March 2012

Avoidant Personality Disorder

Charles A. Sanislow
Wesleyan University, csanislow@wesleyan.edu

Ellen E. Bartolini
Wesleyan University

Emma C. Zoloth
Wesleyan University

Recommended Citation
Sanislow, C. A., Bartolini, E., & Zoloth. (2012). Avoidant Personality Disorder. In V. S. Ramachandran (Ed.), *Encyclopedia of Human Behavior*, 2nd Ed. (pp. 257-266) Academic Press: San Diego.

Avoidant Personality Disorder

C A Sanislow, E E Bartolini, and E C Zoloth, Wesleyan University, Middletown, CT, USA

Glossary

Anhedonia A mental health symptom, commonly seen in mood disorders and schizophrenia-related disorders, involving the inability to experience pleasure from enjoyable activities.

Comorbidity The presence of two or more psychiatric diagnoses found simultaneously in the same individual. Comorbidity may reflect the presence of two distinct pathologies, but may also reflect imperfect diagnostic categories.

Distress disorders A higher order classification of the broad range of anxiety and depressive disorders.

DSM The *Diagnostic and Statistical Manual of Mental Disorders* (current version: *Diagnostic and Statistical Manual of Mental Disorders*, 4th revision, text revision, or DSM-IV-TR) is published by the American Psychiatric Association and provides a multiaxial classification system for mental disorders, with personality disorders such as APD listed under Axis II disorders.

FFM The Five Factor Model of personality describes five broad personality domains: openness, conscientiousness, extraversion, agreeableness, and neuroticism. Each domain has six facets descriptive of lower-order personality traits.

Generalized social phobia A subtype of social phobia marked by a fear of social situations across all aspects of the social world. GSP is very closely linked to APD.

ICD The *International Statistical Classification of Diseases and Related Health Problems* (current version: *International Classification of Diseases*, 10th Revision, Clinical Modification, or ICD-10-CM) is published by the World Health Organization and provides a classification system for a broad range of medical symptoms and conditions, including mental health diagnoses. It is widely used internationally but is less common within the United States.

SASB Structural Analysis of Social Behavior, a model of personality based on interpersonal theory that describes patterns of behavior, suggests origins of maladaptive interpersonal behavior, and guides psychotherapy process.

Social anxiety disorder The term introduced in the DSM-IV as an alternative name for social phobia.

Social phobia A disorder marked by an enduring fear of social situations and the embarrassment that may result from participation in social interactions.

Introduction

When does anxiety in interpersonal situations become pathological, and what makes it so? Clearly, functional impairment is an important element. For personality disorders in general, there is the assumption that there are clinically significant deficits in both the self and interpersonal relationships. For avoidant personality disorder (APD) self-definition encompasses a desire for affiliation hobbled by a sense of personal inadequacy, and intense fears of interpersonal rejection stemming from a heightened sensitivity to criticism from others is another key feature, leading to social detachment that is perhaps the most obvious clinical feature of APD. In broader terms, the feelings of the person suffering APD have been described as anxiety, and the behaviors as shyness, suggesting overlap with other forms of psychopathology. Historically, one thing that differentiates APD from other forms of psychopathology, however, is that APD is characterized by isolative interpersonal behaviors combined with a desire to be close to others that is stilted by fears of rejection.

Diagnosis

APD effects about 1–2% of the general population, and is frequently present among patients in outpatient psychiatric clinics, often ranging between 10% and 20% of the cases. Personality pathology corresponding to APD is included in the two major diagnostic manuals for psychiatric diagnosis of mental disorders: the tenth edition of the *International Statistical Classification of Diseases*, or the 'ICD-10,' which is published by the World Health Organization, and the fourth edition of *Diagnostic and Statistical Manual of Mental Disorders*, or the 'DSM-IV-TR,' which is published by the American Psychiatric Association. Both diagnostic manuals specify avoidant personality pathology as chronic and enduring. The actual diagnosis 'APD' is listed among DSM-IV-TR personality disorders, whereas the corresponding diagnosis in ICD-10 is 'Anxious (Avoidant) Personality.' The DSM-IV-TR diagnostic criteria are shown in Table 1, and criteria from the ICD-10 in Table 2. (The 'TR' in DSM-IV-TR stands for 'Text Revision.' The fourth edition of the DSM, published in 1994, was updated in 2000 by revisions to the 'text' describing some diagnoses; however, none of the diagnostic criteria were altered).

DSM Definition and Criteria

In the DSM-IV-TR, APD (code number 301.82) is characterized by a "...pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation..." (p. 718). The diagnostic title 'Avoidant Personality Disorder' was first introduced into official diagnostic nomenclature with the DSM-III, which was published in 1980. Within the DSM (DSM-III through DSM-IV-TR) Axis II, APD resides in 'Cluster C' of the Personality Disorders, along with Dependent and

Table 1 DSM-IV-TR diagnostic criteria for avoidant personality disorder

A pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, beginning by early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:
(1) avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection
(2) is unwilling to get involved with people unless certain of being liked
(3) shows restraint within intimate relationships because of the fear of being shamed or ridiculed
(4) is preoccupied with being criticized or rejected in social situations
(5) is inhibited in new interpersonal situations because of feelings of inadequacy
(6) views self as socially inept, personally unappealing, or inferior to others
(7) is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing

Source: American Psychiatric Association (2000) *Diagnostic and Statistical Manual for Mental Disorders*, 4th edn., text revision, p. 721. Washington, DC: American Psychiatric Association.

Table 2 ICD-10 diagnostic criteria for anxious (avoidant) personality disorder

Anxious (avoidant) personality disorder is characterized by at least four of the following:
(1) Persistent and pervasive feelings of tension and apprehension
(2) Belief that oneself is socially inept, personally unappealing, or inferior to others
(3) Excessive preoccupation about being criticized or rejected in social situations
(4) Unwillingness to get involved with people unless certain of being liked
(5) Restrictions in lifestyle because of need of security
(6) Avoidance of social or occupational activities that involve significant interpersonal contact, because of fear of criticism, disapproval, or rejection

Source: World Health Organization (1992) *The International Statistical Classification of Disease* (ICD), 10th edn., pp. 155–156. Geneva: World Health Organization.

Obsessive–Compulsive Personality Disorders. Personality disorders in this cluster share features of internalizing distress including anxiousness and fearfulness. As is the case with all personality disorders in the DSM-IV-TR, there is for APD the general requirement of "...an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture and is manifest in at least two of the following areas: cognition, affectivity, interpersonal functioning, or impulse control..." (p. 686).

Of the seven criteria for the DSM-IV-TR APD shown in Table 1, at least four are required for a patient to meet the diagnostic threshold. The first criterion, 'avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection,' may apply to work or school. Often a person suffering from APD will limit their educational opportunities, and they are likely to choose an occupation where interpersonal contact is minimal. They will also avoid working in teams, preferring to do things themselves. This is to be distinguished from the perfectionism aspect in obsessive–compulsive personality disorder, in which people prefer to work alone because their standards are so high they believe that others would bring the work down.

The second criterion, 'is unwilling to get involved with people unless certain of being liked,' is based on a preoccupation with feelings of inadequacy. This preoccupation essentially creates a cognitive disturbance that interferes with interpersonal interactions in novel social situations. An avoidant person will deal with this by being reticent and reluctant to 'make the first move.' This is unlike the case of dependent personality disorder(DPD) where a person is reticent based on fears that differentiating their opinions from another will destroy or otherwise damage the relationship. For avoidants, the fear is the confirmation of their own perceptions of inadequacy.

The third criterion, 'shows restraint within intimate relationships because of the fear of being shamed or ridiculed,' is also driven by the fear of being criticized. Being avoidant means always being petrified about what is to them, 'deep, dark, secrets' that, if revealed, would almost certainly invite ridicule. Even a slight teasing might be perceived as humiliating. For these reasons, APD is often associated with a great deal of secretive behavior that is, for the most part, irrational, except for the fact that it brings a needed security even in the 'closest' relationships. In contrast, such restraint observed at the clinical surface with DSM-IV-TR 'Cluster A' (odd, eccentric) personality disorders such as schizoid, schizotypal, or paranoid, is better attributed to an indifference to intimacy (schizoid) or paranoid fears underlying secretive behavior (schizotypal and paranoid).

The fourth criterion, 'is preoccupied with being criticized or rejected in social situations,' at the first blush may appear similar to the DSM-IV-TR Axis I clinical syndrome of social phobia. Clearly, anxiety in a social situation is the hallmark of this criterion. For avoidants, any aspect of their being is fair game, from their hairstyle and clothing to their ideas and intellect. In contrast to social phobia, anxiety associated with avoidant personality disorder is not situation specific, but wide-ranging across all areas of the social world. It is not, for example, limited to situations where they might be called on to speak in front of others. A variant of social phobia, generalized social phobia, interestingly appears to diagnostically cooccur with greater frequency than the simple type, and will be considered in greater detail in a later portion of this article.

The fifth criterion, 'is inhibited in new interpersonal situations because of feelings of inadequacy,' represents more than mere cautiousness. Often it involves social comparisons that may have no basis in reality, for instance, the feeling that others whom the avoidant person is with are smarter, more successful, have better relationships, better family life, a better job, etc. Again, rooted in this criterion is the idea of being 'less of a person' across multiple domains. Here again, with APD, the person will unfortunately hold back information about himself or herself, information that might actually lead to the experience of being liked or respected by others if it weren't for this inhibition or competing cognitive process of evaluation of self and others.

The sixth criterion, 'views self as socially inept, personally unappealing, or inferior to others,' is a pervasive inferiority complex that includes the beliefs that one is not at all likeable and possesses no social skills. The insecurity that accompanies these feelings of awkwardness is paired with the belief that others will always judge or otherwise evaluate them negatively. Here, it is important to distinguish this criterion from cognitive features of depressive disorders. For depressive disorders, whether they are shorter in duration but intense, such as the case of major depression, or longer in duration but less intense, such as dysthymic disorder, the key distinction is that in APD, these feelings of ineptness and being unlikeable are independent of depressive mood states. In other words, the depressed mood may come and go or otherwise vacillate, but with APD, the inferiority remains constant.

The seventh criterion, 'is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing,' translates to 'never be the first to express deeper feelings.' Thus, the risk is not about 'risk-taking behavior' as might be found in people with antisocial tendencies or thrill seekers. For APD, the risk is much more pedestrian and mundane. The person will be loath to reveal feelings that may expose him or her, whether positive or negative. Even if someone has a positive feeling, the typical approach would be to wait for the other to share the feeling or observation and then to agree with that observation rather than risk the certain humiliation that would come with a 'stupid' disclosure that was 'off the mark.'

ICD Definition and Criteria

The ICD-10 diagnosis, anxious (avoidant) personality disorder (code number F60.6) is very similar to that of DSM-IV-TR, despite the slight variation in the title. As with the DSM-IV-TR, anxious PD features must meet the accepted general criteria for personality disorder including characteristic and enduring disturbances in a person's inner experience and behavior that is outside the accepted norm. Disturbances in specific processes that impede functioning may include cognition, affect, impulse control, and interpersonal relatedness. In the ICD-10, the behaviors must also be seen as maladaptive and inflexible, evidence personal distress or otherwise have an adverse impact, and be of long duration and not attributable to other mental or organic disorders.

Comparing the APD criteria from the ICD-10 to the DSM-IV-TR reveals many similarities and a few differences. On the whole, the criteria appear to be tapping an isomorphic construct. Both require four criteria for a diagnosis, though the ICD-10 has total of six possible criteria compared to seven in the DSM-IV-TR. Comparing Tables 1 and 2, reveals an almost direct correspondence of ICD-10 to DSM-IV-TR criteria (ICD-10 #2 to DSM-IV-TR #5, ICD-10 #3 to DSM-IV-TR #4, ICD-10 #4 to DSM-IV-TR #2, and ICD-10 #6 to DSM-IV-TR #1). Of the two remaining ICD-10 criteria (#s 1 and 6), criterion #6, 'Restrictions in lifestyle because of need of security,' roughly approximates DSM-IV-TR criterion #7, 'is unusually reluctant to take personal risks or engage in new activities because they may prove embarrassing,' and may also partially capture DSM-IV-TR criterion #6, 'is inhibited in new interpersonal situations because of feelings of inadequacy.' A subtle difference is that the ICD-10 focuses on 'security' which is in contrast to the DSM-IV-TR focus on 'embarrassment' or 'feelings of inadequacy.' Finally, the first ICD-10 criterion #1, 'Persistent and pervasive feelings of tension and apprehension,' appears to tap a more general construct of anxiety. In contrast, DSM-IV-TR attempts to focus more specifically on anxiety related to a negative concept of self.

In the version of the ICD-10 updated in the year 2007, there is a general description of anxious [avoidant] personality disorder that reads as follows:

> Personality disorder characterized by feelings of tension and apprehension, insecurity, and inferiority. There is a continuous yearning to be liked and accepted, a hypersensitivity to rejection and criticism with restricted personal attachments, and a tendency to avoid certain activities by habitual exaggeration of the potential dangers or risks in everyday situations. (Chapter V of Version 2007 published on the Web)

In Version 2007 of the Web-based ICD-10, there are no specific criteria lists for any of the personality disorders, hinting at a shift to more prototypic representations or descriptions of personality pathology. This is consistent with future plans for the APD diagnosis in the next edition of the DSM.

ICD-11, DSM-5, and the Future of APD

Both the ICD-11 and the DSM-5 are under revision at the time this article is going to press, and so there are many uncertainties about the future diagnostic conceptualizations of APD. Though still subject to further revisions, a general model of personality disorders for the DSM-5 has been developed and informs the likely diagnostic future of APD in this manual. While the DSM-IV had conceptualized personality disorders in terms of essential features, the committee developing DSM-5 is considering a prototypic model in which specific domains or facets may be characteristics of multiple disorders.

The DSM-IV opens the discussion of APD in terms of its key feature, namely, a "pervasive pattern of special inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation." This idea of a disorder having one 'essential feature' is different from the DSM-5, which opens with the phrase "Individuals who match this personality disorder type" and also later uses the phrase "individuals resembling this type," both of which illustrate prototypic description rather than one derived from a polythetic collection of an essential number of criteria.

One proposal is to change the diagnostic system from a categorical system to a hybrid prototype-dimensional system based on a prototype rating and ratings on six-domain trait dimensions. The first component is an assessment of where an individual fits in the five severity levels of personality functioning using the Self and Interpersonal Functioning Continuum. This assessment of level of personality functioning was not a part of the DSM-IV, as historically the diagnosis of a functional impairment was seen as sufficient evidence of a personality disorder without a quantitative rating of disturbance. The second component is the prototype rating system. Each personality disorder has a prototypic description that emphasizes typical deficits and features of the disorder. Patients are

compared to the prototype in terms of how well they match the description, and a rating from 1 (no match) to 5 (very good match) is made. The description of the APD prototype is shown in Table 3.

The second component of the proposed personality disorder diagnosis for DSM-5 has roots in trait theories of personality, including the Five Factor Model developed by Thomas Widiger, Paul Costa, and many others. The resulting DSM-5 model is a 'hybrid' system that combines specific personality disorder 'types' along with ratings for traits and functioning. Traits relevant to APD in the DSM-5 rating system include the tendency to feel responsible for bad things that happen, anhedonia, having difficulty allowing oneself to acknowledge or express wishes and emotions, and a desire to be recognized as unique. As shown in Table 3, the traits are rated 0 (very little or not at all descriptive) to 3 (extremely descriptive). The American Psychiatric Association maintains a web site illustrating the diagnoses and keeping the field abreast of updates to the proposed revisions.

The future of APD, or anxious personality disorder, in the ICD-11 is less certain at this point in time. Mental disorders in general are among a handful of disorders that are a focal point for substantial revision. In contrast to the DSM, which focuses solely on mental disorders, the ICD covers all disease-related classification and the 'Mental and Behavioral Disorders' is but one component of the manual. Empirical studies on the structure of mental disorders are being presented to the work group for ICD Mental and Behavioral Disorders led by Dr. Steven Hyman, and there exists the possibility for substantial revision, including folding the symptoms of personality disorders into clinical syndromes. These considerations stem from questions raised by overlapping features of psychopathology and personality disorders in the current form of diagnoses, which call for new ways to examine and parse clinical symptoms to better address the problem of diagnostic comorbidity, a problem for many disorders including APD to which we now turn.

Comorbidity

Like APD, fear or avoidance of social situations and fear of possible scrutiny characterize social phobia, an Axis I disorder, in the DSM-IV-TR. However, the social situations tend to be more circumscribed for social phobia than for APD. Still, there is considerable diagnostic overlap between APD and social phobia, especially the generalized subtype of social phobia where a number of social settings are associated with an anxious state. In light of this overlap, and as the DSM moves more toward a dimensional approach, a key question reemerges: Does APD exist as part of a continuum, representing the more chronic, wide-ranging, and severe point on a spectrum of anxiety disturbance? In general, empirical results have supported the idea of a continuum model where APD is a more severe and pervasive form of 'social phobia' that is so long-standing that it has become integral to personality and interpersonal functioning. Perhaps it is an anchor point toward the more extreme end, with social phobia falling somewhere in the middle, and anxious behavior colloquially described as 'shyness' falling in the more mild, clinically insignificant end of the continuum. In considering the continuum model, it is important to determine if it is merely quantitative differences that distinguish the two disorders.

Are APD and Social Phobia Separate Disorders?

The question of whether or not social phobia and APD are separate and distinct forms of psychopathology is a question that has plagued the field since the diagnosis was introduced in the 1980 DSM-III. Many studies have found overlap between APD and social phobia; this overlap may reflect shared or similar facets of the pathology, or it could be due to similarities in the descriptive criteria for the diagnoses. In the revisions from the DSM-III to DSM-IV-TR, there have been several adjustments to the criteria to reduce the diagnostic overlap and increase specificity. As previously described, the proposed revisions for the DSM-5 include reformulating APD as avoidant type; characterized by a 'negative sense of self, associated with a profound sense of inadequacy, and inhibition in establishing intimate interpersonal relationships,' specifying that, for APD, the social anxiety stems from the personal feeling of inadequacy.

Despite modifications and changes in wording and emphasis of criteria in DSM-III through DSM-IV, a trend for the cooccurrence of these two disorders has persisted. An apparent lack of qualitative differences leads researchers to hypothesize that the difference between the two is quantitative. Given similarities in criteria sets, this finding is somewhat intuitive and unsurprising as similar relations are also found between other Axis I and personality disorders. For APD, various research groups including the collaborative longitudinal personality study (CLPS) have reported significant associations with Axis I disorders, including social phobia, that have anxiety/inhibition as criteria. Several personality disorders also show this same association with related Axis I disorders with which they share criteria. A potential limitation in many of these studies is that data is derived from clinical samples that are comorbid for multiple Axis I and II disorders. However, other researchers, such as Chambless and colleagues have assessed impairment and distress among participants with the generalized type of social phobia, with and without APD, using self-report and observation and found no significant differences between the groups when they controlled for social phobia, thus supporting the continuum hypothesis.

To argue against the continuum model, it has been noted that higher levels of social avoidance, depressive symptoms, neuroticism, introversion, and social and occupational impairment were found for participants with generalized social phobia in combination with APD than for those participants with generalized social phobia alone. Thus it may be that APD differs from social phobia because it manifests itself in more severe cases of depression, introversion, and social and occupational impairment. Rettew has argued for a qualitative distinction between APD and social anxiety disorders, suggesting that widening the assessment scope to include nonsocial domains (introversion, passivity, fear of novelty, for example) would increase the likelihood of clarifying the distinction between APD and social phobia. Regardless of the outcome of this debate, two things seem clear. First, those with APD are

Table 3 Prototype description for avoidant personality disorder DSM-5 presently under consideration by the DSM task force

Prototype description

Individuals who match this personality disorder type have a negative sense of self, associated with a profound sense of inadequacy, and inhibition in establishing intimate interpersonal relationships. More specifically, they feel anxious, inadequate, inferior, socially inept, and personally unappealing; are easily ashamed or embarrassed; and are self-critical, often setting unrealistically high standards for themselves. At the same time, they may have a desire to be recognized by others as special and unique. Avoidant individuals are shy or reserved in social situations, avoid social and occupational situations because of fear of embarrassment or humiliation, and seek out situations that do not include other people. They are preoccupied with and very sensitive to being criticized or rejected by others and are reluctant to disclose personal information for fear of disapproval or rejection. They appear to lack basic interpersonal skills, resulting in few close friendships. Intimate relationships are avoided because of a general fear of attachments and intimacy, including sexual intimacy.

Individuals resembling this type tend to blame themselves or feel responsible for bad things that happen, and to find little or no pleasure, satisfaction, or enjoyment in life's activities. They also tend to be emotionally inhibited or constricted and have difficulty allowing themselves to acknowledge or express their wishes, emotions – both positive and negative – and impulses. Despite high standards, affected individuals may be passive and unassertive about pursuing personal goals or achieving successes, sometimes leading to aspirations or achievements below their potential. They are often risk-averse in new situations.

Traits

Domain	Facet	Description
Negative emotionality	Anxiousness	Having frequent, persistent, and intense feelings of nervousness/tenseness/ being on edge; worry and nervousness about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful and threatened by uncertainty
	Separation anxiety	Having fears of rejection by, and/or separation from, significant others; feeling distress when significant others are not present or readily available; active avoidance of separation from significant others, even at a cost to other areas of life
	Pessimism	Having a negative outlook on life; focusing on and accentuating the worst aspects of current and past experiences or circumstances; expecting the worst outcome
	Low self-esteem	Having a poor opinion of one's self and abilities; believing that one is worthless or useless; disliking or being dissatisfied with one's self; believing that one cannot do things or do them well
	Guilt/Shame	Having frequent and persistent feelings of guilt/ shame/ blameworthiness, even over minor matters; believing one deserves punishment for wrongdoing
Introversion	Intimacy avoidance	Disinterest in and avoidance of close relationships, interpersonal attachments, and intimate sexual relationships
	Social withdrawal	Preference for being alone to being with others; reticence in social situations; avoidance of social contacts and activity; lack of initiation of social contact
	Restricted affectivity	Lack of emotional experience and display; emotional reactions, when evident, are shallow and transitory; unemotional, even in normally emotionally arousing situations
	Anhedonia	Lack of enjoyment from, engagement in, or energy for life's experiences; deficit in the capacity to feel pleasure or take interest in things
	Social detachment	Indifference to or disinterest in local and worldly affairs; disinterest in social contacts and activity; interpersonal distance; having only impersonal relations and being taciturn with others (e.g., solely goal- or task-oriented interactions)
Compulsivity	Risk aversion	Complete lack of risk-taking; unwillingness even to consider taking even minimal risks; avoidance of activities that have even a small potential to cause injury or harm to oneself; strict adherence to behaviors to minimize health and other risks

Source: Accessed from http://www.dsm5.org/ on 30 December 2010.

Ratings are made on the prototype (1 = no match to 5 = very good match) and on the traits (0 = very little or not at all descriptive to 3 = extremely descriptive).

more severely impaired; whether or not the distinction is qualitative or quantitative is secondary. Second, it may be helpful to understand APD as a dysfunctional developmental adaptation to chronic social anxiety that, along with low self-worth, becomes folded into an individual's personhood.

In sum, the evolution of the criteria for APD from DSM-III to DSM-IV-TR, and beyond to those under consideration for DSM-5, places greater emphasis on the characteristics or traits of fear of novelty, passivity, and introversion, along with a poor sense of self and the expectation to draw the criticism from others. The proposed changes for APD emphasize introversion and avoidance of activities, including social situations, while criteria for social phobia emphasize the anxiety limited to what is felt in the midst of social situations.

There are several aspects among the APD criteria that highlight nonsocial factors, such as low self-esteem and guilt/shame. There is also an emphasis on behavior in intimate relationships in the criteria for APD that is not present in the social phobia. Additionally, criteria for social phobia highlight the reaction to social situations; fear and anxiety out of proportion to the danger presented by the situation, which is not discussed in APD definitions. These distinctions may eventually clarify qualitative differences, or may suggest personality traits that make individuals more vulnerable to anxiety. It is worth noting that differences in the criteria sets for APD and social phobia are not wholly mutually exclusive, and the rates of cooccurrence still merit investigation and raise questions about the Axis I and Axis II division in the DSM. This suggests

the possibility that there are core pathological elements that may be the same if diagnosis were based on a different level than the clinical reports and observation, for instance, neural, cognitive, or more basic temperamental features.

APD and Other Personality Disorders

Prior to the introduction of APD in the 1980 DSM-III, 'avoidant' personality was captured by the diagnosis of schizoid personality and the psychoanalytic construct of 'phobic character.' In 1969, Millon first argued for a distinct diagnostic construct for 'avoidant personality disorder' but it was not until the DSM-III that APD was officially cleaved from the old DSM I/II diagnosis of schizoid personality. Thus, among the personality disorders, APD and schizoid personality disorder share a close relationship based on their diagnostic lineage, though there have been efforts to distinguish the two. Both personality types tend to engage primarily in solitary as opposed to social activities, and appear aloof or inhibited in social situations. Although similar on this clinical symptom, the distinction between avoidant and schizoid personality disorders resides in motivation or desire for intimacy for APD, something that is said to be lacking in schizoid. In addition, there is a capacity, albeit an often unfulfilled capacity, for social attachment in APD that does not seem to be present for schizoid personality disorder. Unlike individuals with avoidant personality disorder, who intensely desire relationships and avoid them because of exaggerated fears of rejection, persons with schizoid personality disorder have little or no apparent interest in developing interpersonal relationships. In 1982, Millon clarified this distinction in motivation for attachment, and his distinction has been included in the criteria and the text description of APD in the DSM ever since. For schizoid, the motivation was passive, whereas for avoidant, it was active. Millon's distinction between active and passive detachment was central to the official introduction of avoidant personality disorder in DSM-III.

Like schizoid, those with schizotypal or paranoid personality disorder may also react negatively to the idea of interpersonal relationships. However, in both of these cases, the wariness in interpersonal relatedness is more apt to stem from paranoia rather than the hypervigilance for criticism common to APD or the indifference of schizoid. Schizoid, schizotypal, and paranoid personality disorders all reside in the DSM Cluster A 'odd-eccentric.' Though paranoid features connote a certain sense of fear, that type of reaction is based more on disordered thinking rather than anxious fear based on the anticipation of criticism, as is the case with APD.

Another personality disorder that may share some similarity on the clinical surface with APD is dependent personality disorder. Like APD, dependent personality disorder rests in the anxious or fearful 'Cluster C' of DSM Axis II personality disorders. Characteristic of both disorders are low self-esteem, rejection sensitivity, and an excessive need for reassurance. Both may be defined in terms of attachment anxiety. However, a key distinction of APD is that the anxiety is driven by a fear of rejection, whereas in the case of dependent personality the anxiety stems from fear of separation and/or rejection once a relationship has been established. Thus, with dependent personality disorder, distress is clear in the midst of a close relationship or after a close relationship ends. Often, those with dependent personality disorder scurry to find a new relationship after one has ended. People suffering from APD, on the other hand, are slow to enter into new relationships.

Stability and Course

A primary distinction between Axis I and Axis II personality disorders in the DSM system is the chronic and enduring course of personality disorders relative to clinical syndromes on Axis I. This long-held assumption is part of the definition of personality disorders as chronic and enduring, which has been challenged with recent empirical studies that have examined the prospective course of personality disorders, such as the CLPS and the McLean Study for Adult Development. The general finding from both of these longitudinal, naturalistic studies is that personality disorders remit diagnostically much more often than was originally assumed. This pattern has been demonstrated specifically with APD in report from the CLPS led by Grilo (at the symptomatic level) and by Sanislow (at the construct level). However, other CLPS reports led by Skodol have shown that functional impairment, including social and occupational deficits, persist for APD and other personality disorders even though the symptom counts may drop below diagnostic threshold (true for other personality disorders, too). Thus, clinically significant impairments that impede the social relationships and occupational potential of those with APD remain evident over the long run.

DSM-IV-TR personality disorder criteria are a mixture of traits, symptoms, and behaviors, and it is reasonable to query if certain APD symptoms tend to persist more than others. In another CLPS report led by McGlashan, it was evident that certain APD criteria were more enduring than others. In assessments conducted 2 years later by clinical interviewers blind to the baseline diagnoses, the criteria 'feels inadequate' and 'socially inept' were the most persistent. 'Preoccupation with rejection,' 'need to be liked first,' and 'void risks for fear of embarrassment' continued to a moderate degree, while 'fears ridicule and shame' and 'avoids jobs with interpersonal contact' were the most likely to remit. Thus, the top two most persistent criteria include both a deficit in self and an interpersonal deficit. At the other end, the least persistent are tied to behavior in a specific situation (jobs with interpersonal contact) and fear-based anxiety (fear ridicule and shame). The more persistent are more global, representing general personality constructs, whereas the least persistent are based on behaviors (interpersonal jobs) and symptom based (fear). Like APD's Axis I counterpart, social phobia, these latter two criteria may be easier to overcome than one's sense of self or more global deficits in social skills.

Interpersonal Experiences, Development, and Risk for APD

Like other personality disorders, interpersonal problems are a critical feature of avoidant personality disorder. In fact, almost all DSM criteria for APD describe aspects of the interpersonal

problems generated and encountered by an individual with APD. The most articulate description of the interpersonal features of the APD symptoms are derived from Lorna Smith Benjamin's *structural analysis of social behavior* (SASB). The SASB codes patterns of interpersonal behavior of both the self and the other, and also codes for the patterns of interpersonal behavior that one has repeatedly experienced as they relate to how a person perceives or thinks about him or herself. Benjamin has applied this model to the DSM personality disorders, including APD, and has linked characteristic interpersonal patterns to APD criteria. From there, it is possible to trace back characteristic interpersonal experiences of the person suffering APD and to infer how they 'talk to' or otherwise treat themselves.

Interpersonal Origins of APD

According to Benjamin's interpersonal theory, the people with APD live in a state expecting degrading, humiliating attack. Their self-protective response to this possibility, which for them looms with certainty, is social withdrawal. This promotes a perception of others that borders on paranoid and a reliance on safety at home that can sap the resources of the few individuals with whom the person with APD does have a relationship. Benjamin describes these patterns in her book, *The Interpersonal Diagnosis of DSM-IV Personality Disorders*. The origins of this pattern of behavior require that the person had enough love and nurturance to form a good sense of self, and the difficult interpersonal transactions came during later stages of psychological development. For instance, "exhortations combined with degrading mockery" (p. 292) put a premium on the need to occlude any personal failings, thus leading to intense self-scrutiny along with vulnerability to criticism. For Benjamin, the *sine qua non* for APD is a "...defensive withdrawal out of fear of humiliation, attack, and rejection, and the wish for acceptance" (p. 298). Clearly, for professionals treating the persons with APD, it is important provide uncritical support while not pushing them too far, too fast.

Treatment

Individual therapy has historically been used as a treatment for APD. This type of therapy can be difficult for an avoidant, because the maladaptive behaviors and thought processes characteristic of APD interpersonal relationships also extend to the relationship with the therapist. Those with APD often fear being rejected by the therapist, tend to doubt the authenticity of the therapist's concern, and are likely to reject help. Therapists should take extreme care to avoid behavior that may be interpreted as judgmental, as the person with APD is generally sensitive to even mild criticism, and should be prepared for the patient to perceive the therapist as critical even if there is no real basis for this perception. Benjamin stresses that therapists should aim to provide 'accurate empathy' and 'warm support' in order to build trust. Once trust has been successfully established, the therapeutic relationship may serve as a testing ground for new coping skills. In the context of a 'safe' relationship, dysfunctional beliefs about the therapy relationship can be frankly examined, serving as a model for the patients to evaluate other relationships in their life.

Cognitive behavioral therapy (CBT) techniques, which encourage patients to identify the fears of rejection and criticism that underlie APD and then modify these distorted thought processes, have proven particularly helpful in the treatment of APD. Cognitive restructuring, for example, involves examining the patient's thoughts about the feared situations and challenging them. This technique is predicated on the theory that social anxiety arises from misconceptions about dangers that social situations pose and other false and overly negative cognitions. The process of cognitive restructuring includes identifying these negative beliefs, evaluating their accuracy, and recognizing possible alternatives to help address the overwhelming anxiety characteristic of patients with APD.

Behavioral therapy strategies to treat APD generally fall under two categories: graduated exposure and skills training. Exposure therapy rests on the idea that graduated exposure to the fear-provoking situation (in this case, social interaction) will help the individual overcome their fear and bring about behavioral change. For those suffering APD, exposure therapy typically involves learning relaxation techniques and then applying them to gradually higher-risk social situations both in and outside of therapy. This treatment is most effective when the patient is fully engaged in the threatening situation and is open to becoming fully immersed in the experience despite the negative emotions destined to arise. For the person with APD, this is difficult because it runs counter to instinctive avoidance of engaging in frightening social situations. The response by someone suffering from APD is not always obvious avoidance, and a patient may surreptitiously or unwittingly utilize maladaptive cognitive processing strategies to reduce their anxiety such as not fully attending to the stimuli meant to induce negative emotion. Thus, in the case where social anxiety has become bound with self-definition and esteem, exposure therapy may prove ineffective.

Social skills training is intended to directly address any interpersonal deficits the avoidant may exhibit. This strategy is predicated on the assumption that people with APD exhibit poor social skills, and that teaching them positive social skills will increase positive reactions from others and thus reduce anxiety. Much of this work has focused more specifically on shyness and related social deficits, and clinical researchers who have targeted the symptomatic aspects have demonstrated good results that are applicable to treatments aimed at APD. For instance, basic skills training in social behaviors such as assertiveness, eye contact, self-disclosure, nonverbal social cues, and listening skills are likely to invite positive, warm, and uncritical responses from others and thus help the person suffering from APD build confidence.

Both social skills training and graduated exposure therapy can be performed in a group or individualized setting, though there are obvious advantages for those patients who can tolerate group treatment as the results may more effectively generalize to other areas of the patients' lives. As with any therapeutic treatment, a personalized approach matched to the patient's needs is desirable, though much more research is needed on how to effectively identify needs and match those needs with different interventions.

Treatment Outcome Studies

Alden and colleagues conducted a rare study that specifically focused on group treatment for APD. They performed a

randomized controlled clinical trial investigating the efficacy of graduated exposure therapy alone versus graduated exposure with interpersonal skills training, and found that the APD patients who received both types of treatment had improved in reports of social reticence, social anxiety, and a wide variety of other measures, and that the gains had been maintained 3 months after treatment had ended. However, the treatment groups did not significantly differ from one another in terms of the amount of improvement, suggesting that the addition of social skills training did not increase the benefits of graduated exposure alone. Alden and colleagues later reexamined the data from their study and concluded that variations in the symptom patterns of APD may differentiate treatment response. The reanalysis showed that patients who exhibited more distrust and anger benefitted most from graduated exposure, while patients with problems asserting themselves were shown to benefit from both treatments, especially an intimacy-focused social skills training. Unfortunately, despite the gains made by the APD patients during treatment, the patients still functioned significantly below normal levels of social behavior at the conclusion of the 10 week treatment. The authors suggest that a longer period of treatment may be necessary to further increase progress. Research is also needed to compare the efficacy of group and individual therapy for APD, as Alden studied all treatments in a group setting.

Insights from Treatment of Social Anxiety

Scientific research on the clinical outcomes for treatment of the APD diagnosis per se is very limited. Other, related forms of anxiety, such as social phobia, have been more frequently studied and this more general work offers insights about techniques that may be effective for APD. Like APD, treatment for social anxiety often consists of CBT techniques such as cognitive restructuring, graduated exposure, relaxation techniques, and social skills training. Heimberg reviewed the efficacy of treatment for social anxiety looking at the efficacy of types of CBT as treatment for social anxiety. He reported that all types of CBT produce better effect sizes than no treatment control groups, and exposure alone and exposure plus cognitive restructuring produce similar, significant effect sizes, while social skills training, cognitive restructuring, and relaxation training all produce slightly less change than exposure-based interventions. No differences were found between individual and group treatments, and these gains were maintained at follow-up assessments. Another group of researchers, Alden and colleagues, looked at exposure alone versus exposure plus social skills training versus a waitlist control group for adults who reported impairment in various areas of social functioning, including experiencing extreme shyness. The group given the combination of exposure plus social skills training reported significantly improved functioning compared to other groups.

Pharmacotherapy

A number of studies have looked at the effectiveness of pharmacotherapy for social anxiety disorders, although results are inconclusive as to whether the benefits of medication are clinically significant over CBT and other psychotherapy approaches. Antidepressants, particularly the SSRI's are the most studied and appear to be the most effective medication treatment, although antianxiety medications may provide short-term relief. Beta blockers are also often helpful. In comparative studies, most work demonstrates that medication groups and CBT groups improve about the same, and curiously, placebo groups also show significant improvement, though usually to a lesser degree. A combination of medication plus CBT is common in practice, but the efficacy of adding medication to CBT, relative to CBT alone, is not well studied enough to draw firm conclusions. Most important, studies examining longer-term outcomes of medication versus psychotherapy are needed.

Limits to Understanding APD Treatment from Other Disorders

Treatment for social anxiety appears to address some, but not all types of impairment in APD. It addresses the social impairment, and can thus be somewhat helpful in treating APD. In his review, Heimberg showed that one of the factors predicting outcomes of treatment is the severity of symptoms at pretreatment. Patients with both social anxiety disorder and APD tend to begin treatment more impaired than those with social anxiety alone, and while they showed improvement, they were still more impaired than patients with just social anxiety at posttreatment. Patients with the generalized type of social anxiety (the diagnosis of social anxiety most similar to APD) also tended to be more impaired, and CBT was less effective for this type than for those with the nongeneralized types of social anxiety. This result is not too surprising as treatment for social anxiety typically does not address nonsocial characteristics that typify APD, such as guilt/shame, avoidance of (nonsocial) activities, fear of novelty, and passivity.

Conclusion

Most diagnosticians and taxonomists of psychopathology and personality are well aware that these diagnoses are constructs that help us to organize patterns in myriad traits, symptoms, and behaviors and to recognize those features that coalesce and thus suggest some coherence. As such, diagnostic constructs such as APD provide a useful explanatory tool to help understand and communicate among professionals, and to develop, implement, and guide treatments. The APD diagnosis provides valuable clinical utility, but diagnostic systems are not perfect, in part because the diagnostic constructs themselves are not 'real' or natural kinds. Rather, diagnostic constructs are approximations of a hypothetical construct; one that itself is not directly observable or otherwise tangible. In the absence of an etiological understanding and the identification of a specific pathology (rather than a syndrome), problems such as diagnostic overlap are part of the course. Thus, it is important to bear in mind that the comorbidity with APD and Axis I disorders such as social phobia may be a matter of intensity, or that criteria overlap and comorbidity with other Axis II disorders such as schizoid personality disorder may reflect shared pathological mechanisms or more simply may be an artifact of our diagnostic architecture.

APD is a useful diagnostic construct that tells us about a person chronically suffering extreme levels of anxiety that stems

from a negative view of the self, as evident in social avoidance. While APD has manifest interpersonal 'symptoms,' it is equally a problem of one's own inner experience. Core to the disorder is the fear of being perceived as a failure, and this fear is so intense that it drives the person suffering from APD to isolation. The relief experienced from this self-imposed isolation can further reinforce the problem, and thus perpetuate a long-standing personality pattern from which it is difficult to break free.

The anticipated DSM-5 and ICD-11, along with a host of issues that the field is presently tackling, present challenges beyond human prescience when describing a diagnosis that may change or disappear altogether as knowledge advances. For instance, although the prototype description helps make clear the definition of APD, a trait approach to diagnosis may be favored in the DSM-5. Nonetheless, there are exciting possibilities of changes ahead, including whether dimensional approaches offer advantages over categorical approaches, or if an optimal number of factors or criteria better captures a form of personality-related pathology than does the DSM nomenclature that has persisted for the last three decades. Last, questions about the boundary between Axis I and II disorders have also been raised, for APD with social phobia. Future developments in personality pathology and psychiatric diagnosis are sure to be exciting, and whatever viewpoint one holds of the DSM system, it has in the last three decades yielded a wealth of empirical information to scaffold for future diagnostic efforts.

See also: Anxiety Disorders; Self-Esteem; Separation Anxiety; Social Anxiety Disorder.

Further Reading

Alden L (1989) Short-term structured treatment for avoidant personality disorder. *Journal of Consulting and Clinical Psychology* 57: 756–764.

Alden LE and Capreol MH (1993) Avoidant personality disorder: Interpersonal problems as predictors of treatment response. *Behavior Therapy* 24: 357–376.

Alnaes R and Torgersen S (1988) The relationship between DSM-III symptom disorders (Axis I) and personality disorders (Axis II) in an outpatient population. *Acta Psychiatrica Scandinavica* 78: 485–492.

American Psychiatric Association (1980) *Diagnostic and Statistical Manual for Mental Disorders*, 3rd edn. Washington, DC: American Psychiatric Association.

American Psychiatric Association (2000) *Diagnostic and Statistical Manual for Mental Disorders*, 4th edn., text revision. Washington, DC: American Psychiatric Association.

American Psychiatric Association (2010) DSM-5 Development. (2010) *DSM-5:* The Future of Psychiatric Diagnosis. Retrieved from http://www.dsm5.org/Pages/Default.aspx.

Benjamin LS (1974) Structural analysis of social behavior. *Psychological Review* 81: 392–425.

Benjamin LS (1996) *Interpersonal Diagnosis and Treatment of Personality Disorders*, 2nd edn. New York: Guilford.

Brooks RB, Baltazar PL, and Munjack DJ (1989) Co-occurence of personality disorders with panic disorder, social phobia, and generalized anxiety disorder: A review of the literature. *Journal of Anxiety Disorders* 3: 259–285.

Cappe RF and Alden LE (1986) A comparison of treatment strategies for clients functionally impaired by extreme shyness and social avoidance. *Journal of Consulting and Clinical Psychology* 54: 796–801.

Chambless DL, Fydrich T, and Rodebaugh TL (2008) Generalized social phobia and avoidant personality disorder: Meaningful distinction or useless duplication? *Depression and Anxiety* 25: 8–19.

Costa PT and Widiger TA (1994) *Personality Disorders and the Five-Factor Model of Personality*. Washington, DC: American Psychological Association.

Cuthbert BN (2005) Dimensional models of psychopathology: Research agenda and clinical utility. *Journal of Abnormal Psychology* 14: 565–569.

Grilo CM, Shea MT, Sanislow CA, et al. (2004) Two-year stability and change in schizotypal, borderline, avoidant, and obsessive-compulsive personality disorders. *Journal of Consulting and Clinical Psychology* 72: 767–775.

Heimberg RG (2002) Cognitive-behavioral therapy for social anxiety disorder: Current status and future directions. *Society of Biological Psychiatry* 51: 101–108.

Horney K (1945) *Our inner conflicts*. New York: Norton.

Lenzenweger MF, Lane MC, Loranger AW, and Kessler RC (2007) DSM-IV personality disorders in the National Comorbidity Survey Replication. *Biological Psychiatry* 62: 553–564.

McGlashan TH, Grilo CM, Sanislow CA, et al. (2005) Two-year prevalence and stability of individual criteria for schizotypal, borderline, avoidant, and obsessive-compulsive personality disorders. *The American Journal of Psychiatry* 162: 883–889.

Millon T (1969) *Modern Psychopathology: A Biosocial Approach to Maladaptive Learning and Functioning*. Philadelphia: W.B. Saunders.

Millon T (1982) *Millon Clinical Multiaxial Inventory Manual*, 2nd ed. Minneapolis: National Computer Systems.

Otto M, Pollack M, Gould R, Worthington J, McArdle E, and Rosenbaum JE (2000) A comparison of the efficacy of clonazepam and cognitive behavioral group therapy for the treatment of social phobia. *Journal of Anxiety Disorders* 14: 345–358.

Ralevski E, Sanislow CA, Grilo CM, et al. (2005) Avoidant personality disorder and social phobia: Distinct enough to be separate disorders? *Acta Psychiatrica Scandinavica* 112: 208–214.

Rettew DC (2000) Avoidant personality disorder, generalized social phobia, and shyness: Putting the personality back into personality disorders. *Harvard Review of Psychiatry* 8: 283–297.

Sanderson WC, Wetzler S, Beck AT, and Betz F (1994) Prevalence of personality disorders among patients with anxiety disorders. *Psychiatry Research* 51: 167–174.

Sanislow CA, Little TD, Ansell EB, et al. (2009) Ten-year stability and latent structure of the DSM-IV schizotypal, borderline, avoidant, and obsessive-compulsive personality disorders. *Journal of Abnormal Psychology* 118: 507–519.

Sanislow CA and McGlashan TH (1998) Treatment outcome of personality disorders. *Canadian Journal of Psychiatry* 43: 237–250.

Sanislow CA, Morey LC, Grilo CM, et al. (2002) Confirmatory factor analysis of DSM-IV schizotypal, borderline, avoidant, and obsessive-compulsive personality disorders: Findings from the Collaborative Longitudinal Study of Personality Disorders. *Acta Psychiatrica Scandinavica* 105: 28–36.

Shea MT, Stout RL, Yen S, et al. (2004) Associations in the course of personality disorders and axis I disorders over time. *Journal of Abnormal Psychology* 113: 499–508.

Skodol AE, Gunderson JG, Shea MT, et al. (2005) The collaborative longitudinal personality disorders study (CLPS): Overview and implications. *Journal of Personal Disorders* 19: 487–504.

Skodol AE, Oldham JM, Bender DS, et al. (2005) Dimensional representations of DSM-IV personality disorders: Relationships to functional impairment. *The American Journal of Psychiatry* 162: 1919–1925.

Skodol AE, Pagano ME, Bender DS, et al. (2005) Stability of functional impairment in patients with schizotypal, borderline, avoidant, or obsessive-compulsive personality disorder over two years. *Psychological Medicine* 35: 443–451.

Stein MB, Liebowitz MD, Lydiard RL, Pitts CD, Bushnell MS, and Gergel I (1998) Paroxetine treatment of generalized social phobia (social anxiety disorder). *Journal of the American Medical Association* 280: 708–713.

Trull TJ, Widiger TA, and Frances A (1987) Covariation of criteria sets for avoidant, schizoid, and dependent personality disorders. *The American Journal of Psychiatry* 144: 767–771.

Turner S, Beidel D, and Jacob R (1994) Social phobia: A comparison of behavior therapy and atenolol. *Journal of Consulting and Clinical Psychology* 62: 350–358.

van Velzen CJM, Emmelkamp PMG, and Scholing A (2000) Generalized social phobia versus avoidant personality disorder: Differences in psychopathology, personality traits, and social and occupational functioning. *Journal of Anxiety Disorders* 14: 395–411.

Widiger TA (1992) Generalized social phobia versus avoidant personality disorder: A commentary on three studies. *Journal of Abnormal Psychology* 101: 340–343.

Widiger TA, Trull TJ, Clarkin JF, Sanderson C, and Costa PT (1994) A description of the DSM-III-R and DSM-IV personality disorders with the five-factor model of personality. In: Costa PT and Widiger TA (eds.) *Personality disorders and the five-factor model of personality*, pp. 41–56. Washington, DC: American Psychological Association.

World Health Organization (1992) *The International Statistical Classification of Disease (ICD)*, 10th edn. Geneva: World Health Organization.

World Health Organization (2007) *The International Statistical Classification of Disease (ICD)*, 10th edn. Retrieved from http://apps.who.int/classifications/apps/icd/icd10online/.

Zanarini MC, Frankenburg FR, Hennen J, Reich DB, and Silk KR (2006) Prediction of the 10-year course of borderline personality disorder. *The American Journal of Psychiatry* 163: 827–832.

Zimmerman M, Rothschild L, and Chelminski I (2005) The prevalence of DSM-IV personality disorders in psychiatric outpatients. *The American Journal of Psychiatry* 162: 1911–1918.

Relevant Websites

http://www.dsm5.org/Pages/Default.aspx – DSM-5 Development Website.
http://apps.who.int/classifications/apps/icd/icd10online/ – ICD-10/11 Website.
http://www.mentalhelp.net/poc/view_doc.php?type=doc&id=29133&cn=8 – Interview with Professor Lorna Benjamin on SASB and the Structure and Treatment of Personality Disorders.