ABSTRACT

The findings of Herbert, Hope, and Bellack (1992), Holt, Heimberg, and Hope (1992), and Turner, Beidel, and Townsley (1992) are largely consistent. Avoidant personality disorder and generalized social phobia appear to be overlapping constructs that have only minor differences with respect to severity of dysfunction. This commentary addresses the implications of the findings with respect to the validity of the categorical distinction in the Diagnostic and Statistical Manual of Mental Disorders (rev. 3rd ed.; American Psychiatric Association, 1987) between avoidant personality and generalized social phobia, revisions of their respective diagnostic criteria, and their reclassification as either an anxiety or a personality disorder. Methodological and substantive suggestions for future research are also discussed.

The placement of the personality disorders on a separate axis in the American Psychiatric Association's revised third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM—III—R; American Psychiatric Association, 1987) has contributed to substantial interest in the validity of the distinction between the personality disorders and various clinical syndromes (Gorton & Akhtar, 1990). It is stated in the introduction to DSM—III—R that "there is no assumption that each mental disorder is a discrete entity with sharp boundaries (discontinuity) between it and other mental disorders" (American Psychiatric Association, 1987, p. xxii), but this denial is belied by the fact that in practice the DSM—III—R is used by clinicians and researchers to provide categorically distinct mental disorder diagnoses (Carson, 1991). Whether a person who is suffering from social inhibitions is diagnosed as having a personality or an anxiety disorder can have considerable clinical, social, and professional repercussions (e.g., in treatment decisions, insurance coverage, and research funding; Frances, Pincus, Widiger, Davis, & First, 1990). Most social, clinical, forensic, and research agencies use the DSM—III—R, and the DSM—III—R makes categorical distinctions.

The appearance in the Journal of Abnormal Psychology of three independent studies on the validity of the distinction between generalized social phobia (GSP) and avoidant personality disorder (APD) by Herbert, Hope, and Bellack (1992), Holt, Heimberg, and Hope (1992), and Turner, Beidel, and Townsley (1992) attests to the theoretical and clinical importance of this particular differential diagnosis. GSP is a subtype of social phobia wherein the person is fearful of most social situations (which often begins in late childhood or early adolescence); APD is a subtype of personality disorder
wherein the person exhibits a pervasive pattern of social discomfort, fear of negative evaluations, and
 timidity (which begins by early adulthood; American Psychiatric Association, 1987). Collectively and
 individually, the studies by Herbert et al., Holt et al., and Turner et al. provide a particularly informative
 empirical evaluation of this difficult and controversial differential diagnosis. This commentary was
 requested by the Editor of the Journal of Abnormal Psychology to facilitate their comparison,
 integration, and consideration for future research. I discuss in particular the implications of the findings
 with respect to the validity of the DSM—III—R distinction between APD and GSP, a revision of the
 diagnostic criteria, a reclassification of either APD or GSP, and future research.

Is the DSM—III—R Distinction Between Generalized Social Phobia and Avoidant
Personality Disorder Valid?

The findings were largely consistent across the three studies. There were many cases of GSP without
APD but few cases of APD without GSP. The studies by Holt et al. (1992) and Turner et al. (1992) may
have been biased against finding APD cases without GSP because only persons with overt anxiety
symptomatology are likely to attend an anxiety disorders clinic. However, this bias did not
occur in Herbert et al. (1992), as their subjects were solicited through media advertisements for persons
who were troubled by extreme shyness and social anxiety. Future studies may identify more cases of
APD without GSP, but it is apparent by simply reading the DSM—III—R criteria for APD that these
cases will be rather infrequent. As Turner et al. indicated, three of the DSM—III—R APD criteria
explicitly involve GSP symptomatology: (a) avoidance of social or occupational activities that involve
significant interpersonal contact, (b) reticence in social situations because of a fear of saying something
inappropriate or foolish, and (c) fearful of being embarrassed by blushing, crying, or showing signs of
anxiety in front of other people (American Psychiatric Association, 1987). Given that the DSM—III—R
also specifies that GSP will typically appear in late childhood or early adolescence and tends to be
chronic thereafter (American Psychiatric Association, 1987), it is evident that most persons who are
diagnosed with APD will also be diagnosed with GSP (particularly those with the APD criteria of
reticence in social situations and fears of being embarrassed, as suggested by the findings of Holt et al.,

All three studies did find significant differences between the GSP subjects with and without APD, and
Holt et al. (1992) concluded that "the separate determination of [a GSP] subtype and presence of APD
appears to have heuristic value among social phobia patients" (p. 323). However, the authors of all of
these studies appear to be more impressed by the lack of either substantial or qualitative distinctions
between GSP and APD. Turner et al. (1992) suggested that "the generalized subtype and APD groups
are more similar than they are different" (p. 330). "These data suggest that on the basis of the current
diagnostic criteria, [GSP] and APD differ primarily in the severity of social anxiety and social
functioning" (Turner et al., 1992, p. 331). Herbert et al. (1992) likewise concluded that "none of the
differences that emerged between the two groups point to qualitative dimensions that might distinguish
them as separate categories of psychopathology" (p. 338). "The most parsimonious
interpretation...appears to be that GSP and APD represent different points on a continuum
of severity" (Herbert et al., 1992, p. 338). Finally, Holt et al. (1992) concluded as well that "APD and
[GSP] do not denote distinct categories" (p. 324). "APD may simply identify the most severe social
phobics along a continuum" (Holt et al., 1992, p. 324).

These results do not imply that the categorical distinction between personality disorders and anxiety
disorders is without any validity or clinical utility, but they do suggest that there is no distinct boundary
between the constructs of a personality and an anxiety disorder. It is likely to be useful and meaningful
to distinguish between GSP and schizoid personality disorder and to distinguish between APD and
generalized anxiety disorder, but GSP and APD may represent boundary conditions of the anxiety and
personality disorders (respectively) that involve essentially the same psychopathology. It is then inaccurate and misleading to provide both diagnoses to the same patient, because such dual diagnosis suggests that the patient is suffering from two distinct and comorbid mental disorders. A person who meets the criteria for both GSP and APD is not suffering from two comorbid mental disorders but simply one disorder that meets the criteria for two different diagnoses.

**Must the Diagnostic Criteria Be Revised?**

The authors of all three studies emphasized that no qualitative distinctions between APD and GSP were evident under the *DSM—III—R* diagnostic criteria. Herbert et al. (1992) and Holt et al. (1992) have therefore recommended that future revisions of the *DSM* attempt to minimize the overlap through a refinement of the diagnostic criteria. In neither of the articles, however, did the authors indicate what modifications might salvage the APD and GSP distinction.

Turner, Beidel, Dancu, and Keys (1986) reported earlier that APD and social phobics were distinguished on the basis of APD deficits in social skills. This finding was not replicated in the current studies. "As one attempts to reconcile the findings...the most obvious difference is the changes in the criteria for the diagnosis of APD in the *DSM—III—R* " (Turner et al., 1992, p. 331). Turner et al. (1992) therefore suggested that the distinction between APD and GSP would be viable if the *DSM—IV* reverted to the *DSM—III* (American Psychiatric Association, 1980) criteria for APD. However, an equally substantial revision in the *DSM—III—R* was the broadening of the criteria for social phobia beyond a circumscribed stimulus to include a generalized subtype. A return to the *DSM—III* criteria would simply be a return to the original problem that many of the cases of social phobia do not involve a circumscribed anxiety disorder but rather a more pervasive and generalized timidity, inhibition, and avoidance (i.e., APD). It is possible that revisions to individual GSP or APD criteria may be implemented to create an explicit distinction (e.g., delete the APD criteria that overlap with GSP or require that GSP not be evident since adolescence or chronic thereafter), but to the extent that APD and GSP are overlapping constructs, any distinction between them may be as meaningful as making black-white distinctions among overlapping shades of gray. Rather than make artificial distinctions along a continuum of pathology, it may be more informative to acknowledge the existence of the continuum and to provide a more precise classification of the degree to which a social avoidance is circumscribed or pervasive.

If the categorical distinctions are retained in future revisions of the *DSM*, it will be useful to provide further specification of the GSP and the APD diagnostic criteria to help clarify the areas of overlap and to maximize the replication of empirical research. It is not clear, for example, whether the three studies in fact used the same diagnostic criteria for GSP and APD. This is because the *DSM—III—R* criteria for GSP do not define what is meant by "most social situations" (American Psychiatric Association, 1987, p. 243), and there are a variety of possible interpretations. Herbert et al. (1992) used GSP criteria developed by Heimberg, Holt, Schneier, Spitzer, and Liebowitz (1991) that are apparently more restrictive than those in the *DSM—III—R*. Their criteria for a discrete social phobia in which the distress is limited to only one situation (e.g., public speaking) was said to be consistent with a *DSM—III—R* nongeneralized social phobia. However, the "more pervasively impaired persons are divided into two quantitatively defined subtypes: nongeneralized social phobia, in which anxiety and avoidance extend to many different social contexts, although functioning remains adequate in some spheres, and GSP, in which anxiety and avoidance extend to most or all social contexts" (Herbert et al., 1992, p. 333). Given that the *DSM—III—R* criteria for GSP are given only if the fears involve most social situations, one might have expected there to be considerable agreement between the *DSM—III—R* GSP and Heimberg et. al.'s GSP diagnostic criteria, but Herbert et al. reported that 9 of the 23 persons diagnosed with GSP under *DSM—III—R* criteria were diagnosed as nongeneralized under Heimberg et al.'s criteria. Herbert et al. concluded that their findings supported the validity of Heimberg et al.'s criteria, but the findings they obtained with those criteria were no better than the findings they obtained with the *DSM—III—R* criteria.
GSP diagnostic criteria. Heimberg et al.'s criteria also failed to be any more specific or clear. One is still left with the ambiguity of what is meant by *many*, *some*, and *most* social situations, the definitions of which are likely to vary across studies.

Turner et al. (1992) were more explicit in how they defined *most* situations, but the criteria they used may only illustrate the difficulty in defining a meaningful or compelling distinct boundary between the categorical diagnoses. They interpreted GSP to mean a fear not of most social situations but a fear of the most commonly occurring social situations. Their GSP is concerned less with the number of social situations that are involved than whether the situations are common (frequently experienced) social situations, rather than public performance situations. "Patients were assigned a generalized subtype diagnosis if they feared parties (social gatherings), initiating conversations, or maintaining conversations, and patients were given a specific subtype diagnosis if they feared only circumscribed situations, such as giving speeches, speaking in meetings, eating or writing in public, or using public restrooms" (Turner et al., 1992, pp. 327). A person who was phobic of many different performance-oriented social situations (i.e., giving speeches, speaking in meetings, eating in public, as well as using public restrooms) would be diagnosed with a specific social phobia, whereas a person with a fear only of initiating conversations (and no other) would be diagnosed with GSP. In those cases of persons with specific phobias who also feared parties or conversations, "they did so only in circumscribed situations (e.g., related to their job) and, therefore, were not assigned the generalized-subtype diagnosis" (p. 327).

The boundary is equally debatable for the diagnosis of APD. The decision to require four of seven criteria for the DSM—III—R diagnosis of APD was not informed by any empirical data (Perry, 1990), and a person with just three avoidant symptoms (e.g., easily hurt by criticism or disapproval, avoids social or occupational activities that involve significant interpersonal contact, and is unwilling to get involved with people unless certain of being liked; American Psychiatric Association, 1987) would clearly have maladaptive avoidant personality traits (Widiger, in press). Holt et al. (1992) did in fact use a more liberal threshold for their DSM—III—R diagnosis of APD. They considered an APD criterion to be present if it received a score of either 1 or 2 on the Personality Disorder Examination (Loranger, 1988). However, only a score of 2 indicates that the item is at "criterion level or pathological"; a score of 1 indicates that the item is simply "exaggerated or accentuated" (Loranger, 1988, p. 10). Loranger indicated that a DSM—III—R diagnosis is based on the number of criteria that obtain a rating of 2. Many of the subjects diagnosed with DSM—III—R APD by Holt et al. would not be diagnosed with DSM—III—R APD by other researchers (at least those who would use the guidelines provided by Loranger, 1988, for the scoring of the Personality Disorder Examination).

The consistency of the results obtained by Herbert et al. (1992), Holt et al. (1992), and Turner et al. (1992), despite the inconsistency in the way the diagnoses of GSP and APD were made, can be interpreted as supporting the robustness of the findings. No matter what variation in diagnostic criteria were used, the findings were largely the same. The variability in diagnostic criteria also illustrates the arbitrariness and complexity of any explicit or specific distinction between GSP and APD. There may be a multitude of different options for how one can slice the pie, and the absence of any obvious point at which to make the cut itself suggests the absence of any distinct boundary between GSP and APD.

Is Generalized Social Phobia a Personality Disorder or Is Avoidant Personality Disorder an Anxiety Disorder?

If a valid or meaningful distinction between GSP and APD cannot be made, then which diagnosis must be given? The authors of all three studies appear to have suggested that APD is a more severe variant of GSP. APD may then perhaps be deleted in the DSM-IV or at least subsumed within a spectrum of anxiety disorders as a more severe variant of GSP. However, one can also interpret the results of these
three studies as indicating that GSP is a less severe variant of APD. This perspective would have been more apparent if the studies had been conducted by personality disorder researchers in a general outpatient clinic with the schizoid and dependent personality disorders, rather than a discrete social phobia, for comparison groups.

To the extent that GSP involves a chronic and pervasive fear of most social situations (such as dating, parties, and talking to co-workers; Holt et al., 1992) that has been evident since late childhood or early adolescence (American Psychiatric Association, 1987, pp. 242), it is by definition a personality disorder (American Psychiatric Association, 1987, pp. 16, 335). The fundamental personality trait of neuroticism includes a facet of trait anxiety, and persons who have always been excessively aloof, reserved, inhibited, shy, and avoidant across most social situations are said to be introverted by personality researchers (McCrae & Costa, 1990). These persons do have clinically significant avoidant behavior that is responsive to cognitive, behavioral, and pharmacologic treatment, but that is not inconsistent with most theories of personality functioning (e.g., Alden, 1989; Pilkonis, 1984).

However, subsuming GSP within Axis II APD may be equally as misleading as subsuming APD within GSP. GSP and APD are disorders in which anxious and avoidant behaviors predominate. Anxiety and personality are not mutually exclusive constructs, and the need to differentiate them is to some extent a procrustean artifact of the DSM—III—R categorical nosology. It may then be preferable to classify GSP-APD on both Axis I and Axis II to emphasize that in these cases the distinction between an anxiety disorder and a personality disorder is less meaningful and clinically useful than recognizing that one is dealing with a boundary condition that includes features of both an anxiety and a personality disorder.

An even more radical proposal is to abandon the anxiety and personality categorical distinctions altogether and simply rate a patient on the degree to which the social avoidance is pervasive. Heimberg et al.’s (1991) proposal takes an initial step in this direction by recommending a classification of three quantitatively defined subtypes. The advantage of this approach is the provision of more precise descriptions of idiosyncratic cases and the avoidance of arbitrary categorical distinctions. A potential disadvantage is that it requires a more detailed and perhaps complex assessment on the part of the clinician.

**Future Research**

It is conceivable that future researchers may be more successful than Herbert et al. (1992), Holt et al. (1992), and Turner et al. (1992) in obtaining a clear distinction between APD and GSP. Herbert et al. suggested that treatment response may be more discriminating, and Holt et al. suggested that physiological measures may prove so. However, one of the more commendable features of the studies under discussion is their inclusion of a variety of external validators, including behavioral challenge tests. It is likely that cross-sectional studies will obtain significant differences on one or more correlates of phobia or of avoidant psychopathology, but the similarities between GSP and APD, to paraphrase Turner et al., are likely to remain more compelling than their differences.

Longitudinal research, however, will be particularly informative. Comparable issues have occurred in the differentiation of the borderline personality and mood disorders (Gunderson & Phillips, 1991; Widiger, 1989) and it is becoming increasingly apparent that the constructs of a personality and a mood (anxiety) disorder cannot be readily disentangled with cross-sectional research. It is rarely clear, for example, whether an observed relation (e.g., correlation with an external validator) reflects a predisposition of the personality disorder pathology to the occurrence of the mood disorder symptomatology, a complication of the mood disorder pathology, an underlying spectrum of pathology that is shared by the personality and mood disorders, an artifact of insensitive and overlapping
diagnostic criteria, or some combination of these.

It may be the case, for example, that the APD and GSP symptomatology assessed in the three studies was not in fact characteristic of long-term functioning. Both could have been sequelae of an earlier, more specific social phobia. It may still be meaningful to diagnose the person at the current time with a late-onset APD or GSP, but until subjects are followed across time, the interaction and course of Axis I GSP and Axis II APD will remain ambiguous.

Cross-sectional research that may be informative will be epidemiologic studies that sample a sufficiently large number of subjects across a fully representative and comprehensive domain of interpersonal functioning to allow for the use of various taxometric techniques that assess whether there are in fact distinct breaks in the distribution of scores (Widiger, in press). There may be a qualitative distinction between APD and GSP that is difficult to identify with a limited number of subjects obtained from only a narrowly confined range of dysfunction. Differences between APD and GSP may become more apparent when the full range of functioning is represented. It is likely, however, that this research will only confirm the findings of Herbert et al., Holt et al., and Turner et al. that GSP and APD are overlapping constructs that have only minor differences with respect to the severity of dysfunction.

References


