



# Comorbidity of Avoidant Personality Disorder in Generalized Social Phobia and its Impact on Psychopathology

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## ÖZET:

Kaçınan kişilik bozukluğunun genelleşmiş sosyal fobi ile birlikteliği ve psikopatoloji üzerindeki etkisi

**Amaç:** Kaçınan Kişilik Bozukluğu (KKB), sosyal fobinin (SF) özel bir alttipi olan genelleşmiş sosyal fobi (GSF) ile yüksek ölçüde birlikte görülür. KKB ve GSF'li olan hastalar daha yüksek oranda sosyal bozukluk ve depresyonla birliktelik sergilerler. Bu nedenle GSF psikopatolojisinde KKB'nun etkilerini araştırdık.

**Yöntem:** DSM IV kriterlerine göre SF tanısı konan 24 hastaya, Eksen II bozuklukları tanısı için Yapılandırılmış Klinik Görüşmesi Türkçe Versiyonu (SCID II) uygulandı. Sorulara verilen yanıtlar, KKB birlikteliği açısından analiz edildi. Çalışma örneklem grubu, KKB olan ve olmayan GSF'li hastalar olarak iki ayrı gruba bölündü. Her iki grup, demografik özellikleri belirleyen kendilik-bildirimli ölçekler kullanılarak karşılaştırıldı.

**Bulgular:** KKB birlikteliği olan GSF hastaları, KKB birlikteliği olmayan GSF hastalarından anlamlı olarak daha yüksek oranda depresyon bildirdiler. KKB birlikteliği olan GSF hastaları yalnızca GSF'li olan hastalara oranla anlamlı oranda daha yüksek sosyal korku ve kaçınma davranışı bildirdiler. Umutsuzluk, aleksitimi, anksiyete ve işlevsel bozukluk açısından iki grup arasında anlamlı bir fark bulunmadı.

**Sonuçlar:** KKB, GSF ile birlikte olduğu zaman psikopatolojinin derecesini arttırmasına karşın yine de bu durum daha fazla işlevsel bozuklukla sonuçlanmıyordu.

**Anahtar sözcükler:** Sosyal fobi, kaçınan kişilik bozukluğu, komorbidite, psikopatoloji

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## ABSTRACT:

Comorbidity of avoidant personality disorder in generalized social phobia and its impact on psychopathology

**Objective:** Avoidant personality disorder (APD) is highly comorbid with social phobia (SP), particularly the specific subtype of SP, generalized SP (GSP). Patients with SP and APD have greater social impairment and depressive comorbidity; thus, we investigated the extent of the effect of APD on the psychopathology of GSP.

**Method:** Twenty-four patients diagnosed with SP according to DSM-IV criteria, were asked to complete the Structural Clinical Interview for Diagnosis of Axis I disorders (SCID-II). Responses to the questions were analyzed for APD comorbidity. The study sample was then divided into two groups as follows: GSP patients with APD and GSP patients without APD. The patient groups were compared, using various self-report measures regarding demographic characteristics. GSP patients with APD reported significantly higher levels of depression than GSP patients without APD.

**Results:** GSP patients with APD also reported significantly greater social fear and avoidance than the patients with GSP alone. No significant differences were found between two groups regarding hopelessness, alexithymia, anxiety, and functional impairment.

**Conclusions:** When occurring with GSP, APD increased the degree of psychopathology; however, this did not result in greater functional impairment.

**Key words:** Social phobia, avoidant personality disorder, comorbidity, psychopathology

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## INTRODUCTION

Social phobia (SP) is an anxiety disorder characterized by marked and persistent fear of social or performance situations in which embarrassment may occur (1). Eating, drinking, speaking, or writing in front of others; meeting with authority figures; or being observed are the most common triggers for SP. When confronted with a situation such as this, the person with SP will attempt to avoidance, and if avoidance is impossible, the person with SP may experience anticipatory anxiety or panic attacks. When fears such as these involve most social situations, the disorder is referred to as generalized social phobia (GSP). Patients with GSP usually fear both public performance

situations and social interactions (2). In contrast, avoidant personality disorder (APD) is a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation that begins by early adulthood and is present in a variety of contexts (1).

GSP is more common form of social anxiety disorder (SAD), and patients with this condition fear various social situations. Comorbidity with other psychiatric conditions and functional impairment are more common in patients with GSP. Individuals with non-generalized SAD fear specific social situations (e.g., speaking or writing in public) but they seldom seek psychiatric help. The clinical course of SAD is chronic without spontaneous remission, and the illness onset usually occurs prior to adolescence in

more than half of afflicted patients (2).

Several studies have described the frequent comorbidity of APD and SP, especially the generalized subtype (3). Patients with SP who also meet the criteria for APD experience greater social impairment and comorbid depressive episode (4-7). Based on these data, APD and SP might be components of a single psychopathologic spectrum, rather than existing as two separate nosological disorders (8-10). Patients who experience symptoms of social anxiety due to APD have been excluded from the SP category in the earlier DSM-III, but the DSM-IV allowed the additional diagnosis of APD under the category of SP. It has been noted that the relationship between SP and APD should not always lead to the assumption that APD is a severe form of SP, because APD can also occur with other anxiety disorders and psychiatric conditions such as body dysmorphic disorder, atypical depression, or eating disorders (11). Some authors consider APD to be a fundamental problem of interpersonal relationships, whereas SP is specific to performance situations. The prevalence of APD in patients with SP ranged from 21-90%, depending upon the study (2,11-13). High rates of SP in subjects with APD have led some authors to question whether the patients who meet APD criteria would also meet the criteria for SP (13). However, studies showed that not all APD patients display symptoms of SP.

Herbert et al. (6) reported that 61% of patients with GSP (N=23) had concurrent APD and patients with concurrent APD had higher rates of persistent anxiety, social anxiety, depression, and general psychopathology compared to patients without concurrent APD. Alpert et al. (8) mentioned that adult depressive patients with comorbid SP and APD experienced atypical depression more frequently than those without SP and APD. According to this study, depressive patients who have comorbid SP and APD had an earlier onset of the depressive disorder, had more frequent axis I diagnoses, and had more impairment in terms of social adaptation and assertiveness. Hope et al. (14) reported that for patients with GSP and APD with SP, the severity of the symptoms were higher before treatment; however, their treatment responses were similar to those of patients without GSP and APD. In a sample from Turkish participants, SP patients with APD were found to have greater social fear and avoidance compared with the

patients without comorbid APD (15). In another study from Turkey, Sevincok et al. (16) found that all 17 patients with GSP also met the diagnostic criteria for APD. The authors concluded that APD and GSP might be overlapping conditions that show small differences depending on the degree of impairment.

The purpose of this study is to investigate the degree to which APD influences the psychopathology of GSP. SP patients interviewed with Structural Clinical Interviews for Diagnosis of Axis II disorders (SCID-II) and those who also meet criteria for APD were compared with SP patients without APD using various psychometric measures. The results of this study may contribute to the discussions of the relationship between APD and SP, providing critical data for the investigation of whether these two conditions represent different aspects of a single spectrum of psychopathology or whether they are actually two separate conditions.

## METHODS

### Subjects

Patients who were admitted to the Department of Psychiatry at Vakıf Gureba Hospital, Istanbul, Turkey, and diagnosed by two psychiatrists as having GSP (N=24) according to DSM-IV criteria were included in the study. Written informed consent was obtained from all patients before entering the study. Patients with SP were divided into two groups according to the SCID-II results: patients with APD and patients without APD. Patients enrolled into the study were assessed with a socio-demographic questionnaire, as well as assessed with various self-report tools to measure levels of depression, anxiety, hopelessness, alexithymia, social anxiety and avoidance, and disability. The characteristics of the measures used in the study are as follows:

### Interviews

**SCID-II.** The SCID-II is a structured method of interview developed according to the DSM-III-R classification, which provides help in diagnosing axis II personality disorders (17). The translation of the assessment into Turkish and the administration of the SCID-II have been performed previously by Sorias et al. (18).

## Assessments

**Beck Depression Scale.** This scale measures somatic, emotional, cognitive, and motivational symptoms related to depression. The goal of this scale is not to diagnose depression but to provide objective assessment about the severity of depressive symptoms. It includes 21 symptom categories, each having 4 items. Each item is scored from 0 to 3. The sum of these scores provides the final score for depression; with a higher score indicating a more severe illness (19,20). Validity and reliability tests of the scale for use in Turkish were performed by Tegin (21).

**Beck Anxiety Scale.** This instrument is a self-report scale revealing the frequency of anxiety symptoms experienced by the individual. It is a Likert-type scale composed of 21 items scored from 0 to 3. Higher total scores correlate with greater severity of anxiety symptoms (22). The validity and reliability of the scale for use in Turkish was done by Ulusoy (23).

**Beck Hopelessness Scale.** This scale measures an individual's negative expectations about the future. It consists of 20 items scored as a 0 or 1. The "yes" choice is awarded 1 point for each of the first 11 items, whereas the "no" choice receives a value of 1 in the remaining 9 items. Total scores range from 0 to 20. High total scores are correlated with a greater degree of feelings of hopelessness (20,24). The validity and reliability of the scale for use in Turkish was reported by Durak (25).

**Toronto Alexithymia Scale (TAS).** This scale is a 26-item scale that measures alexithymia and its validity and reliability have been proven often in the literature (26). In the original (English) version of the scale, the items are scored from 1 to 5, whereas the Turkish version is organized in the form of "yes/no" choices and has been shown to be both valid and reliable in this format in Turkish. Higher scores with this scale indicate more severe alexithymia. The TAS has 4 sub-scales, and a total score of 11 has been suggested as the cut-off point for the Turkish version (27). We analyzed total scores of the scale in this study and did not evaluate sub-scale scores separately.

**Liebowitz Social Anxiety Scale (LSAS).** The LSAS is a 24-item, clinician-administered scale composed of 13 items related to performance and 11 items related to social interaction situations. The scale evaluates the situations in which SP patients experience anxiety and avoidance. A

total score for social fear and social avoidance is obtained through ratings. It is also possible to rate "performance fear", "social fear", and "social avoidance" sub-scales separately (28,29).

**Sheehan Disability Scale (SDS).** The SDS is a scale used to measure impairment related to the areas of "work", "social life/leisure activities", and "family life/household responsibilities". Scoring by the patient ranges from 0 to 10 (15,30).

## Data analysis

Statistical analyses were performed with a Chi-square test for qualitative data and the student's t-test was utilized for quantitative data, and  $p < 0.05$  was considered significant.

## RESULTS

Of the 24 SP patients, 9 were female and 15 were male. Eighteen of the patients were single and 6 were married. The mean age for each subject was  $24.0 \pm 6$  years (mean  $\pm$  SD), the mean age of onset of the illness was  $19.4 \pm 5.7$  years and mean duration of the illness was  $4.6 \pm 3.4$  years. Patient occupations were as follows: 13 students, 5 civil servants, 2 housewives, 2 unemployed, 1 manual-laborer, and 1 self-employed. Twenty patients described their economic status as moderate, 3 as low, and 1 as high. Three patients graduated from an elementary school, 19 patients from a high school, and 2 patients from a college. Since APD is highly comorbid with GSP, only GSP patients were included. With SCID-II interviews, GSP patients were separated into two groups: those with APD ( $n=7$ ) and without APD ( $n=17$ ). The APD with SP group were male. The ADP-only group was fairly evenly divided (9 male, 8 female), and this gender difference between two groups was statistically significant ( $p < 0.01$ ). The mean age of subjects was not significantly different between groups. The mean duration of the illness was  $4.0 \pm 2.7$  years in the group of GSP with APD, and  $6.2 \pm 4.6$  years in the group without APD, a difference that was not significant. GSP patients with APD had higher mean scores from the Beck Depression Scale and the LSAS compared to GSP patients without APD ( $p < 0.05$  and  $p < 0.01$ , respectively). The scores of the Beck Anxiety Scale were higher in patients with APD and the difference

between the two groups tended to be statistically significant ( $p=0.07$ ). There were no statistically significant differences in the scores of the TAS, the Beck Hopelessness Scale, and the Sheehan Disability Scale between the groups (Table 1).

finding is consistent with the results of previous studies. Schneier and colleagues 4 reported APD in 89% of GSP patients, a rate reported to be as high as 100% in the study done by Sevincok et al. (16), and variously reported to be 70% by Tukul et al. (15), 50% by Chatterjee et al. (33), and

**Table 1: Psychometric Measure Scores of GSP Patients with and without APD (mean  $\pm$  SD)**

	APD + GSP (n= 17)	GSP (n= 7)	p-value
Beck Anxiety Scale	29.0 $\pm$ 10.1	19.2 $\pm$ 12.0	$p=0.07$
Beck Depression Scale	23.1 $\pm$ 8.7	13.7 $\pm$ 7.0	$p=0.024$
Beck Hopelessness Scale	10.2 $\pm$ 5.9	6.8 $\pm$ 5.2	$p>0.05$
Leibowitz Social Anxiety Scale-Fear	64.8 $\pm$ 11.9	49.5 $\pm$ 9.7	$p=0.009$
Leibowitz Social Anxiety Scale-Avoidance	65.9 $\pm$ 13.8	47.1 $\pm$ 8.7	$p=0.007$
Sheehan Disability Scale-Family	4.2 $\pm$ 2.5	3.8 $\pm$ 1.9	$p>0.05$
Sheehan Disability Scale-Work Life	5.7 $\pm$ 2.9	5.5 $\pm$ 2.2	$p>0.05$
Sheehan Disability Scale-Social Life	6.9 $\pm$ 1.8	5.7 $\pm$ 1.9	$p>0.05$
Toronto Alexithymia Scale	12.0 $\pm$ 3.0	11.1 $\pm$ 4.3	$p>0.05$

## DISCUSSION

Social Phobia (SP) is known to start during adolescence and the mean age of onset ranges between 15 to 20 years (31). In two Turkish studies, the mean age of onset of SP was reported to be  $12.5 \pm 4.1$  years by Sevincok et al. (16); and  $17.4 \pm 7.3$  years by Tukul et al. (15). Our results are similar to Tukul et al.'s findings. The majority (62.5%) of our GSP patients were male and this difference was statistically significant. Although epidemiological studies of SP in community samples report the prevalence of SP to be more common in females, males and females were equally afflicted in clinical sample studies (32) Tukul and colleagues 15 also reported that 76.6% of their SP patients were men. In our opinion, the finding of a higher prevalence of SP in men in Turkish clinical samples is important and merits further discussion. Perhaps, shyness and timidity, which are encouraged and well accepted in Turkish women, are perceived as a deficit in Turkish men who could be more distressed from the manifestations of SP. Cultural dimensions of this finding should be expanded via epidemiological studies. Seventy-five percent of our study patients diagnosed as GSP were single, a result consistent with previously published results reporting that patients with SP more frequently lived alone, had never married, or had divorced, compared to control groups. However, our findings of this nature are not remarkable as the majority (54%) of our study population were students.

In our study, GSP was more frequently comorbid with APD (70.8%), and this was statistically significant. Our

88% by Nagata et al. (34). In a study conducted with patients with major depression, Alpert and his colleagues 8 found that two-thirds of patients diagnosed with SP and APD met both SP and APD diagnoses concurrently. Similar to the results reported by Tukul et al.'s (15), we found a greater proportion of males to be comorbid for SP and APD.

When the two groups were compared using psychometric measures, no significant differences were found in the levels of alexithymia, hopelessness, and anxiety, but anxiety levels were higher in patient comorbid for SP and APD, and the difference approached statistical significance ( $p=0.07$ ). Our results agree with previous studies that reported high levels of anxiety in the GSP patients with APD (5,35). In our study; GSP patients with APD had significantly higher levels of depression compared to the patients without APD. In a study conducted by Herbert et al. (6), mean scores for anxiety and depression were significantly higher in the comorbid group than the group with GSP and not APD. Alpert et al. (8) reported that depressive patients, who were comorbid for SP and APD, had greater risk for atypical depression and social dysfunction compared to the depressive patients with SP only. In a study by Tran et al. (36), mean scores of depression were found to be significantly higher in GSP patients with APD compared to the GSP patients without APD. Recurrent depression associated with a sense of inferiority and loss of interest to social interactions has been suggested to be instrumental for development of APD (8). Liebowitz and colleagues (37) reported that the presence of APD augmented the treatment response to

pharmacotherapy in patients with SP.

GSP patients with APD had higher scores in LSAS and avoidance scales than patients without APD; whereas, there were no differences in Sheehan Disability Scale scores between the groups. These findings are in agreement with findings suggesting that the presence of APD resulted increased psychopathology in patients with GSP. In other studies, anxiety and avoidance scores from the LSAS were higher in GSP patients with APD than in GSP patients without APD (7,35). Tukul's group (15) reported that social anxiety and avoidance were observed more frequently in GSP cases with APD. Unlike our results, their sample of GSP patients with APD experienced greater impairment in the areas related to family life and household responsibilities. However, the authors did not discuss why SP patients had more impairment in family life rather than areas such as work and social life, which typically cause anxiety.

Several studies reported that both pharmacotherapy and cognitive-behavioral therapies were equally effective in GSP with and without APD (38,39). In our opinion; this is indirect evidence indicating that the presence of APD does not cause additional functional impairment. This conclusion does not support the concept of considering APD as a severe form of GSP. When we consider our findings that general anxiety levels are not significantly higher in the GSP with APD group, we can assume that patients with APD manage social anxiety and avoidance to some degree and the affect of their illness on their quality of life is not greater than that of patients with only GSP, an idea that should be further explored. In a study of comorbidity of GSP and APD, Herbert et al. (6) reported that all individuals who met the criteria for APD, also met the criteria for GSP and that social anxiety and functional impairment were higher in patients with APD. Based on these results, the authors suggested that GSP and APD were only quantitatively different psychopathologies belonging to the same spectrum, rather than being qualitatively separate disorders (6). The results of our study reveal that some patients with GSP may not have APD and suggest that although GSP and APD are partly overlapping based on DSM-IV criteria; they may still be considered two distinct disorders. APD has also been frequently reported to occur concurrently with other psychiatric disorders such as panic disorder, atypical

depression, and body dysmorphic disorder (8,11,40). It has been suggested that APD should not be considered a more severe form of GSP, because, although the definitions of these two conditions are similar, a diagnosis of SP focuses more on phobic signs, whereas an APD diagnoses emphasize avoidant personality features and their influence on interpersonal relations (11). According to Widiger (13), GSP and APD are overlapping conditions that show minor differences depending on the degree of impairment. In addition, there have been discussions about whether the term "avoidant" was adequate for characterizing this type of personality (11).

The limitations of this study must be emphasized. First, avoidant personality and anxiety measures were measured at a single time. The longitudinal course of psychopathology, treatment and global functioning should be examined. We did not show the data of comorbidity, using Axis I and Axis II. Our data suggests that some of our patients might have a mood disorder. Second, it should be acknowledged that the study was carried out with a relatively small sample. Therefore, the conclusions should not be considered definitive, and further studies should be conducted with larger patient samples.

In conclusion; the presence of APD increases social anxiety and avoidance in GSP. Individuals experiencing GSP concurrent with APD were found to be more depressive than individuals with pure SP. However, presence of APD did not lead to greater functional impairment in GSP patients. APD was not detected in some of the patients with GSP. These results do not support the assumption that APD is a severe form of GSP. On the contrary, although there are some overlapping features on the basis of diagnostic criteria, these two categories represent two different conditions. It may be noted that, in the category of SP or social anxiety, the fear related to performance situations and its autonomic signs are prominent, where as in the category of APD, the obstacle in the interpersonal relationships due to the fear of being ridiculed or disapproved by others is more prominent and these should be considered suggestive of different symptom levels.

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