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# Avoidant personality disorder and social phobia: distinct enough to be separate disorders?

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**Objective:** Existing evidence from anxiety disorder research indicates that social phobics (SP) with avoidant personality disorder (AVPD) experience more anxiety and show more impairment than patients with SP alone. The purpose of this study was to examine whether in patients diagnosed with AVPD, the co-occurrence of SP adds to its severity. We hypothesized that the addition of SP will not add to the severity of AVPD alone.

**Method:** Two groups of patients (AVPD = 224; AVPD/SP = 101) were compared at baseline and 2 years later on multiple demographic and clinical variables.

**Results:** Patients with AVPD and an additional diagnosis of SP differed little from patients with AVPD alone.

**Conclusion:** These findings suggest that AVPD and SP may be alternative conceptualizations of the same disorder.

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## Introduction

Avoidant personality disorder (AVPD) and social phobia (SP) were first introduced in the psychiatric nomenclature in the third edition of The Diagnostic and Statistical Manual of Mental Disorders (1). They were placed on two separate axes; SP was placed on axis I among the clinical syndromes and AVPD was placed on axis II among the personality disorders. From the beginning, the similarity between AVPD and SP was apparent, although both disorders came from somewhat different historical and clinical traditions (2, 3). The empirical evidence is consistent with the conceptual overlap indicating that both disorders were often given to the same individual, and that the degree of severity, rather than the nature of specific symptoms, differentiated the two conditions (4, 5). Repeated attempts to remedy this problem by changing diagnostic criteria only intensified rather than minimizing the confusion (6). Most problematic is that evidence comparing the two conditions comes almost exclusively from anxiety disorder

clinics that compare individuals with SP alone and SP with AVPD.

This research can be grouped into three general categories: studies reporting on i) rates of co-occurrence of the two disorders; ii) research contrasting the two disorders on a variety of clinical, cognitive, and behavioral measures and treatment response; and iii) longitudinal studies.

Over the past two decades, predominantly high rates of co-occurrence of SP with AVPD (21–89%) have been reported in the literature (7–18). The overlap between the two disorders remains relatively high across different populations, different instruments, and changes in classification systems (1, 19).

Studies that compare SP with SP co-occurrent with AVPD patients generally show some differences between the groups (20–27). The differences appear more quantitative than qualitative in nature. Most studies show that the group with comorbid AVPD experiences more anxiety, and show more impairment than those without AVPD. Psychological and psychopharmacological treatments for SP patients show consistent

improvement in comorbid AVPD symptoms when symptoms of SP improve (11, 12, 21, 24, 28–32).

Turner et al. (33) conducted the only study that compared SP patients without AVPD and AVPD patients without SP. They found that the AVPD group was less socially skilled and more socially inhibited than the SP group. There were no other notable differences between the groups on any psychophysiological or cognitive measures. In summary, the evidence points to a quantitative difference in severity between the two conditions when the sample is identified by a diagnosis of SP and AVPD varies in its comorbidity.

A number of longitudinal studies have examined whether the presence of anxiety disorders in childhood and adolescence predicts the presence of Cluster C personality disorders later in life, and vice versa (34–36). The findings show a consistent association between axis I anxiety disorders and axis II Cluster C personality disorders, although the more specific relationship between SP and AVPD has not been tested. In summary, the general conclusion from anxiety research has been that SP and AVPD are not distinct disorders, and SP with AVPD represents a more severe group on an SP continuum.

A recent report from our group examined the longitudinal co-varying course of AVPD (as well as three other PDs with co-occurring axis I disorders over a 2-year period) (37). That analysis showed that remission from SP was related to remission from AVPD, and vice versa. This result indicates an interactive relationship between these conditions and (at least) affirms a spectrum relationship.

The present report examines whether adding an axis I SP disorder to AVPD generates differences between the two groups. Our hypothesis is that it will not. Here we compare a large sample of patients diagnosed with DSM-IV AVPD without SP to a sample with AVPD and SP, at baseline and 2 years later. Comparisons between the two groups are made on demography, axis I and axis II comorbidity, personality traits, diagnostic stability, treatment utilization, and functional impairment. The study addresses three major limitations of prior studies comparing SP with SP and AVPD: i) lack of studies using the DSM-IV diagnostic classification system; ii) small number of participants (sample sizes range from  $n = 8$  to 28); and iii) no reports of long-term follow-up of patients diagnosed with AVPD with or without SP.

#### Aims of the study

To provide further clinical-phenomenological data to inform the ongoing debate as to whether AVPD

and SP should be considered separate disorders or should be consolidated as an axis I or axis II condition.

## Material and methods

### Participants

The sample for this study consisted of 668 participants recruited as part of a multi-site, Collaborative Longitudinal Personality Study (CLPS) of four personality disorders (avoidant, borderline, schizotypal and obsessive-compulsive). Participants meeting criteria for major depression without a personality disorder were selected as a comparison group. Detailed description of the study group and study objectives have been reported elsewhere (38, 39).

The sample consisted of treatment-seeking in-patients and out-patients, and individuals who responded to advertisements. Participants were eligible for entry into the study if they were between the ages of 18 and 45 years; met criteria for one or more of the four personality disorders or had major depression without personality disorder; had no organic mental disorder; had no history of schizophrenia, schizoaffective or schizophreniform disorder; and were not acutely psychotic or acutely intoxicated. All participants signed an informed consent after the study procedure was fully explained to them.

For this report participants were selected if at baseline they met DSM-IV criteria for AVPD with or without SP. The total sample consisted of 325 participants. Of the 325 participants, 224 met criteria for AVPD and not SP, and 101 met criteria for both AVPD and SP.

### Measures

*Axis I disorders.* Axis I disorders were assessed using the Structured Clinical Interview for DSM – IV, Patient Version (SCID-I/P) (40). The SCID-I/P assesses both current and lifetime incidence of axis I pathology including mood, anxiety, psychotic, somatoform and substance use disorders. Each disorder is rated on a 3-point scale (1 = not present, 2 = subthreshold and 3 = threshold). The inter-rater reliability coefficients for the use of the SCID-IP by the CLPS interviewers have been reported elsewhere (41) and ranged from 0.63 to 0.88. The kappa coefficient for inter-rater reliability for SP was 0.63.

*Axis II disorders.* Axis II disorders were assessed using the semi-structured Diagnostic Interview for

Personality Disorders – IV (DIPD-IV) (42). The DIPD-IV assesses the 10 DSM-IV personality disorders, and the appendix disorders, depressive and passive-aggressive. Each disorder is rated on a 3-point scale (0 = not present; 1 = present but of uncertain clinical significance; 2 = definitely present). A diagnosis of personality disorder is made if symptoms are present for at least 2 years and they are typical of the subject for most of their adult life. The inter-rater reliability coefficients for the current instrument using the CLPS sample have been reported elsewhere (41) and ranged from 0.58 to 1.0. The kappa coefficient for inter-rater reliability for AVPD was 0.68 while the test-retest kappa was 0.73.

*Axis II follow-along.* The Diagnostic Interview for Personality Disorders – IV Follow-Along Version (DIPD-IV-FAV) (42) was used to assess the longitudinal course of axis II disorders. The instrument was modified to include only questions for the four personality disorders being followed by CLPS (borderline, avoidant, schizotypal, and obsessive-compulsive). The instrument is used to determine whether and when criterion changes have occurred since the last interview. For each criterion, ratings of 0, 1 or 2 are assigned for each month. Kappa reliability coefficients of 0.73 have been reported for 12 months retrospective reporting of AVPD.

*Personality traits.* The NEO Personality Inventory – Revised (NEO-PI-R) (43) is a 240-item self-report measure designed to assess the five-factor model of personality: neuroticism, extraversion, openness to experience, agreeableness and conscientiousness. Each item is answered on a 5-point Likert scale from strongly disagree to strongly agree.

*Global functioning.* Global functioning was assessed using the DSM-IV Global Assessment of Functioning Scale (GAFS). A combined level of functioning and severity of symptomatology rating over the past month is made on a 100-point scale with lower scores reflecting lower level of functioning.

*Longitudinal course of psychopathology and treatment history.* The Longitudinal Interval Follow-Up Evaluation (LIFE) (44) was used to document the longitudinal course of both axis I disorders and treatment history. The severity of psychopathology is assessed for each axis I disorder on a weekly basis by using Psychiatric Status Ratings (PSRs). For all axis I disorders except major depression a

3-point scale was used to generate PSR ratings (1 = no symptoms, 2 = subthreshold degree of symptomatology, 3 = meets full criteria for the disorder). For major depression a 6-point scale is used to generate PSR ratings (1 or 2 = minimal or no symptoms; 3 or 4 = subthreshold degree of symptomatology; 5 or 6 = meets full criteria for the disorder). Excellent reliability has been reported for the LIFE (45, 46). The nature, type and amount of treatment is also documented in detail with the LIFE.

#### Procedure

*Baseline evaluation.* All potential participants were first screened to determine eligibility. The Personality Screening Questionnaire, an abbreviated version of the Personality Disorder Questionnaire (47) was used to screen potential participants for presence of any of the four PDs required for inclusion in the study. The Inventory for Diagnosis of Depression (48) was used to screen potential participants for presence of major depressive disorder. Participants who met inclusion criteria were asked to come for a face-to-face interview to detail their axis I, axis II pathology and functioning/treatment history. All interviews were conducted by experienced interviewers who were trained and monitored for reliability (41).

*Follow-up evaluations.* Follow-up interviews were conducted at 6, 12 and 24 months following inclusion in the study. At each follow-up point the longitudinal course of axis I pathology and treatment history was assessed using the LIFE. The DIPD-IV was administered at a 2-year follow-up by an interviewer blind to the subject's axis II pathology. The DIPD-IV follow-along was administered at every follow-up. The GAFS was also administered at every follow-up point and all participants were asked to complete the NEO.

#### Statistical analyses

Comparisons among categorical variables were made using a  $\chi^2$  test. Single comparisons for continuous variables were made using *t*-tests. Multiple comparisons were conducted using Univariate Analysis of Variance (ANOVA), unless considerable overlap existed between variables, as in the case of the NEO-PI, where Multivariate Analyses of Variance (MANOVA) was utilized.

At the 2-year follow-up we compared the groups on rates of short- and long-term remission from AVPD. The participant was considered in a short-term remission from AVPD if he/she reported two

or fewer AVPD criteria present for at least two consecutive months during the 2-year follow-up. The participant was considered in a long-term remission from AVPD if he/she reported two or fewer AVPD criteria for at least 12 consecutive months before the follow-up interview. Survival analysis was used to test differences in remission rates for both groups over 2 years.

## Results

### Baseline comparisons

Demographic information for the two groups is provided in Table 1. There were no significant differences between the groups on any demographic variable. There were no differences between the groups on axis I or axis II comorbidity rates (see Table 2).

The AVPD no SP group endorsed only one of seven individual avoidant criteria with lower frequency than the comparison group (see Table 3). The AVPD no SP patients reported being less 'reluctant to take risks' ( $\chi^2 = 6.98$ ,  $P = 0.03$ ). The two groups also differed in the actual number of avoidant criteria. Although the findings were statistically significant ( $t = -2.08$ ,  $P = 0.04$ ) the differences were not clinically meaningful (AVPD no SP = 5.45, AVPD and SP = 5.72).

Table 1. Demographic characteristics for avoidant personality disorder (AVPD) no social phobia (SP) ( $N = 224$ ) and AVPD and SP ( $N = 101$ ) patients

	AVPD no SP	AVPD and SP	$\chi^2$	$P$
Age, mean (SD)	32.1 (8.04)	33.1 (8.34)		
Female, $n$ (%)	150 (67.0)	61 (60.4)		
Racial affiliation, $n$ (%)				
White	166 (74.1)	83 (82.2)	3.29	0.348
African-American	25 (11.2)	10 (9.9)		
Hispanic	26 (11.6)	6 (5.9)		
Other	7 (3.1)	2 (2.0)		
Marital status, $n$ (%)				
Single	127 (56.7)	61 (60.4)	3.72	0.590
Married	45 (20.1)	19 (18.8)		
Living together	15 (6.7)	8 (7.9)		
Separated/divorced	37 (16.5)	6 (6.0)		
Education, $n$ (%)				
High school or lower	70 (31.2)	27 (27.7)	2.83	0.899
Part/college graduate	107 (47.8)	52 (51.6)		
Part/completed graduate	47 (21.0)	22 (21.8)		
Current employment status, $n$ (%)				
Full-time	44 (19.6)	32 (31.7)	6.93	0.850
Part-time	36 (16.1)	9 (8.9)		
Unemployed	88 (39.3)	39 (38.7)		
Student	51 (22.8)	21 (20.8)		
Current occupation, $n$ (%)				
Manual/skilled work	70 (35.1)	25 (27.7)	7.7	0.059
Small business	53 (26.6)	23 (25.5)		
Clerical/technical	51 (25.6)	36 (40.0)		
Administrative/executive	25 (12.6)	6 (6.6)		

Table 2. Frequency of axis I and axis II disorders (current) in avoidant personality disorder (AVPD) no social phobia (SP) ( $N = 224$ ) and AVPD and SP ( $N = 101$ ) patients

	AVPD no SP	AVPD and SP	$\chi^2$	$P$
Axis I, $n$ (%)				
No current axis I	29 (12.9)			
Any mood disorder	150 (67.0)	69 (68.3)	0.274	0.872
Any bipolar disorder	29 (12.9)	8 (7.9)	2.44	0.270
Any anxiety disorder*	128 (57.1)	50 (49.5)	1.19	0.351
Any eating disorder	44 (19.6)	22 (21.8)	0.399	0.819
Any substance disorder	51 (22.8)	14 (13.9)	3.80	0.150
Axis II, $n$ (%)				
Paranoid	31 (13.8)	21 (20.8)	2.12	0.145
Schizotypal	34 (15.2)	14 (13.9)	0.020	0.888
Schizoid	7 (3.1)	7 (6.9)	1.66	0.197
Dependent	25 (11.2)	25 (11.2)	0.075	0.784
Obsessive-compulsive	84 (37.5)	35 (34.7)	0.136	0.712
Depressive	83 (37.1)	45 (44.6)	1.43	0.231
Passive-aggressive	23 (10.3)	11 (10.9)	0.000	1.00
Histrionic	8 (3.6)	0 (0)	6.02	0.062
Borderline	94 (42.0)	38 (37.6)	0.379	0.538
Narcissistic	13 (5.8)	5 (5.0)	0.001	0.970
Antisocial	20 (8.9)	7 (6.9)	0.140	0.709

\*Excluding SP.

There were no differences between the groups on the number of medications received, the number of months in therapy(s), or weeks spent in treatment facilities. A comparison of the GAFS scores revealed no difference between the groups ( $t = -1.18$ ,  $P = .240$ ). The overall level of functioning in both groups was low, with a mean of 55.7 for the AVPD no SP group and a mean of 57.3 for the AVPD and SP group. When the GAFS scores were analyzed categorically ( $< 50$ ,  $51-60$ ,  $61-70$ ,  $> 71$ ), there was again no difference between the groups. The omnibus  $F$ -test comparing the two groups on the NEO-PI-R five factors was not significant ( $F = 1.78$ ,  $P = .116$ ).

### Comparisons at 2-year follow-up

A sample of 266 participants completed the 2-year follow-up at the time of the analysis. Comparisons were made for 182 participants in the AVPD no SP group and 84 in the AVPD and SP group (81.3 and 83.2% of the baseline sample respectively). The sample of 59 participants who were not available for follow-up were not different at baseline on any demographic or clinical variables from the sample of 266 participants who were followed up for 2 years. At the 2-year follow-up point parallel comparisons were made on all the variables used in the baseline analyses, except demographics. In addition, we tested the diagnostic stability of the two samples over 2 years.

We compared the percentage of patients in each group that met diagnostic criteria for AVPD 2 years later. The difference was statistically significant

Table 3. DSM-IV diagnostic criteria for avoidant personality disorder (AVPD) among AVPD no social phobia (SP) ( $n = 224$ ) and AVPD and SP ( $n = 101$ ) patients

	AVPD no SP	AVPD and SP	$\chi^2$	$P$
Views self as socially inept	202 (90.2)	95 (94.1)	3.75	0.15
Preoccupied with being rejected	196 (87.5)	93 (92.1)	3.84	0.14
Needs to be liked	181 (80.8)	86 (85.1)	1.74	0.42
Feels inadequate	209 (93.3)	95 (94.1)	2.94	0.23
Fears being ridiculed/shamed	145 (64.7)	59 (58.4)	1.26	0.53
Avoids jobs with interpersonal contact	149 (66.5)	73 (72.3)	1.16	0.56
Not take risks	138 (61.6)	77 (76.2)	6.98	0.03

Values are presented as  $n$  (%).

Table 4. Avoidant personality disorder (AVPD) diagnosis at 2-year follow-up for the AVPD no social phobia (SP) ( $n = 182$ ) and AVPD and SP ( $n = 84$ ) patients

	AVPD no SP	AVPD and SP	$\chi^2$	$P$
Diagnosis present	84 (46.2)	54 (64.3)	6.86	0.009
Short-term remission	71 (41.0)	22 (27.5)	3.05	0.087
Long-term remission	59 (34.1)	19 (23.8)	2.74	0.10

Values are presented as  $n$  (%).

with AVPD and SP group having significantly more patients who met AVPD diagnosis than the AVPD no SP group (64.3 and 46.2%;  $\chi^2 = 6.09$ ,  $P = 0.009$ ). However, there were no differences between the groups on short-term (AVPD no SP = 43.4% vs. AVPD and SP = 40.4%) or long-term (AVPD no SP = 41.2% vs. AVPD and SP = 31.0%) remission rates (see Table 4). The survival analysis revealed no significant difference in remission rates over 2 years between the two groups ( $\chi^2 = 3.1$ ,  $P = 0.078$ ).

There were no differences between the groups on comorbid rates for axis I and axis II disorders. There was no difference in GAFS scores between the groups ( $t = -0.997$ ,  $P = 320$ ) and mean values were in the low range indicating that on average the groups were not at a high level of functioning (AVPD no SP mean = 57.6, AVPD and SP mean = 59.4). When the GAFS scores were analyzed categorically, the results were again not significant. The omnibus  $F$ -test comparing the two groups on the NEO-PI-R five factors was not significant ( $F = 1.17$ ,  $P = 325$ ).

## Discussion

Based on our findings of the 2-year follow-up we concluded that the AVPD no SP group could not be meaningfully distinguished from the AVPD and SP group.

It is possible that our sample of treatment-seeking PD patients with or without SP represent a generally more ill group than individuals with

treatment-seeking SP. The findings from anxiety disorder studies suggest that adding AVPD to SP leads to a worse outcome because personality disorders by definition are chronic conditions with an unremitting course that start in childhood and lead to impairment in many areas of functioning throughout one's life. However, the same descriptions are also part of the characteristics that define SP (49–51). Furthermore, as Rettew has suggested (52), SP and AVPD not only may share similar etiology, phenomenology, course and treatment, but also may share identical underlying personality features, such as shyness. If similar descriptors of course and outcome are used to characterize the two conditions, and their diagnostic criteria significantly overlap, and they share similar temperamental make up, it should be no surprise that we found almost no differences between our groups.

A possible limitation is that the high prevalence of other axis I and axis II disorders may have masked potential differences that could have been detected in samples with less comorbid diagnoses. Another limitation of our study is that elements of our axis I interview were truncated to reduce assessment burden so patients with SP were not further classified as having a generalized or distinct subtype. Studies show that generalized social phobias are more similar to patients with AVPD than social phobics who exhibit fears of specific situations. Finally, we did not include in this scale a comparison group consisting of patients diagnosed with SP only. Comparing mutually exclusive groups may represent a better test of the hypothesis that the two disorders are distinct.

Shea et al. (36), using the same CLPS data, concluded that the strong time-varying association between SP and AVPD suggests that the disorders may share some of the same underlying pathological processes. Our findings are an extension of the above conclusion, and further suggest they may be one disorder. This suggestion is not new. DSM-IV clearly states: 'There appears to be a great deal of overlap between Avoidant Personality Disorder and Social Phobia, Generalized Type, so much so that they may be alternative conceptualizations of the same or similar condition' (p. 663). Consideration should be given to integrating these disorders into one construct.

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