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Toward resolution of a longstanding controversy in personality disorder diagnosis: Contrasting correlates of schizoid and avoidant traits

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ABSTRACT

Although the construct validity and clinical utility of separate schizoid and avoidant personality disorder (PD) categories has been controversial since avoidant PD was first introduced in DSM-III, few studies have compared individuals with schizoid versus avoidant features on variables relevant to their contrasting personality dynamics. Those few investigations that exist have yielded inconclusive results. In this study a mixed-sex sample of nonclinical participants ($N = 123$) completed the International Personality Disorder Examination Screening Questionnaire (IPDE-SQ) and self-report measures of attachment style, defense style, empathy, internalized shame, need to belong, rejection sensitivity, and social anhedonia. High levels of social anhedonia were uniquely predictive of schizoid features; high levels of need to belong and internalized shame were uniquely predictive of avoidance. These findings support retaining the two PD categories in future versions of the DSM. Supplementary analyses revealed that among women—but not men—schizoid and avoidant traits were positively and significantly intercorrelated; it may be that women show more of a blended schizoid–avoidant profile, whereas men display the more prototypical categorical profile where either schizoid or avoidant features predominate.

1. Introduction

The existence of separate schizoid and avoidant personality disorder (PD) categories has been controversial since avoidant PD was first introduced in DSM-III (American Psychiatric Association, 1980) several decades ago (see Triebwasser, Chemerinski, Roussos, & Siever, 2012). Livesley (1986) suggested that pathological detachment would be better conceptualized as a continuum not divisible into discrete subcategories, but differentiated on the basis of the individual's desire for social relationships. In this perspective schizoid pathology would represent one end of the spectrum, a form of detachment characterized by aversion to social contact, and avoidant pathology would represent the other end of the spectrum, reflecting withdrawal motivated by fears of social rejection.

Controversy notwithstanding, Millon's (1986) distinction between schizoid and avoidant PDs has continued in the DSM-5 (American Psychiatric Association, 2013), and in other diagnostic systems as well (e.g., the International Classification of Diseases [ICD-10]; World Health Organization, 2004). The essential feature of schizoid PD in DSM-5 is "a pervasive pattern of detachment from social relationships and a restricted range of expression of emotion" (American Psychiatric Association, 2013, p. 652). In addition, the schizoid individual is described as neither desiring nor enjoying close relationships, having few friends, typically choosing to engage in solitary activities, expressing minimal interest in sexual activity, indifferent to positive and negative evaluation from others, and as showing constricted affect and lack of social reciprocity. The essential feature of avoidant PD is "a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation" (American Psychiatric Association, 2013, p. 672). In addition, the avoidant individual is described as being overly sensitive to negative evaluation, only participating in social relationships if they are assured of being accepted, and being socially withdrawn and inhibited due to fears of being embarrassed in the presence of others.

Despite the controversy over the validity and clinical utility of separate avoidant and schizoid PDs, few studies have contrasted individuals with schizoid versus avoidant features on variables theoretically relevant to their differential diagnosis. Moreover, research contrasting schizoid and avoidant individuals has yielded inconclusive results. For example, Mittal, Kalus, Bernstein, and Siever (2007) summarized data from studies reporting PD co-morbidity and found schizoid-avoidant co-morbidity rates to

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range from 10% to 88%. Meyer, Pilkonis, and Beevers (2004) found the correlation between schizoid and avoidant dimensional symptom scores to be modest in magnitude (r = .16); a slightly larger correlation (r = .23) was obtained by Morse, Robins, and Gittes-Fox (2002) in a mixed sample of psychiatric patients.

Other studies examining overlapping trait patterns in schizoid and avoidant patients have also yielded mixed results. For example, Widiger, Trull, Clarkin, Sanderson, and Costa (2002) found that both schizoid PD and avoidant PD loaded negatively on the Five Factor Model (FFM) Extraversion factor, but avoidant PD also loaded positively on the Neuroticism factor whereas schizoid PD did not. Using a structured diagnostic interview for PDs in a community sample, Ullrich et al. found that both schizoid PD and avoidant PD dimensional symptom scores were negatively correlated with a factor labeled "successful intimate relationships". Along somewhat different lines, Morse et al. (2002) found that schizoid PD and avoidant PD dimensional symptom scores were positively correlated with scores on measures of autonomy (r's were .30 and .45, respectively); only avoidant PD scores were significantly related to sociotropy (r = .47; r for schizoid PD scores was −.06).

2. The present study

Given inconsistent findings in this area, and continued interest in understanding the degree to which schizoid and avoidant PDs represent separate disorders, or may be better conceptualized as variants of a single syndrome, the present study contrasts personality test scores of nonclinical participants with schizoid versus avoidant features on an array of salient variables. Dimensions purported to distinguish schizoid and avoidant PD were identified through review of the clinical and empirical literature, and a subset of variables was selected as core defining characteristics of each syndrome. These were rejection sensitivity (Downey & Feldman, 1996), need to belong (Leary, Kelly, Cottrell, & Shreindorfer, 2013), social anhedonia (Mishlove & Chapman, 1985), attachment style (Wei, Russel, Mallinckrodt, & Vogel, 2007), internalized shame (Cook, 1991), empathy (Spreng, McKinnon, Mar, & Levine, 2009), and defense style. General patterns in the literature with respect to these core features in schizoid versus avoidant PD may be summarized as follows:

2.1. Attachment style and need to belong

Individuals with schizoid PD have been conceptualized as lacking basic affiliative needs whereas individuals with avoidant PD have been viewed as possessing strong needs for support and social acceptance (Triebwasser et al., 2012). Therefore, attachment style and need to belong should differ in schizoid and avoidant individuals.

2.2. Rejection sensitivity and internalized shame

Individuals with avoidant PD have been conceptualized as being hypersensitive to rejection, shame, and embarrassment; individuals with schizoid PD are conceptualized as being indifferent to social feedback (Triebwasser et al., 2012). Thus, rejection sensitivity and internalized shame should differ in schizoid and avoidant individuals.

2.3. Empathy

Contemporary views of schizoid PD indicate that a deficit in the capacity for mentalization is a core feature of this disorder, and lack of empathy has consistently been identified as a defining trait of schizoid PD in both the DSM-5 (American Psychiatric Association, 2013) and in trait-based models. In contrast, avoidant individuals are viewed as being highly sensitive to others' internal states and expressed emotions (see Ahktar, 1987).

2.4. Defense style

Psychodynamic accounts of schizoid PD and avoidant PD highlight defense style and the characteristic use of specific defense mechanisms as distinguishing features of these syndromes (Ahktar, 1987; McWilliams, 2006). Furthermore, psychiatric conceptualizations of schizoid PD (e.g., Triebwasser et al., 2012) place it among the schizophrenia-spectrum which implies greater psychiatric severity than avoidant PD, including greater use of the maladaptive defense style and decreased use of the adaptive defense style.

Thus, to the extent that schizoid and avoidant PDs actually represent distinct forms of personality pathology, then: (1) schizoid individuals should display significantly higher levels of social anhedonia, avoidant attachment, and maladaptive defense mechanisms than avoidant individuals; and (2) avoidant individuals should display significantly higher levels of rejection sensitivity, internalized shame, empathy, need to belong, anxious attachment, and adaptive defense mechanisms than schizoid individuals.

3. Method

3.1. Participants

Participants (N = 123) included male (N = 58) and female (N = 65) students (undergraduate and master-level) enrolled in psychology courses at Adelphi University (Mean age = 20.55, SD = 3.59, Range = 18–40). Participants were recruited from the Adelphi online experiment sign up system and received course credit for taking part. The Institutional Review Board (IRB) of Adelphi University approved the current study.

3.2. Measures

3.2.1. International Personality Disorders Examination Screening Questionnaire (IPDE-SQ)

The IPDE-SQ DSM-IV module (Loranger, 1999) is a 77-item, true–false, self-report measure of DSM-IV/DSM-5 PD symptoms used by the World Health Organization in large-scale epidemiological studies of PDs. Egan, Austin, Elliot, Patel, and Charlesworth (2003) reported significant correlations (r's ranged from .42 to .71) between PD diagnoses generated by the IPDE-SQ and PD diagnoses generated by psychiatric semi-structured diagnostic interview; reliability (alpha) coefficients ranged from .25 to .62. As with most PD questionnaires, several authors have reported that the IPDE-SQ generates high rates of false positives but low rates of false negatives relative to diagnostic interviews (Egan et al., 2003).

3.2.2. Experiences in Close Relationships Scale—Short Form (ECR-SF)

The ECR-SF (Wei et al., 2007) is a 12-item self-report scale of adult attachment. It measures two core dimensions: attachment anxiety and attachment avoidance. The subscales of the ECR-SF are comprised of six items each. Each item is scored on a 7-point scale ranging from 1 (*disagree strongly*) to 7 (*agree strongly*). The attachment anxiety and avoidance subscales showed expected associations with measures of intimacy fears and need for reassurance as well as emotional and social detachment (Wei et al., 2007). Wei et al. (2007) reported retest reliability coefficients for the ECR-