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The relationship between avoidant personality disorder and social phobia

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Abstract

The main explanatory hypothesis for the distinction between social phobia (SP) and avoidant personality disorder (APD) has been the severity continuum hypothesis, stating that APD only differs from SP in terms of severity of dysfunction and symptomatic distress, that is, social anxiety and depressive symptoms. This study aimed at a comprehensive evaluation of this hypothesis in a large sample (n = 2192) of thoroughly assessed patients, most of whom had a diagnosis of personality disorder. Social phobia was stronger associated with APD than with other personality disorders, and APD was stronger associated with SP than with other symptom disorders. Social phobia–pure patients had a higher level of global functioning and lower levels of general symptom distress and interpersonal problems than APD-pure patients. The 2 groups were similar on domains that pertain to social anxiety and introversion, but APD was associated with a broader array of symptoms and interpersonal problems and was substantially lower on the personality domain of conscientiousness. Avoidant personality disorder was stronger associated with eating disorders, and SP was stronger associated with panic disorder. The APD diagnosis seems to capture a broader constellation of symptoms and personality features pointing toward more severe personality dysfunction. Our findings suggest that the severity continuum hypothesis lacks specificity and exploratory power to account for both similarities and differences between SP and APD.
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1. Introduction

The coexistence of social phobia (SP) and avoidant personality disorders (APDs) in the current classification system *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition* (*DSM-IV*), [1] illustrates 2 different approaches to social anxiety. On the one hand, social anxiety can be considered as a symptom disorder and grouped together with the other phobias, as was done by Janet in 1903 [2]. On the other hand, it can be conceptualized within a broader constellation of traits and symptoms that may constitute the psychological makeup of a person to whom the term *personality disorder* (*PD*) can be applied [3]. The issue is of special importance because it pertains to a main topic on the PD research agenda for *DSM, Fifth Edition*, that is, the relationship of personality disorders to symptom disorders [4]. The high prevalence of both SP and APD further underscores the significance of this issue; reviews of population studies have estimated the lifetime prevalence of SP to range from 5% to 13% [5,6] and the prevalence of APD from 0.5% to 5% [7,8]. Both disorders are associated with a considerable decrease in social and occupational functioning [9,10].

From the very moment SP and APD were entered in the formal psychiatric nomenclature *DSM, Third Edition* (*DSM-III*), in 1980 [11], there has been a debate about the distinction between the 2 disorders. The sole *DSM-III* study that addressed this issue found enough evidence to support the position of separating these 2 conditions [12]. However, the distance between APD and SP might have been artificially high because of the way APD was conceptualized in *DSM-III*. That is, for the diagnosis of APD to be established, all 5 APD criteria had to be met, which may have implied that all persons belonging to the APD category were highly dysfunctional. In *DSM, Revised Third Edition* (*DSM-III-R*) [13], this prerequisite was abandoned—APD was redefined by a polythetic criterion set in which any 4 of 7 criteria could be met to warrant the diagnosis. Three other major changes had an impact on the relationship between SP and APD. First, co-occurrence between SP and APD was

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allowed, as the diagnosis of SP was no longer ruled out if the criteria for APD were met. Second, a new SP subtype was introduced, generalized SP, based on the empirical findings that most people with SP experience social fear in more than one social situation [12,14]. Third, according to Millon [15], revisions of the *DSM-III-R* APD criteria were strongly influenced by the psychoanalytically informed concept of the phobic character, resulting in the removal of the criterion of poor self-esteem and the inclusion of criteria that were almost identical to the SP criteria, for example, fear of being embarrassed by blushing and fear of saying something inappropriate. Accordingly, studies evaluating the distribution of the APD criteria in SP found these particular criteria to be the most common in SP [16,17].

In 1992, 3 *DSM-III-R* studies were published supporting the *severity continuum hypothesis*, stating that APD only differs from SP in terms of severity of social anxiety and social functioning [16,18-20]. However, sample sizes in these studies were small, patients were only assessed for symptoms relevant for SP, and all patients were recruited for the treatment of anxiety disorders. Subsequent *DSM-III-R* studies aimed at addressing these limitations by different means: by using a larger sample size [21]; by using a sample of patients with a primary diagnosis of depression [22]; by comparing SP patients with patients who had panic disorder [23]; by systematically assessing different subtypes of SP [24]; by taking into account a wider array of psychopathology [25]; or by considering co-occurrences with other PDs [26,27]. The results of these studies were inconsistent; some clearly supported the continuum hypothesis [25,28], whereas others supposed that APD constitutes a category that represents more than just social anxiety [16,19,20,24,25].

Most knowledge on the relationship between SP and APD comes from *DSM-III-R* studies. It may not be possible to merely generalize this knowledge to the *DSM-IV* situation because major revisions of the *DSM-IV* APD construct were aimed at making APD more distinct from SP [15] by de-emphasizing descriptions of fear in social situations and reintroducing the concept of poor self-esteem, with more emphasis on social inadequacy. The few *DSM-IV* studies that have reported on the overlap between SP and APD found the prevalence of SP within APD to range from 31% to 86% [6,28-30]. To our knowledge, only 2 *DSM-IV* studies have focused on the differences between SP and APD. In a community survey of 581 individuals, Tillfors et al [28] concluded that their findings were in support of the continuum hypothesis. However, the study comprised only a few clinical variables and relied on self-report questionnaire to assess PD diagnoses, which is known to produce many false-positive cases. In the Collaborative Longitudinal Personality Disorders Study, Ralevski et al [29] found that in a large sample of subjects with APD, there were no differences between those with and those without SP concerning demographic variables, co-occurrence patterns, or clinical course. The study did not include SP patients without PD, neither did it account for additional personality pathology.

The high degree of overlap between SP and APD, highlighted by numerous *DSM-III-R* co-occurrence studies, tends to be viewed as supporting the continuum hypothesis [31] mainly because of the high rates of SP within APD patients, ranging from 25% to 100% [12,16,17,19,22-24,26,32-36]. However, as outlined by Johnson and Lydiard in 1995 [34], APD patients without SP may prove to be a category of major clinical importance; and they called for studies focusing on this group of patients. Still, only one study, the aforementioned study of Ralevski et al [29], has addressed this issue, finding that additional SP did not add to the severity of APD. Thus, more studies of patients with APD without SP are needed.

Overall, the severity continuum hypothesis can be approached in 2 different ways. First is by studying the overlap between the 2 disorders compared with other axis I and II disorders. This implies that co-occurrences should not only be investigated from the viewpoint of SP (the association between SP and the different PDs), but also from the viewpoint of APD (the association between APD and the symptom disorders). Second is by comparing patients with SP and patients with APD on a number of clinical characteristics, for example, measures of global functioning, symptom profile, interpersonal problems, and personality traits that are supposed to include temperamental dispositions. Because of the high overlap between SP and APD, large samples are required to include groups of sufficient size of patients without co-occurring SP and APD, so-called pure SP and pure APD patients. Such materials have previously not been available until the one being reported in this article, which counts 2274 patients, including 891 patients with APD and 683 patients with SP. However, as the diagnostic threshold for APD is fulfilling at least 4 of 7 criteria, patients with so-called pure SP may also have some avoidant traits, fulfilling anything from 0 to 3 criteria.

In this study, we aimed at a comprehensive evaluation of the severity continuum hypothesis in a large sample of carefully assessed patient by examining the following relations that can be derived from this hypothesis:

1. Social phobia is stronger associated with APD than with the other PDs.
2. Avoidant personality disorder should be stronger associated with SP than with the other symptom disorders.
3. When comparing SP patients without any PD (SP-pure) with APD patients without SP or any other PD (APD-pure), APD-pure patients should be more anxious and depressed, have more interpersonal problems related to social fear, and have a lower level of global functioning, but not differ from SP-pure patients on other kinds of psychopathology.
4. Avoidant personality disorder is associated with high neuroticism and low extraversion on the Five-Factor

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