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Interconnections between Childhood Trauma, Narcissistic Vulnerability, and Social Anxiety Disorder: A Cross-Sectional Study

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ABSTRACT

Objective: This study aims to explore the interconnections between social anxiety disorder (SAD), adverse childhood experiences, and pathological narcissism.

Methods: The study included 66 patients diagnosed with SAD according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition criteria and 55 healthy controls. All participants were assessed using The Liebowitz Social Phobia Scale (LSAS), Childhood Trauma Questionnaire (CTQ), Hypersensitive Narcissism Scale (HSNS), and Narcissistic Personality Inventory-16 (NPI-16) scales. Statistical analyses included descriptive statistics, Student's t-test, Chi-squared test, correlation tests to examine relationships between variables, and logistic regression to identify significant predictors of SAD, particularly focusing on the role of childhood trauma and narcissistic traits.

Results: The SAD patients had significantly higher scores on the CTQ total and subscales, as well as on the HSNS, compared to the healthy control group ($p < .001$). Additionally, there was a positive correlation between LSAS scores and both CTQ ($r = .585$, $p < .01$) and HSNS scores ($r = .582$, $p < .01$). However, no significant association was found between NPI-16 scores and LSAS or CTQ scores ($r = -.064$, $p > .05$).

Conclusion: This study highlights the increased levels of narcissistic pathology and history of childhood trauma in SAD patients. Vulnerable narcissism emerges as a key factor in SAD, emphasizing the need for comprehensive treatment approaches considering childhood trauma and narcissistic vulnerability.

Keywords: Vulnerable narcissism, grandiose narcissism, social anxiety, childhood trauma, DSM-5

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INTRODUCTION

Social anxiety disorder (SAD) is a mental disorder characterized by extreme anxiety symptoms when exposed to situations and environments requiring social interaction or public performance.[1] This disorder, which typically begins in the teenage years, is influenced by multiple factors.[2] One of the main contributors to its etiology is childhood trauma.[3,4] A study conducted in Türkiye found that

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anxiety disorders were more frequently detected in individuals who reported experiencing emotional abuse in childhood. It was revealed that emotional neglect and abuse are common experiences among people diagnosed with SAD, and these individuals often recall their parents as being uncaring during their childhood.[5]

Childhood trauma is a prevalent factor that can contribute to the development of narcissism, though its connection to social anxiety disorder remains unclear.[2,6] Although one of the common etiological causes of both social anxiety disorder and narcissism is childhood trauma, the similarities between narcissism and social anxiety disorder have not been discussed sufficiently in the literature. Previous studies have primarily focused on grandiose narcissism and its association with early maladaptive schemas and anxiety disorders. However, the link between grandiose narcissism and social anxiety disorder has not consistently been demonstrated. In contrast, vulnerable narcissism, characterized by shame, social anxiety, and self-suppression, has shown more relevant connections with social anxiety. Research indicates that individuals with vulnerable narcissism often avoid social situations due to fear of negative evaluation, which aligns with the core symptoms of social anxiety disorder.[7,8] Eldoğan and Tunçel highlighted the similarities between traits of vulnerable narcissism and social anxiety disorder, noting that individuals in both conditions negatively evaluate situations when they do not receive approval from others, feel ashamed, and avoid anxiety-inducing social situations.[8] A study conducted by Schurman reported that there might be a strong relationship between vulnerable narcissism and social anxiety.

Research has separately investigated the connections between childhood trauma and pathological narcissism with social anxiety disorder. However, no study has simultaneously explored the relationship between both forms of narcissism, childhood trauma, and social anxiety disorder. The purpose of this study is to investigate the relationship between childhood trauma, narcissistic vulnerability, and SAD. We hypothesized that individuals with SAD would have higher levels of childhood trauma and narcissistic vulnerability than healthy controls. By exploring these relationships, we seek to enhance the understanding of the mechanisms contributing to the development of SAD and to offer insights that could inform clinical approaches and treatment strategies for individuals affected by both narcissism and social anxiety disorder

MATERIAL AND METHODS

Participants and Procedure

This cross-sectional study was carried out with participants at the Psychiatry outpatient clinic of Bağcılar Training and Research Hospital between December 2023 and June 2024. The study included 66 patients diagnosed with Social Anxiety Disorder (SAD) according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition criteria (DSM-5), confirmed by two senior psychiatrists. Patients met the following inclusion criteria: ages 18 to 65, diagnosed with SAD per DSM-5 criteria, literate, and no psychiatric disorders, including narcissistic personality disorder. The exclusion of individuals with narcissistic personality disorder was crucial to isolate the effects of vulnerable narcissism on SAD without the confounding influence of grandiose narcissism associated with narcissistic personality disorder. The control group included healthy volunteers, matched by sex and age, who had no history of psychiatric or neurological disorders. Exclusion criteria for both groups included the presence of a mental retardation, comorbid psychiatric disorder, being under 18 years, and a history of neurological diseases impairing communication, such as organic mental disorders, head trauma, dementia, or epilepsy. Participants were invited to join the study after being informed about its purpose and methods, and those who agreed provided written and verbal consent before completing a Semi-Structured Sociodemographic and Clinical Data Form, The Liebowitz Social Phobia Scale (LSAS), the Childhood Trauma Questionnaire (CTQ), Narcissistic Personality Inventory-16 (NPI), and Hypersensitive Narcissism Scale (HSNS).

Ethics committee approval for this research was obtained from the Hamidiye Scientific Research Ethics Committee of the University of Health Sciences (Approval no: 22362, Date: October 19, 2023). and the study was conducted following the Declaration of Helsinki.

Measures

A Semi-structured Sociodemographic and Clinical Data Form

It's a form utilized for recording participant characteristics, encompassing factors like sex, age, and clinical variables.

The Liebowitz Social Phobia Scale (LSAS)

LSAS was developed to assess the levels of fear and avoidance in individuals with SAD in social interaction and performance situations.[9] The scale consists of 24 items: 11 items evaluate social interaction and 13 items evaluate performance, with two subscales. A high score on the scale indicates a high level of social anxiety symptoms.[10] Soykan et al. (2003) conducted validity and reliability studies for the Turkish version of the scale, reporting a Cronbach's alpha coefficient of .94 for the entire scale.[11]

Childhood Trauma Questionnaire (CTQ)

The CTQ is used to evaluate the traumatic events that are experienced during childhood and early youth years. The scale, developed by Bernstein et al., comprises 28 items and utilizes a 5-point Likert-type response format.[12] It has five subscales, each containing five questions. The reliability and validity studies for the Turkish form were carried out by Sar et al. The Cronbach's alpha, indicating the internal consistency of the scale, was reported as 0.93.[13]

Hypersensitive Narcissism Scale (HSNS)

The HSNS was developed by Hendin and Cheek (1997) to assess the recessive or latent side of narcissism, which may not be as overt as grandiose narcissism.[14] The scale includes a short form containing 8 items and a long form comprising 10 items, with participants rating each item on a 5-point Likert scale. A high score on the long form indicates a high level of vulnerable narcissism symptoms. Validity and reliability studies for the Turkish version of the scale were conducted by Şengül et al. (2015), with a Cronbach's Alpha value calculated as .66.[15]

Narcissistic Personality Inventory-16 (NPI-16)

The NPI was employed to measure grandiose narcissism. Originally developed as a 54-item scale by Raskin and Hall (1979), it was later refined to a 40-item form through item and factor analysis.[16] The NPI was further condensed to 16 items by Ames et al. in 2005, becoming widely utilized. Higher scores indicate elevated levels of grandiose narcissism. The Turkish validity and reliability study of the 16-item NPI was conducted by Atay (2009), revealing a Cronbach's alpha value of .63, indicating the scale's reliability.[17]

Statistical Analysis

The analysis of the study data was performed using the Statistical Package for Social Sciences version 24.0 software (IBM Corp.; Armonk, NY, USA). Descriptive statistics, such as mean, standard deviation, percentage, and frequency values, were presented. Normality of numerical data distributions was assessed using the Kolmogorov-Smirnov test prior to further analyses. Chi-square and Fisher Exact Test were applied to compare categorical variables between groups, while Student's t-test was used for continuous variables. Pearson correlation test was used for parametric variables. Additionally, a logistic regression analysis was conducted to identify predictors of social anxiety disorder. Statistical significance was set at $p < 0.05$.

RESULTS

The demographic and clinical variables were compared to between the social anxiety disorder and healthy control groups (Table 1). The SAD group had a mean age of 24.28 ± 8.07 years compared to 26.52 ± 5.48 years in the healthy control group, although this difference was not statistically significant (p = .083). Males constituted 59.1% of the SAD group and 41.8% of the healthy control group, with no significant difference (p = .058). The SAD group had significantly fewer years of education (13.38 ± 3.06 years) compared to the healthy control group (15.69 ± 2.69 years, p < .001). Additionally, the rate of unemployment or irregular employment was significantly higher in the SAD group (71.2%) compared to the healthy control group (34.5%, p < .001). Marital status (married) showed no significant difference between the groups, with 15.2% in the SAD group and 16.4% in the healthy control group (p = .408). Smoking was reported by 30.8% of the SAD group and 25.5% of the healthy control group, which was not statistically significant (p = .465). A history of alcohol/substance use was present in 16.7% of the SAD group compared to 29.1% in the healthy control group (p = .102). Family migration history was noted in 9.1% of the SAD group and 12.7% of the healthy control group (p = .520). The loss of a parent or caregiver during early childhood was reported by 4.5% of the SAD group and none in the healthy control group (p = .250). A family history of psychiatric disorders was present in 36.7% of the SAD group and 29.6% of the healthy control group (p = .081). History of suicide attempts was reported by 7.8% of the SAD group and none in the healthy control group (p = .061). History of psychiatric disorders during childhood and adolescence was reported by 10.9% of the SAD group and 5.5% of the healthy control group (p = .337). The demographic data reveal significant differences in education and employment between the SAD group and the healthy control group. The lack of significant differences in other variables suggests that the primary distinctions lie in education and employment status.

The SAD group scored significantly higher on the Childhood Trauma Questionnaire (CTQ) total and its subscales, including physical abuse, emotional abuse, emotional neglect, sexual abuse, and physical neglect, compared to the healthy control group (p < .001 for all comparisons). Specifically, the mean CTQ total score was 69.67 ± 4.23 in the SAD group versus 38.47 ± 12.79 in the healthy control group. Physical abuse scores were 9.13 ± 2.57 vs. 5.34, emotional abuse scores were 9.36 ± 1.58 vs. 6.74 ± 1.93, emotional neglect scores were 22.04 ± 2.85 vs. 10.58 ± 3.83, sexual abuse scores were 9.50 ± 1.79 vs. 5.20 ± 0.70, and physical neglect scores were 16.03 ± 2.05 vs. 7.23 ± 2.28 (Table 2).

Additionally, the HSNS scores were significantly higher in the SAD group (33.58 ± 6.42) compared to the healthy control group (27.21 ± 5.92, p < .001). However, there was no significant difference in the NPI-16 scores between the two groups (23.84 ± 2.60 vs. 24.03 ± 1.41, p = .616) (Table 2). The significantly higher CTQ and HSNS scores in the SAD group highlight the association between childhood trauma, hypersensitive narcissism, and social anxiety disorder. The lack of significant difference in NPI-16 scores suggests that grandiose narcissism may not be as closely related to social anxiety disorder in this sample.

Correlation analyses revealed that LSAS scores were significantly positively correlated with both the HSNS scores (r = .582, p < .01) and the CTQ total scores (r = .585, p < .01). However, there was no significant correlation between LSAS scores and NPI-16 scores (r = -.064). Additionally, a positive significant correlation was found between HSNS and CTQ total scores (r = .461, p < .01) (Table 3). The significant positive correlations between LSAS scores, HSNS, and CTQ total scores suggest that higher social anxiety is associated with increased hypersensitive narcissism and childhood trauma. The lack

Table 1. Basic Characteristics of Participants

	Total Sample (n = 121)			
	Social Anxiety Disorder (N:66)	Healthy Control (N:55)		
	Mean ± SD / n (%)	Mean ± SD / n (%)	p	
Age	24.28 ± 8.07	26.52 ± 5.48	.083	S
Sex (male)	39 (59.1)	23 (41.8)	.058	χ^2
Education (years)	13.38 ± 3.06	15.69 ± 2.69	.000	S
Employment (no/irregular)	47 (71.2)	19 (34.5)	.000	χ^2
Marital Status (married)	10 (15.2)	9 (16.4)	.408	χ^2
Smokers (yes)	20 (30.8)	14 (25.5)	.465	χ^2
History of Alcohol/ Substance Use (yes)	11 (16.7)	16 (29.1)	.102	χ^2
History of Family Migration (yes)	6 (9.1)	7 (12.7)	.520	χ^2
*Loss of a Parent/Caregiver During Early Childhood (yes)	3 (4.5)	0 (0.0)	.250	F
Family History of Psychiatric Disorders (yes)	22 (36.7)	34 (29.6)	.081	χ^2
*History of Suicide Attempts (yes)	5 (7.8)	0 (0.0)	.061	F
*History of Psychiatric Disorders During Child and Adolescent (yes)	7 (10.9)	3 (5.5)	.337	χ^2

S Student's t-test/ χ^2 Chi-squared test/ F Fisher Exact Test/ p < 0.05 statistically significant

Table 2. Comparison of the Between Social Anxiety Disorder and Healthy Control Groups Childhood Trauma Questionnaire, Hypersensitive Narcissism Scale, and Narcissistic Personality Inventory-16

	Total Sample (n = 121)		
	Social Anxiety Disorder (N:66)	Healthy Control (N:55)	
	Mean ± SD	Mean ± SD	p
Childhood Trauma Questionnaire Total	69.67 ± 4.23	38.47 ± 12.79	.000
Physical abuse	9.13 ± 2.57	5.34 ± 0.92	.000
Emotional abuse	9.36 ± 1.58	6.74 ± 1.93	.000
Emotional neglect	22.04 ± 2.85	10.58 ± 3.83	.000
Sexual abuse	9.50 ± 1.79	5.20 ± 0.70	.000
Physical neglect	16.03 ± 2.05	7.23 ± 2.28	.000
Hypersensitive Narcissism Scale	33.58 ± 6.42	27.21 ± 5.92	.000
Narcissistic Personality Inventory-16	23.84 ± 2.60	24.03 ± 1.41	.616
Liebowitz Social Anxiety Scale	115.10 ± 25.87	74.72 ± 12.15	.000

The Student t test was used. $p < 0.05$ statistically significant

of correlation with NPI-16 scores further supports the differentiation between vulnerable and grandiose narcissism in relation to social anxiety.

Table 4 shows the logistic regression analysis for SAD. The model was significant ($\chi^2(2) = 120.764$, $p < 0.001$) with high classification accuracy (96.7%) and Nagelkerke R^2 of 0.844. The CTQ was a significant predictor ($B = 0.184$, $p < 0.001$), with an odds ratio of 1.202, indicating that higher childhood trauma scores increase the odds of SAD by 20.2%. In contrast, the HSNS was not a significant predictor ($B = 0.122$, $p = 0.062$), with an odds ratio of 1.130. The logistic regression analysis confirms that childhood trauma is a significant predictor of social anxiety disorder, while hypersensitive narcissism does not significantly predict social anxiety in this model. This highlights the importance of childhood trauma in understanding the development of SAD.

Table 3. Correlation Analysis of Clinical Variables

	Correlations			
r	1	2	3	4
1. Liebowitz Social Anxiety Scale	1			
2. Narcissistic Personality Inventory-16	-.064	1		
3. Hypersensitive Narcissism Scale	.582**	-.004	1	
4. Childhood Trauma Questionnaire Total	.585**	-.028	.461**	1

r: the Pearson correlation coefficient. *Correlation is significant at the 0.01 level (2-tailed).

Table 4. Logistic Regression Analysis for Social Anxiety Disorder

				95% C.I.for EXP(B)	
	B	Sig.	Exp(B)	Lower	Upper
Hypersensitive Narcissism Scale	.122	.062	1,130	0,994	1,284
Childhood Trauma Questionnaire	.184	.000	1,202	1,126	1,284
Constant	-13.987	.000	.000		

A logistic regression analysis was conducted; Model $\chi^2(2) = 120.764$, $p < 0.001$, with a classification accuracy of 96.7% and Nagelkerke R^2 of 0.844. $p < 0.05$ statistically significant

DISCUSSION

This study has provided a review of relevant areas of research in which social anxiety disorder, narcissism, and childhood trauma history may be interconnected, and we observed the close relationship of social anxiety disorder with vulnerable narcissism and childhood trauma history.

Narcissism is characterized by grandiosity, arrogance, self-love, low concern for others, lack of empathy, and a need for admiration and approval in interpersonal relationships.[18,19] Individuals with narcissistic traits may view themselves as unique and superior, disregard social norms, and take pleasure in others' suffering.[20] They often focus on short-term gains to maintain self-esteem, neglecting long-term benefits, and blame external factors or others for their failures.[20] In both DSM-5 and earlier editions, narcissism is defined by grandiosity and superiority.[21] Kohut further divided narcissism into two dimensions: the horizontal division, where individuals conceal their weaknesses with grandiose feelings, and the vertical division, where they experience denial, shame, and vulnerability.[22] Similarly, researchers have distinguished between grandiose narcissism and vulnerable narcissism. Grandiose narcissism involves arrogance, lack of empathy, need for approval, entitlement, dominance, extreme reactions to criticism, and a belief in superiority.[15] Although the relationship between grandiose narcissism and lack of empathy has been confirmed many times, the relationship between SAD and empathy remains unclear.[23] Additionally, individuals with SAD tend to be overly concerned with perceived personal flaws in social competence rather than overreacting to criticism. In our study, we did not observe a significant association between grandiose narcissism and SAD. This lack of correlation may stem from several factors. Firstly, the distinct nature of grandiose narcissism, which is characterized by traits such as arrogance, entitlement, and a strong need for admiration, may not overlap sufficiently with the symptoms of SAD, which primarily involves intense fear of social interactions and perceived personal inadequacies. Secondly, limitations in our measurement tools or methodologies might have influenced the ability to detect a relationship between these constructs. Finally, the specific characteristics of our sample, such as its size or demographic composition, could also play a role in this finding. To gain a clearer understanding of the potential interactions between grandiose narcissism and SAD, future research should address these aspects by employing diverse methodologies, larger and more representative samples, and refined measurement tools.

Vulnerable narcissism is characterized by shame, social anxiety, hopelessness, loneliness, interpersonal coldness, insecurity, dissatisfaction, social avoidance, and self-suppression.[24] Those exhibiting traits of vulnerable narcissism may feel anxious in social settings due to the fear of humiliation and negative feedback, resulting in avoidance. Moreover, they frequently experience intense distress when faced with rejection, embarrassment, or exclusion.[25] Considering the characteristics of vulnerable narcissism, it is noteworthy that it has many similarities with the symptoms of social anxiety disorder.[26] Those with social anxiety disorder fear social interactions, believe in ridicule or embarrassment, and commonly avoid such situations. These characteristics are also linked with vulnerable narcissism, as

individuals experiencing its symptoms tend to avoid situations where they may not receive approval, perceive them negatively, and anticipate negative evaluations or feelings of shame from others.[25] In our study, in parallel with all these, we observed a relationship between vulnerable narcissism and social anxiety disorder.

Etiological models of SAD propose that early childhood trauma contributes to its development.[27,28] Swain et al. recently discovered a positive correlation between post-traumatic stress symptoms, stemming from childhood trauma, and anxiety in young adolescents, suggesting potential long-term social and emotional consequences.[29] Simon et al. found that childhood trauma, particularly emotional neglect, was linked to greater symptom severity in individuals with SAD.[30] However, Keyes et al. reported that the association between specific traumatic events and psychopathology was not statistically significant, emphasizing the critical role of preventing childhood trauma in reducing the incidence of common psychiatric disorders.[31] Yet, the impact of childhood trauma on adult clinical functioning in SAD remains unclear. Research indicates that childhood trauma, particularly in the context of SAD, can desensitize cortisol reactivity.[32] Maeda et al. suggest that deficits in cortisol reactivity lead to avoidance behaviors, contributing to persistent fear responses, which may significantly influence the psychopathology of social anxiety.[32] We found that all adverse childhood experiences, regardless of neglect or abuse type, are more prevalent in individuals with social anxiety disorder. Furthermore, we observed a positive correlation between trauma severity and SAD symptoms. Consistent with this, our logistic regression analysis revealed that childhood trauma remains a significant predictor of social anxiety disorder, highlighting its crucial role in the disorder's etiology.

Genetic factors, adverse upbringing conditions, and traumatic events are suggested as potential causes of narcissism.[33] However, due to its complex nature, studies investigating the significant factors in its development remain inconsistent.[6] Narcissism is a multi-dimensional personality structure, with distinct grandiose and vulnerable forms. Both types share traits such as persistent self-importance, a craving for admiration, and hostile characteristics.[34] Despite these similarities, the structures of grandiose and vulnerable narcissism do not completely align.[35] Recent evidence suggests a link between childhood maltreatment and both pathological types of narcissism. However, research on this relationship has yielded conflicting results.[6] While a recent meta-analysis identified childhood maltreatment as a risk factor for both vulnerable and grandiose narcissism, our study found a specific association only with vulnerable narcissism.[35]

The interplay between childhood trauma, vulnerable narcissism, and SAD highlights the importance of tailored treatment approaches. For individuals with SAD who have a history of childhood trauma, trauma-focused therapies such as trauma-informed cognitive-behavioral therapy (CBT) and eye movement desensitization and reprocessing are particularly effective.[36] These approaches address the long-lasting impact of trauma on current anxiety symptoms. Additionally, for individuals with vulnerable narcissism, adapting CBT to focus on distorted self-perceptions and incorporating interpersonal therapy to enhance social skills can be beneficial.[37] Combining these therapies provides a comprehensive treatment plan that addresses both SAD symptoms and the underlying issues related to narcissistic traits and childhood trauma.[38]

Our study's cross-sectional design limits the ability to draw causal inferences between childhood trauma, vulnerable narcissism, and SAD. A key limitation is the relatively small sample size, which may affect the generalizability of the findings. Additionally, self-report measures, subject to response biases, were used in this study. Future research should incorporate objective measures and larger, more diverse samples to enhance the accuracy and applicability of findings. Furthermore, exploring the impact of comorbid conditions and varying severities of SAD could provide deeper insights. Results from a single clinical setting may not apply to other contexts, suggesting that multi-site studies could offer a more comprehensive understanding.

CONCLUSION

This study demonstrates that individuals with SAD have experienced higher levels of childhood trauma and exhibit higher levels of narcissistic vulnerability compared to healthy controls. Furthermore, the level of social anxiety is positively associated with childhood trauma and narcissistic vulnerability. These data highlight the importance of considering childhood trauma and narcissistic traits in the treatment of SAD.

Availability of Data and Materials: The data that support the findings of this study are available on request from the corresponding author.

Ethics Committee Approval: Ethics committee approval was received for this study from the ethics committee of University of Health Sciences (Approval no: 22362, Date: October 19, 2023)

Informed Consent: Written informed consent was obtained from individuals who participated in this study.

Peer-review: Internally and externally peer-reviewed.

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