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EDITORIAL

The relationship of social phobia to avoidant personality disorder: a proposal to reclassify avoidant personality disorder based on clinical empirical findings

J. Reich

Harvard and Stanford Medical Schools, Departments of Psychiatry, 2255 North Point St., Suite 102, San Francisco, CA 94123, USA

Summary – In the DSM system social phobia and avoidant personality have been conceptualized as independent entities. Each had separate, if overlapping diagnostic criteria. The specific inclusion and exclusion criteria provided by DSM allowed empirical research to guide future revisions. This review evaluates the empirical literature and evolution of the concepts of these diagnoses from DSM-III to DSM-IIR to DSM-IV. The empirical evidence leads us to the conclusion that there is no dividing line between social phobia and avoidant personality disorder. In addition to their being no dividing line diagnostically between the disorders, there appears to be no separation of the two by treatment techniques. This raises interesting questions about how we differentiate Axis I from Axis II disorders. Suggestions for revisions of the social phobia and avoidant personality disorder categories are given. © 2000 Éditions scientifiques et médicales Elsevier SAS

avoidant personality disorder /social phobia

INTRODUCTION

There has been a long-standing question as to how social fears relate to personality disorders. At one time anxiety was considered the hallmark of a personality disorder, e.g., the concept of neurosis. The development of the avoidant personality disorder (APD) category in DSM-III stimulated interest in the relationship of social fears to personality disorders. By examining the relationship of social phobia (SP) to the personality disorders clinicians and researchers could examine this question empirically in disorders defined by specific criteria.

The conceptualization of APD in DSM-III relied heavily on the work of Millon [22]. Millon felt that although APD would overlap to some extent with schizoid, schizotypal, dependent and paranoid personality disorders, it was clearly a category in its own right. (Many DSM personality disorders overlap with each other to some extent.) For Millon the distinction between APD and SP was clear. As he put it, "Avoidant is essentially a problem of relating to persons; social phobia is largely a problem of performing in situations. The avoidant PD has a feeling of low self-esteem; social phobia implies no such self critical judgment" [22].

SP researchers have examined the relationship between SP and personality disorder. One review is by Johnson and Lydiard. They address the diagnostic question, "…social phobia itself has many features in common with a personality disorder" [18]. They note that the rate of personality disorders appears higher among patients diagnosed as having SP than among other anxiety disorders. The high rate of APD in SP as well as other personality disorders (dependent, borderline, schizotypal and obsessive) is discussed. They make the observation that some empirical studies indicate that the presence of co-morbid depression appears to correlate highly with the presence of APD. APD without co-morbidity with SP may therefore, at times, be an epiphenomena of co-morbidity with another Axis I

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disorder. This would mean that the APD, in this case, would be only associated with depression and would not appear when the depression is not present. In this example a person who had the criteria for APD when depressed does not have these symptoms when the depression has resolved.

Johnson and Lydiard also examine the overlap between the generalized form of SP (GSP) and APD. Their review of empirical studies shows that while some distinctions can be made in different studies between GSP and APD the most remarkable finding is the similarity between the two disorders. They raise the question as to whether there are different subtypes of APD. One would be an overlapping concept with GSP while the second APD without GSP (which is rare, but diagnosed) would be a separate subtype. Johnson and Lydiard believe that at least four items of DSM-IV APD (criteria 1, 2, 3 and 7) emphasize shame and embarrassment and therefore overlap with SP; the clinical overlap of the two disorders is understandable.

Widiger [42] reviewed three empirical studies examining the overlap between GSP and APD. These studies used DSM-III-R criteria. He notes that while there are cases of GSP without APD, there are very few cases of APD without GSP. He feels that the criteria are written in such a way that there will be very few of the APD without GSP cases found. He concludes that although there are distinctions that can be made between GSP with and without APD, there is no evidence for a demarcation between the two disorders, which would justify the diagnosis of two separate categorical disorders. He concludes that the disorder should be listed on both the anxiety and personality disorder categories, even though it appears to be a single disorder.

DIAGNOSTIC ISSUES IN USING THE DSM

The diagnosis of both SP and APD using the DSM system has been a bit of a moving target as the criteria change somewhat with each revision (see *table I*). The DSM-III criteria for APD emphasized low self-esteem, social withdrawal and sensitivity to rejection. Social phobia emphasized social withdrawal, but also lists fear of being humiliated, which could be seen as very similar to the APD criteria of low self-esteem. Already we have questions about the overlap of the two disorders. If someone is afraid of social situations due to fear of humiliation, wouldn't that lead to low self-esteem? If someone avoided social situations due to low self-esteem, but did not have performance difficulties, behavior theory would tell us that the low self-esteem would decondition as societal pressures brought the person into more and more social situations. At the DSM-III level there are two reasons the disorders would be diagnosed separately, one a matter of scope and the second arbitrary. The item of scope is the concept that the difficulty in SP is much more restricted (applies to fewer situations) than APD. The second reason for separate diagnosis was definitional, that SP could not be diagnosed in the presence of APD by definition in DSM-III.

At the DSM-III-R level there is still the same conceptual overlap, but several factors have now made the overlap stronger. The definitional exclusion of an SP diagnosis in the presence of APD has (appropriately) been dropped. Research in SP has now shown that it can appear in more than one setting and therefore can be generalized. The DSM-III-R has responded to this empirical data by creating a generalized version of SP. This again reduces the distance between the two disorders. The underlying theoretical concept that APD is social withdrawal without performance problems and SP is performance problems without self-esteem difficulties is more or less retained. The APD criteria of reticence in social situations and fears of being embarrassed do begin to sound like performance difficulties, however.

DSM-IV makes some changes but we are still basically left with the initial diagnostic question of whether we are cutting nature at the joint or at the bone by postulating one disorder (APD) of internal image (problems with self-esteem), but not performance anxiety and another disorder (SP) of social performance problems without internal image problems (e.g., problems with self-esteem.) The answer to this question has to lie in empirical data (see next section).

A more general question is whether there is some guidance as to the nature of a personality disorder that would help us in our diagnostic considerations. The DSM-IV defines personality disorder as an enduring pattern of experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two or more of the following areas: cognition, affectivity, interpersonal functioning or impulse control. The pattern is inflexible, pervasive, causes distress or impairment and is of long duration. The untreated form of GSP would fit this definition, although with treatment it may no longer be inflexible or of long duration. This does not mean that GSP is a personality disorder, however. Other Axis I

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Table I. DSM criteria for avoidant personality disorder and for social phobia

	Social phobia	*Avoidant PD*
DSM III criteria	A persistent, 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 Causes significant distress. Not due to avoidant personality disorder or other mental disorder	Hypersensitivity to rejection. Unwillingness to enter into relationships. Social withdrawal. Desire for affection and acceptance. Low self-esteem
DSM IIIR criteria	A persistent fear of one or more…social phobic situations) in which the person is exposed to possible scrutiny by others and fears that he or she may do something or act in a way that will be humiliating or embarrassing. Unrelated to other Axis I or III disorders Exposure to phobic stimulus causes anxiety response. Situation is avoided or endured with anxiety. Causes occupational or social dysfunction or subjective distress. May be generalized	A pervasive pattern of social discomfort, fear of negative evaluation and timidity, beginning in early adulthood and present in a variety of contexts as indicated by four of the following: easily hurt by criticism no close friends unwilling to get involved with people. Avoids activities with significant interpersonal contact. Reticent in social situations. Fears being embarrassed. Exaggerates potential difficulties
DSM IV criteria	A marked and persistent fear of one or more social or performance situations. Exposure to feared social situation invariably provokes anxiety. Feared situations are avoided or endured with distress. Significant occupational or social dysfunction may be generalized	A persistent pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation… as indicated by four of the following: avoids activities involving significant interpersonal contact, unwilling to get involved with people, shows restraint in intimate relationships, preoccupied with being criticized or rejected, inhibited in new interpersonal situations, views self as socially inept, unappealing or inferior is, unusually reluctant to take personal risks.

disorders, which if left untreated would meet these criteria, are not considered personality disorders (i.e., chronic major depression, generalized anxiety disorder.) We are left with the situation, that while GSP does broadly fit the criteria of a personality disorder, the diagnostic history of the DSM does not appear to require that we place it in that category.

STUDIES COMPARING SOCIAL PHOBIA TO APD

We now turn to empirical literature comparing SP and APD to answer two questions. The first is the co-morbidity of the two disorders. If the disorders were separate we would expect, at best, modest co-morbidity. If they were highly related or identical disorders we would expect a much higher overlap. (We wouldn't expect 100% overlap due to inherent measurement errors – especially for the personality disorders – and the different wording of the two sets of criteria.) If there was a high overlap we would want to examine differences between GSP and APD to determine whether, although highly overlapping and similar, there were distinct criteria or aspects which justified a distinction between the two. These empirical studies are summarized in *table II*.

Of the 13 studies reporting on overlap, the average co-morbidity was 56% (range 22-89%). These figures were drawn from a wide range of populations using different measurement instruments in a wide range of settings. Different interview techniques were used in different settings and interviewers had different levels of training in diagnosing personality disorders. In addition, as disorders wax and wane, there is an additional source of variability. Given that this is about the same level of agreement that might be found by comparing two different DSM personality measurement instruments on the same population and that subthreshold cases were usually not taken into account, this probably represents the highest level of overlap we could expect from these diverse settings and measurement techniques. It seems clear that GSP highly, if not completely, overlaps with APD. Also adding to this conclusion is that very few cases of APD without GSP were found. No study found enough of these APD without GSP patients to form a separate comparison group, even those studies with relatively large sample sizes.

This leads us to the second question of whether the addition of the diagnosis of APD to GSP creates a disorder with significant differences from GSP alone as

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Table II. Studies comparing social phobia to avoidant personality disorder

Study	*Population*	*Instruments**	*Procedure*	*Findings*
Alpert et al. [3]	patients with major depression who also had SP or APD N = 92	SCIDI, II (DSM-IIIR)	cross-sectional examination	66 % had both APD & SP. Of those with APD & SP 55 % had atypical depression
Alnaes & Torgersen [2]	consecutive psychiatric outpatients N = 289	SCID1, SIDP (DSM-III)	cross-sectional examination	84 % of SP also have APD
Brown et al. [4]	patients from an anxiety disorder clinic who had SP N = 110	ADIS-R, PDE (DSM-III-R)	examines subtypes of SP and APD on outcome cog/beh tx	generalized SP (GSP) plus APD had more depression.
Emmanuel et al. [8]	outpatients with GSP N = 44	SCID-II (DSM-III-R)	cross-sectional comparison of overlap of personality disorders with GSP	73 % of GSP had APD
Fahlen [10]	SP recruited for a drug trial. N = 63 SP, N = 58 controls	SCID and clinical personality interview. 140-item avoidant personality questionnaire. (DSM-III-R)	cross-sectional comparisons and factor analysis	60 % had APD and 18 % subthreshold APD.
Feske et al. [11]	anxiety outpatients with generalized SP (GSP) N = 48	DSM-III-R criteria.	cross-sectional comparison	71 % had APD APD had more severe social fears and more depression
Hofmann et al. [13]	patients recruited for study with SP, SP + AVD, controls N = 52	SCIDI, II (DSM-III)	comparison of SP & SP + APD in behavioral trial of public speaking	differences in heartrate SP & SP-APD. 88 % with APD also had GSP
Herbert et al. [12]	patients recruited for a beh tx program. All had GSP N = 23	SCID-R ADIS-R (DSM-III-R)	comparison of GSP with and without APD	61 % of GSP also met APD. APD had lower GAS and more co-morbid dx.
Hope et al. [16]	SP recruited for a beh tx study N = 23	SCID-R, ADIS-R (DSM-III-R)	examined subtypes of SP and APD	61 % of SP had APD. No higher association of APD with GSP than specific SP
Holt et al. [15]	patients recruited from an anxiety disorders clinic N = 30	ADIS-R PDE (DSM-III-R)	GSP with and without APD and SP without APD compared	APD appears to just identify a slightly more severe type of GSP
Jansen et al. [17]	patients from a Netherlands outpatient psych clinic N = 117	Axis I clinical interview, Axis II SCID-II (DSM-III-R)	panic vs SP for personality variables	fear of being embarrassed discriminated best between panic and SP. 31 % of SP had APD
Mersch et al. [21]	patients recruited by Swedish newspaper for SP tx study N = 34	Axis I, clinical interview Axis II SCID-II (DSM-III-R)	SP with and without personality disorder	23 % had APD. Those with APD were somewhat more disabled
Noyes et al. [24]	panic and SP patients recruited from news media. SP N = 46	SICD (DSM-III-R), PDQ (DSM-III)	examines personality traits in panic and SP	GSP had 50 % more personality traits from the anxious and schizoid clusters than SP.
Reich et al. [29]	SP outpatients N = 14	Axis I, SCIDI, SCIDII (DSM-III-R)	pharm tx study	50 % of SP also had APD
Sanderson et al. [33]	SP, GSP outpatients N = 51	SCID-II (DSM-III-R)	cross-sectional comparison	61 % had a personality disorder and 37 % had APD
Schneier et al. [35]	SP drawn from an anxiety disorders clinic N = 50	Axis I, semi-structured interview Axis II, SCID-II (DSM-III-R)	comparison of subtypes of SP and relationship to APD	APD in discrete SP = 21 %. APD in GSP = 89 %
Tran and Chambless [37]	outpatients with a primary dx of SP N = 45	Axis I, SCID (DSM-III-R) Axis II, MCMI or MCMI-II	comparison of subtypes of SP	GSP more socially disabled than SP. APD-GSP had more depression than GSP
Turner et al. [39]	outpatients SP, GSP = 71	SCID (DSMII-R)	cross-sectional, association with personality disorders	37 % had a personality disorder, 22 % prevalence of APD
Turner et al. [38]	SP from an anxiety disorder clinic N = 89	ADIS-R, SCID-II (DSM-III-R)	comparison of specific SP, GSP and APD	GSP is more similar than different from APD, differing on only one of four dimensions (social anxiety). There was no difference in social skills between GSP and APD
Turner et al. [40]	SP from an anxiety disorder clinic N = 21	Axis I, ADIS Axis II, consensus (DSM-III)	comparison of SP and APD	GAS and SP very similar, but indication that APD have poorer social skills

* PDE stands for Personality Disorder Examination (Loranger et al., Cornell University); SCID stands for Structured Clinical Interview for DSM Disorders (Spitzer et al., New York State Psychiatric Institute); ADIS-R stands for Anxiety Disorder Interview Schedule – Revised (Barlow et al., Boston University); beh stands for behavioral; tx stands for treatments; dx stands for diagnoses

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to require a separate diagnosis. Turner et al. [40] felt that APD might indicate a syndrome of patients with poorer social skills; however, his later work [38] and that of others did not maintain that distinction. The studies making this comparison indicate that APD plus GSP is a group that is somewhat more symptomatic and disabled than GSP alone, but with no distinguishing characteristics to clearly differentiate it from GSP alone. The co-morbid GSP plus APD groups appear to have a higher co-morbidity with depressive symptoms.

THE ASSOCIATION OF SOCIAL PHOBIA TO OTHER PERSONALITY DISORDERS

A review of the studies which examine social phobia and other personality disorders [2, 8, 12, 17, 24, 29, 30, 34, 35, 39] shows some mild association with the DSM schizoid personality disorder cluster, but more strongly to the DSM anxious personality disorder cluster. It is quite possible that some of the association with the schizoid personality cluster (especially in the self-report instruments) may be due to measurement artifact. It can be difficult for personality instruments to distinguish between social fears of long standing where a person has had a desire to have social interaction, but has given up hope and true schizoid personality cluster symptoms develop. (Schizoid or paranoid personality traits may be at times part of the ultimate adaptation of people with long-standing social fears who failed to overcome them [23]. Overall, after APD, dependent personality disorder is the strongest association.

It is not uncommon for an Axis I disorder to be associated with several Axis II disorders. In this case the other personality disorders (besides APD) that SP is co-morbid with is what would be expected from any Axis I anxiety disorder.

An alternate approach to considering whether APD plus GSP belongs in the personality realm is to consider whether APD is distinct from other DSM personality disorders. A review and empirical work by Reich [26] indicates that, of all the personality disorders, APD had the poorest discrimination from the other personality disorders. The article concludes that a good case could be made for merging it with dependent personality disorder (with which it was highly associated). In one treatment study of SP, dependent personality traits declined in the same manner as avoidant traits declined [9, 10], further strengthening that concept that these traits are related.

Since APD is hard to distinguish as a separate personality disorder, this is an argument in favor of merging it with a virtually identical Axis I disorder.

TREATMENT AND OUTCOME STUDIES FOR SOCIAL PHOBIA AND APD

Although treatment response is not part of the definition for SP or APD, these studies can give us valuable nosologic information. If the same treatments work for different disorders, or symptoms of one disorder get better as a second disorder is treated, this increases the possibility that these disorders are related or may even be the same disorder.

PSYCHOPHARMACOLOGIC TREATMENT STUDIES

The second half of *table III* lists pharmacologic treatment studies for APD and SP that include APD or avoidant personality traits. Although the studies vary in many respects, there is preliminary evidence that benzodiazepines, SSRIs and various forms of MAOIs may be effective for APD or avoidant traits associated with SP. Of specific note are the studies of Fahlen [9, 10] Liebowitz et al. [19] and Reich et al. [29]. All of these studies had reasonably good sample sizes and careful measurements of avoidant personality traits. All demonstrated that as SP symptoms were treated, avoidant personality traits were also reduced.

PSYCHOLOGICAL TREATMENTS

The first part of *table III* lists psychological treatment studies of APD or SP associated with APD. These studies use cognitive or behavioral treatments or both. Overall it appears that both APD and SP co-morbid with APD do respond to treatment. The SP without GSP tends to be least disabled, followed by GSP, followed by GSP co-morbid with APD. Although all start at different baselines of morbidity, all seem to respond to treatment. Since some subjects are more disabled their final scores don't reach the level of those who started out less disabled, but all show improvement. Two studies specifically point out that the presence of APD did not affect treatment response [13, 14, 16]. This is an unusual finding since we now know that the presence of a personality disorder will often reduce the efficacy of the treatment of a comorbid Axis I disorder [31]. One possible explanation of this is that if APD and GSP are merely variants of the same disorder, there

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Table III. Treatment studies social phobia and avoidant personality disorder

Study (psychotherapy)	*Population*	*Instruments*	*Procedure*	*Findings*
Alden and Capreol [1]	76 outpatients with APD	MCMI and PDE (DSM-III)	three active cognitive / behavioral tx and a control gp	APD patients responded to tx, although some tx better suited to specific subtypes
Brown et al. [4]	patients from an anxiety disorder clinic who had SP N = 110	ADIS-R, PDE (DSM-III-R)	beh/cog tx on three gps: APD + GSP, GSP, SP	all groups improved from their baseline scores
Feske et al. [11]	anxiety outpatients with generalized SP (GSP) N = 48	DSM-III-R criteria.	Exposure based tx of SP, SP + APD	both groups improved from baseline
Hofmann et al. [13, 14]	outpatients, SP, SP + APD N = 16	Axis I, SCID Axis II, unstructured interview (DSM-III-R)	gp beh tx speaking anxiety	Both groups improved equally
Hope et al. [16]	SP recruited for a beh tx study N = 23	SCID-R, ADIS-R (DSM-III-R)	cog / beh gp tx, SP, GSP, GSP + APD	the presence of APD in GSP did not affect tx response
Mersch et al. [21]	Patients recruited by Swedish newspaper for SP tx study N = 34	Axis I, clinical interview Axis II SCID-II (DSM-III-R)	SP with and without personality disorder, beh tx	gps with and without a personality disorder benefited from tx
Renneberg et al. [32]	outpatients with APD from an anxiety disorder clinic N = 17	SCID I and II (DSM-III-R)	intensive gp tx APD	sx improved and some benefits maintained at one year
Stravynski et al. [36]	psychiatric outpatients with APD, but "no significant" Axis I dx N = 28	clinical interview (DSM-III)	8 sessions of social skills training	clinical improvement maintained at 3 months
Study (psychopharmacologic)				
Deltito and Perugi [5]	outpatient with SP + APD N = 1	clinical interview (DSM-III)	treatment MAOI	good clinical response
Deltito and Perugi [6]	outpatients with APD N = 4	clinical interview (DSM-III-R)	tx MAOI or fluoxitene	good clinical response
Fahlen [9]	SP outpatients N = 57	standardized interviews, personality trait questionnaire (DSM-III-R)	tx reversible MAOI	at endpoint sig reduction in APD in tx gp as compared to controls
Liebowitz et al. [19]	SP outpatients 75 % had GSP N = 74	DSM-III criteria	drug trial, atenolol, phenelzine, and placebo	64 % response to phenelzine at 8 wks with sig reduction in APD traits
Reich et al. [29]	SP outpatients N = 14	Axis I, SCIDI, SCIDII (DSM-III-R)	tx alprazolam	significant reduction in avoidant personality traits over 8 wks
Versiani et al. [41]	SP outpatients N = 78	SCID-I (DSM-III-R)	drug trial, MAOI vs placebo	82-91 % of the MAOI group reported being almost asymptomatic

PDE: Personality Disorder Examination; SCID: Structured Clinical Interview for DSM Disorders; ADIS-R: Anxiety Disorder Interview Schedule-Revised; beh: behavioral; tx: treatments; dx: diagnoses; gp: group; cog: cognitive

is no additive morbidity to the additional APD diagnosis, it is merely an indicator of a slightly more disabled form of the same disorder (SP or GSP).

COURSE OF SOCIAL PHOBIA

There are relatively few studies of the course of SP. Two prospective studies review this literature and also give us valuable information. Reich et al. [27, 28] find very few longitudinal studies of SP, with many of them using a weaker retrospective design and most studies not extending as long as a year. The general findings are that SP tends to be chronic with low remission rates. Using the more rigorous methodology and prospective methods gives rates of complete remission at 65 weeks as about 12% [27, 28]. This rate is the same for SP

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without GSP and GSP. Although we have no specific measures of course of GSP plus APD, the high level of overlap of GSP and APD would seem to indicate a similar course for APD and GSP.

This low level of remission is surprising, especially as the patients in that study were usually being treated at university clinics. One explanation is the naturalistic nature of the study where, at times, patients would leave treatment. A careful reading of pharmacologic and psychological treatment trials reveals another. Although many of these trials are successful, a close reading reveals that although they significantly reduce symptoms, they do not bring patients back into the normal range. The chronic course of the disorder could be that of either a personality disorder or that of a chronic Axis I disorder.

DISCUSSION

One of the first questions that must be asked is whether SP and APD are the same or different disorders. The empirical evidence we have now on co-morbidity and treatment comes down strongly on the side of there being just one disorder with different subtypes. There is clearly no distinct symptomatic delineation between SP, GSP and APD. Treatment studies do not distinguish between subtypes. The original "performance in situations versus problems in relating to people" theoretical distinction has not been empirically validated.

If we are dealing with one disorder we then have to determine the best nosology based on current empirical data. If we are dealing with one disorder, the question arises whether it is an Axis I or an Axis II disorder. To determine this we have to look closely at the definition of a DSM-IV personality disorder. It states, in part, that a personality disorder is "…an *enduring* pattern of experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two or more of the following areas: cognition, affectivity, interpersonal functioning or impulse control. The pattern is *inflexible*, *pervasive*, causes distress or impairment and is of long duration." (I have emphasized words to indicate the parts of the definition that may be causing us nosologic problems.) These words, "enduring, inflexible and pervasive", imply that a personality disorder cannot change or be treated. Whenever a disorder becomes treatable, this definition would remove it from Axis II to Axis I. Examples I gave earlier in this article included chronic major depression and GAD.

However, it may be that this particular definition of personality disorder (requiring the disorder to be unchangeable and untreatable) is outdated. We know for example that certain personality traits (i.e., antisocial) decrease somewhat with age. We also know that many emotional disorders that appear to be personality disorder (except for duration) alleviate themselves with successful removal of the stress (often treatment of an Axis I disorder) [25]. The ICD also has a category to reflect this, 'Stress-induced personality disorders.'

A stress-induced personality disorder is personality dysfunction that appears during a period of emotional stress. It can be either permanent as in the ICD definition or resolve when the stress resolves.

In the particular case of APD the previously cited pharmacologic treatment studies showing reduction in avoidant traits with resolution of SP is relevant to this concept of stress-induced personality disorders. Also relevant is the study by Dilsaver [7]. This study demonstrates that 45.2% of depressed patients were socially phobic only when depressed. This information combined with our findings in the review that APD tends to be co-morbid with depressive symptoms further raises the possibility that APD can be conceptualized, in part, as an epiphenomena of Axis I disorders.

The criteria of Livesley et al. [20] for the delineation of a separate personality disorder are not met. These are 1) The distribution of the phenotypic features of personality disorder are discontinuous; or 2) Although not having a discontinuous distribution, there is a threshold effect; or 3) The traits are continuous, but the structure differs in normal and abnormal populations; or 4) The latent structures are discontinuous.

Also, following strictly to DSM-IV guidelines would lead us to eliminate APD, and eventually many other personality disorders (as their treatments improve) from the personality disorders. However, this may be too radical a change which 'throws out the baby with the bathwater'. The conceptualization of chronic mental disorders as long-term and needing multiple dimensional approaches (cognition, affectivity, interpersonal functioning, impulse control and more recently, genetics) to understand them is still valuable and complements Axis I treatment trials, which sometimes tend to take a shorter-term view.

The solution I would see is to create the subcategory in Axis II for chronic Axis I disorders "with significant personality features." In this case of APD it would be listed in the Axis I disorders, but if significant personality features were present it could also be listed under

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Axis II as "A chronic Axis I disorder with significant personality disorder features, secondary to social phobia with dysfunctional avoidant traits." (This category could be used for many different Axis I disorders by specifying a different Axis I disorder and the different relevant personality traits.) Since many features that we have in the past called personality dysfunction appear to resolve with successful treatment of the Axis I disorder, the personality disorder section should further be modified to reflect the possibility of 'stress-induced personality disorders', as is already done in the ICD system. These changes would allow personality researchers to bring their particular expertise to chronic disorders, which are now becoming treatable.

One of the questions that will have to be investigated is the area of negative anticipation of events. The question here may be whether it is a cognitive style or a depression variant. Another area that will need to be investigated is the relationship of the symptoms of hypersensitivity and anxiety. The DSM-IV definition of APD lists only hypersensitivity, but they are likely interrelated.

This leaves us with some nosologic housecleaning for the unaccounted for (or left-over) symptoms. Dependent personality disorders have the strongest avoidant trait overlap. Therefore, adding a subsection to dependent PD of "with avoidant features" appears reasonable. This would create a place for some avoidant personality symptoms that are not related to SP in an existing disorder that is already closely associated with avoidant traits. Although rare, there are a few cases of APD without SP found in the empirical literature. To better understand the nature and significance of APD without SP a research category of APD without SP should be kept to encourage more research to determine whether this much smaller category of APD would eventually warrant its own category.

CONCLUSIONS

The available empirical evidence supports the conclusion that SP and APD are not separate disorders. It is suggested that the disorder be placed on Axis I with an Axis II cross-listing of "A chronic Axis I disorder with significant personality disorder features, secondary to social phobia, with dysfunctional avoidant personality traits." Since APD would essentially be eliminated, dependent personality disorder (one of its nearest neighbors) should have a subtype of "with avoidant features" as originally suggested by Reich [26]. The appendix of the DSM should list APD (without SP) as a research diagnosis so it can be determined if enough empirical evidence can be gathered to retain it in some form. Suggestions are made as to how to reconceptualize the DSM personality section to accommodate the fact that many disorders once considered personality disorders are now being found to be at least partially treatable or to have a course that modifies symptoms over time.

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