GENERALIZED SOCIAL ANXIETY DISORDER AND AVOIDANT PERSONALITY DISORDER: STRUCTURAL ANALYSIS AND TREATMENT OUTCOME

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There has been considerable controversy about whether generalized social phobia (GSP) and avoidant personality disorder (APD) are redundant diagnostic categories. In light of the ongoing controversy, more data are needed to help determine whether GSP and APD are independent constructs. Data were obtained from 335 people seeking treatment for GSP at a two site clinical trial. Indicators of GSP and APD were obtained along with assessments of demographic factors, level of functioning, and indicators of related psychopathology. Confirmatory factor analyses of indicators of GSP and APD suggested a somewhat better fit for a two-factor solution. Comparisons of GSP patients with and without APD suggested that in addition to having more severe social phobia symptoms, patients with APD were more depressed on a self-report measure and had more functional impairment, thereby suggesting potential utility of the diagnostic category of APD. Furthermore, the presence of APD predicted treatment response, in that patients with APD had more change early in treatment than those without APD. APD and GSP remain highly related constructs, and different aspects of these data support and dispute the utility of the diagnosis of APD in GSP. Possible new directions in conceptualizing APD are discussed.

Key words: social anxiety; APD; diagnosis; comorbidity; CBT; fluoxetine

INTRODUCTION

Generalized social phobia (GSP), also known as generalized social anxiety disorder, is a common, debilitating form of social anxiety, which is defined as a clinically significant fear of a number of interpersonal or performance situations. GSP is associated with greater severity than social phobia (SP) involving more circumscribed social fears (e.g., fear of public speaking), and most patients who seek treatment for SP meet criteria for the generalized subtype [Katzelnick et al., 2001; Kessler et al., 1998].

Although avoidant personality disorder (APD) is an Axis II disorder, which is supposed to be distinct from Axis I disorders, it shares many characteristics with GSP. It is defined by “a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation ... in a variety of contexts” [DSM-IV-TR; APA, 2000; p 721]. Some of the major symptoms overlap considerably with GSP. These symptoms include (1) avoiding jobs with a lot of
interaction for fear of criticism and (2) preoccupation with being criticized or rejected in social situations. In fact, studies examining GSP with and without APD have estimated that as many as 89% of individuals with GSP also meet diagnostic criteria for APD [Schneier et al., 1991]. Because of this significant overlap as well as the finding that those with APD have more severe social anxiety symptoms [e.g., Boone et al., 1999], some researchers have suggested that APD is simply a more severe form of GSP [Heimberg, 1996]. This contention was discussed in the DSM-IV-TR, which states that “there appears to be a great deal of overlap between Avoidant Personality Disorder and Social Phobia, Generalized Type, so much so that they may be alternative conceptualizations of the same or similar conditions” [APA, 2000; p 720]. In light of these findings, some argue that the diagnosis of APD is redundant.

This view, however, is not without controversy, as it is based on data from small convenience samples [Arntz, 1999; see Alden et al., 2002 for a review of the current status of research in APD]. A recent study of the general population found that while individuals with SP with and without APD did not differ on social distress, patients with SP and APD reported greater functional impairment than patients diagnosed with SP only [Tillflors et al., 2004]. Other studies have shown that the presence of APD is a predictor of poorer response to treatment, even after controlling for initial severity of social anxiety [Feske et al., 1996], though other studies have not found APD to be a reliable predictor of outcome (e.g., Oosterbaan et al., 2002). Furthermore, some studies examining prevalence of APD in SP report rates as low as 25% [Alden et al., 2002]. Thus, researchers who support the notion that APD is a valid and distinct diagnosis from GSP suggest that there may be increased risk of APD in GSP compared with other disorders, but that this may be partially due to the narrow definition of APD used in the DSM-IV, which increases the overlap between the two disorders. Arntz [1999] suggested that the DSM return to earlier definitions of APD that have less overlap with GSP by including nonsocial aspects of APD such as “harm-avoidance, inhibition of explorative and expressive behavior, low tolerance of intense emotions” and a general use of avoidant strategies (p 110). Recent research by Taylor et al. [2004] provides some support for this notion in both nonclinical and GSP samples. Specifically, they found that individuals with more DSM-IV APD characteristics had somewhat higher levels of novelty avoidance, nonsocial avoidance, and avoidance of positive emotions than those without APD.

Another reason to retain the diagnosis of APD is that this disorder occurs with other disorders besides GSP, including depression, panic, agoraphobia, posttraumatic stress disorder, and obsessive-compulsive disorder [for a review, see McGlashan et al., 2000]. In fact, APD may occur even more frequently in major depression than in SP. Another analysis of this dataset revealed that only one third of individuals with APD also had SP [Ralevski et al., 2005]. In addition, individuals with APD and SP did not differ on treatment or clinical characteristics from those with APD and no SP. Unfortunately, there was not an SP group without APD to compare to determine whether these groups differed as well. Because APD exists in a variety of disorders, it might have utility as a separate diagnostic category even if its utility for patients also diagnosed with SP is questionable.

Because of the ongoing controversy, it appears that more data are needed on the distinction between GSP and APD, particularly with respect to whether the two are independent constructs. This study examines data collected from a large, collaborative trial on the treatment of GSP [Davidson et al., 2004]. The large sample size allowed us to examine the relationship between the constructs of social anxiety and APD through confirmatory factor analysis. Furthermore, for patients who entered the trial, we were able to determine whether patients with and without comorbid APD differed on other measures, and whether APD predicted response to treatment and dropout status. If the data suggest that APD is a distinct entity, and if it associated with distinct clinical features and outcome, then retaining the diagnosis would be justified with GSP patients. Otherwise, the diagnosis of APD may be best reserved for patients who are not diagnosed with GSP. We hypothesized that, if APD and GSP are distinct constructs, they should emerge as separate and distinct factors in a confirmatory factor analysis of assessment items measuring both constructs. In addition, we explored whether demographics, depression, or functional impairment are differentially related to these constructs, and whether presence of APD is related to treatment response. For the latter, we predicted that individuals with APD would benefit less from treatment than individuals without APD.

METHODS

PARTICIPANTS

A sample of 295 individuals seeking treatment for SP were recruited at two clinical sites as part of a collaborative treatment outcome study between the University of Pennsylvania and Duke University. However, a subset of 252 patients had complete information relevant for the current study, due to missing data. Data were also available for an additional 83 patients who sought treatment but did not enter the treatment study and these data were included for confirmatory factor analyses to expand the heterogeneity of the sample. Only initial screen data were available for these individuals.

Individuals were included in the treatment study if they were between 18 and 65 years of age, were literate...
in English, and met DSM-IV criteria for GSP, defined by significant anxiety in and avoidance of a minimum of four social situations (including at least one performance-related situation). Exclusion criteria were: lifetime history of bipolar disorder, major depression within the past 6 months, substance abuse or dependence within the past 12 months, mental retardation or pervasive developmental disability, or a history of psychosis or organic mental disorder, as defined by the DSM-IV [APA, 1994]. Participants were also excluded if they had an uncontrolled medical condition, prior nonresponse to fluoxetine or cognitive-behavior therapy for SP, current psychoactive medication or psychotherapy, positive urine screen for illicit drugs, pregnancy or lactation, or recent (5 weeks) trial of fluoxetine at a subtherapeutic (<60 mg) dose.

MEASURES

Structured Clinical Interview for the DSM-IV [First et al., 1996]. Axis I disorders were assessed with the Structured Clinical Interview for the DSM-IV (SCID-I), a semi-structured interview. This was used in this study to diagnose SP, as well as other anxiety disorders and mood disorders, and to rule out psychosis and substance abuse. The generalized subtype of SP was determined using a criterion of fear in more that four social situations, including at least one performance situation and two social interaction situations.

Structured Clinical Interview for the DSM-IV [First et al., 1997]. Personality disorders were assessed using the SCID-II interview. Interviewers rated each of seven items (1 = absent, 2 = possible/subthreshold, 3 = definite) to assess characteristics of people with APD after patients completed the SCID-II screener as a self-report measure.

Brief Social Phobia Scale [Davidson et al., 1997]. The Brief Social Phobia Scale (BSPS) is an observer-rated 18-item scale comprised of fear, avoidance, and physiological symptoms of social anxiety, and has been shown to have good interrater reliability, correlate well with other measures of social anxiety, and be sensitive to treatment effects [Davidson et al., 2004].

Beck Depression Inventory [Beck, 1967]. The 21-item scale assesses symptoms of depression that have been present in the past week including difficulties with sleep, irritability, and feeling like a failure.

Hamilton Rating Scale for Depression [Hamilton, 1960]. Hamilton Rating Scale for Depression (HRSD) is a 17-item interviewer administered measure that assesses severity of depressive symptoms. It has been used extensively in depression research, and has been shown to be reliable and valid.

Sheehan Disability Scale [Sheehan, 1983]. The Sheehan Disability Scale is a measure of self-reported functional impairment in social, work, and family domains. The total score was calculated by examining the sum of the ratings for each of the domains.

TREATMENT

Patients were randomly assigned to one of five possible treatment conditions: fluoxetine pharmacotherapy, comprehensive cognitive-behavior group therapy (CCBT), CCBT+fluoxetine pharmacotherapy, CCBT+pill placebo (PBO) and PBO only. All participants received 14 weeks of active treatment. Results suggested that all active treatments were superior to PBO, but no differences between the active treatments emerged [for more details, see Davidson et al., 2004].

PROCEDURES

Participants were recruited through advertisements for treatment for shyness in newspapers, public transportation, and other sources. All completed an intake assessment to establish inclusion and exclusion criteria; this included the SCID-I and the APD module of the SCID-II, the BSPS, and a battery of self-report measures. The assessment sessions lasted approximately 2 hr and were conducted by trained Master’s and Doctoral-level interviewers.

Following the intake assessment, individuals meeting criteria for the study were placed on a waiting list until 10 individuals had been enrolled. At this point, participants were evaluated again using the BSPS and the HRSD, and self-report measures (week 0). Participants were then randomly assigned in cohorts of 10 individuals to one of the five treatments. Treatment lasted for 14 weeks, and independent assessments on the BSPS were obtained at weeks 0, 4, 8, and 14.

DATA ANALYSIS

Confirmatory factor analyses were conducted with the data from the total sample (n = 335) using maximum likelihood estimations with LISREL version 8.8 software. Indicators in these models consisted of the 7 items from the SCID-II APD section and the 18 items of the pretreatment BSPS. First, we compared a unitary model (APD and GSP indicators reflecting one latent construct) with a two-factor model (APD and GSP indicators each reflecting separate latent constructs). In this two-factor model, the latent factors were allowed to covary. Goodness of fit indices were selected based on the criteria recommended by Hu and Bentler [1999]. Because the two-factor model was nested within the one-factor model, a χ² difference test was conducted to determine whether the fit was significantly different. Furthermore, given that experts [e.g., Arntz, 1999] have argued that some specific symptoms included in the DSM-IV definition of APD (especially “avoids occupational activities that involve significant interpersonal contact” and “is preoccupied with being criticized or rejected in social situations”) overlap with the diagnosis of GSP, we examined three other models in which these items were either
indicators of both constructs, only GSP, or eliminated from the model.

Next, we examined the co-occurrence of APD with GSP and the clinical and discriminant validity of APD in terms of clinical characteristics using the sample of patients for whom data were available (n = 252). Clinical and demographic characteristics were examined by testing differences between means in individuals with and without APD, and by using the number of APD symptoms as a continuous variable in zero order correlations. Finally, treatment response was examined using the sample of 252 patients. For treatment response, we used piecewise linear mixed effects models, with an unstructured covariance matrix because this model fit the overall data the best [see Davidson et al., 2004]. This analysis examines the differences in change in symptoms on the BSPS from weeks 0 to 4 and weeks 4 to 14 separately, but within the same model. Given our previous findings regarding Beck Depression Inventory (BDI) predicting treatment outcome [Ledley et al., 2005], we examined whether treatment condition, BDI and APD were significantly related to change over time for both weeks 0–4 and weeks 4–14. In addition, we examined whether response and drop status were related to APD status (see Table 2).

**RESULTS**

**APD AND GSP: ONE- AND TWO-FACTORS MODELS**

Model modification indices suggested that allowing the error terms of the seven corresponding fear and avoidance items to correlate significantly improved fit. Thus, these modifications were made in all of the models tested. The two-factor model had a significant $\chi^2$ ($\chi^2(267) = 610, P < .0001$), a Goodness of Fix Index of .86, a Comparative Fit Index of .90, a root mean square residual of 0.078, and a root mean square error of approximation of 0.068. All of these values indicate an adequate fit for the model except the $\chi^2$. The single factor model had slightly worse fit according to all indices (see Table 1), and $\chi^2$ difference test revealed a significantly better model for the two factors ($\chi^2(1) = 59, P < .001$). The addition of paths to the GSP latent factor from the two APD items that were proposed to overlap with GSP improved the fit of the two-factor model significantly ($\chi^2(2) = 10, P < .05$). The fit was somewhat better than the original two-factor model, but was worse than the model in which the two APD items of interest were allowed to load onto the GSP factor only. However, when these items were removed from the model, the best model fit emerged (see Table 1). See Figure 1 for path diagrams of the original one-factor and two-factor models and the final model. The same pattern of results was found when the sample was randomly split in half and examined separately for each half and when examining only those patients who entered treatment.

We next examined whether demographic variables, functional impairment, and depressive symptoms differentiated patients with GSP from patients with comorbid GSP and APD. APD was common among individuals with GSP, with 174 participants (69%) meeting diagnostic criteria for APD. Individuals without APD did not differ from those with APD in gender (49 versus 54% males, respectively), average age (39, SD = 10, versus 37, SD = 11, respectively), ethnicity (78 versus 77% Caucasian, respectively), marital status (44 versus 37% married), or employment status (63 versus 67% full time employed; all $P > .15$). Patients diagnosed with GSP and comorbid APD had more severe social anxiety, depressive symptoms (as measured by the BDI), and impairment than individuals without APD (see Table 2). However, GSP patients with APD did not significantly differ from those without APD on depression as measured by HRSD.

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**TABLE 1. Results of confirmatory factor analyses for one-factor, two-factor, and adjusted models**

<table>
<thead>
<tr>
<th></th>
<th>One-factor</th>
<th>With two APD items on APD only</th>
<th>With two APD items on both factors</th>
<th>With two APD items on GSP only</th>
<th>Without two APD items</th>
</tr>
</thead>
<tbody>
<tr>
<td>$\chi^2$ (df)</td>
<td>669 (268)</td>
<td>610 (267)</td>
<td>600 (265)</td>
<td>635 (267)</td>
<td>506 (222)</td>
</tr>
<tr>
<td>RMSEA</td>
<td>.075</td>
<td>.068</td>
<td>.068</td>
<td>.071</td>
<td>.067</td>
</tr>
<tr>
<td>NFI</td>
<td>.86</td>
<td>.88</td>
<td>.88</td>
<td>.87</td>
<td>.89</td>
</tr>
<tr>
<td>CFI</td>
<td>.88</td>
<td>.90</td>
<td>.86</td>
<td>.85</td>
<td>.87</td>
</tr>
<tr>
<td>GFI</td>
<td>.84</td>
<td>.86</td>
<td>.86</td>
<td>.85</td>
<td>.87</td>
</tr>
<tr>
<td>RMR</td>
<td>.081</td>
<td>.078</td>
<td>.076</td>
<td>.077</td>
<td>.079</td>
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<tr>
<td>Correlation of two factors</td>
<td>.61</td>
<td>.57</td>
<td>.67</td>
<td>.57</td>
<td>.57</td>
</tr>
</tbody>
</table>

Two items from APD criteria that appeared to overlap significantly with the definition of GSP were included as indicators of APD in the two-factor model, or as noted in the table in other models.

APD, Avoidant Personality Disorder; GSP, Generalized Social Phobia; RMSEA, Root Mean Square Error of Approximation; NFI, Normed Fit Index; CFI, Comparative Fit Index; GFI, Goodness of Fit Index; RMR, Root Mean Square Residual.
Figure 1. Path diagrams with standardized loadings on (a) one-factor model (b) two-factor model, and (c) a two-factor model with two items removed.
patients who had APD improved more in the first response status (see Table 2). Furthermore, APD status was unrelated to dropout or impact response according to treatment condition. interactions, suggesting that APD did not differentially were no significant treatments by time by condition were no significant effects for time 2 by APD. There significant (\(P<.001\)) and weeks 4–14 (\(F(1, 469) = 73.1, P<.001\)) and weeks 4–14 (\(F(1, 469) = 60.9, P<.001\)). However, the interaction of APD by weeks 0–4 was significant (\(F(1, 521) = 6.1, P = .01\)), suggesting that patients who had APD improved more in the first 4 weeks than those who did not have APD (adjusted mean change for APD = 7.6, not APD = 5.7). There were no significant effects for time 2 by APD. There were no significant treatments by time by condition interactions, suggesting that APD did not differentially impact response according to treatment condition. Furthermore, APD status was unrelated to dropout or response status (see Table 2).

### DISCUSSION

The aim of this study was to examine the relationship between the constructs of GSP and APD in a sample of patients seeking treatment for social anxiety. Despite the large sample size and use of structural equation modeling, the results were somewhat ambiguous. Overall, the best fit did appear to be with a two-factor model that excluded the two items from APD that seemed to overlap significantly with social anxiety (worrying about being criticized or rejected in social situations and avoiding activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection). Furthermore, individuals with APD had more severe social anxiety, minor differences in self-reported depressive symptoms, but more substantial differences in functional impairment. In addition, APD did not predict differential treatment response. However, even the best fitting two-factor model was not an excellent fit for the data, according to accepted goodness of fit indices. Because APD and GSP factors were assessed with different instruments (relying on somewhat different assessment scales of present, possible, absent versus 0–4 level of severity), method variance could account for the two-factor model being superior to the one-factor model. In addition, the presence of APD was not related to the interviewer rating of depression, demographics, or job status. Overall, the data appear to partially support the utility of the distinction of APD and GSP, though the picture continues to be quite complex.

The fact that individuals with APD improved more than those without APD early in treatment was unexpected. However, the finding is consistent with results of some studies [see Alden et al., 2002] but not others [e.g., Feske et al., 1996]. It is possible that the greater severity of patients with APD gives greater opportunity for change earlier in treatment, or that the finding was due to a regression to the mean.

The relationship between APD and depressive symptoms fits with previous data [Van Velzen et al., 2000, and Feske et al., 1996]. More data are needed to understand why the difference was greater on the BDI than the HRSD. It is possible that the greater emphasis on cognitive symptoms of depression in the BDI detected a difference in the way that individuals with

| TABLE 2. Clinical characteristics of GSP patients with and without APD |
|-----------------------------|---------------------|---------------------|------------------|
|                             | GSP only | GSP+APD |
|                             | \(n = 78\) | \(n = 174\) |
|                             | \(M\)    | \(SD\)   | \(M\)   | \(SD\) |
| Pretreatment                |          |          |          |        |
| BSPS total                  | 35.6     | 9.9      | 40.3    | 9.3    |
| BDI                         | 9.8      | 7.0      | 12.6    | 8.3    |
| HRSD                        | 8.1      | 5.8      | 8.9     | 6.3    |
| Sheehan                     | 14.0     | 6.2      | 17.2    | 5.4    |
| Treatment                   |          |          |          |        |
| CGI responder-ITT           | 39 (50%) | 83 (48%) | 0.1     | .02    |
| CGI responder-completers    | 33 (55%) | 74 (60%) | 0.4     | .05    |
| N dropout                   | 18 (23%) | 51 (29%) | 0.9     | .06    |
|                            |          |          |          |        |

BSPS, Brief Social Phobia Scale total score; BDI, Beck Depression Inventory; HRSD, Hamilton Rating Scale for Depression; Sheehan, Sheehan Disability Scale; CGI, Clinicians Global Improvement Scale.

Sample sizes differ slightly due to missing data.

*\(P<.05\).

**\(P<.001\).

Similar results were found when examining severity of APD (number of symptoms) using correlational analyses (see Table 3), with the exception of a significant correlation being found between the number of APD symptoms and HRSD. When partialing out BSPS scores, correlations between number of APD symptoms and BDI (partial \(r = .27, P<.001\)), Sheehan disability (partial \(r = .18, P<.05\)), and HRSD (partial \(r = .15, P<.05\)) remained significant.

In terms of treatment outcome on the BSPS, we examined whether APD was differentially related to outcome over the 14-week time period (weeks 0–4 and 4–14) using piecewise mixed effects models, when including treatment condition, depressive symptoms, and APD status in a multifactorial model. There was a main effect of time for weeks 0–4 (\(F(1, 469) = 73.1, P<.001\)) and weeks 4–14 (\(F(1, 469) = 60.9, P<.001\)). However, the interaction of APD by weeks 0–4 was significant (\(F(1, 521) = 6.1, P = .01\)), suggesting that patients who had APD improved more in the first 4 weeks than those who did not have APD (adjusted mean change for APD = 7.6, not APD = 5.7). There were no significant effects for time 2 by APD. There were no significant treatments by time by condition interactions, suggesting that APD did not differentially impact response according to treatment condition. Furthermore, APD status was unrelated to dropout or response status (see Table 2).

### TABLE 3. Correlations among pretreatment characteristics

<table>
<thead>
<tr>
<th></th>
<th>APD</th>
<th>BSPS</th>
<th>BDI</th>
<th>HRSD</th>
<th>Sheehan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(r)</td>
<td>(\frac{\text{mean}}{\text{SD}})</td>
<td>(r)</td>
<td>(\frac{\text{mean}}{\text{SD}})</td>
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</table>
| Sample sizes differ slightly (\(n = 243–214\)) due to missing data.

**\(P<.01\).

**\(P<.001\).
APD think, whereas the more somatic/behavioral symptoms emphasized by the HRSD did not detect these differences. Some researchers have proposed a complete overhaul of the personality disorder categories, which would exclude the APD diagnosis [Shedler and Westen, 2004]. In their revised system, APD most loaded on a factor that they called dysphoria, which purportedly reflects neuroticism. Our data lend partial support to this notion, in that individuals diagnosed with APD reported higher levels of depressive symptoms on the BDI. In contrast, the HRSD did not evidence a difference. More research is clearly needed to determine whether avoidant personality should be distinct from neuroticism or dysphoria per se.

There are a number of limitations to the current findings given the select sample (treatment seeking, predominantly nondepressed with little comorbidity) and the measures (only the SCID II for evaluation of APD). However, this is one of the largest samples that have examined the relationship between GSP and APD and to our knowledge is the only one that used structural equation modeling to examine this issue. Replication in other samples is warranted.

FUTURE DIRECTIONS

A number of distinctions may be helpful to further differentiate GSP from APD in future diagnostic criteria, and may also prove useful clinically. Given that the data are not available on this issue, we are drawing from our clinical experience for these suggestions. Clinical impression suggests that patients with APD often avoid a range of situations that make them feel uncomfortable—not just anxiety-provoking social situations (this observation is mirrored in recent findings by Taylor et al. [2004]). All patients with SP avoid social situations in part because of the aversive experience of anxiety. However, during treatment, individuals without APD seem to “trust” the notion that repeated exposure to their anxiety-inducing situation will decrease their anxiety and that eventually, these situations might even become pleasant and enjoyable. Those with APD, on the other hand, often seem unable or unwilling to tolerate the anxiety associated with confronting social situations. They might decide that remaining socially anxious is easier than confronting anxiety-provoking situations and feeling badly. Furthermore, patients with APD might have difficulty imagining that social situations can be pleasant and enjoyable. This notion is supported by Taylor et al. [2004], whose data suggest that patients with APD may avoid all intense emotions (both positive and negative). Thus, individuals with APD may have less experience with and less desire for experiences that bring on positive emotions like happiness or joy.

A related possibility is that APD may be characterized by a fear of novel experiences more broadly defined (i.e., even if no intense emotion is expected).

The current DSM criteria mention avoidance of occupational activities and new activities, but this avoidance is couched in terms of fear of rejection. It is possible that patients with APD fear and avoid these activities for reasons other than rejection. New experiences could be dangerous (e.g., trying a new sport), unpleasant (e.g., trying a new food), or simply unknown (e.g., reading a book by a new author) and rather than face the possibility of discomfort, people with APD avoid. This fear of novelty maps on very well to the temperament style of behavioral inhibition that is seen in infants and children and has been found to be linked to later SP [e.g., Schwartz et al., 1999]. Clinically, individuals who continue to have APD after treatment may need exposure to situations beyond those that are social to learn that novel experiences in general should not be avoided, learning which would lead to broader benefit in terms of functioning and quality of life. Accordingly, perhaps the improvement of patients with APD after treatment for GSP may be due to their ability to generalize their experiences in novel social situations to other areas.

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