.). London: Routledge.
- Jakobwitz, S., & Egan, V. (2006). The dark triad and normal personality traits. *Personality and Individual Differences*, *40*, 331-339. Retrieved from <http://www.sciencedirect.com/science/article/B6V9F-4H2FXN0-5/2/69a5505b8e5dbe53594003e0550c393e>
- Janet, P. (1903). *Les Obsessions et la Psychasthénie [The Obsessions and Psychasthenia]* (Vol. 1). Paris: Alcan.
- Janet, P. (1914). Psychoanalysis. *The Journal of Abnormal Psychology*, *9*, 1-35. doi:10.1037/h0070276
- Janet, P., & Raymond, F. (1903). *Les obsessions et la psychasthénie [The Obsessions and Psychasthenia]* (Vol. 2). Paris: Alcan.
- Jinkwan, K., Rapee, R. M., & Gaston, J. E. (2008). Symptoms of offensive type Taijin-Kyofusho among Australian social phobics. *Depression & Anxiety*, *25*, 601-608. doi:10.1002/da.20345
- Jones, E. (1911). The pathology of morbid anxiety. *The Journal of Abnormal Psychology*, *6*, 81-106. doi:10.1037/h0074306
- Jones, E. (1913). The relation between the anxiety neurosis and anxiety hysteria. *The Journal of Abnormal Psychology*, *8*, 1-9. doi:10.1037/h0074126
- Jones, E. (1923). The God Complex: The belief that one is God, and the resulting character traits. In E. Jones (Ed.), *Essays in Applied Psychoanalysis* (Vol. 1, pp. 204-226). London: International Psychoanalytic Press.
- Jordan, C. H., Spencer, S. J., Zanna, M. P., Hoshino-Browne, E., & Correll, J. (2003). Secure and Defensive High Self-Esteem. *Journal of Personality and Social Psychology*, *85*, 969-978.

- Juster, H. R., Heimberg, R. G., Frost, R. O., & Holt, C. S. (1996). Social phobia and perfectionism. *Personality and Individual Differences, 21*, 403-410. doi:10.1016/0191-8869(96)00075-X
- Kachin, K. E., Newman, M. G., & Pincus, A. L. (2001). An interpersonal problem approach to the division of social phobia subtypes. *Behavior Therapy, 32*, 479-501.
- Kaminer, D., & Stein, D. J. (2003). Social anxiety disorder. *World Journal of Biological Psychiatry, 4*, 103-110. Retrieved from <Go to ISI>://000186056300002
- Karen, R. (1994). *Becoming attached: Unfolding the mystery of the infant–mother bond and its impact on later life*. New York, NY US: Warner Books.
- Kasahara, Y. (1986). Fear of eye-to-eye confrontation among neurotic patients in Japan. In T. S. Lebra & W. P. Lebra (Eds.), *Japanese Culture and Behavior*. (pp. 379-387). Honolulu: University of Hawaii Press.
- Kasahara, Y. (1987). Social Phobia in Japan. *Social Phobia in Japan and Korea: Proceedings of the First Cultural Psychiatry Symposium Between Japan and Korea* (pp. 3-14). Seoul: The East Asian Academy of Cultural Psychiatry.
- Kashdan, T. B., Collins, R. L., & Elhai, J. D. (2006). Social anxiety and positive outcome expectancies on risk-taking behaviors. *Cognitive Therapy & Research, 30*, 749-761. doi:10.1007/s10608-006-9017-x
- Kashdan, T. B., Elhai, J. D., & Breen, W. E. (2008). Social anxiety and disinhibition: An analysis of curiosity and social rank appraisals, approach-avoidance conflicts, and disruptive risk-taking behavior. *Journal of Anxiety Disorders, 22*, 925-939. Retrieved from <http://www.sciencedirect.com/science/article/B6VDK-4PT2954-1/2/71aef1cecbdc8a61981086966a69ee29>
- Kashdan, T. B., & Hofmann, S. G. (2008). The high-novelty-seeking, impulsive subtype of generalized social anxiety disorder. *Depression & Anxiety, 25*, 535-541. doi:10.1002/da.20382
- Kashdan, T. B., McKnight, P. E., Richey, J. A., & Hofmann, S. G. (2009). When social anxiety disorder co-exists with risk-prone, approach behavior: Investigating a neglected, meaningful subset of people in the National Comorbidity Survey-Replication. *Behaviour Research and Therapy, 47*, 559-568. Retrieved from <http://www.sciencedirect.com/science/article/B6V5W-4VY2CBF-1/2/6b43ef545aa7a6f89b2a55910f7944e1>
- Kasper, A. M. (1965). The narcissistic self in a masochistic character. *International Journal of Psycho-Analysis, 46*, 475-486. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1966-05638-001&site=ehost-live>
- Kaufman, M. R. (1941). A clinical note on social anxiety. *Psychoanalytic Review, 28*, 72-77. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1941-02583-001&site=ehost-live>
- Keller, M. B. (2003). The lifelong course of social anxiety disorder: a clinical perspective. *Acta Psychiatrica Scandinavica, 108*, 85. doi:10.1034/j.1600-0447.108.s417.6.x
- Kerig, P. K., & Stellwagen, K. K. (2010). Roles of callous-unemotional traits, narcissism, and Machiavellianism in childhood aggression. *Journal of Psychopathology and Behavioral Assessment, 32*, 343-352. doi:10.1007/s10862-009-9168-7
- Kernberg, O. F. (1967). Borderline Personality Organization. *Journal of the American Psychoanalytic Association, 15*, 641-685.

- Kernberg, O. F. (1968). The treatment of patients with borderline personality organization. *The International Journal of Psychoanalysis*, 49, 600-619. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1969-15904-001&site=ehost-live&scope=site>
- Kernberg, O. F. (1970). Factors in the psychoanalytic treatment of narcissistic personalities. *Journal of the American Psychoanalytic Association*, 18, 51-85.
- Kernberg, O. F. (1975). *Borderline conditions and pathological narcissism*. New York: Jason Aronson Inc.
- Kernberg, O. F. (1985). *Internal world and external reality : object relations theory applied*. Northvale, N.J.: Jason Aronsen Inc.
- Kernberg, O. F. (1989). An ego psychology object relations theory of the structure and treatment of pathologic narcissism: An overview. *Psychiatric Clinics of North America*, 12, 723-729. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1990-08065-001&site=ehost-live>
- Kernberg, O. F. (1998a). Narcissistic personality disorders. *Journal of European Psychoanalysis*, 7, 7-18. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1998-04855-001&site=ehost-live>
- Kernberg, O. F. (1998b). Pathological narcissism and narcissistic personality disorder: Theoretical background and diagnostic classification. In E. F. Ronningstam (Ed.), *Disorders of narcissism: Diagnostic, clinical, and empirical implications*. (pp. 29-51). Washington, DC, US: American Psychiatric Association.
- Kernberg, O. F. (2011). Psychoanalysis and the university: A difficult relationship. *The International Journal of Psychoanalysis*, 92, 609-622. doi:10.1111/j.1745-8315.2011.00454.x
- Kernis, M. H., Cornell, D. P., Sun, C.-R., Berry, A., & Harlow, T. (1993). There's more to self-esteem than whether it is high or low: The importance of stability of self-esteem. *Journal of Personality and Social Psychology*, 65, 1190-1204. doi:10.1037/0022-3514.65.6.1190
- Kernis, M. H., Grannemann, B. D., & Barclay, L. C. (1989). Stability and level of self-esteem as predictors of anger arousal and hostility. *Journal of Personality and Social Psychology*, 56, 1013-1022. doi:10.1037/0022-3514.56.6.1013
- Kernis, M. H., Grannemann, B. D., & Barclay, L. C. (1992). Stability of self-esteem: Assessment, correlates, and excuse making. *Journal of Personality*, 60, 621-644. doi:10.1111/1467-6494.ep9209210979
- Kernis, M. H., Greenier, K. D., Herlocker, C. E., Whisenhunt, C. R., & Abend, T. A. (1997). Self-perceptions of reactions to doing well or poorly: The roles of stability and level of self-esteem. *Personality and Individual Differences*, 22, 845-854. doi:10.1016/s0191-8869(96)00263-2
- Kernis, M. H., Whisenhunt, C. R., Waschull, S. B., Greenier, K. D., Berry, A. J., Herlocker, C. E., & Anderson, C. A. (1998). Multiple facets of self-esteem and their relations to depressive symptoms. *Personality and Social Psychology Bulletin*, 24, 657-668. doi:10.1177/0146167298246009

- Kessler, R. C., McGonagle, K. A., Zhao, S., & Nelson, C. B. (1994). Lifetime and 12-month prevalence of DSM-III—R psychiatric disorders in the United States: Results from the National Comorbidity Study. *Archives of General Psychiatry*, *51*, 8-19. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psych&AN=1994-21473-001&site=ehost-live&scope=site>
- Kim, E. J. (2005). The effect of the decreased safety behaviors on anxiety and negative thoughts in social phobics. *Journal of Anxiety Disorders*, *19*, 69-86.
- Kim, J., Rapee, R. M., & Gaston, J. E. (2008). Symptoms of offensive type Taijin-Kyomsho among Australian social phobics. *Depression and Anxiety*, *25*, 601-608. doi:10.1002/da.20345
- Kim, K. (1987). Discussion to Professor Kasahara's paper *Social Phobia in Japan and Korea: Proceedings of the First Cultural Psychiatry Symposium Between Japan and Korea* (pp. 15-17). Seoul: The East Asian Academy of Cultural Psychiatry.
- Kinoshita, Y., Chen, J., Rapee, R. M., Bögels, S., Schneier, F. R., Choy, Y., . . . Furukawa, T. A. (2008). Cross-cultural study of conviction subtype Taijin Kyofu: Proposal and reliability of Nagoya-Osaka diagnostic criteria for social anxiety disorder. *Journal of Nervous and Mental Disease*, *196*, 307-313.
- Kirmayer, L. J. (1991). The place of culture in psychiatric nosology: Taijin kyofusho and DSM-III--R. *Journal of Nervous and Mental Disease*, *179*, 19-28. doi:10.1097/00005053-199101000-00005
- Kleinknecht, R. A., Dinnel, D. L., Kleinknecht, E. E., & Hiruma, N. (1997). Cultural factors in social anxiety: A comparison of social phobia symptoms and Taijin Kyofusho. *Journal of Anxiety Disorders*, *11*, 157-177. doi:10.1016/S0887-6185(97)00004-2
- Kleinknecht, R. A., Dinnel, D. L., Tanouye-Wilson, S., & Lonner, W. (1994). Cultural variation in social anxiety and phobia: A study of Taijin Kyofusho. *the Behavior Therapist*, *17*, 175-178.
- Knox, J. (1999). The relevance of attachment theory to a contemporary Jungian view of the internal world: internal working models, implicit memory and internal objects. *Journal of Analytical Psychology*, *44*, 511. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=3251707&site=ehost-live&scope=site>
- Knox, J. (2001). Memories, fantasies, archetypes: an exploration of some connections between cognitive science and analytical psychology. *Journal of Analytical Psychology*, *46*, 613-635. doi:10.1111/1465-5922.00270
- Knox, J. (2003). Trauma and defences: Their roots in relationship. *The Journal of Analytical Psychology*, *48*, 207-233.
- Kohut, H. (1966). Forms and Transformations of Narcissism. *Journal of the American Psychoanalytic Association*, *14*, 243-272. doi:10.1177/000306516601400201
- Kohut, H. (1971). *The analysis of the self: a systematic approach to the psychoanalytic treatment of narcissistic personality disorders* New York: International Universities Press.
- Kohut, H. (1977). *The Restoration of the Self*. New York: International Universities Press.
- Kohut, H. (1986). Forms and transformations of narcissism. In A. P. Morrison (Ed.), *Essential papers on Narcissism* (pp. 61-87). New York: New York University Press.
- Kohut, H., & Wolf, E. S. (1978). The Disorders of the self and their treatment: An outline. *International Journal of Psychoanalysis*, *59*, 413-425.

- Kondas, O. (1967). Reduction of examination anxiety and stage-fright' by group desensitization and relaxation. *Behaviour Research and Therapy*, 5, 275-281. doi:10.1016/0005-7967(67)90019-8
- Kraft-von Ebing, R. F. (1892). *Psychopathia Sexualis* (C. G. Chaddock, Trans.). London: F.A. Davis Co.
- Krantz, D. L. (1965). Toward a role for historical analysis: The case of psychology and physiology. *Journal of the History of the Behavioral Sciences*, 1, 278-283. doi:10.1002/1520-6696(196507)1:3<278::AID-JHBS2300010309>3.0.CO;2-L
- Kräupl, F. (1948). Some observations on the analytical group treatment of a phobic patient. *Journal of Mental Science*, 94, 77-88. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psych&AN=1948-05072-001&site=ehost-live&scope=site>
- Kubarych, T. S., Deary, I. J., & Austin, E. J. (2004). The Narcissistic Personality Inventory: Factor structure in a non-clinical sample. *Personality and Individual Differences*, 36, 857-872.
- Kuder, G. F., & Richardson, M. W. (1937). The theory of the estimation of test reliability. *Psychometrika*, 2, 151-160. doi:10.1007/BF02288391
- Kyoichi, K. (1987). Discussion of Dr Lee's paper *Social Phobia in Japan and Korea: Proceedings of the First Cultural Psychiatry Symposium Between Japan and Korea* (pp. 53-55). Seoul: The East Asian Academy of Cultural Psychiatry.
- Lange, W.-G., Keijsers, G., Becker, E. S., & Rinck, M. (2008). Social anxiety and evaluation of social crowds: Explicit and implicit measures. *Behaviour Research and Therapy*, 46, 932-943. Retrieved from <http://www.sciencedirect.com/science/article/B6V5W-4SD6SMY-1/2/bf8e08249faddc5d28ce865add3de69d>
- Lawson, R., Waller, G., Sines, J., & Meyer, C. (2008). Emotional awareness among eating-disordered patients: the role of narcissistic traits. *European Eating Disorders Review*, 16, 44-48. doi:10.1002/erv.838
- Leary, M. R. (1983a). A brief version of the Fear of Negative Evaluation scale. *Personality and Social Psychology Bulletin*, 9, 371-375. doi:10.1177/0146167283093007
- Leary, M. R. (1983b). *Understanding social anxiety: Social, personality, and clinical perspectives*. Beverley Hills, CA: Sage.
- Leary, M. R., & Kowalski, R. M. (1995). The self-presentation model of social anxiety. In R. G. Heimberg, M. R. Liebowitz, D. A. Hope, & F. R. Schneier (Eds.), *Social phobia: Diagnosis, assessment, and treatment*. (pp. 94-111). New York, NY US: Guilford Press.
- Lee, S.-H. (1987). Social Phobia in Korea *Social Phobia in Japan and Korea: Proceedings of the First Cultural Psychiatry Symposium Between Japan and Korea* (pp. 24-52). Seoul: The East Asian Academy of Cultural Psychiatry.
- Lee, S.-H., & Oh, K. S. (1999). Offensive type of social phobia: Cross-cultural perspectives. *International Medical Journal*, 6, 271-279. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psych&AN=2000-13084-003&site=ehost-live>
- Lenzenweger, M. F., Clarkin, J. F., Kernberg, O. F., & Foelsch, P. A. (2001). The Inventory of Personality Organization: Psychometric properties, factorial composition, and criterion relations with affect, aggressive dyscontrol, psychosis proneness, and self-domains in a nonclinical sample. *Psychological Assessment*, 13, 577-591.

- Leung, A. W., & Heimberg, R. G. (1996). Homework compliance, perceptions of control, and outcome of cognitive-behavioral treatment of social phobia. *Behaviour Research and Therapy*, *34*, 423-432. doi:10.1016/0005-7967(96)00014-9
- Lewinsky, H. (1941). The nature of shyness. *British Journal of Psychology*, *32*, 105-113. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1942-00206-001&site=ehost-live>
- Liebowitz, M. (1987). Social phobia. *Modern Problems in Pharmacopsychiatry*, *22*, 141-173.
- Liu, Y., Liu, J., & Wu, L. (2010). Are You Willing and Able? Roles of Motivation, Power, and Politics in Career Growth. *Journal of Management*, *36*, 1432-1460. doi:10.1177/0149206309359810
- Lloyd, S. (2006). *An anxious society: The French importation of Social Phobia and the appearance of a new model of the self*. (PhD Thesis), McGill University, Montreal, Quebec, Canada.
- Lorenz, K. (1961). *King Solomon's Ring : New Light on Animal Ways*. London: Methuen
- Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy*, *33*, 335-343. doi:10.1016/0005-7967(94)00075-u
- Macevoy, H. J. (1903). Biography of a Fixed Idea [Biographie d'une idee fixe]. Observation of Casper. (Arch. de Neurol., No. 76, April, 1902.) Casper. *Journal of Mental Science*, *49*, 179-. doi:10.1192/bjp.49.204.179
- Mahler, M. (1972). Rapprochement Subphase of the Separation-Individuation Process. *Psychoanalytic Quarterly*, *41*, 487-506.
- Maples, J., Collins, B., Miller, J. D., Fischer, S., & Seibert, A. (2011). Differences between grandiose and vulnerable narcissism and bulimic symptoms in young women. *Eating Behaviors*, *12*, 83-85. doi:10.1016/j.eatbeh.2010.10.001
- Marks, I. M. (1970a). The classification of phobic disorders. *British Journal of Psychiatry*, *116*, 377-386. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1971-00944-001&site=ehost-live&scope=site>
- Marks, I. M. (1970b). The origins of phobic states. *American Journal of Psychotherapy*, *24*, 652-676. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1971-10338-001&site=ehost-live&scope=site>
- Marks, I. M. (1995). Advances in behavioral-cognitive therapy of social phobia. *Journal of Clinical Psychiatry*, *56*, 25-31. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1996-92026-001&site=ehost-live&scope=site>
- Marks, I. M., & Gelder, M. G. (1966). Different ages of onset in varieties of phobia. *American Journal of Psychiatry*, *123*, 218-221. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1966-11297-001&site=ehost-live&scope=site>
- Marks, I. M., & Mathews, A. (1979). A brief standard rating scale for phobic patients. *Behaviour Research and Therapy*, *17*, 263-267.

- Masterson, J. F. (1987). Borderline and narcissistic disorders: An integrated developmental object-relations approach. In J. S. Grotstein, M. F. Solomon, & J. A. Lang (Eds.), *The borderline patient: Emerging concepts in diagnosis, psychodynamics and treatment, Vols. 1 & 2.* (pp. 205-217). Hillsdale, NJ, England: Analytic Press, Inc.
- Masterson, J. F. (1993). *The emerging self: A developmental, self, and object relations approach to the treatment of the closet narcissistic disorder of the self.* Philadelphia, PA, US: Brunner/Mazel.
- Masterson, J. F. (1995). Paradise lost--Bulimia, a closet narcissistic personality disorder: A developmental, self, and object relations approach. In R. C. Marohn & S. C. Feinstein (Eds.), *Adolescent psychiatry: Developmental and clinical studies, Vol. 20.* (pp. 253-266). Hillsdale, NJ, England: Analytic Press, Inc.
- Masterson, J. F. (2004). Evolution of the Masterson Approach. In J. F. Masterson & A. R. Lieberman (Eds.), *A therapist's guide to the personality disorders: The Masterson Approach.* (pp. 1-11). Phoenix, AZ, US: Zeig, Tucker & Theisen.
- Matsunaga, H., Kiriike, N., Matsui, T., Iwasaki, Y., & Stein, D. J. (2001). Taijin kyofusho: A form of social anxiety disorder that responds to serotonin reuptake inhibitors? *International Journal of Neuropsychopharmacology, 4*, 231-237. doi:10.1017/s1461145701002474
- Mattick, R. P., & Clarke, J. C. (1998). Development and validation of measures of social phobia scrutiny fear and social interaction anxiety. *Behaviour Research and Therapy, 36*, 455-470. doi:10.1016/S0005-7967(97)10031-6
- Maudsley, H. (1895). *The Pathology of mind: A Study of Its Distempers, Deformities, and Disorders.* London: MacMillon and Co.
- Mayes, R., & Horwitz, A. V. (2005). DSM-III and the revolution in the classification of mental illness. *Journal of the History of the Behavioral Sciences, 41*, 249-267. doi:10.1002/jhbs.20103
- Mazalin, D., & Klein, B. (2008). Social Anxiety and the Internet: Positive and Negative Effects. *E-Journal of Applied Psychology [Online], 4*, 43-50. Available: <http://ojs.lib.swin.edu.au/index.php/ejap/article/view/48/157>. Retrieved from Available: <http://ojs.lib.swin.edu.au/index.php/ejap/article/view/8/157>
- McEwan, K., Gilbert, P., & Duarte, J. (2012). An exploration of competitiveness and caring in relation to psychopathology. *British Journal of Clinical Psychology, 51*, 19-36. doi:10.1111/j.2044-8260.2011.02010.x
- McLeod, H. J., Coertze, L., & Moore, E. (2009). The relationship between insight and social rank appraisals in people with schizophrenia. *British Journal of Clinical Psychology, 48*, 329-334. doi:10.1348/978185409x443378
- Miller, A. (1979). Depression and grandiosity as related forms of narcissistic disturbances. *The International Journal of Psychoanalysis, 6*, 61-76. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1991-56678-001&site=ehost-live&scope=site>
- Miller, J. D., & Campbell, W. K. (2008). Comparing Clinical and Social-Personality Conceptualizations of Narcissism. *Journal of Personality, 76*, 449-476. doi:10.1111/j.1467-6494.2008.00492.x

- Miller, J. D., & Campbell, W. K. (2010). The Case for Using Research on Trait Narcissism as a Building Block for Understanding Narcissistic Personality Disorder. *Personality Disorders: Theory, Research, and Treatment*, 1, 180-191. Retrieved from <http://www.sciencedirect.com/science/article/B6KF0-50XPS72-4/2/cd585e285a7d5808ba6088995fd1b233>
- Miller, J. D., Maples, J., & Campbell, W. K. (2011). Comparing the construct validity of scales derived from the Narcissistic Personality Inventory: A reply to Rosenthal and Hooley (2010). *Journal of Research in Personality*, 45, 401-407. doi:DOI: 10.1016/j.jrp.2010.12.004
- Miller, J. D., Widiger, T. A., & Campbell, W. K. (2010). Narcissistic personality disorder and the DSM-V. *Journal of Abnormal Psychology*, 119, 640-649. doi:10.1037/a0019529
- Milligan, G. W., & Cooper, M. C. (1987). Methodology review: Clustering methods. *Applied Psychological Measurement*, 11, 329-354. doi:10.1177/014662168701100401
- Millon, T. (1969). *Modern Psychopathology: A Biosocial Approach to Maladaptive Learning and Functioning*. Philadelphia: W.B. Saunders.
- Millon, T. (1981). *Disorders of Personality : DSM-III: Axis II*. New York: Wiley.
- Millon, T., Grossman, G., Millon, C., Meagher, S., & Ramnath, R. (2004). *Personality Disorders in Modern Life*. Wiley: New Jersey.
- Mitchell, K. R., & Orr, F. E. (1974). Note on treatment of heterosexual anxiety using short-term massed desensitization. *Psychological Reports*, 35, 1093-1094. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1975-12224-001&site=ehost-live&scope=site>
- Montebarocci, O., Surcinelli, P., Baldaro, B., Trombini, E., & Rossi, N. (2004). Narcissism Versus Proneness to Shame and Guilt. *Psychological Reports*, 94, 883-887. doi:10.2466/pr0.94.3.883-887
- Moore, J. (2010). Philosophy of science, with special consideration given to behaviorism as the philosophy of the science of behavior. *Psychological Record*, 60, 137-150. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=48110301&site=ehost-live&scope=site>
- Moore, J. (2011). Behaviorism. *Psychological Record*, 61, 449-465. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=65033133&site=ehost-live&scope=site>
- Morey, L. C., Waugh, M. H., & Blashfield, R. K. (1985). MMPI Scales for DSM-III Personality Disorders: Their Derivation and Correlates. *Journal of Personality Assessment*, 49, 245-251. doi:10.1207/s15327752jpa4903\_5
- Morita, S. (1928/1998). *Morita therapy and the true nature of anxiety-based disorders (shinkeishitsu)* (A. Kondo, Trans.). Albany, NY, US: State University of New York Press.
- Mullins, L. S., & Kopelman, R. E. (1988). Toward an Assessment of the Construct Validity of Four Measures of Narcissism. *Journal of Personality Assessment*, 52, 610. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=6385595&site=ehost-live>
- Murray, H. A. (1938). *Explorations in Personality : A Clinical and Experimental Study of Fifty Men of College Age*. New York: John Wiley.

- Myerson, A. (1944). The social anxiety neurosis--its possible relationship to schizophrenia. *American Journal of Psychiatry*, *101*, 149-156. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1945-03003-001&site=ehost-live>
- Nagata, T., Oshima, J., Wada, A., Yamada, H., Iketani, T., & Kiriike, N. (2003). Open trial of milnacipran for Taijin-Kyofusho in Japanese patients with social anxiety disorder. *International Journal of Psychiatry in Clinical Practice*, *7*, 107. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=10282169&site=ehost-live&scope=site>
- Nagata, T., van Vliet, I., Yamada, H., Kataoka, K., Iketani, T., & Kiriike, N. (2006). An open trial of paroxetine for the "offensive subtype" of taijin kyofusho and social anxiety disorder. *Depression & Anxiety (1091-4269)*, *23*, 168-174. doi:10.1002/da.20153
- Nagata, T., Wada, A., Yamada, H., Iketani, T., & Kiriike, O. (2005). Effect of milnacipran on insight and stress coping strategy in patients with Taijin Kyofusho. *International Journal of Psychiatry in Clinical Practice*, *9*, 193-198. doi:10.1080/13651500510029228
- Nakamura, K. (1992). A review of social phobia research and treatment: From a Morita therapist's perspective. *International Bulletin of Morita Therapy*, *5*, 35-45. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1993-34350-001&site=ehost-live>
- Nakamura, K. (2006). Taijin-Kyofu-Sho (Phobia of Interpersonal Situation) and Social Phobia. In C. M. Velotis (Ed.), *New Developments in Anxiety Disorder Research* (pp. 199-215). New York: Nova Science Publishers.
- Nakamura, K., Kitanishi, K., Miyake, Y., Hashimoto, K., & Kubota, M. (2002). The neurotic versus delusional subtype of taijin-kyofu-sho: Their DSM diagnoses. *Psychiatry & Clinical Neurosciences*, *56*, 595. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=8717257&site=ehost-live&scope=site>
- Nardi, A. E. (2005). Early diagnosis can decrease the social and economic burden of social anxiety disorder. *Australian and New Zealand Journal of Psychiatry*, *39*, 641-642. doi:10.1111/j.1440-1614.2005.01638\_5.x
- Ng, H. K. S., Tam, K.-P., & Shu, T.-M. (2011). The money attitude of covert and overt narcissists. *Personality and Individual Differences*, *51*, 160-165. doi:10.1016/j.paid.2011.03.036
- Nunnally, J. C. (1974). *Introduction to Statistics for Psychology and Education*: McGraw-Hill.
- Nunnally, J. C. (1978). *Psychometric theory* (2nd ed.). New York: McGraw-Hill.
- Okada, R. (2010). The relationship between vulnerable narcissism and aggression in Japanese undergraduate students. *Personality and Individual Differences*, *49*, 113-118. doi:10.1016/j.paid.2010.03.017
- Olivares, J., García-López, L. J., & Hidalgo, M. D. (2001). The Social Phobia Scale and the Social Interaction Anxiety Scale: Factor structure and reliability in a Spanish-speaking population. *Journal of Psychoeducational Assessment*, *19*, 69-80. doi:10.1177/073428290101900105

- Ono, Y., Yoshimura, K., Yamauchi, K., Asai, M., Young, J., Fujuhara, S., & Kitamura, T. (2001). Taijin kyofusho in a Japanese community population. *Transcultural Psychiatry, 38*, 506-514. doi:10.1177/136346150103800408
- Orr, F. E., Mitchell, K. R., & Hall, R. F. (1975). Effects of reductions in social anxiety on behaviour in heterosexual situations. *Australian Psychologist, 10*, 139-148. doi:10.1080/00050067508256451
- Osman, A., Gutierrez, P. M., Barrios, F. X., Kopper, B. A., & Chiros, C. E. (1998). The Social Phobia and Social Interaction Anxiety Scales: Evaluation of psychometric properties. *Journal of Psychopathology and Behavioral Assessment, 20*, 249-264. doi:10.1023/a:1023067302227
- Pace, E. A. (1902). Review of "Les Timides et la Timidité". *Psychological Review, 9*, 100-101. doi:10.1037/h0069253
- Page, A. C., Hooke, G. R., & Morrison, D. L. (2007). Psychometric properties of the Depression Anxiety Stress Scales (DASS) in depressed clinical samples. *British Journal of Clinical Psychology, 46*, 283-297. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=26614422&site=ehost-live&scope=site>
- Pandey, R., Mandal, M. K., Taylor, G. J., & Parker, J. D. A. (1996). Cross-cultural alexithymia: Development and validation of a Hindi translation of the 20-item. *Journal of Clinical Psychology, 52*, 173-176. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=9606230195&site=ehost-live&scope=site>
- Parker, G. A. (1974). Assessment strategy and the evolution of fighting behaviour. *Journal of Theoretical Biology, 47*, 223-243. Retrieved from <http://www.sciencedirect.com/science/article/B6WMD-4F1SV94-12Y/2/b73f95df9ef48bb19d9649f0fe371ef4>
- Parker, J. D. A., Bagby, R. M., Taylor, G. J., Endler, N. S., & Schmitz, P. (1993). Factorial validity of the 20-item Toronto Alexithymia Scale. *European Journal of Personality, 7*, 221-232. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=12110425&site=ehost-live>
- Parker, J. D. A., Taylor, G. J., & Bagby, R. M. (2003). The 20-Item Toronto Alexithymia Scale III. Reliability and factorial validity in a community population. *Journal of Psychosomatic Research, 55*, 269-275.
- PDM Taskforce. (2006). *Psychodynamic Diagnostic Manual (PDM)*. Silver Spring, MD: Alliance of Psychoanalytic Organizations.
- Perugi, G., Nassini, S., Maremmanni, I., Madaro, D., Toni, C., Simonini, E., & Akiskal, H. S. (2001). Putative clinical subtypes of social phobia: a factor-analytical study. *Acta Psychiatrica Scandinavica, 104*, 280-288. doi:10.1034/j.1600-0447.2001.00128.x
- Pincus, A. L., Ansell, E. B., Pimentel, C. A., Cain, N. M., Wright, A. G. C., & Levy, K. N. (2009). Initial construction and validation of the Pathological Narcissism Inventory. *Psychological Assessment, 21*, 365-379.
- Piqueras, J. A., Olivares, J., & López-Pina, J. A. (2008). A new proposal for the subtypes of social phobia in a sample of Spanish adolescents. *Journal of Anxiety Disorders, 22*, 67-77. doi:10.1016/j.janxdis.2007.01.007
- Pishyar, R., Harris, L. M., & Menzies, R. G. (2004). Attentional Bias For Words And Faces In Social Anxiety. *Anxiety, Stress & Coping, 17*, 23-36. doi:10.1080/10615800310001601458

- Pishyar, R., Harris, L. M., & Menzies, R. G. (2008). Responsiveness of measures of attentional bias to clinical change in social phobia. *Cognition & Emotion, 22*, 1209-1227. doi:10.1080/02699930701686008
- Pitman, R. K. (1984). Janet's Obsessions and Psychasthenia: A synopsis. *Psychiatric Quarterly, 56*, 291-314. doi:10.1007/BF01064475
- Price, J. S. (1992). The agonistic and hedonic modes: definition, usage, and the promotion of mental health. *World Futures, 35*, 87-115.
- Price, J. S., Gardner, R., Jr., Wilson, D. R., Sloman, L., Rohde, P., & Erickson, M. (2007). Territory, rank and mental health: The history of an idea. *Evolutionary Psychology, 5*, 531-554.
- Prifitera, A., & Ryan, J. J. (1984). Validity of the Narcissistic Personality Inventory (NPI) in a Psychiatric Sample. *Journal of Clinical Psychology, 40*, 140-142. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=18720053&site=ehost-live&scope=site>
- Przeworski, A., Newman, M. G., Pincus, A. L., Kasoff, M. B., Yamasaki, A. S., Castonguay, L. G., & Berlin, K. S. (2011). Interpersonal Pathoplasticity in Individuals with Generalized Anxiety Disorder. *Journal of Abnormal Psychology, 120*, 286-298. doi:10.1037/a0023334
- Publius Ovidius Naso. (1812). *Metamorphoses* (S. Garth, Trans.): Suttaby, Evance, and Fox.
- Rabung, S., Jaeger, U., Streeck, U., & Leichsenring, F. (2006). Psychometrische Überprüfung der Social Phobia Scale (SPS) und der Social Interaction Anxiety Scale (SIAS) im stationären Setting. *Diagnostica, 52*, 143-153. doi:10.1026/0012-1924.52.3.143
- Rachman, S. (1959). The treatment of anxiety and phobic reactions by systematic desensitization psychotherapy. *The Journal of Abnormal and Social Psychology, 58*, 259-263. doi:10.1037/h0040150
- Ralevski, E., Sanislow, C. A., Grilo, C. M., Skodol, A. E., Gunderson, J. G., Shea, M. T., . . . McGlashan, T. H. (2005). Avoidant personality disorder and social phobia: distinct enough to be separate disorders? *Acta Psychiatrica Scandinavica, 112*, 208-214. doi:10.1111/j.1600-0447.2005.00580.x
- Rapaport, D. (1966). Dynamic psychology and Kantian epistemology. *Journal of the History of the Behavioral Sciences, 2*, 192-199. doi:10.1002/1520-6696(196607)2:3<192::AID-JHBS2300020303>3.0.CO;2-C
- Rapee, R. M. (1998). *Overcoming Shyness and Social Phobia: A Step-by-Step Guide*: Jason Aronson, Incorporated.
- Rapee, R. M., & Heimberg, R. G. (1997). A cognitive-behavioral model of anxiety in social phobia. *Behaviour Research and Therapy, 35*, 741-756. Retrieved from <http://www.sciencedirect.com/science/article/B6V5W-3SX0JVW-5/2/92f05a235098d0bd6bb8a5239441ec07>
- Raskin, R. N. (1980). Narcissism and creativity: Are they related? *Psychological Reports, 46*, 55-60. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1981-10496-001&site=ehost-live&scope=site>
- Raskin, R. N., & Hall, C. S. (1979). A narcissistic personality inventory. *Psychological Reports, 45*, 590-590. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1981-08131-001&site=ehost-live>

- Raskin, R. N., & Hall, C. S. (1981). The Narcissistic Personality Inventory: Alternative Form Reliability and Further Evidence of Construct Validity. *Journal of Personality Assessment*, 45, 159. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=6383755&site=ehost-live>
- Raskin, R. N., & Novacek, J. (1989). An MMPI Description of the Narcissistic Personality. *Journal of Personality Assessment*, 53, 66. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=6385871&site=ehost-live&scope=site>
- Raskin, R. N., & Novacek, J. (1991). Narcissism and the use of fantasy. *Journal of Clinical Psychology*, 47, 490-499. doi:10.1002/1097-4679(199107)47:4<490::AID-JCLP2270470404>3.0.CO;2-J
- Raskin, R. N., & Terry, H. (1988). A principal-components analysis of the Narcissistic Personality Inventory and further evidence of its construct validity. *Journal of Personality and Social Psychology*, 54, 890-902. doi:10.1037/0022-3514.54.5.890
- Rathvon, N., & Holmstrom, R. W. (1996). An MMPI-2 Portrait of Narcissism. *Journal of Personality Assessment*, 66, 1. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=6380084&site=ehost-live&scope=site>
- Rector, N. A., Kocovski, N. L., & Ryder, A. G. (2006). Social Anxiety and the Fear of Causing Discomfort to Others. *Cognitive Therapy & Research*, 30, 279-296. doi:10.1007/s10608-006-9050-9
- Reich, A. (1960). Pathologic forms of self-esteem regulation. *The Psychoanalytic Study of the Child*, 15, 215-232.
- Reich, J. (2000). The relationship of social phobia to avoidant personality disorder: A proposal to reclassify avoidant personality disorder based on clinical empirical findings. *European Psychiatry*, 15, 151-159. doi:10.1016/s0924-9338(00)00240-6
- Rettew, D. C. (2000). Avoidant Personality Disorder, Generalized Social Phobia, and Shyness: Putting the Personality Back into Personality Disorders. *Harvard Review of Psychiatry*, 8, 283. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=10909790&site=ehost-live&scope=site>
- Rhodewalt, F., Madrian, J. C., & Cheney, S. (1998). Narcissism, self-knowledge organization, and emotional reactivity: The effect of daily experiences on self-esteem and affect. *Personality and Social Psychology Bulletin*, 24, 75-87. doi:10.1177/0146167298241006
- Rhodewalt, F., & Morf, C. C. (1995). Self and interpersonal correlates of the Narcissistic Personality Inventory: A review and new findings. *Journal of Research in Personality*, 29, 1-23. doi:10.1006/jrpe.1995.1001
- Rhodewalt, F., & Morf, C. C. (1998). On self-aggrandizement and anger: A temporal analysis of narcissism and affective reactions to success and failure. *Journal of Personality and Social Psychology*, 74, 672-685. doi:10.1037/0022-3514.74.3.672
- Rhodewalt, F., Tragakis, M. W., & Finnerty, J. (2006). Narcissism and self-handicapping: Linking self-aggrandizement to behavior. *Journal of Research in Personality*, 40, 573-597.

- Rodebaugh, T. L., Woods, C. M., & Heimberg, R. G. (2007). The reverse of social anxiety is not always the opposite: The reverse-scored items of the social interaction anxiety scale do not belong. *Behavior Therapy, 38*, 192-206. doi:10.1016/j.beth.2006.08.001
- Rose, P. (2002). The happy and unhappy faces of narcissism. *Personality and Individual Differences, 33*, 379-392.
- Rosenfeld, H. A. (1987). *Impasse and Interpretation. Therapeutic and anti-therapeutic factors in the psychoanalytic treatment of psychotic, borderline, and neurotic patients*. New York: Brunner-Routledge.
- Rosenfeld, H. A. (1988). On masochism: A theoretical and clinical approach. In R. A. Glick & D. I. Meyers (Eds.), *Masochism: Current psychoanalytic perspectives*. (pp. 151-174). Hillsdale, NJ England: Analytic Press, Inc.
- Rosenthal, S. A., & Hooley, J. M. (2010). Narcissism assessment in social-personality research: Does the association between narcissism and psychological health result from a confound with self-esteem? *Journal of Research in Personality, 44*, 453-465. doi:DOI: 10.1016/j.jrp.2010.05.008
- Roth, D. A. (2004). Cognitive Theories of Social Phobia. In B. Bandelow & D. J. Stein (Eds.), *Social Anxiety Disorder* (pp. 143-159). New York: Marcel Dekker, Inc.
- Russ, E., Shedler, J., Bradley, R., & Westen, D. (2008). Refining the construct of narcissistic personality disorder: Diagnostic criteria and subtypes. *American Journal of Psychiatry, 165*, 1473-1481.
- Sacher-Masoch, L. v. (1923/2007). *Venus in Furs* (F. Savage, Trans.). London: Bookkake.
- Safren, S. A., Turk, C. L., & Heimberg, R. G. (1998). Factor structure of the Social Interaction Anxiety Scale and the Social Phobia Scale. *Behaviour Research and Therapy, 36*, 443-453. doi:10.1016/s0005-7967(98)00032-1
- Sahebi, A., Asghari, M. J., & Salari, R. S. (2004). Validation of depression anxiety and stress scale (DASS-21) for an Iranian population. *Journal of Iranian Psychologists, 1*.
- Salkovskis, P. M., Clark, D. M., Hackmann, A., Wells, A., & Gelder, M. G. (1999). An experimental investigation of the role of safety-seeking behaviours in the maintenance of panic disorder with agoraphobia. *Behaviour Research and Therapy, 37*, 559-574. Retrieved from <http://www.sciencedirect.com/science/article/B6V5W-3WH646T-4/2/6974d4ec7288c983f3011a5e6055aff4>
- Sandler, J. (1954). Studies in psychopathology using a self-assessment inventory. I. The development and construction of the inventory. *British Journal of Medical Psychology, 27*, 142-145. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1955-02471-001&site=ehost-live>
- Sandler, J., De Monchaux, C., & Dixon, J. J. (1958). Patterns of anxiety: The correlates of social anxieties. *British Journal of Medical Psychology, 31*, 24-31. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1959-08711-001&site=ehost-live>
- Sasaki, J., & Tanno, Y. (2006). Two Cognitions Observed in Taijin-Kyofusho and Social Anxiety Symptoms. *Psychological Reports, 98*, 395-406.

- Schilder, P. (1938). The social neurosis. *Psychoanalytic Review*, 25, 1-19. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1938-02478-001&site=ehost-live>
- Schlenker, B. R. (1980). *Impression management: The self-concept, social identity and interpersonal relations*. California: Brooks/Cole.
- Schlenker, B. R., & Leary, M. R. (1982). Social anxiety and self-presentation: A conceptualization model. *Psychological Bulletin*, 92, 641-669. doi:10.1037/0033-2909.92.3.641
- Schuerger, J. M., Foerster, S. B., Serkownek, K., & Ritz, G. (1987). History and validities of the Serkownek subscales for MMPI Scales 5 and 0. *Psychological Reports*, 61, 227-235. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1988-31491-001&site=ehost-live>
- Schurman, C. L. (2000). *Social phobia, shame and hypersensitive narcissism*. (PhD Thesis), The Wright Institute, Berkeley, California.
- Sedikides, C., Campbell, W. K., Reeder, G. D., Elliot, A. J., & Gregg, A. P. (2002). Do others bring out the worst in narcissists? The 'others exist for me' illusion. In Y. Kashima, M. Foddy, & M. J. Platow (Eds.), *Self and identity: Personal, social, and symbolic*. (pp. 103-124). Mahwah, NJ, US: Lawrence Erlbaum Associates Publishers.
- Sedikides, C., Rudich, E. A., Gregg, A. P., Kumashiro, M., & Rusbult, C. (2004). Are Normal Narcissists Psychologically Healthy?: Self-Esteem Matters. *Journal of Personality and Social Psychology*, 87, 400-416.
- Shedler, J. (2006). *That was then, this is now: Psychoanalytic Psychotherapy for the rest of us*. University of Colorado School of Medicine. Retrieved from [http://www.psychsystems.net/Publications/Shedler/Shedler%20\(2006\)%20That%20was%20then,%20this%20is%20now%20R7.pdf](http://www.psychsystems.net/Publications/Shedler/Shedler%20(2006)%20That%20was%20then,%20this%20is%20now%20R7.pdf)
- Sica, C., Musoni, I., Chiri, L. R., Bisi, B., Lolli, V., & Sighinolfi, C. (2007). Social Phobia Scale (SPS) e Social Interaction Anxiety Scale (SIAS): Traduzione ed adattamento Italiano. *Bollettino di Psicologia Applicata*, 252, 59-71. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=2007-13941-007&site=ehost-live&scope=site>
- Simonsson-Sarnecki, M., Lundh, L.-G., Törestad, B., Bagby, R. M., Taylor, G. J., & Parker, J. D. A. (2000). A Swedish translation of the 20-item Toronto Alexithymia Scale: Cross-validation of the factor structure. *Scandinavian Journal of Psychology*, 41, 25-30. doi:10.1111/1467-9450.00167
- Skinner, B. F. (1957). *Verbal Behavior*. New York: Appleton-Century-Crofts, Inc.
- Skinner, B. F. (1985). Cognitive science and behaviourism. *British Journal of Psychology*, 76, 291. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=5700408&site=ehost-live&scope=site>
- Sloman, L. (2002). Involuntary Defeat Strategy as Backdrop for Depression. In G. A. Cory & R. Gardner (Eds.), *The Evolutionary Neuroethology of Paul MacLean: Convergences and Frontiers* (pp. 119-132). CT: Praeger
- Smolewska, K., & Dion, K. (2005). Narcissism and Adult Attachment: A Multivariate Approach. *Self & Identity*, 4, 59-68. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=15566090&site=ehost-live>

- Solomon, R. S. (1982). Validity of the MMPI Narcissistic Personality Disorder Scale. *Psychological Reports, 50*, 463-466. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1982-29459-001&site=ehost-live>
- Soyer, R. B., Rovenpor, J. L., Kopelman, R. E., Mullins, L. S., & Watson, P. J. (2001). Further Assessment of the Construct Validity of Four Measures of Narcissism: Replication and Extension. *Journal of Psychology, 135*, 245. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=6002403&site=ehost-live>
- Sperry, L. (2006). Psychopharmacology as an Adjunct to Psychotherapy in the Treatment of Personality Disorders. *Journal of Individual Psychology, 62*, 324-337. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=23596615&site=ehost-live&scope=site>
- Spielberger, C. D., Gorsuch, R. L., Lushene, P. R., Vagg, P. R., & Jacobs, G. A. (1983). *Manual for the State-Trait Anxiety Inventory*.: Consulting Psychologists Press, Inc.
- Spiers, H., & Lynch, M. (1977). The Gay Rights Freud. *Body Politic, 8*. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=qth&AN=10383007&site=ehost-live&scope=site>
- Stangier, U., Heidenreich, T., Berardi, A., Golbs, U., & Hoyer, J. (1999). Die Erfassung sozialer Phobie durch Social Interaction Anxiety Scale (SIAS) und die Social Phobia Scale (SPS). *Zeitschrift für Klinische Psychologie, 28*, 28-36. doi:10.1026//0084-5345.28.1.28
- Stein, M. B., & Deutsch, R. (2003). In search of social phobia subtypes: Similarity of feared social situations. *Depression & Anxiety (1091-4269), 17*, 94-97. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=10002230&site=ehost-live&scope=site>
- Stein, M. B., Torgrud, L. J., & Walker, J. R. (2000). Social Phobia Symptoms, Subtypes, and Severity: Findings From a Community Survey. *Arch Gen Psychiatry, 57*, 1046-1052. doi:10.1001/archpsyc.57.11.1046
- Steinley, D. (2006a). K-means clustering: A half-century synthesis. *British Journal of Mathematical & Statistical Psychology, 59*, 1-34. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=21291408&site=ehost-live>
- Steinley, D. (2006b). Profiling Local Optima in K-Means Clustering: Developing a Diagnostic Technique. *Psychological Methods, 11*, 178-192.
- Strachey, J. (1953). Editors Introduction: Inhibitions, Symptoms and Anxiety (A. Strachey, Trans.). In J. Strachey (Ed.), *The Standard Edition of the Complete Psychological Works of Sigmund Freud* (Vol. 20, pp. 76-??). London: Hogarth Press.
- Sturman, E. D. (2011). Involuntary subordination and its relation to personality, mood, and submissive behavior. *Psychological Assessment, 23*, 262-276. doi:10.1037/a0021499
- Suk Choo, C. (1997). Social anxiety (phobia) and East Asian culture. *Depression & Anxiety, 5*, 115-120. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=11772655&site=ehost-live>

- Suslow, T., Donges, U.-S., Kersting, A., & Arolt, V. (2000). 20-Item Toronto Alexithymia Scale: Do difficulties describing feelings assess proneness to shame instead of difficulties symbolizing emotions? *Scandinavian Journal of Psychology, 41*, 329. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=5315755&site=ehost-live&scope=site>
- Suzuki, K., Takei, N., Kawai, M., Minabe, Y., & Mori, N. (2003). Is Taijin Kyofusho a Culture-Bound Syndrome? . *The American Journal of Psychiatry, 160*, 1358.
- Sweetingham, R., & Waller, G. (2008). Childhood experiences of being bullied and teased in the eating disorders. *European Eating Disorders Review, 16*, 401-407. Retrieved from <http://www.scopus.com/scopus/inward/record.url?eid=2-s2.0-53349144507&partnerID=40>
- Szabó, M. (2010). The short version of the Depression Anxiety Stress Scales (DASS-21): Factor structure in a young adolescent sample. *Journal of Adolescence, 33*, 1-8. doi:10.1016/j.adolescence.2009.05.014
- Szabó, M. (2011). The emotional experience associated with worrying: anxiety, depression, or stress? *Anxiety, Stress & Coping, 24*, 91-105. doi:10.1080/10615801003653430
- Tabachnick, B. G., & Fidell, L. S. (2007). *Using multivariate statistics* (5th ed.). Boston: Pearson/Allyn & Bacon.
- Takahashi, T. (1989). Social phobia syndrome in Japan. *Comprehensive Psychiatry, 30*, 45-52. doi:10.1016/0010-440X(89)90117-X
- Tarumi, S., Ichimiya, A., Yamada, S., Umesue, M., & Kuroki, T. (2004). Taijin Kyofusho in University Students: Patterns of Fear and Predispositions to the Offensive Variant. *Transcultural Psychiatry, 41*, 533-546. doi:10.1177/1363461504047933
- Taylor, G. J., & Bagby, R. M. (2004). New Trends in Alexithymia Research. *Psychotherapy and Psychosomatics, 73*, 68-77. doi:10.1159/000075537
- Taylor, G. J., Bagby, R. M., & Parker, J. D. A. (2003). The 20-Item Toronto Alexithymia Scale IV. Reliability and factorial validity in different languages and cultures. *Journal of Psychosomatic Research, 55*, 277-283.
- Taylor, S. (1996). Meta-analysis of cognitive-behavioral treatments for social phobia. *Journal of Behavior Therapy and Experimental Psychiatry, 27*, 1-9. doi:http://dx.doi.org/10.1016/0005-7916(95)00058-5
- Tillfors, M., Furmark, T., Carlbring, P., & Andersson, G. (2015). Risk profiles for poor treatment response to internet-delivered CBT in people with social anxiety disorder. *Journal of Anxiety Disorders, 33*, 103-109. doi:http://dx.doi.org/10.1016/j.janxdis.2015.05.007
- Tillfors, M., Furmark, T., Ekselius, L., & Fredrikson, M. (2004). Social phobia and avoidant personality disorder: One spectrum disorder? *Nordic Journal of Psychiatry, 58*, 147-152. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=12751150&site=ehost-live>
- Townsend, J. S., & Martin, J. A. (1983). Whatever happened to neurosis? An overview. *Professional Psychology: Research and Practice, 14*, 323-329. doi:10.1037/0735-7028.14.3.323

- Tran, G. Q., & Chambless, D. L. (1995). Psychopathology of social phobia: Effects of subtype and of avoidant personality disorder. *Journal of Anxiety Disorders, 9*, 489-501. doi:10.1016/0887-6185(95)00027-1
- Trout, J. M. (1897). La Timidité, Étude Psychologique. *Psychological Review, 4*, 443-445. doi:10.1037/h0065461
- Trower, P., & Gilbert, P. (1989). New theoretical conceptions of social anxiety and social phobia. *Clinical Psychology Review, 9*, 19-35. doi:10.1016/0272-7358(89)90044-5
- Trower, P., Gilbert, P., & Sherling, G. (1990). Social anxiety, evolution, and self-presentation: An interdisciplinary perspective. In H. Leitenberg (Ed.), *Handbook of social and evaluation anxiety*. (pp. 11-45). New York, NY US: Plenum Press.
- Trower, P., & Turland, D. (1984). Social phobia. In S. M. Turner (Ed.), *Behavioral theories and treatment of anxiety* (pp. 321-365). New York: Plenum.
- Turner, S. M., Beidel, D. C., & Townsley, R. M. (1992). Social phobia: A comparison of specific and generalized subtypes and avoidant personality disorder. *Journal of Abnormal Psychology, 101*, 326-331. doi:10.1037/0021-843x.101.2.326
- Twenge, J. M., Konrath, S., Foster, J. D., Keith Campbell, W., & Bushman, B. J. (2008). Egos Inflating Over Time: A Cross-Temporal Meta-Analysis of the Narcissistic Personality Inventory. *Journal of Personality, 76*, 875-902. doi:10.1111/j.1467-6494.2008.00507.x
- Van Der Waals, H. G. (1965). Problems of narcissism. *Bulletin of the Menninger Clinic, 29*, 293-311. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psyh&AN=1966-03101-001&site=ehost-live&scope=site>
- van Velzen, C. J. M., Emmelkamp, P. M. G., & Scholing, A. (2000). Generalized social phobia versus avoidant personality disorder: Differences in psychopathology, personality traits, and social and occupational functioning. *Journal of Anxiety Disorders, 14*, 395-411. doi:10.1016/s0887-6185(00)00030-x
- Vassilopoulos, S. (2005). Social Anxiety and the Effects of Engaging in Mental Imagery. *Cognitive Therapy & Research, 29*, 261-277. doi:10.1007/s10608-005-2993-4
- Vater, A., Schröder-Abé, M., Ritter, K., Renneberg, B., Schulze, L., Bosson, J. K., & Roepke, S. (2013). The narcissistic personality inventory: A useful tool for assessing pathological narcissism? Evidence from patients with narcissistic personality disorder. *Journal of Personality Assessment, 95*, 301-308. doi:10.1080/00223891.2012.732636
- 10.1177/1073191110382845
- Vazire, S., & Funder, D. C. (2006). Impulsivity and the self-defeating behavior of narcissists. *Personality and Social Psychology Review, 10*, 154-165. doi:10.1207/s15327957pspr1002\_4
- Veljaca, K.-A., & Rapee, R. M. (1998). Detection of negative and positive audience behaviours by socially anxious subjects. *Behaviour Research and Therapy, 36*, 311-321. doi:10.1016/s0005-7967(98)00016-3
- Vertue, F. M. (2003). From Adaptive Emotion to Dysfunction: An Attachment Perspective on Social Anxiety Disorder. *Personality & Social Psychology Review (Lawrence Erlbaum Associates), 7*, 170-191.
- Vriends, N., Becker, E. S., Meyer, A., Michael, T., & Margraf, J. (2007). Subtypes of social phobia: Are they of any use? *Journal of Anxiety Disorders, 21*, 59-75. doi:10.1016/j.janxdis.2006.05.002

- Waschull, S. B., & Kernis, M. H. (1996). Level and stability of self-esteem as predictors of children's intrinsic motivation and reasons for anger. *Personality and Social Psychology Bulletin*, *22*, 4-13. doi:10.1177/0146167296221001
- Watson, D., & Friend, R. M. (1969). Measurement of Social-Evaluative Anxiety. *Journal of Consulting and Clinical Psychology*, *33*, 448-457.
- Watson, J. B. (1913). Psychology as the behaviourist views it. *Psychological Review*, *20*, 158-177. doi:10.1037/h0074428
- Watson, J. B. (1914). *Behavior : an introduction to comparative psychology*. New York: H. Holt.
- Watson, J. B. (1916). Behavior and the Concept of Mental Disease. *The Journal of Philosophy, Psychology and Scientific Methods*, *13*, 589-597. Retrieved from <http://www.jstor.org/stable/2012555>
- Watson, P. J., Biderman, M. D., & Sawrie, S. M. (1994). Empathy, sex role orientation, and narcissism. *Sex Roles*, *30*, 701-723. doi:10.1007/bf01544671
- Watson, P. J., Grisham, S. O., Trotter, M. V., & Biderman, M. D. (1984). Narcissism and Empathy: Validity Evidence for the Narcissistic Personality Inventory. *Journal of Personality Assessment*, *48*, 301. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=6385820&site=e=ehost-live>
- Watson, P. J., & Hickman, S. E. (1995). Narcissism, self-esteem, and parental nurturance. *Journal of Psychology*, *129*, 61. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=9503303600&site=ehost-live&scope=site>
- Watson, P. J., Hickman, S. E., & Morris, R. J. (1996). Self-reported narcissism and shame: Testing the defensive self-esteem and continuum hypotheses. *Personality and Individual Differences*, *21*, 253-259. doi:10.1016/0191-8869(96)00063-3
- Watson, P. J., & Morris, R. J. (1990). Irrational beliefs and the problem of narcissism. *Personality and Individual Differences*, *11*, 1137-1140. doi:10.1016/0191-8869(90)90025-m
- Watson, P. J., Morris, R. J., & Miller, L. (1997). Narcissism and the self as continuum: Correlations with assertiveness and hypercompetitiveness. *Imagination, Cognition and Personality*, *17*, 249-259. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psych&AN=1998-02677-005&site=ehost-live&scope=site>
- Watson, P. J., Taylor, D., & Morris, R. J. (1987). Narcissism, sex roles, and self-functioning. *Sex Roles*, *16*, 335-350. doi:10.1007/bf00289546
- Weeks, J. W., Jakatdar, T. A., & Heimberg, R. G. (2010). Comparing and contrasting fears of positive and negative evaluation as facets of social anxiety. *Journal of Social and Clinical Psychology*, *29*, 68-94. doi:10.1521/jscp.2010.29.1.68
- Weisman, O., Aderka, I. M., Marom, S., Hermesh, H., & Gilboa-Schechtman, E. (2011). Social rank and affiliation in social anxiety disorder. *Behaviour Research and Therapy*, *49*, 399-405. doi:10.1016/j.brat.2011.03.010
- Widiger, T. A. (1992). Generalized social phobia versus avoidant personality disorder: A commentary on three studies. *Journal of Abnormal Psychology*, *101*, 340-343. doi:10.1037/0021-843x.101.2.340
- Widiger, T. A. (2005). Social Anxiety, Social Phobia, and Avoidant Personality. In W. R. Crozier & L. E. Alden (Eds.), *The essential handbook of social anxiety for clinicians*. (pp. 219-240). New York, NY US: John Wiley & Sons Ltd.

- Wilson, D. R. (2002a). The evolved basis of mood and thought disorders: Neuroethologic, game mathematic, and evolutionary epidemiologic analyses. In G. A. Cory, Jr. & R. Gardner, Jr. (Eds.), *The evolutionary neuroethology of Paul MacLean: Convergences and frontiers*. (pp. 133-151). Westport, CT US: Praeger Publishers/Greenwood Publishing Group.
- Wilson, D. R. (2002b). The Evolved Basis of Mood and Thought Disorders: Neuroethologic, Game Mathematic, and Evolutionary Epidemiologic Analyses. In G. A. Cory & R. Gardner (Eds.), *The Evolutionary Neuroethology of Paul MacLean: Convergences and Frontiers* (pp. 133-149). CT: Praeger
- Wink, P. (1991). Two faces of narcissism. *Journal of Personality and Social Psychology*, *61*, 590-597. doi:10.1037/0022-3514.61.4.590
- Wink, P. (1992a). Three Narcissism Scales for the California Q-set. *Journal of Personality Assessment*, *58*, 51. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=6395113&site=ehost-live>
- Wink, P. (1992b). Three Types of Narcissism in Women from College to Mid-Life. *Journal of Personality*, *60*, 7-30. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=9203303857&site=ehost-live>
- Wink, P. (1996). Narcissism. In C. G. Costello (Ed.), *Personality Characteristics of the Personality Disordered* (pp. 146-172). New York: John Wiley & Sons.
- Wink, P., & Donahue, K. (1997). The relation between two types of narcissism and boredom. *Journal of Research in Personality*, *31*, 136-140. doi:10.1006/jrpe.1997.2176
- Wink, P., & Gough, H. G. (1990). New Narcissism Scales for the California Psychological Inventory and MMPI. *Journal of Personality Assessment*, *54*, 446. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=6391019&site=ehost-live>
- Winnicott, D. W. (1953). Transitional Objects and Transitional Phenomena — A Study of the First Not-Me Possession. *International Journal of Psychoanalysis*, *34*, 89-97.
- Wittchen, H. U., & Fehm, L. (2003). Epidemiology and natural course of social fears and social phobia. *Acta Psychiatrica Scandinavica. Supplementum*, *108*, 4. doi:10.1034/j.1600-0447.108.s417.1.x
- Wolpe, J. (1958). *Psychotherapy by reciprocal inhibition*. Stanford, Calif.: Stanford University Press.
- Wolpe, J. (1982). *The practice of behavior therapy*. New York: Pergamon Press.
- Woods, D. J. (1979). Carving nature at its joints? Observations on a revised psychiatric nomenclature. *Journal of Clinical Psychology*, *35*, 912-920. doi:10.1002/1097-4679(197910)35:4<912::aid-jclp2270350445>3.0.co;2-f
- World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders : clinical descriptions and diagnostic guidelines*. Geneva World Health Organization.
- Yamauchi, K. T., & Templer, D. J. (1982). The Development of a Money Attitude Scale. *Journal of Personality Assessment*, *46*, 522-528. doi:10.1207/s15327752jpa4605\_14

- Ye, D.-M., Qian, M.-Y., Liu, X.-H., & Chen, X. (2007). Revision of Social Interaction Anxiety Scale and Social Phobia Scale. *Chinese Journal of Clinical Psychology, 15*, 115-117. Retrieved from <http://ezproxy.lib.swin.edu.au/login?url=http://search.ebscohost.com/login.aspx?direct=true&db=psych&AN=2007-08812-002&site=ehost-live&scope=site>
- Yerkes, R. M., & Morgulis, S. (1909). The method of Pavlov in animal psychology. *Psychological Bulletin, 6*, 257-273. Retrieved from <http://www.sciencedirect.com/science/article/B6WY5-4NSX3V7-1/2/272411d2be419c2a7699a5b417389453>
- Zeigler-Hill, V., & Besser, A. (2011). Humor style mediates the association between pathological narcissism and self-esteem. *Personality and Individual Differences, 50*, 1196-1201. doi:10.1016/j.paid.2011.02.006
- Zerbe, K. J. (1994). Uncharted waters: Psychodynamic considerations in the diagnosis and treatment of social phobia. *Bulletin of the Menninger Clinic, 58*, A3. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=pbh&AN=9410253971&site=ehost-live>
- Zhong, J., Wang, A., Qian, M., Zhang, L., Gao, J., Yang, J., . . . Chen, P. (2008). Shame, personality, and social anxiety symptoms in Chinese and American nonclinical samples: A cross-cultural study. *Depression and Anxiety, 25*, 449-460. doi:10.1002/da.20358
- Zhu, X., Yi, J., Yao, S., Ryder, A. G., Taylor, G. J., & Bagby, R. M. (2007). Cross-cultural validation of a Chinese translation of the 20-item Toronto Alexithymia scale. *Comprehensive Psychiatry, 48*, 489-496. doi:10.1016/j.comppsy.2007.04.007
- Zimbardo, P. G. (1977). *Shyness: What it is, what to do about it.* . Reading, MA: Perseus Press.
- Zlomke, K. R. (2009). Psychometric properties of internet administered versions of Penn State Worry Questionnaire (PSWQ) and Depression, Anxiety, and Stress Scale (DASS). *Computers in Human Behavior, 25*, 841-843. doi:10.1016/j.chb.2008.06.003

**Appendices**

## Appendix 1: Study one flyer

### **Understanding the experience of social anxiety**

Senior Investigator: A/Prof. Glen Bates

Second Investigator: James S. Williams

The purpose of this study is to undertake a detailed examination of social anxiety with specific emphasis on the relationship of various personality factors to social anxiety. The aim is to better understand the factors that contribute to the differences between people in the experience of social anxiety. The study's findings are expected to have implications for improving the ways in which we can help people to overcome their anxiety.

Participation in this study involves completion of an online questionnaire which can be accessed through the link below. All responses are completely anonymous, no identifying data is collected at any stage and participation can be discontinued at any time.

Any questions regarding the study can be directed to either;

A/Prof. Glen Bates ([gbates@swin.edu.au](mailto:gbates@swin.edu.au)) or James Williams ([JSWilliams1979@optusnet.com.au](mailto:JSWilliams1979@optusnet.com.au))

**<http://www.media.swin.edu.au/surveyor/survey.asp?s=01142152179171233221>**

## Social Phobia Scale (SPS)

### Appendix 2: Study one consent form

 <p>SWINBURNE UNIVERSITY OF TECHNOLOGY</p>	<p>Social Phobia, emotional expression, and personality factors.</p>
	<p>Investigators: A/Professor Glen Bates and James Williams</p> <p>We are conducting a study to examine the relationship between Social Phobia, emotional expression, and their relationship to personality factors. If you volunteer to participate, you will be asked to complete a questionnaire, which takes approximately 40-45 minutes to complete. There are no right or wrong answers. If you are uncertain how to answer, your first reaction is usually the best.</p> <p>Your responses to the questionnaire will be completely anonymous and confidential. The results of the study may be published in a scientific journal, however only group data will be presented and no individual will be identifiable.</p> <p>Your participation in this study is completely voluntary. Your initial agreement to participate does not stop you from discontinuing participation and you are free to withdraw at any time. Please consider the purposes and time commitment of this study before you decide whether or not to participate. Retain this information sheet for your own records.</p> <p>By completing and sending your responses to this questionnaire, you are expressing your consent for your data to be used in the study.</p> <p>Sometimes, completing surveys of this nature can be distressing for some people. If you experience distress and would like to discuss this with someone, please contact; Swinburne Psychology Centre [<a href="http://www.swin.edu.au/sbs/pc/">http://www.swin.edu.au/sbs/pc/</a>], on (03) 9214 8653, The Anxiety Recovery Centre Victoria (ARCVic) on 03 9886 9337, or Lifeline on 13 11 14. Information and support can also be obtained from the Anxiety Disorders Association of Victoria website, located at <a href="http://www.adavic.org/">http://www.adavic.org/</a>.</p> <p>This research conforms to the principles set out in the Swinburne University of Technology Policy on Research Ethics and the NHMRC guidelines as specified in the National Statement on Ethical Conduct on Research Involving Humans.</p> <p>If you have any questions about this study, please contact the Investigators:</p> <p>A/Professor. Glen Bates (Senior Investigator) Phone: 9214 8100 Email: <a href="mailto:gbates@swin.edu.au">gbates@swin.edu.au</a></p> <p>James Williams Email: <a href="mailto:jswilliams1979@optusnet.com.au">jswilliams1979@optusnet.com.au</a></p> <p>If you have any queries or concerns, which the Senior Investigator was unable to satisfy, contact: The Chair, FLSS Research Ethics Committee Faculty of Life and Social Sciences, Mail H31 Swinburne University of Technology, Hawthorn, Victoria 3122</p> <p>If you have a complaint about the way you were treated during this study please write to: The Chair, Human Research Ethics Committee Swinburne University of Technology, Hawthorn, Victoria 3122</p>

**Appendix 3: Study one questionnaire**

**Demographic questions**

Are you male or female?    1. Male        2. Female

What is your age in years? \_\_\_\_\_

Circle the number which best describes your relationship status now.

1. Single, never been in an intimate relationship
2. Currently in an intimate relationship or married
3. Divorced or separated
4. Other

If applicable, what is the length of the current relationship? \_\_\_\_\_

Circle the number which best describes your educational status now.

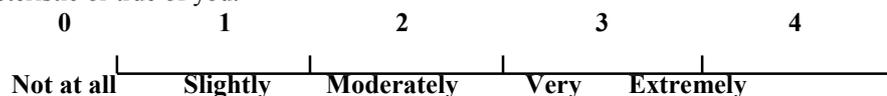
1. Have not completed secondary level (e.g., high school or college)
2. Completed secondary level
3. Partially completed tertiary level (e.g., university)
4. Completed tertiary level
5. Postgraduate student
6. Completed postgraduate studies

Have you been diagnosed with any of the following conditions in the past two years?  
(Select more than one option if applicable)

1. Depression
2. Social Anxiety/Social Phobia
3. Other Anxiety Disorder
4. Other Mood Disorder

**Social Phobia Scale (SPS)**

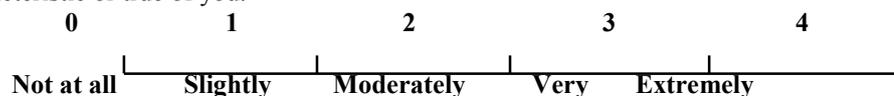
Below is a list of statements. Please read each in turn and indicate the degree to which you feel the statement is characteristic or true of you.



1	I become anxious if I have to write in front of people	0	1	2	3	4
2	I become self-conscious when using public toilets	0	1	2	3	4
3	I can suddenly become aware of my own voice and of others listening to me	0	1	2	3	4
4	I get nervous that people are staring at me as I walk down the street	0	1	2	3	4
5	I fear I may blush when I am with others	0	1	2	3	4
6	I feel self-conscious if I have to enter a room where others are already seated	0	1	2	3	4
7	I worry about shaking or trembling when I'm watched by other people	0	1	2	3	4
8	I would get tense if I had to sit facing other people on a bus or train	0	1	2	3	4
9	I get panicky that others might see me to be faint, sick or ill	0	1	2	3	4
10	I would find it difficult to drink something if in a group of people	0	1	2	3	4
11	It would make me feel self-conscious to eat in front of a stranger at a restaurant	0	1	2	3	4
12	I am worried people will think my behaviour odd	0	1	2	3	4
13	I would get tense if I had to carry a tray across a crowded cafeteria	0	1	2	3	4
14	I worry I'll lose control of myself in front of other people	0	1	2	3	4
15	I worry I might do something to attract the attention of others	0	1	2	3	4
16	When in an elevator, I am tense if people look at me	0	1	2	3	4
17	I can feel conspicuous standing in a queue	0	1	2	3	4
18	I get tense when I speak in front of other people	0	1	2	3	4
19	I worry my head will shake or nod in front of other people	0	1	2	3	4
20	I feel awkward and tense if I know people are watching me	0	1	2	3	4

## Social Interaction Anxiety Scale (SIAS)

Below is a list of statements. Please read each in turn and indicate the degree to which you feel the statement is characteristic or true of you.



1	I get nervous if I have to speak to someone in authority (teacher, boss, etc.)	0	1	2	3	4
2	I have difficulty making eye-contact with others	0	1	2	3	4
3	I become tense if I have to talk about myself or my feelings	0	1	2	3	4
4	I find difficulty mixing comfortably with the people I work with	0	1	2	3	4
5	I tense-up if I meet an acquaintance in the street	0	1	2	3	4
6	When mixing socially I am uncomfortable	0	1	2	3	4
7	I feel tense if I am alone with just one person	0	1	2	3	4
8	I am at ease meeting people at parties et cetera	0	1	2	3	4
9	I have difficulty talking with other people	0	1	2	3	4
10	I find it easy to think of things to talk about	0	1	2	3	4
11	I worry about expressing myself in case I appear awkward	0	1	2	3	4
12	I find it difficult to disagree with another's point of view	0	1	2	3	4
13	I have difficulty talking to attractive persons of the opposite sex	0	1	2	3	4
14	I find myself worrying that I won't know what to say in social situations	0	1	2	3	4
15	I am nervous mixing with people I don't know well	0	1	2	3	4
16	I feel I'll say something embarrassing when talking	0	1	2	3	4
17	When mixing in a group I find myself worrying I will be ignored	0	1	2	3	4
18	I am tense mixing in a group	0	1	2	3	4
19	I am unsure whether to greet someone I know only slightly	0	1	2	3	4

**Narcissistic Personality Inventory (NPI)**

Please read the following statements carefully and indicate whether they are true or not of you by selecting the appropriate response

1	I have a natural talent for influencing people	TRUE	FALSE
2	Modesty doesn't become me	TRUE	FALSE
3	I would do almost anything on a dare	TRUE	FALSE
4	I know that I am good because everybody keeps telling me so	TRUE	FALSE
5	If I ruled the world the world it would be a better place	TRUE	FALSE
6	I can usually talk my way out of anything	TRUE	FALSE
7	I like to be the centre of attention	TRUE	FALSE
8	I will be a success	TRUE	FALSE
9	I think I am a special person	TRUE	FALSE
10	I see myself as a good leader	TRUE	FALSE
11	I am assertive	TRUE	FALSE
12	I like to have authority over other people	TRUE	FALSE
13	I find it easy to manipulate people	TRUE	FALSE
14	I insist upon getting the respect that is due me	TRUE	FALSE
15	I like to display my body	TRUE	FALSE
16	I can read people like a book	TRUE	FALSE
17	I like to take responsibility for making decisions	TRUE	FALSE
18	I want to amount to something in the eyes of the world	TRUE	FALSE
19	I like to look at my body	TRUE	FALSE
20	I am apt to show off if I get the chance	TRUE	FALSE
21	I always know what I am doing	TRUE	FALSE
22	I rarely depend on anyone else to get things done	TRUE	FALSE
23	Everybody likes to hear my stories	TRUE	FALSE
24	I expect a great deal from other people	TRUE	FALSE
25	I will never be satisfied until I get all that I deserve	TRUE	FALSE
26	I like to be complimented	TRUE	FALSE
27	I have a strong will to power	TRUE	FALSE
28	I like to start new fads and fashions	TRUE	FALSE
29	I like to look at myself in the mirror	TRUE	FALSE
30	I really like to be the centre of attention	TRUE	FALSE
31	I can live my life if any way I want	TRUE	FALSE
32	People always seem to recognize my authority	TRUE	FALSE
33	I would prefer to be a leader	TRUE	FALSE
34	I am going to be a great person	TRUE	FALSE
35	I can make anybody believe anything I want them to	TRUE	FALSE
36	I am a born leader	TRUE	FALSE
37	I wish somebody would someday write my biography	TRUE	FALSE
38	I get upset when people don't notice how I look when I go out in public	TRUE	FALSE
39	I am more capable than other people	TRUE	FALSE
40	I am an extraordinary person	TRUE	FALSE

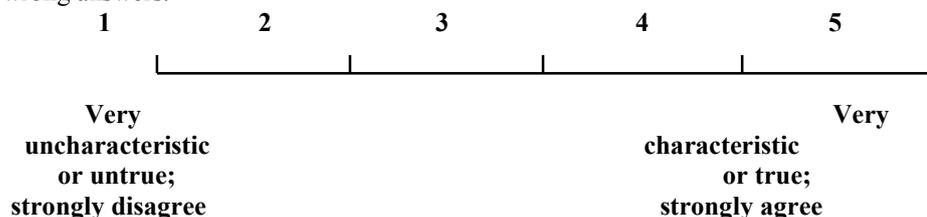
## Narcissistic Personality Disorder Scale (NPDS)

Please read the following statements carefully and indicate whether they are true or not of you by selecting the appropriate response

1	I enjoy detective or mystery stories	TRUE	FALSE
2	My sex life is satisfactory	TRUE	FALSE
3	A minister can cure disease by praying and putting his hand on your hand	TRUE	FALSE
4	I believe that my home life is as pleasant as that of most people I know	TRUE	FALSE
5	I certainly feel useless at times	TRUE	FALSE
6	It makes me impatient to have people ask my advice or otherwise interrupt me when I am working on something important	TRUE	FALSE
7	There is something wrong with my mind	TRUE	FALSE
8	I seldom or never have dizzy spells	TRUE	FALSE
9	I believe there is a Devil and a Hell in afterlife	TRUE	FALSE
10	I enjoy children	TRUE	FALSE
11	Life is a strain for me much of the time	TRUE	FALSE
12	My sex life is satisfactory	TRUE	FALSE
13	Once in a while I think of things too bad to talk about	TRUE	FALSE
14	I cannot keep my mind on one thing	TRUE	FALSE
15	I have certainly had more than my share of things to worry about	TRUE	FALSE
16	I often feel as if things were not real	TRUE	FALSE
17	I have felt embarrassed over the type of work that one or more members of my family have done	TRUE	FALSE
18	I worry quite a bit over possible misfortunes	TRUE	FALSE

## Hypersensitive Narcissism Scale (HSNS)

Below is a list of statements. Please look at each one in turn, and indicate by circling the appropriate number beside the statement, the extent to which you believe that the item is characteristic of you. There are no right or wrong answers.



1	I can become entirely absorbed in thinking about my personal affairs, my health, my cares or my relations to others	1	2	3	4	5
2	My feelings are easily hurt by ridicule or by the slighting remarks of others	1	2	3	4	5
3	When I enter a room I often become self-conscious and feel that the eyes of others are upon me	1	2	3	4	5
4	I dislike sharing the credit of an achievement with others	1	2	3	4	5
5	I dislike being with a group unless I know that I am appreciated by at least one of those present	1	2	3	4	5
6	I feel that I am temperamentally different from most people	1	2	3	4	5
7	I often interpret the remarks of others in a personal way	1	2	3	4	5
8	I easily become wrapped up in my own interests and forget the existence of others	1	2	3	4	5
9	I feel that I have enough on my hands without worrying about other people's troubles	1	2	3	4	5
10	I am secretly "put out" when other people come to me with their troubles, asking me for my time and sympathy	1	2	3	4	5

## Dimensions of Anger Reactions Scale (DAR)

Do your best to judge as accurately as you can, the degree to which the following statements describe your feelings and behaviours. Then rate the degree to which each statement applies to you

1. I often find myself getting angry at people or situations

0	1	2	3	4	5	6	7	8
Not at All	Very Little	A Little	Some, Not Much	Moderately So	Fairly Much	Much	Very Much	Exactly So

2. When I do get angry, I get really mad

0	1	2	3	4	5	6	7	8
Not at All	Very Little	A Little	Some, Not Much	Moderately So	Fairly Much	Much	Very Much	Exactly So

3. When I get angry, I stay angry

0	1	2	3	4	5	6	7	8
Not at All	Very Little	A Little	Some, Not Much	Moderately So	Fairly Much	Much	Very Much	Exactly So

4. When I get angry at someone, I want to hit or clobber the person

0	1	2	3	4	5	6	7	8
Not at All	Very Little	A Little	Some, Not Much	Moderately So	Fairly Much	Much	Very Much	Exactly So

5. My anger interferes with my ability to do my job

0	1	2	3	4	5	6	7	8
Not at All	Very Little	A Little	Some, Not Much	Moderately So	Fairly Much	Much	Very Much	Exactly So

6. My anger prevents me from getting along with people

0	1	2	3	4	5	6	7	8
Not at All	Very Little	A Little	Some, Not Much	Moderately So	Fairly Much	Much	Very Much	Exactly So

7. My anger has had a bad effect on my health

0	1	2	3	4	5	6	7	8
Not at All	Very Little	A Little	Some, Not Much	Moderately So	Fairly Much	Much	Very Much	Exactly So

## Depression, Anxiety, Stress Scale

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

*The rating scale is as follows:*

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of time
- 3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (e.g., in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

### Experience of Shame Scale (ESS)

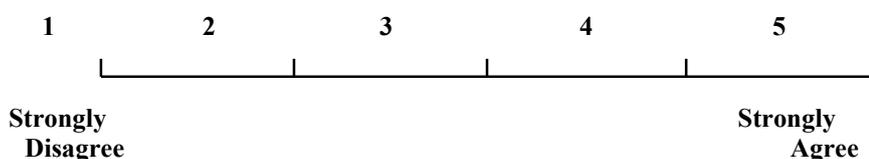
Everybody at times can feel embarrassed, self-conscious or ashamed. These questions are about such feelings if they have occurred at any time in the past year. There are no 'right' or 'wrong' answers. Please indicate the response which applies to you by selecting the appropriate option.

- 1 = Not at all  
 2 = A little  
 3 = Moderately  
 4 = Very much

1	Have you felt ashamed of any of your personal habits?	1	2	3	4
2	Have you worried about what other people think of any of your personal habits?	1	2	3	4
3	Have you tried to cover up or conceal any of your personal habits?	1	2	3	4
4	Have you felt ashamed of your manner with others?	1	2	3	4
5	Have you worried about what other people think of your manner with others?	1	2	3	4
6	Have you avoided people because of your manner?	1	2	3	4
7	Have you felt ashamed of the sort of person you are?	1	2	3	4
8	Have you worried about what other people think of the sort of person you are?	1	2	3	4
9	Have you tried to conceal from others the sort of person you are?	1	2	3	4
10	Have you felt ashamed of your ability to do things?	1	2	3	4
11	Have you worried about what other people think of your ability to do things?	1	2	3	4
12	Have you avoided people because of your inability to do things?	1	2	3	4
13	Do you feel ashamed when you do something wrong?	1	2	3	4
14	Have you worried about what other people think of you when you do something wrong?	1	2	3	4
15	Have you tried to cover up or conceal things you felt ashamed of having done?	1	2	3	4
16	Have you felt ashamed when you said something stupid?	1	2	3	4
17	Have you worried about what other people think of you when you said something stupid?	1	2	3	4
18	Have you avoided contact with anyone who knew you said something stupid?	1	2	3	4
19	Have you felt ashamed when you failed at something which was important to you?	1	2	3	4
20	Have you worried about what other people think of you when you fail?	1	2	3	4
21	Have you avoided people who have seen you fail?	1	2	3	4
22	Have you felt ashamed of your body or any part of it?	1	2	3	4
23	Have you worried about what other people think of your appearance?	1	2	3	4
24	Have you avoided looking at yourself in the mirror?	1	2	3	4
25	Have you wanted to hide or conceal your body or any part of it?	1	2	3	4

## Toronto Alexithymia Scale (TAS)

Below is a list of statements. Please look at each one in turn, and indicate by circling the appropriate number beside the statement, the extent to which you agree with each statement, where:  
*1 = Strongly Disagree and 5 = Strongly Agree*



1	I am often confused about what emotion I am feeling	1	2	3	4	5
2	It is difficult for me to find the right words for my feelings	1	2	3	4	5
3	I have physical sensations that even doctors don't understand	1	2	3	4	5
4	I am able to describe my feelings easily	1	2	3	4	5
5	I prefer to analyse problems rather than just describe them	1	2	3	4	5
6	When I am upset, I don't know if I am sad, frightened, or angry	1	2	3	4	5
7	I am often puzzled by sensations in my body	1	2	3	4	5
8	I prefer to just let things happen rather than to understand why they turn out that way	1	2	3	4	5
9	I have feelings that I can't quite identify	1	2	3	4	5
10	Being in touch with emotions is essential	1	2	3	4	5
11	I find it hard to describe my feelings easily	1	2	3	4	5
12	People tell me to describe my feelings more	1	2	3	4	5
13	I don't know what is going on inside me	1	2	3	4	5
14	I often don't know why I am angry	1	2	3	4	5
15	I prefer talking to people about their daily activities rather than their feelings	1	2	3	4	5
16	I prefer to watch "light" entertainment shows rather than psychological dramas	1	2	3	4	5
17	It is difficult for me to reveal my innermost feelings	1	2	3	4	5
18	I can feel close to someone, even in moments of silence	1	2	3	4	5
19	I find examination of my feelings useful in solving personal problems	1	2	3	4	5
20	Looking for hidden meanings in movies or plays distracts from their enjoyment	1	2	3	4	5

## Inventory of Personality Organisation (IPO)

The following section contains statements about a variety attitudes, feelings and behaviours that people have during their lives. Please read carefully, and complete these questions as they apply to you. Please answer these questions as openly as you can. When thinking of yourself and your experiences, do not count as important those attitudes, feeling, or behaviours you might have had only while under the influence of alcohol or other drugs

1	2	3	4	5
Never True	Rarely True	Sometimes True	Often True	Always True

1	I am a "hero worshipper" even if I am later found wrong in my judgment	1	2	3	4	5
2	I feel that people I once thought highly of have disappointed me by not living up to what I expected of them	1	2	3	4	5
3	I feel it has been a long time since anyone really taught or told me anything I did not already know	1	2	3	4	5
4	It is hard for me to trust people because they so often turn against me or betray me	1	2	3	4	5
5	I need to admire people in order to feel secure	1	2	3	4	5
6	I find myself doing things which at other times I think are not too wise like having promiscuous sex, lying, drinking, having temper tantrums or breaking the law in minor ways	1	2	3	4	5
7	People tell me I have difficulty in seeing shortcoming in those I admire	1	2	3	4	5
8	I feel I don't get what I want	1	2	3	4	5
9	People tell me I behave in contradictory ways	1	2	3	4	5
10	I think people are basically either good or bad: there are few who are really in between	1	2	3	4	5
11	People tend to use me unless I watch out for it	1	2	3	4	5
12	I act in ways that appear to others as unpredictable and erratic	1	2	3	4	5
13	I have favourite people whom I not only admire, but almost idealise	1	2	3	4	5
14	I find myself doing things which feel okay while I'm doing them but which later find hard to believe I did	1	2	3	4	5
15	People tend to respond to me by either overwhelming me with love or abandoning me	1	2	3	4	5
16	I tend to feel things in a somewhat extreme way, experiencing either great joy or intense despair	1	2	3	4	5
17	I feel like a fake or imposter, that others see me as quite different from the way I really am	1	2	3	4	5
18	I feel I am a different person at home as compared to how I am at work or at school	1	2	3	4	5
19	I feel that my tastes and opinions are not really my own, but have been borrowed from other people	1	2	3	4	5
20	Some of my friends would be surprised if they knew how differently I behave in different situations	1	2	3	4	5
21	I fluctuate between being warm and giving at some times, and being cold and indifferent at other times	1	2	3	4	5
22	People tell me I provoke or mislead them so as to get my way	1	2	3	4	5
23	I can't explain the changes in my behaviour	1	2	3	4	5
24	I do things on impulse that I think are socially unacceptable	1	2	3	4	5
25	I get into relationships with people I don't really like because it's hard for me to say no	1	2	3	4	5
26	My life, if it were like a book, seems to me more like a series of short stories written by different authors than like a long novel	1	2	3	4	5
27	I pick up hobbies and interests and then drop them	1	2	3	4	5
28	When others see me as having succeeded, I'm elated and, when they see me as failing, I feel devastated	1	2	3	4	5
29	I'm afraid that people who become important to me will suddenly change in their feelings towards me	1	2	3	4	5
30	It is hard for me to be sure about what others think of me, even people who have known me very well	1	2	3	4	5
31	Being alone is difficult for me	1	2	3	4	5

## Inventory of Personality Organisation (IPO)

32	I see myself in totally different ways at different times	1	2	3	4	5
33	In the course of an intimate relationship, I'm afraid of losing a sense of myself	1	2	3	4	5
34	My life goals change frequently from year to year	1	2	3	4	5
35	My goals keep changing	1	2	3	4	5
36	After becoming involved with people, I am surprised to find out what they are really like	1	2	3	4	5
37	Even people who know me well cannot guess how I'm going to behave	1	2	3	4	5
38	When everything around me is unsettled and confused, I feel that way inside	1	2	3	4	5
39	I am not sure whether a voice I have heard, or something that I have seen is my imagination or not	1	2	3	4	5
40	When I'm nervous or confused, it seems like things in the outside world don't make sense either	1	2	3	4	5
41	I feel almost as if I'm someone else, like a friend or relative, or even someone I don't know	1	2	3	4	5
42	I think I see things which, when I take a closer look, turn out to be something else	1	2	3	4	5
43	When I am uncomfortable, I can't tell whether it is emotional or physical	1	2	3	4	5
44	I can see things or hear things that nobody else can see or hear	1	2	3	4	5
45	I hear things that other people claim are not really there	1	2	3	4	5
46	I have heard or seen things when there is no apparent reason for it	1	2	3	4	5
47	I find that I do things which get other people upset and I don't know why such things upset them	1	2	3	4	5
48	I can't tell whether certain physical sensations I'm having are real or whether I'm imagining them	1	2	3	4	5
49	I feel that my wishes or thoughts will come true as if by magic	1	2	3	4	5
50	People see me as being rude or inconsiderate, and I don't know why	1	2	3	4	5
51	I understand and know things that nobody else is able to understand or know	1	2	3	4	5
52	I know that I cannot tell others certain things about the world that I understand but that to others would appear crazy	1	2	3	4	5
53	I have seen things which do not exist in reality	1	2	3	4	5
54	I feel as if I have been somewhere or done something before when I really haven't	1	2	3	4	5
55	I can't tell whether I simply want something to be true or whether it really is true	1	2	3	4	5
56	I believe that things will happen simply by thinking about them	1	2	3	4	5
57	Somehow, I never know quite how to conduct myself with people	1	2	3	4	5

## Appendix 4: Study one ethics approval

16/05



SWINBURNE  
UNIVERSITY OF  
TECHNOLOGY

Shaping Swinburne's Future Today  
The Entrepreneurial University  
The Research Intensive University  
Internationalisation  
Flexible Learning and Teaching  
The Intersectoral Advantage

**Swinburne Signals**  
Collaborate  
Create  
Concentrate  
Communicate  
Celebrate

**Research Ethics Committee**  
Faculty of Life and Social Sciences  
Social and Behavioural Sciences Ethics Committee

**RECOMMENDATION FOR ETHICS APPROVAL**

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Project ID Number: **16/05**

Project Title: Social phobias, emotional expression and personality factors

Project Duration: 1/4/05 to 31/12/05

Principal Investigators: Glen Bates

Associate Investigators:

Student Investigator:

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*Office use only*

**Recommendation of the SBS Research Ethics Committee:**

Project Not Approved [Revise and Resubmit]

Project Approved:

Project Approved: Hawthorn & Lilydale campuses

Project Approved Subject to:

- ① Student signatures asap.
- ② Questionnaire typos corrected
- ③ Correct address of SBS ethics in CSS!

**You must submit any requested documentation to: Kate Fielding, Secretary, FLSS (SBSEC) Ethics Committee, Room AS317, before commencement of data collection. x5017**

Chair: *[Signature]* Date: *13/4/05*

Issue Date: 15 March 2005

F:\Research\Ethics Committees\Recommendation.dot/mp/26 Nov 03

  
*copy sent 5/10/05 to GB*

### Appendix 5: Study two flyers

Hi,

My name is James Williams. I am currently undertaking a PhD in Psychology at Swinburne University in Melbourne, Australia. I am interested in some of the personality processes involved in social phobia and social anxiety. The findings of the study are expected to have implications for improving the ways in which we can help people to overcome their anxiety.

I am just wondering if anyone was interested in participating in this study. I am looking for people who suffer from social anxieties and also those who do not. The study is entirely web based and can be found at <http://opinio.online.swin.edu.au/s?s=5214>

The questionnaire is long but you can save your progress and return to finish the questionnaire later.

If anyone has any questions about the study, please feel free to contact me -JSWilliams1979@gmail.com  
Your participation in this project would be greatly appreciated.

Kind regards

James Williams

## Appendix 6: Study two consent form

Understanding the Experience of Social Anxiety:

An analysis of Social Anxiety, Taijin-Kyofusho and their relationship to personality

Investigators: Professor Glen Bates and James Williams

We are conducting a study to examine the relationship between Social Anxiety and Taijin-Kyofusho (a culture bound variant of Social Anxiety) and to examine their relationship to various personality factors.

If you volunteer to participate, you will be asked to complete a questionnaire, which takes approximately 45 minutes to complete. There are no right or wrong answers. If you are uncertain how to answer, your first reaction is usually the best.

Your responses to the questionnaire will be completely anonymous and confidential. The results of the study may be published in a scientific journal, however only group data will be presented and no individual will be identifiable.

Your participation in this study is completely voluntary. Your initial agreement to participate does not stop you from discontinuing participation and you are free to withdraw at any time. Please consider the purposes and time commitment of this study before you decide whether or not to participate. Print and retain this information sheet for your own records. If you are interested in participating in this Australian project from outside of Australia, you should be alert to any local or government restrictions on involvement in foreign research activity.

By completing and sending your responses to this questionnaire, you are expressing your consent for your data to be used in the study.

Sometimes, completing surveys of this nature can be distressing for some people. If you experience distress and would like to discuss this with someone, low cost counselling is available from the Swinburne Psychology Clinic (03) 9214 8653. Free counselling is also available to Swinburne Students, for details, call 9214 8025. Alternatively, you can contact the Anxiety Recovery Centre Victoria (ARCVic) on 03 9886 9337, or Lifeline on 13 11 14. Information and support can also be obtained from the Anxiety Disorders Association of Victoria website, located at <http://www.adavic.org/>  
If you have any questions about this study, please contact the Investigators:

Professor Glen Bates - [gbates@swin.edu.au](mailto:gbates@swin.edu.au)

James Williams - [jwilliams@swin.edu.au](mailto:jwilliams@swin.edu.au)

This project has been approved by or on behalf of Swinburne's Human Research Ethics Committee (SUHREC) in line with the National Statement on Ethical Conduct in Human Research. If you have any concerns or complaints about the conduct of this project, you can contact:  
Research Ethics Officer, Swinburne Research (H68),  
Swinburne University of Technology, P O Box 218, HAWTHORN VIC 3122.  
Tel (03) 9214 5218 or +61 3 9214 5218 or [resethics@swin.edu.au](mailto:resethics@swin.edu.au)

**Appendix 7: Study two questionnaire**

**Demographics****Personal profile**

## Demographic information

Are you male or female? (Circle one.)    1. Male                    2. Female

What is your age in years? \_\_\_\_\_

Circle the number which best describes your relationship status now.

1. Single, never been in an intimate relationship
2. Single, have previously been in an intimate relationship
2. Currently in an intimate relationship or married
3. Divorced or separated
4. Other

If applicable, what is the length of the current relationship? \_\_\_\_\_

Circle the number which best describes your educational status now.

1. Have not completed secondary level (e.g., high school or college)
2. Completed secondary level
3. Partially completed tertiary level (e.g., university)
4. Completed tertiary level
5. Postgraduate student
6. Completed postgraduate studies

Have you ever been diagnosed with any of the following conditions at any point in time? (Circle more than one option if applicable)

- 1 Depression
- 2 Social Anxiety/Social Phobia
- 3 Other Anxiety Disorder
- 4 Other Mood Disorder

Have you been diagnosed with any of the following conditions in the past **two years**? (Circle more than one option if applicable)

1. Depression
2. Social Anxiety/Social Phobia
3. Other Anxiety Disorder
4. Other Mood Disorder

**Demographics**

If you selected any of the previous options, are you currently taking any medications for this condition?

Yes

No

If yes, what medications are you currently taking?

MAOI

RIMA

SSRI

SNRI

Unsure

Other (please specify): \_\_\_\_\_

Have you previously sought treatment for the above conditions?

Yes

No

If yes, what kind of professional did you seek for treatment (circle all that apply)?

Psychologist

Psychiatrist

GP

Counsellor

Other (Please specify): \_\_\_\_\_

Are you currently receiving treatment for the above conditions?

Yes

No

If yes, from whom are you currently receiving treatment (circle all that apply)?

Psychologist

Psychiatrist

GP

Counsellor

Other (Please specify): \_\_\_\_\_

**Social Phobia Scale (SPS)**

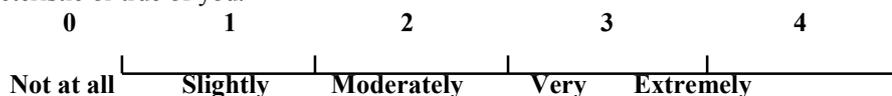
Below is a list of statements. Please read each in turn and indicate the degree to which you feel the statement is characteristic or true of you.

0                      1                      2                      3                      4  
 Not at all      Slightly      Moderately      Very      Extremely

1	I become anxious if I have to write in front of people	0	1	2	3	4
2	I become self-conscious when using public toilets	0	1	2	3	4
3	I can suddenly become aware of my own voice and of others listening to me	0	1	2	3	4
4	I get nervous that people are staring at me as I walk down the street	0	1	2	3	4
5	I fear I may blush when I am with others	0	1	2	3	4
6	I feel self-conscious if I have to enter a room where others are already seated	0	1	2	3	4
7	I worry about shaking or trembling when I'm watched by other people	0	1	2	3	4
8	I would get tense if I had to sit facing other people on a bus or train	0	1	2	3	4
9	I get panicky that others might see me to be faint, sick or ill	0	1	2	3	4
10	I would find it difficult to drink something if in a group of people	0	1	2	3	4
11	It would make me feel self-conscious to eat in front of a stranger at a restaurant	0	1	2	3	4
12	I am worried people will think my behaviour odd	0	1	2	3	4
13	I would get tense if I had to carry a tray across a crowded cafeteria	0	1	2	3	4
14	I worry I'll lose control of myself in front of other people	0	1	2	3	4
15	I worry I might do something to attract the attention of others	0	1	2	3	4
16	When in an elevator, I am tense if people look at me	0	1	2	3	4
17	I can feel conspicuous standing in a queue	0	1	2	3	4
18	I get tense when I speak in front of other people	0	1	2	3	4
19	I worry my head will shake or nod in front of other people	0	1	2	3	4
20	I feel awkward and tense if I know people are watching me	0	1	2	3	4

## Social Interaction Anxiety Scale (SIAS)

Below is a list of statements. Please read each in turn and indicate the degree to which you feel the statement is characteristic or true of you.



1	I get nervous if I have to speak to someone in authority (teacher, boss, etc.)	0	1	2	3	4
2	I have difficulty making eye-contact with others	0	1	2	3	4
3	I become tense if I have to talk about myself or my feelings	0	1	2	3	4
4	I find difficulty mixing comfortably with the people I work with	0	1	2	3	4
5	I tense-up if I meet an acquaintance in the street	0	1	2	3	4
6	When mixing socially I am uncomfortable	0	1	2	3	4
7	I feel tense if I am alone with just one person	0	1	2	3	4
8	I am at ease meeting people at parties et cetera	0	1	2	3	4
9	I have difficulty talking with other people	0	1	2	3	4
10	I find it easy to think of things to talk about	0	1	2	3	4
11	I worry about expressing myself in case I appear awkward	0	1	2	3	4
12	I find it difficult to disagree with another's point of view	0	1	2	3	4
13	I have difficulty talking to attractive persons of the opposite sex	0	1	2	3	4
14	I find myself worrying that I won't know what to say in social situations	0	1	2	3	4
15	I am nervous mixing with people I don't know well	0	1	2	3	4
16	I feel I'll say something embarrassing when talking	0	1	2	3	4
17	When mixing in a group I find myself worrying I will be ignored	0	1	2	3	4
18	I am tense mixing in a group	0	1	2	3	4
19	I am unsure whether to greet someone I know only slightly	0	1	2	3	4

## TKS Scale

## TKS

Below is a list of statements. Please read each in turn and indicate the degree to which you feel the statement applies to you on a seven point scale from

1 (*Exactly True*) to 7 (*Totally False*)

1	I am afraid that I may unintentionally hurt others feelings	1	2	3	4	5	6	7
2	I tend to stop doing what I want if others think I am not doing it right	1	2	3	4	5	6	7
3	I cannot really feel relaxed even when I chat with my friends	1	2	3	4	5	6	7
4	When I see others, sometimes I am afraid that my looks might leave a bad impression on them	1	2	3	4	5	6	7
5	Because I perceive myself as having a displeasing appearance, it bothers me to present myself to other people	1	2	3	4	5	6	7
6	I am afraid that when talking with others my trembling voice will offend them	1	2	3	4	5	6	7
7	Sometimes I stiffen or blush when I am with my friends	1	2	3	4	5	6	7
8	I cannot help thinking how my eyes look when someone looks me in the eye	1	2	3	4	5	6	7
9	I get more nervous when I see someone I know than when I see a stranger	1	2	3	4	5	6	7
10	I am afraid that when talking with others my trembling head, hands and/or feet will offend them	1	2	3	4	5	6	7
11	I am afraid that my presence will offend others	1	2	3	4	5	6	7
12	When I talk with others, I feel ugly and fear that I bore them	1	2	3	4	5	6	7
13	Because I perceive myself as being very awkward, it bothers me to present myself to other people	1	2	3	4	5	6	7
14	Sometimes I cannot laugh when I talk to another person because I become very anxious and my face stiffens	1	2	3	4	5	6	7
15	I am afraid my family will find out that something is wrong with me	1	2	3	4	5	6	7
16	At a hair dresser's shop, I cannot stand for the hair dresser to look me in the face	1	2	3	4	5	6	7
17	I feel small and feel like apologizing to others	1	2	3	4	5	6	7
18	I am afraid I will blush in front of other people and as a result offend them	1	2	3	4	5	6	7
19	I do not know where I should look when I talk to others	1	2	3	4	5	6	7
20	I cannot really feel relaxed when I chat with strangers	1	2	3	4	5	6	7
21	When I talk with my friends, I am afraid that they might point out my faults	1	2	3	4	5	6	7
22	When I am with others I sometimes feel that I am stupid and feel sorry for them for being with me	1	2	3	4	5	6	7
23	When I am with others I sometimes feel that I am stupid and feel sorry for them for being with me	1	2	3	4	5	6	7
24	I am afraid that when talking with others my stiff facial expression will offend them	1	2	3	4	5	6	7
25	I am afraid that my sweating or having nervous perspiration will offend other people	1	2	3	4	5	6	7
26	I am afraid that my body odours will offend other people	1	2	3	4	5	6	7
27	I am afraid that my staring at other people's body parts will offend them	1	2	3	4	5	6	7
28	I am afraid that I will release intestinal gas in the presence of others and offend them	1	2	3	4	5	6	7
29	I am afraid that eye to eye contact with other people will offend them	1	2	3	4	5	6	7
30	When I talk to strangers, I am afraid that they might point out my faults	1	2	3	4	5	6	7
31	I am afraid that my physical appearance will in some way offend others'	1	2	3	4	5	6	7
32	Sometimes I stiffen or blush when I am with strangers	1	2	3	4	5	6	7

Please read the following statements carefully and rate to what degree do you think that each aspect of you listed makes others uncomfortable

Where 1 = Not at all and 5 = Extremely

	1 Not at all	2	3	4	5 Extremely
Bad facial expression	1	2	3	4	5
Body odour, foul breath, or unpleasant smell of hair	1	2	3	4	5
Staring into someone's face	1	2	3	4	5
Expression of the eyes	1	2	3	4	5
Voice and tone	1	2	3	4	5
Awkward unnatural movement and behaviour	1	2	3	4	5
Way of speaking	1	2	3	4	5
Shakiness of hands from tension	1	2	3	4	5
Body figure	1	2	3	4	5
Blush from tension or failure	1	2	3	4	5
Character	1	2	3	4	5
Expression	1	2	3	4	5
Attitude	1	2	3	4	5
Perspiration from tension or failure	1	2	3	4	5

Please read the following statements carefully and rate to what degree do you think that you are avoided due to this aspect of yourself

Where 1 = Not at all and 5 = Extremely

	1 Not at all	2	3	4	5 Extremely
Bad facial expression	1	2	3	4	5
Body odour, foul breath, or unpleasant smell of hair	1	2	3	4	5
Staring into someone's face	1	2	3	4	5
Expression of the eyes	1	2	3	4	5
Voice and tone	1	2	3	4	5
Awkward unnatural movement and behaviour	1	2	3	4	5
Way of speaking	1	2	3	4	5
Shakiness of hands from tension	1	2	3	4	5
Body figure	1	2	3	4	5
Blush from tension or failure	1	2	3	4	5
Character	1	2	3	4	5
Expression	1	2	3	4	5
Attitude	1	2	3	4	5
Perspiration from tension or failure	1	2	3	4	5

**Narcissistic Personality Inventory (NPI)**

Please read the following statements carefully and indicate whether they are true or not of you by selecting the appropriate response

1	I have a natural talent for influencing people	TRUE	FALSE
2	Modesty doesn't become me	TRUE	FALSE
3	I would do almost anything on a dare	TRUE	FALSE
4	I know that I am good because everybody keeps telling me so	TRUE	FALSE
5	If I ruled the world the world it would be a better place	TRUE	FALSE
6	I can usually talk my way out of anything	TRUE	FALSE
7	I like to be the centre of attention	TRUE	FALSE
8	I will be a success	TRUE	FALSE
9	I think I am a special person	TRUE	FALSE
10	I see myself as a good leader	TRUE	FALSE
11	I am assertive	TRUE	FALSE
12	I like to have authority over other people	TRUE	FALSE
13	I find it easy to manipulate people	TRUE	FALSE
14	I insist upon getting the respect that is due me	TRUE	FALSE
15	I like to display my body	TRUE	FALSE
16	I can read people like a book	TRUE	FALSE
17	I like to take responsibility for making decisions	TRUE	FALSE
18	I want to amount to something in the eyes of the world	TRUE	FALSE
19	I like to look at my body	TRUE	FALSE
20	I am apt to show off if I get the chance	TRUE	FALSE
21	I always know what I am doing	TRUE	FALSE
22	I rarely depend on anyone else to get things done	TRUE	FALSE
23	Everybody likes to hear my stories	TRUE	FALSE
24	I expect a great deal from other people	TRUE	FALSE
25	I will never be satisfied until I get all that I deserve	TRUE	FALSE
26	I like to be complimented	TRUE	FALSE
27	I have a strong will to power	TRUE	FALSE
28	I like to start new fads and fashions	TRUE	FALSE
29	I like to look at myself in the mirror	TRUE	FALSE
30	I really like to be the centre of attention	TRUE	FALSE
31	I can live my life if any way I want	TRUE	FALSE
32	People always seem to recognize my authority	TRUE	FALSE
33	I would prefer to be a leader	TRUE	FALSE
34	I am going to be a great person	TRUE	FALSE
35	I can make anybody believe anything I want them to	TRUE	FALSE
36	I am a born leader	TRUE	FALSE
37	I wish somebody would someday write my biography	TRUE	FALSE
38	I get upset when people don't notice how I look when I go out in public	TRUE	FALSE
39	I am more capable than other people	TRUE	FALSE
40	I am an extraordinary person	TRUE	FALSE

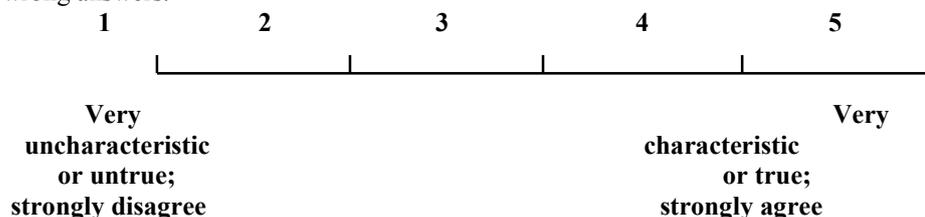
**Narcissistic Personality Disorder Scale (NPDS)**

Please read the following statements carefully and indicate whether they are true or not of you by selecting the appropriate response

1	I enjoy detective or mystery stories	TRUE	FALSE
2	My sex life is satisfactory	TRUE	FALSE
3	A minister can cure disease by praying and putting his hand on your hand	TRUE	FALSE
4	I believe that my home life is as pleasant as that of most people I know	TRUE	FALSE
5	I certainly feel useless at times	TRUE	FALSE
6	It makes me impatient to have people ask my advice or otherwise interrupt me when I am working on something important	TRUE	FALSE
7	There is something wrong with my mind	TRUE	FALSE
8	I seldom or never have dizzy spells	TRUE	FALSE
9	I believe there is a Devil and a Hell in afterlife	TRUE	FALSE
10	I enjoy children	TRUE	FALSE
11	Life is a strain for me much of the time	TRUE	FALSE
12	My sex life is satisfactory	TRUE	FALSE
13	Once in a while I think of things too bad to talk about	TRUE	FALSE
14	I cannot keep my mind on one thing	TRUE	FALSE
15	I have certainly had more than my share of things to worry about	TRUE	FALSE
16	I often feel as if things were not real	TRUE	FALSE
17	I have felt embarrassed over the type of work that one or more members of my family have done	TRUE	FALSE
18	I worry quite a bit over possible misfortunes	TRUE	FALSE

## Hypersensitive Narcissism Scale (HSNS)

Below is a list of statements. Please look at each one in turn, and indicate by circling the appropriate number beside the statement, the extent to which you believe that the item is characteristic of you. There are no right or wrong answers.



1	I can become entirely absorbed in thinking about my personal affairs, my health, my cares or my relations to others	1	2	3	4	5
2	My feelings are easily hurt by ridicule or by the slighting remarks of others	1	2	3	4	5
3	When I enter a room I often become self-conscious and feel that the eyes of others are upon me	1	2	3	4	5
4	I dislike sharing the credit of an achievement with others	1	2	3	4	5
5	I dislike being with a group unless I know that I am appreciated by at least one of those present	1	2	3	4	5
6	I feel that I am temperamentally different from most people	1	2	3	4	5
7	I often interpret the remarks of others in a personal way	1	2	3	4	5
8	I easily become wrapped up in my own interests and forget the existence of others	1	2	3	4	5
9	I feel that I have enough on my hands without worrying about other people's troubles	1	2	3	4	5
10	I am secretly "put out" when other people come to me with their troubles, asking me for my time and sympathy	1	2	3	4	5

## Dimensions of Anger Reactions Scale (DAR)

Do your best to judge as accurately as you can, the degree to which the following statements describe your feelings and behaviours. Then rate the degree to which each statement applies to you

1. I often find myself getting angry at people or situations

0	1	2	3	4	5	6	7	8
Not at All	Very Little	A Little	Some, Not Much	Moderately So	Fairly Much	Much	Very Much	Exactly So

2. When I do get angry, I get really mad

0	1	2	3	4	5	6	7	8
Not at All	Very Little	A Little	Some, Not Much	Moderately So	Fairly Much	Much	Very Much	Exactly So

3. When I get angry, I stay angry

0	1	2	3	4	5	6	7	8
Not at All	Very Little	A Little	Some, Not Much	Moderately So	Fairly Much	Much	Very Much	Exactly So

4. When I get angry at someone, I want to hit or clobber the person

0	1	2	3	4	5	6	7	8
Not at All	Very Little	A Little	Some, Not Much	Moderately So	Fairly Much	Much	Very Much	Exactly So

5. My anger interferes with my ability to do my job

0	1	2	3	4	5	6	7	8
Not at All	Very Little	A Little	Some, Not Much	Moderately So	Fairly Much	Much	Very Much	Exactly So

6. My anger prevents me from getting along with people

0	1	2	3	4	5	6	7	8
Not at All	Very Little	A Little	Some, Not Much	Moderately So	Fairly Much	Much	Very Much	Exactly So

7. My anger has had a bad effect on my health

0	1	2	3	4	5	6	7	8
Not at All	Very Little	A Little	Some, Not Much	Moderately So	Fairly Much	Much	Very Much	Exactly So

## Depression, Anxiety, Stress Scale

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

*The rating scale is as follows:*

- 0 Did not apply to me at all
- 1 Applied to me to some degree, or some of the time
- 2 Applied to me to a considerable degree, or a good part of time
- 3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (e.g., in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

## Inventory of Personality Organisation (IPO)

The following section contains statements about a variety attitudes, feelings and behaviours that people have during their lives. Please read carefully, and complete these questions as they apply to you. Please answer these questions as openly as you can. When thinking of yourself and your experiences, do not count as important those attitudes, feeling, or behaviours you might have had only while under the influence of alcohol or other drugs

1	2	3	4	5
Never True	Rarely True	Sometimes True	Often True	Always True

1	I am a "hero worshipper" even if I am later found wrong in my judgment	1	2	3	4	5
2	I feel that people I once thought highly of have disappointed me by not living up to what I expected of them	1	2	3	4	5
3	I feel it has been a long time since anyone really taught or told me anything I did not already know	1	2	3	4	5
4	It is hard for me to trust people because they so often turn against me or betray me	1	2	3	4	5
5	I need to admire people in order to feel secure	1	2	3	4	5
6	I find myself doing things which at other times I think are not too wise like having promiscuous sex, lying, drinking, having temper tantrums or breaking the law in minor ways	1	2	3	4	5
7	People tell me I have difficulty in seeing shortcoming in those I admire	1	2	3	4	5
8	I feel I don't get what I want	1	2	3	4	5
9	People tell me I behave in contradictory ways	1	2	3	4	5
10	I think people are basically either good or bad: there are few who are really in between	1	2	3	4	5
11	People tend to use me unless I watch out for it	1	2	3	4	5
12	I act in ways that appear to others as unpredictable and erratic	1	2	3	4	5
13	I have favourite people whom I not only admire, but almost idealise	1	2	3	4	5
14	I find myself doing things which feel okay while I'm doing them but which later find hard to believe I did	1	2	3	4	5
15	People tend to respond to me by either overwhelming me with love or abandoning me	1	2	3	4	5
16	I tend to feel things in a somewhat extreme way, experiencing either great joy or intense despair	1	2	3	4	5
17	I feel like a fake or imposter, that others see me as quite different from the way I really am	1	2	3	4	5
18	I feel I am a different person at home as compared to how I am at work or at school	1	2	3	4	5
19	I feel that my tastes and opinions are not really my own, but have been borrowed from other people	1	2	3	4	5
20	Some of my friends would be surprised if they knew how differently I behave in different situations	1	2	3	4	5
21	I fluctuate between being warm and giving at some times, and being cold and indifferent at other times	1	2	3	4	5
22	People tell me I provoke or mislead them so as to get my way	1	2	3	4	5
23	I can't explain the changes in my behaviour	1	2	3	4	5
24	I do things on impulse that I think are socially unacceptable	1	2	3	4	5
25	I get into relationships with people I don't really like because it's hard for me to say no	1	2	3	4	5
26	My life, if it were like a book, seems to me more like a series of short stories written by different authors than like a long novel	1	2	3	4	5
27	I pick up hobbies and interests and then drop them	1	2	3	4	5
28	When others see me as having succeeded, I'm elated and, when they see me as failing, I feel devastated	1	2	3	4	5
29	I'm afraid that people who become important to me will suddenly change in their feelings towards me	1	2	3	4	5
30	It is hard for me to be sure about what others think of me, even people who have known me very well	1	2	3	4	5
31	Being alone is difficult for me	1	2	3	4	5

### Inventory of Personality Organisation (IPO)

32	I see myself in totally different ways at different times	1	2	3	4	5
33	In the course of an intimate relationship, I'm afraid of losing a sense of myself	1	2	3	4	5
34	My life goals change frequently from year to year	1	2	3	4	5
35	My goals keep changing	1	2	3	4	5
36	After becoming involved with people, I am surprised to find out what they are really like	1	2	3	4	5
37	Even people who know me well cannot guess how I'm going to behave	1	2	3	4	5
38	When everything around me is unsettled and confused, I feel that way inside	1	2	3	4	5
39	I am not sure whether a voice I have heard, or something that I have seen is my imagination or not	1	2	3	4	5
40	When I'm nervous or confused, it seems like things in the outside world don't make sense either	1	2	3	4	5
41	I feel almost as if I'm someone else, like a friend or relative, or even someone I don't know	1	2	3	4	5
42	I think I see things which, when I take a closer look, turn out to be something else	1	2	3	4	5
43	When I am uncomfortable, I can't tell whether it is emotional or physical	1	2	3	4	5
44	I can see things or hear things that nobody else can see or hear	1	2	3	4	5
45	I hear things that other people claim are not really there	1	2	3	4	5
46	I have heard or seen things when there is no apparent reason for it	1	2	3	4	5
47	I find that I do things which get other people upset and I don't know why such things upset them	1	2	3	4	5
48	I can't tell whether certain physical sensations I'm having are real or whether I'm imagining them	1	2	3	4	5
49	I feel that my wishes or thoughts will come true as if by magic	1	2	3	4	5
50	People see me as being rude or inconsiderate, and I don't know why	1	2	3	4	5
51	I understand and know things that nobody else is able to understand or know	1	2	3	4	5
52	I know that I cannot tell others certain things about the world that I understand but that to others would appear crazy	1	2	3	4	5
53	I have seen things which do not exist in reality	1	2	3	4	5
54	I feel as if I have been somewhere or done something before when I really haven't	1	2	3	4	5
55	I can't tell whether I simply want something to be true or whether it really is true	1	2	3	4	5
56	I believe that things will happen simply by thinking about them	1	2	3	4	5
57	Somehow, I never know quite how to conduct myself with people	1	2	3	4	5

**Social Comparison Scale (SC)**

## The Social Comparison Scale

In relation to others I feel (please circle the answer that applies to you);

Inferior	Superior
Incompetent	Competent
Unlikable	Likable
Left out	Accepted
Different	Same
Untalented	More talented
Weaker	Stronger
Unconfident	More confident
Undesirable	More desirable
Unattractive	More attractive
Outsider	Insider

**Social Comparison Scale (SC)**

In relation to others, I feel...

Superior	1	2	3	4	5	6	7	8	9	10	Inferior
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In relation to others, I feel...

Incompetent	1	2	3	4	5	6	7	8	9	10	Competent
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In relation to others, I feel...

Unlikable	1	2	3	4	5	6	7	8	9	10	Likable
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In relation to others, I feel...

Left out	1	2	3	4	5	6	7	8	9	10	Accepted
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In relation to others, I feel...

Different	1	2	3	4	5	6	7	8	9	10	Same
-----------	---	---	---	---	---	---	---	---	---	----	------

In relation to others, I feel...

Untalented	1	2	3	4	5	6	7	8	9	10	More talented
------------	---	---	---	---	---	---	---	---	---	----	---------------

In relation to others, I feel...

Weaker	1	2	3	4	5	6	7	8	9	10	Stronger
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In relation to others, I feel...

Unconfident	1	2	3	4	5	6	7	8	9	10	More confident
-------------	---	---	---	---	---	---	---	---	---	----	----------------

In relation to others, I feel...

Undesirable	1	2	3	4	5	6	7	8	9	10	More desirable
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In relation to others, I feel...

Unattractive	1	2	3	4	5	6	7	8	9	10	More attractive
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In relation to others, I feel...

Outsider	1	2	3	4	5	6	7	8	9	10	Insider
----------	---	---	---	---	---	---	---	---	---	----	---------

## Appendix 8: Study two ethics approval

From: Keith Wilkins <KWilkins@groupwise.swin.edu.au>

Subject: SUHREC Project 2008/027 Ethics Clearance

To: Prof Glen Bates/Mr James Williams, FLSS

Dear Glen and James

SUHREC Project 2008/027 A reformulation of social anxiety - A psychological analysis of social anxiety subtypes Prof Glen Bates, FLSS; Mr James Williams Approved Duration: 17/11/2008 to 31/03/2009 [Adjusted]

I refer to the ethical review of the above project protocol by Swinburne's Human Research Ethics Committee (SUHREC). Your responses to the review, as emailed on 12 November 2008, were put to a delegate of SUHREC for consideration.

I am pleased to advise that, as submitted to date, the project may proceed in line with standard on-going ethics clearance conditions here outlined.

- All human research activity undertaken under Swinburne auspices must conform to Swinburne and external regulatory standards, including the National Statement on Ethical Conduct in Human Research and with respect to secure data use, retention and disposal.
  - The named Swinburne Chief Investigator/Supervisor remains responsible for any personnel appointed to or associated with the project being made aware of ethics clearance conditions, including research and consent procedures or instruments approved. Any change in chief investigator/supervisor requires timely notification and SUHREC endorsement.
  - The above project has been approved as submitted for ethical review by or on behalf of SUHREC. Amendments to approved procedures or instruments ordinarily require prior ethical appraisal/ clearance. SUHREC must be notified immediately or as soon as possible thereafter of (a) any serious or unexpected adverse effects on participants and any redress measures; (b) proposed changes in protocols; and (c) unforeseen events which might affect continued ethical acceptability of the project.
  - At a minimum, an annual report on the progress of the project is required as well as at the conclusion (or abandonment) of the project.
  - A duly authorised external or internal audit of the project may be undertaken at any time.
- Please contact me if you have any queries about on-going ethics clearance. The SUHREC project number should be quoted in communication.

Best wishes for the project.

Yours sincerely

Keith Wilkins

Secretary, SUHREC

\*\*\*\*\*

Keith Wilkins

Research Ethics Officer

Swinburne Research (H68)

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**Appendix 9: Publications and presentations produced as a result of this thesis**

- Williams, J.S. & Bates, G.W. (2010). Narcissistic Social Anxiety. Paper presented at the 27th International Congress of Applied Psychology. Melbourne, Australia.
- Williams, J.S. & Bates, G.W. (2011). Social Anxiety Disorder and Generalized Anxiety Disorder. In G. Murray (Ed.). *A Critical Introduction to DSM*. New York: Nova Science.
- Williams, J.S. & Bates, G.W. (2012). High social rank and social anxiety. Paper presented at the 42nd European Association of Behavioral and Cognitive Therapy Congress, Geneva
- Williams, J.S. & Bates, G.W. (2013). Narcissistic social anxiety. Paper presented at the 7th World Congress of Behavioural and Cognitive Therapies, Lima, Peru