

Social Phobia and Avoidant Personality Disorder: Are They Separate Diagnostic Entities or Do They Reflect a Spectrum of Social Anxiety?

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Abstract: The Axis I disorder social phobia and the Axis II disorder avoidant personality disorder were first introduced in the DSM nomenclature in 1980. Since then a major nosological theme in research has concerned whether or not social phobia and avoidant personality disorder represent distinct clinical categories. Our main aim was to summarize both the current situation regarding this conceptual debate, as well as what we still do not know. In the present review we describe the evolution of these disorders as they have been addressed over time, from their introduction in the DSM-III system to their current descriptions in the DSM-IV. Thereafter, earlier empirical literature concerning this conceptual debate is evaluated, with the main focus on comorbidity between social phobia and avoidant personality disorder. The PsycINFO and PubMed electronic databases were searched for studies, and complementary searches of references in articles and books were conducted. To conclude, the studies summarized provide support for the view that social phobia and avoidant personality disorder are more than arbitrary cutoffs along a continuum of social anxiety.

It has been nearly 30 years since social phobia and avoidant personality disorder were introduced for the first time in the DSM classification system. Since then a high rate of comorbidity between these disorders has been witnessed (1). However, the conceptual boundaries between Axis I social phobia and Axis II avoidant personality disorder are to a large extent still undetermined. This is an important issue, and the main goal of this paper is to summarize the current situation concerning this conceptual debate.

We used the key words “social anxiety” and “avoidant personality disorder” to search for studies in the PsycINFO and PubMed electronic databases. The studies that were located were categorized into clinical and general population studies, treatment studies, family- and twin-studies, and longitudinal studies. This review is restricted to the current knowledge in the above mentioned areas. In the following, we discuss these approaches for investigating the relationship between social phobia and avoidant personality disorder.

Development of DSM Criteria – Social Phobia

Social anxiety, social avoidance and shyness were described as early as the time of Hippocrates, and the term “social phobia” (*phobie des situations sociales*) was first introduced by Janet in 1903 to describe patients who feared being observed while speaking or writing (2). Prior to the 1950s, however, interest in and discussions about social phobia were rare. With the advent of behavioral therapy in the 1950s and 1960s, interest in phobias increased (3), and in the 1960s the British psychiatrist, Isaac Marks, observed that particular phobias, including social phobia, could be distinguished from each other by age of onset (4). However, it was not until 1980, in the third edition of the DSM (5), that social phobia received its own diagnostic criteria. Previously, in the first and second editions of the DSM (DSM-I and DSM-II; 6, 7), all phobias were grouped together according to a psychoanalytic perspective.

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The third edition of the DSM (5) comprised a descriptive, atheoretical, multiaxial and hierarchical system for classification of mental disorders, and a separate Axis II was introduced for personality disorders.

In the DSM-III (5), social phobia was described as a discrete form of performance anxiety that was more akin to a specific phobia. Individuals with a more pervasive social anxiety were classified as having avoidant personality disorder, and the two disorders were not allowed to co-vary. However, a multitude of studies (8–10) have reported that social phobia is not restricted to only a few performance situations like public speaking or eating in front of others, but is instead a more pervasive condition than implied by the DSM-III, affecting a variety of social situations. Consequently, the diagnostic criteria for social phobia were modified in the revised edition of DSM-III-R (11). In this version, comorbidity between social phobia and avoidant personality disorder was allowed, a generalized type was introduced, defined by fear in “most social situations,” and “significant distress” was changed to “interference or marked distress.” In our continued discussion about social phobia and avoidant personality disorder, it should be remembered that what is meant by “most social situations” has not yet been clearly defined, and is therefore open to interpretation. Thus, this change in the diagnostic criteria not only broadened the diagnosis of social phobia but also increased the rate of comorbidity between the Axis I disorder social phobia, especially the generalized type, and the Axis II disorder avoidant personality disorder. In addition, previous studies have reported that social phobia is associated with high comorbidity with other Axis I disorders such as depression, other anxiety disorders, and substance-related problems (1, 12–14).

When developing DSM-IV (15), the DSM-IV task force systematically assessed several diagnostic issues, including the relationship between social phobia and various personality traits, social anxiety caused by stuttering or other conditions, and the validity of social phobia subgroups. Nevertheless, empirical studies clarifying the above issues were scarce, and only slight modifications were made in the fourth edition of the DSM (15). For example,

features specific to children were included in the DSM-IV criteria for social phobia. In addition, the term “social anxiety disorder” was considered because the term “social phobia” was thought to be inappropriate for the more pervasive condition (16). Since there was no consensus on this issue, the task force decided to retain “social phobia” and also to add “social anxiety disorder” as an alternative term.

Development of DSM Criteria – Avoidant Personality Disorder

Features central to the concept of personality disorders are their early onset, pervasiveness, interpersonal focus, impairment and persistence over many years. The term avoidant personality was first introduced by Millon (17). Based mainly on social learning theory, he described this personality as having an “active-detached” pattern representing a fear and mistrust of others.

According to DSM-III, both schizoid and avoidant personality disorders are characterized by social withdrawal, but schizoid personality disorder involves a lack of desire for social relationships, whereas the social withdrawal in avoidant personality disorder is due to hypersensitivity to rejection (18). Individuals with avoidant personality disorder desire social relationships provided that there are strong guarantees of uncritical acceptance.

Doubts have been expressed as to whether avoidant personality disorder merits its own description and whether it is encountered with sufficient clinical frequency to justify being considered a unique disorder (18). Regardless of these concerns, there was apparently an increasing recognition of its prevalence as clinicians became more familiar with its criteria following publication in the DSM-III. Nevertheless, significant changes were introduced when DSM-III-R was published (19). Characteristics associated with hypersensitivity to rejection and low self-esteem were minimized, whereas fears of being inappropriate or embarrassed, as well as tendencies to exaggerate dangers and risks, were added (11). These changes proved problematic and were essentially taken out with publication of the DSM-IV (15, 19). The essential feature of avoidant personality disorder as it is conceptualized in the

current DSM system is a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation and criticism that begins in early adulthood and presents in a variety of contexts (15).

The Relationship Between Social Phobia and Avoidant Personality Disorder

In the DSM system social phobia and avoidant personality disorder are diagnosed as separate entities. The theoretical basis for placing these disorders in different axes in the DSM is mainly the work of Millon, where avoidant personality disorder is described as a problem of relating to other persons without performance problems, and social phobia is described as performance problems in social situations (20). Because the criteria have changed somewhat with each revision, these differences have more or less been retained. Nevertheless, at least four items for diagnosing avoidant personality disorder (1, 2, 3 and 7) in the DSM-IV (15) overlap with the social phobia criteria. Arguably, the change in criterion 7, general avoidance of unfamiliarity, which was modified into a state of avoidance of risk and novelty due to social embarrassment in DSM-IV (from the DSM-III-R), was especially crucial for the conceptualization of avoidant personality disorder. With this change, facets of avoidance extending beyond social situations that were highlighted in theoretical articles, such as avoidance of novelty, as well as unpleasant emotions and cognitions, disappeared (21, 22). Hence, one of the consequences of the fact that social phobia and avoidant personality disorder, as they are currently defined in the DSM system, share several diagnostic and experiential characteristics is that a high rate of comorbidity has been reported, especially between generalized social phobia and avoidant personality disorder (see 20 for a review).

Further, the DSM-IV diagnostic criteria for social phobia clearly point to the dystonic nature of the disorder in that it involves provocation of anxiety or panic, which is recognized as excessive or unreasonable, when exposed to eliciting external situations, and that avoidance, anxious anticipation, or distress in the feared situation interferes

significantly with the person's normal functioning (15). While ego-dystonicity characterizes social phobia according to the DSM system, assessing how avoidant personality disorder is related to the patient's perception of self is more difficult. The criteria for avoidant personality disorder, however, primarily suggest a syntonic perception of the condition in that it involves a pervasive pattern of behaviors and feelings beginning in early adulthood with a strong impact on being with and interacting with others. In addition, it should be remembered that the untreated form of generalized social phobia has many features in common with a personality disorder (8, 23).

On the other hand, existing literature offers no help in assessing whether certain patients with avoidant personality disorder also perceive some or all of their problems as being ego-dystonic, and, if so, whether this is actually an indicator of comorbidity with social phobia. A virtual axis could be envisioned between ego-syntonicity and ego-dystonicity, with the location on that axis depending not only on the diagnosis of social phobia, or avoidant personality disorder, or whether there is comorbidity, but also on other individual factors such as personality traits or temperament or the presence of other comorbid Axis I or Axis II disorders. Analogous to this, it has been shown that levels of the temperament novelty seeking seem to affect whether obsessive-compulsive symptoms in adolescents become ego-syntonic or ego-dystonic (24).

Overlap between social phobia and avoidant personality disorder in clinical and general population studies

In various samples of patients with social phobia, the reported comorbidity with avoidant personality disorder has been high, ranging from 22 to 89% (3, 25–27). Some researchers have interpreted this high rate of overlap to mean that social phobia and avoidant personality disorder reflect a spectrum of social anxiety with no clear demarcation line, i.e., this high rate of overlap could be considered to support a severity continuum hypothesis. According to this hypothesis the most intense form of social anxiety and avoidance, which in the majority of cases afflicts persons with generalized social phobia and co-morbid avoidant personality

disorder, should lie at the upper end of this continuum. On the other hand, if these disorders mirror true differences we should expect more modest rates of overlap. However, in clinical samples there is a risk that the high rate of comorbidity between two disorders could be explained by selection bias. It should also be remembered that the above studies are based on patients who sought treatment at anxiety clinics.

Furthermore, generalized social phobics have been compared to those without co-morbid avoidant personality disorder in a number of clinical studies and have been found to have increased anxiety and depression as assessed with self reports, to be more impaired in daily life, and more often to meet the criteria for another Axis I or II diagnosis (28–32). Hence, none of these differences point to qualitative distinctions; instead, they indicate differences in the degree of social anxiety and function. However, some studies indicate that there may also be qualitative differences between social phobia and avoidant personality disorder. Tran and Chambless (33) and Turner and colleagues (34) found that generalized social phobics with co-morbid avoidant personality disorder exhibited poorer social skills than those without the disorder. However, this discrepancy has not been replicated in other studies (32).

A community study by Tillfors et al. (35) provided further support for the severe continuum hypothesis. They examined empirically derived subgroups of social phobia with and without avoidant personality disorder and found that the presence of co-morbid avoidant personality disorder seems to be associated with a global functioning decrement. However, none of the above studies investigated the overlap between social phobia and avoidant personality disorder in relation to other Axis I and II disorders. As far as we know, only two general population studies have addressed this issue (36, 37). In these studies the prevalence rates for co-occurrence of avoidant personality disorder in persons with social phobia were respectively 30.3% (36) and 35.8% (37), i.e., the co-occurrence was of a moderate sort. Moreover, in addition to this relationship between avoidant personality disorder and social phobia, both studies also revealed

strong associations between avoidant personality disorder and panic disorder with agoraphobia. Hence, these results from the general population, as compared to the clinical population studies, indicate that avoidant personality disorder could be more than merely a severe subgroup of social phobia.

Further, if avoidant personality disorder is other than only a more severe subgroup of social phobia, we should be able to recognize persons with avoidant personality disorder without social phobia. Reich (20) stated in his review of the empirical literature concerning the relationship between social phobia and avoidant personality disorder that: “No study found enough of these avoidant personality disorder without generalized social phobia patients to form a separate comparison group, even those studies with relatively large sample sizes.” Since publication of that review (20) this has continued to be the case (38–40). For example, in a recent large clinical sample ($N = 2192$) Hummelen and colleagues (39) found that half of the patients with avoidant personality disorder did not have social phobia. However, they also found support for the continuum hypotheses in that social phobia was more strongly associated with avoidant personality disorder than other personality disorders, and avoidant personality disorder was also more strongly associated with social phobia than other Axis I disorders. Further, Ralevski and colleagues (40) added vital information to this conceptual debate by examining a sample consisting of patients recruited as part of a longitudinal personality disorder study, which is in contrast to the samples in most previous studies. This investigation focused on whether patients with avoidant personality disorder differed from those with and those without social phobia. It was found that those with avoidant personality disorder with social phobia did not differ from those with pure avoidant personality disorder regarding functional severity, rates of comorbidity for Axis I and Axis II disorders or remission rates two years later. Thus, although a group of persons with avoidant personality disorder without social phobia was recognized, the comparison between social phobia and avoidant personality disorder still provides mixed results.

Studies of treatment for social phobia and avoidant personality disorder

If treatment for social phobia is shown to be ineffective for avoidant personality disorder symptoms, then central mechanisms in the treatment of social phobia are not targeting those with avoidant personality disorder, which in turn could be an indication of true differences between the disorders. The available treatment literature concerning social phobia and avoidant personality disorder is restricted to different forms of cognitive behavior therapy (CBT) and pharmacological treatment (see 20 for a review). In general, persons with social phobia, both those with and those without avoidant personality disorder, respond to CBT treatment. Following treatment, the most disabled group seems to be those with co-morbid avoidant personality disorder (20, 41), although in two studies the addition of an avoidant personality disorder diagnosis did not seem to affect the response to treatment (42, 43). Following pharmacological treatment for social phobia, there has generally been a decrease in the number of fulfilled criteria for avoidant personality disorder (3, 44). Hence, this may indicate that avoidant personality disorder is a somewhat more disabling form of social phobia.

However, earlier research has shown not only an association between avoidant personality disorder and social phobia but also an association between avoidant personality disorder and other Axis I disorders such as depression and panic disorder (with and without agoraphobia). The latter association indicates the importance of examining how patients with psychiatric disorders with a co-morbid avoidant personality disorder other than social phobia respond to treatment. For example, in one study comparing cognitive therapy with interpersonal therapy in depressive patients with co-morbid avoidant personality disorder traits greater reductions in depressive symptoms were found in the cognitive therapy group (45). This may suggest that avoidant personality disorder should not be seen merely as an interpersonal disorder, and that in some cases the avoidant behavior can also extend beyond social situations. Further, it was observed in one study that adding avoidant personality disorder to panic disorder with agoraphobia was associated with less change in the frequency of

panic attacks (46). This may be in line with theories by Beck and Freeman (22) postulating that some persons with avoidant personality disorder have difficulty tolerating intensive emotions, and as a result have more problems exposing themselves to frightening situations. This is also in accordance with Taylor and colleagues (47), who contend that persons with avoidant personality disorder try to avoid intensive emotions of both negative and positive valence.

Clinical reports also provide support for an avoidance that extends beyond social situations in persons with avoidant personality disorder. For example, the clinical impression of Beidel and Turner (48) was that their patients with avoidant personality disorder generally had problems tolerating intensive arousal, and that these patients consequently did not respond well to in vivo exposure treatment. Hence, considered together the above studies and clinical observations support the theoretical reasoning that avoidant behavior in persons with avoidant personality disorder extends beyond social situations.

It should be mentioned in this respect that different psychiatric disorders seem to be maintained by common cognitive and behavioral processes, e.g. selective attention to both external and internal stimuli, avoidant behavior (both on an overt and a subtle level), interpretation bias and emotional reasoning (49). Regarding the relationship between social phobia and avoidant personality disorder, one of the common maintaining mechanisms seems to be the different facets of avoidant behavior, ranging from avoidance of social situations to avoidance of novelty and intense emotions. This could partially explain the fact that treatment of one disorder could have some effect on co-morbid syndromes, e.g., after CBT treatment for social phobia the symptoms of co-morbid avoidant personality disorder symptoms were found to be significantly diminished (50). Further, this might have considerable implications for development of interventions that could be effective for social phobia both with and without avoidant personality disorder, as well as for those with pure avoidant personality disorder. Regarding psychological treatment for social phobia, the individual cognitive therapy developed by Clark and colleagues (51, 52), which

includes cognitive restructuring and behavioral experiments, seems to be one of the most effective therapies, with effect sizes larger than two. Hence, cognitive therapy for social phobia with avoidant personality disorder that is tailored to focus on avoidance that also extends beyond avoidance in social situations would be more effective.

Family and genetic studies of social phobia and avoidant personality disorder

Comorbidity between two different disorders is supported by the disorders having common vulnerabilities (environmental and/or genetic). In a clinical family study Stein and colleagues (53) revealed a tenfold increased risk for generalized social phobia and avoidant personality disorder among relatives of probands with the generalized subtype compared to relatives of comparison probands. Similarly, albeit in epidemiologically identified probands in the general population, Tillfors et al. (54) related family history of excessive social anxiety to social phobia and avoidant personality disorder. Having an affected family member was associated with a two- to threefold increased risk for both social phobia and avoidant personality disorder. Considered together, these findings provide support that social phobia and avoidant personality disorder might not differ with respect to familial aggregation, and instead that they seem to share familial risk factors. Further support for the latter is found in one recent population-based twin study (55) on the relation between avoidant personality disorder and social phobia. This study provides evidence for the involvement of a common genetic vulnerability for these two disorders. However, the associated environmental factors seemed to be uncorrelated.

If the above findings are considered within the larger framework of knowledge about etiological factors in many mental health problems, evidence for both genetic and environmental factors is found in previous twin studies (1, 56, 57). The inherited factor is probably a general predisposition, perhaps manifesting itself in a highly sensitive fear network within the amygdaloid-hippocampal brain area (58) that manifests itself later on, via different learning mechanisms, in negative affect rather than in a specific disorder. A good deal of evidence suggests that this general predisposition is common in

anxiety disorders in general, for example, as well as in depression (1), and may explain the high levels of comorbidity observed between these disorders. This seems to be the case also for the relationship between social phobia and avoidant personality disorder.

Longitudinal studies of social phobia and avoidant personality disorder

Further support for comorbidity between two different disorders could be that one of the disorders acts as a risk factor for the later onset of another, secondary disorder (1), and prospective studies are needed to investigate the temporal course (59). No prospective study was found concerning the development of social phobia and avoidant personality disorder that covers the transition from early adolescence to adulthood. Consequently we have been unable to determine how this pattern of co-occurrence develops. However, we found two longitudinal studies following adult patients, the first of which is the above mentioned study by Ralevski and co-workers (40). They investigated patients with avoidant personality disorder, with and without social phobia, during a period of two years and were unable to distinguish, in a meaningful way, between those with and those without co-morbid social phobia. Massion et al. (60) assessed the effect of personality disorders on time to remission in patients with different Axis I disorders. Among patients with social phobia and co-morbid avoidant personality disorder, they found that the presence of co-morbid avoidant personality disorder five years later predicted a 41% lower likelihood of social phobia remission. One possible explanation for the latter discrepancy, which was emphasized by Ralevski and co-workers (40), could be the possibility that on a general level patients with personality disorders are more disabled than patients with anxiety disorders. Another explanation could be that the conceptualization of avoidant personality disorder may be restricted to social situations to too great an extent.

The general conclusions should be considered with some caution. The assessments of social phobia and avoidant personality disorder in the studies we cited are not without problems. For example, subgroups have been defined differently and

different measures have been used across studies. Nevertheless, some similar patterns have emerged in the results.

Concluding Remarks

To conclude, the extremely high degree of overlap between social phobia and avoidant personality disorder that has been estimated in clinical populations, as well as the finding that social phobics with avoidant personality disorder exhibit more functional impairment than those without that disorder, could be interpreted as favoring the severe continuum hypothesis. However, this can be questioned based on findings in the general population where a more modest overlap has been observed, as well as on the fact that avoidant personality disorder has also been found to be common in panic disorder with agoraphobia as well as in depression. This could in turn indicate that social phobia and avoidant personality disorder have some characteristics in common but that they also have some characteristics that differentiate them. Further, this overlap may reflect a common vulnerability. Indeed, the few studies that are available indicate that social phobia and avoidant personality disorder share a common genetic vulnerability factor. In addition, according to Reichborn-Kjennerud and colleagues (55) it seems that the environment, rather than genetic factors, is the key to the specific transmission pattern of social phobia and avoidant personality disorder, respectively.

On the other hand, both psychological and pharmacological treatments of social phobia also seem to be efficacious for avoidant personality disorder traits. The only difference observed is that those with co-morbid avoidant personality disorder are more disabled after treatment, independent of which treatment technique is used. Could it be the case that some of these “more disabled persons” are those with social phobia with co-morbid avoidant personality disorder with an avoidance that extends beyond social situations, and who are therefore not being targeted by CBT treatment, for example, which focuses mainly on social situations? This is supported in part by Massion and colleagues (60), who found that co-morbid avoidant personality disorder predicted a

41% lower likelihood of social phobia remission during five years of follow-up.

Thus, the empirical studies summarized here may provide support for the view that social phobia and avoidant personality disorder are more than arbitrary cutoffs along a continuum of social anxiety. The overlap between these two disorders seems to mirror a common genetic predisposition/vulnerability that may contribute to both social phobia and avoidant personality disorder as well as to other anxiety disorders and depression. Consequently, we still need more knowledge to clarify the boundaries between social phobia and avoidant personality disorder, and one question of vital importance is how this pattern of co-occurrence develops during the transition from childhood to adulthood.

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