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Avoidant Personality Disorder, Traits, and Type

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Avoidant Personality Disorder, Traits, and Type

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Abstract and Keywords

In this chapter, the evolution of the avoidant personality disorder (AVPD) diagnosis, its current status, and future possibilities are reviewed. AVPD is a chronic and enduring condition involving a poor sense of self and anxiety in social situations, and it is marked by fears of rejection and a distant interpersonal stance. AVPD may be conceptualized at the severe end of a continuum of social anxiety. In the extreme, traits, mechanisms, and symptoms become integral to chronic dysfunction in personality and interpersonal style. While AVPD is a valid diagnostic construct, the optimal organization of AVPD criteria for the diagnosis, and the relationship of avoidant personality traits to anxiety, remain to be determined.

Keywords: avoidant personality disorder, shyness, social phobia, anxiety, DSM, comorbidity

Various forms of psychopathology are marked by social sensitivities combined with a reluctance to engage interpersonally. Mild variations of the dimensions of anxiety and shyness are no doubt familiar to all, whether through our own experience or the experience of others. These are not necessarily pathological in and of themselves, and sometimes they are even adaptive. Imagine the cultural heritage of America without Thoreau, who sequestered himself in the woods to produce his literary work. However, it is when such behaviors in the extreme become inflexible and present across a variety of situations and are maladaptive to functioning that they become pathological. Together with a negative view of self, these dimensions may be described as avoidant personality disorder (AVPD).

AVPD is characterized by a desire for affiliation coupled with a sense of personal inadequacy and intense fears of interpersonal rejection. A heightened sensitivity to criticism and expected condemnation by others are key features of AVPD and lead to the social detachment that marks the disorder. Although surface features of AVPD may seem similar to other distress disorders with anxiety or depression, the hypothesized mechanisms may differ. These differences help to clarify what is represented by the AVPD diagnostic construct, and a tracing of changes in the diagnostic history of AVPD helps to illustrate the “core.”

In the general population, approximately 1.6% of individuals suffer from AVPD (Lenzenweger, Lane, Loranger, & Kessler, 2007; see also Ruscio et al., 2008). In clinical populations, the disorder is very common. For instance, Zimmerman and colleagues reported that it was the most frequent personality disorder diagnosis (14.7%) and indicated in the same report a range from 1% to 37% in clinical-epidemiological studies (Zimmerman, Rothschild, & Chelminski, 2005; see also Torgersen, Chapter 9, this volume).

In the initial portion of this chapter, the AVPD diagnostic construct is reviewed. We first examine the origin of AVPD and trace the history of its development. Next, the current diagnosis within the (p. 550) American Psychiatric Association's (APA) *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; APA, 2000)* is considered in detail. The problems of diagnostic overlap and specificity of the AVPD diagnosis, particularly with schizoid personality disorder and social phobia, become evident from an examination of the refinements made from *DSM-III*

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(APA, 1980) to *DSM-IV* (APA, 1994). The Five-Factor Model (FFM; Costa & McCrae, 1992; Costa & Widiger, 1994) helps to clarify some of the issues of diagnostic co-occurrence and comorbidity, and also sets the stage for proposed revisions for the *DSM-5*. In the next portion of the chapter, the course and stability are reviewed, and this is followed by an examination of the possible mechanisms of AVPD. We then conclude with a summary and suggestions for future directions.

Social Sensitivity and the Historical Roots of Avoidant Personality

Although not under the moniker AVPD, a personality pathology characterized by social avoidance has been described at least as far back as the 1900s. An early portrayal of a socially avoidant personality type was described by Bleuler (1911/1950) who at that time adopted the term “schizoid” to describe “people who are shut in, suspicious” and “comfortably dull and at the same time sensitive” (p. 391). Hoch (1910) had similarly described the “shut-in” personality as reticent, reclusive, sensitive, and shy with a tendency to live in a world of fantasy.

The socially avoidant personality type was later differentiated as two personality types by Kretschmer (1925), who described those with a schizoid temperament as either anaesthetic or hyperaesthetic. Anaesthetics, a close resemblance of the contemporary diagnosis of schizoid personality disorder, were said to be affectively insensitive, dull, and lacking in spontaneity. In contrast, hyperaesthetics, although also withdrawn, were described as excitable and anxious but also tender, shy, sensitive, and distrustful of others and closer to the current characterization of AVPD. In contrast to the anaesthetics, who were generally void of affect and showed signs of impoverished cognition, the hyperaesthetics were thought to close off the outside world and actively avoid social stimulation. This tendency of social avoidance was central to later descriptions of the “detached” personality type by Horney (1945). A short while later, Horney (1950) described a case study of the detached type as “interpersonally avoidant.”

In the first two editions of the *DSM*, there was no diagnosis that directly corresponded to what is now AVPD. “Schizoid personality” (APA, 1952, p. 35; APA, 1968, p. 42) captured those individuals who were shy, interpersonally sensitive, and who avoided close relationships (see also Hopwood and Thomas, Chapter 27, this volume). Detachment was a common reaction to disturbing experiences among such individuals (APA, 1968). Among the personality disorders, there was also a classification for “inadequate personality” (APA, 1952, p. 35; APA, 1968, p. 44) that described individuals who were socially and emotionally ineffectual and who exhibited poor judgment and unstable social relationships. Schizoid personality persisted through three more editions of the *DSM*, but inadequate personality was dropped after *DSM-II*.

Millon (1969) was the first to cleave from schizoid the detached personality characteristics and interpersonal behaviors marked by social avoidance and label them as AVPD. His view, based in social learning theory, described AVPD as the actively detached pattern and emphasized the need to distinguish it from the passively detached schizoid personality (Millon, 1969). In line with Millon’s distinction, the *DSM-III* task force separated the active and passive detachment styles by creating two diagnoses. Schizoid personality disorder corresponded to the passive detachment, and AVPD was reserved for those who actively avoided interpersonal relationships. The diagnostic title “avoidant personality disorder” was introduced into the official diagnostic nomenclature with the *DSM-III* (APA, 1980).

The Modern Diagnosis of Avoidant Personality Disorder

DSM-IV-TR Definition and Criteria

As is the case with all *DSM*-defined personality disorders, there is 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” (APA, 2000, p. 686). Within the Axis II personality disorders of *DSM-III* through *DSM-IV-TR*, AVPD has resided in “Cluster C” along with the dependent and obsessive-compulsive personality disorders.¹ Personality disorders in this cluster share in common features of “internal distress,” including anxiousness and fearfulness. In the *DSM-IV-TR* (APA, 2000), AVPD is characterized by a “pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation” (p. 718).

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(p. 551) At least four of any of the seven *DSM-IV-TR* criteria are required to meet the diagnostic threshold for AVPD. The first criterion “avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection” (APA, 2000, p. 721) may apply to work or school. Often, persons suffering from AVPD 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 obsessive-compulsive personality disorder, where people prefer to work alone because their perfectionism standards are high and others would bring the work down. For the avoidant person, the need is so strong it would not be unusual to refuse a better position or promotion if it would involve greater interpersonal contact, and this is one way that AVPD exacts a toll on functioning.

The second criterion “is unwilling to get involved with people unless certain of being liked” (APA, 2000, p. 721) is based on feelings of inadequacy. In other words, they will hold back, waiting to see what the other thinks or feels before showing their hand. This is unlike the case of dependent personality disorder, where a person is reticent based on fear of differentiating his or her opinions from another, and more intense than mere “shyness.” For the avoidant, the fear is the confirmation of his or her own perceptions and beliefs of inadequacy, and a guarantee of friendship is needed before he or she can move forward in a social situation. Others may perceive the avoidant person as cold and aloof, but his or her behavior reflects a protective stance.

The third criterion “shows restraint within intimate relationships because of the fear of being shamed or ridiculed” (APA, 2000, p. 721) is also driven by the fear of being criticized. Even a slight teasing might be perceived as humiliating. Being avoidant means always being petrified about “deep, dark, secrets” that, if revealed, would almost certainly invite the other to tease the avoidant person. This makes it very difficult for an avoidant person to self-disclose in an intimate relationship, or to more generally share his or her personal reactions and feelings with others. For these reasons, AVPD 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 clinically with *DSM-IV-TR* “Cluster A” (odd, eccentric) personality disorders such as schizoid, schizotypal, or paranoid is in those cases better attributed to an indifference for intimacy (schizoid) or paranoid fears underlying apparently secretive behavior (schizotypal and paranoid).

The fourth criterion “is preoccupied with being criticized or rejected in social situations” (APA, 2000, p. 721) at first blush may appear similar to the *DSM-IV-TR* Axis I clinical syndrome of social phobia. The person who is avoidant is uptight and consumed with thoughts of criticism and rejection. Anxiety in a social situation driven largely by fear is the hallmark of this criterion. For avoidant individuals, any aspect of their being is fair game for criticism. It could be their looks, hair, what they are wearing, or their ideas, intellect, or ability to express their thoughts or feelings. In contrast to social phobia, anxiety associated with avoidant personality disorder is not specific, but wide-ranging across all areas of their social world. It is not, for example, limited to situations where they might be called on to speak in front of others, as in the case of social phobia. A variant of social phobia, the generalized type, is a phobia that appears across a wider range of social situations and is not situation specific. Interestingly, the generalized type appears to diagnostically co-occur with greater frequency than the simple type of social phobia, and it will be considered in greater detail shortly.

The fifth criterion “is inhibited in new interpersonal situations because of feelings of inadequacy” (APA, 2000, p. 721) is more than merely being reserved or cautious. As with the fourth criterion, this is more than social anxiety. Feeling that they are not “good enough,” avoidant persons will deal with this by being reticent and reluctant to “make the first move” because of their discomfort. Often, it involves social comparisons that may have little if no basis in reality, for instance, that others are smarter, more successful, have better relationships, better family life, a better job, and so on. Again, rooted in this criterion is the idea of being “less of a person” across multiple domains. And, here again, with AVPD, the person will hold back personal information, 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 negatively evaluating one’s self, and the subsequent comparison with others.

The sixth criterion “views self as socially inept, personally unappealing, or inferior to others” (APA, 2000, p. 721) 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 intense feelings of awkwardness is paired (p. 552) with thoughts that others will always judge or otherwise evaluate the AVPD negatively, that they are, essentially, unlikable. This is more than an inability to express oneself and is very self-focused. Here, it is important to distinguish this criterion from cognitive

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features of depressive disorders. Depressive disorders are often characterized by a ruminative self-focus. Whether the episode is shorter in duration but more intense (e.g., major depressive disorder), or longer in duration but less intense (e.g., dysthymic disorder) the key distinction for AVPD is that 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 the inferiority remains the same.

The seventh criterion “is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing” (APA, 2000, p. 721) 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 those that might be called thrill seekers. For AVPD, the risk is much more pedestrian and mundane. The person is loath to reveal feelings that may expose him or her, whether the feelings are positive or negative. Even if the avoidant person has a positive feeling, the typical interpersonal move 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 is “off the mark.” This is also more than being reluctant to try something new, or the result of a specific fear of an inability to do something, such as play a particular sport. It is characteristically widespread across nearly all situations.

For the *DSM-IV-TR* diagnosis of AVPD, four (or more) of these seven criteria are required. For some *DSM-IV-TR* diagnoses, the polythetic system has been criticized for leading to heterogeneity (e.g., because two people can share only one criterion but still share the same diagnosis). However, a close inspection of the AVPD criteria reveals the central thematic features of a preoccupation with feelings of inadequacy that impair interpersonal relationships running through each of the seven criteria, and studies have suggested that the seven criteria are unidimensional (e.g., Hummelen, Wilberg, Pedersen, & Karterud, 2006). It seems that there exists a pervasive cognitive disturbance that interferes with interpersonal interactions in a novel social situation. Avoidance of others, whether by overt isolative behaviors or by subtly withholding the more personal details of oneself necessary for intimate relationships, is the primary means of keeping the distress at bay.

Evolution of the Avoidant Personality Disorder Construct: 1980–2010

Even in the relatively short history of the diagnosis since it was officially introduced in the psychiatric nomenclature by its inclusion in the *DSM-III* (APA, 1980), AVPD has undergone substantial changes through the subsequent editions of the *DSM*. Viewpoints have varied from the start and illustrate the effort to narrow and find the “core” of AVPD. As promised, the post-1980 *DSMs* delivered an expansive number of empirical studies of diagnosis, greater in number and more systematic than the time prior to *DSM-III*. Advances in personality theory, particularly a wave of work on the FFM, also contributed greatly to our understanding of personality pathology. In attempts to increase specificity and reduce diagnostic overlap, revisions have been made to the criteria set with each new edition of the *DSM*. Through *DSM-IV*, these changes have been chiefly directed at clarifying the boundary of AVPD and schizoid personality, and addressing the high rate of diagnostic co-occurrence of AVPD and social phobia.

Through *DSM-III*, *DSM-III-R*, and *DSM-IV*, the ordering of the criteria has varied, too. The *DSM-IV* criteria lists were posited to describe first what were believed to be the most essential criteria and to proceed in descending order of importance to the construct. Although factor analytic studies have generally not found empirical support for the approach (e.g., Sanislow et al., 2002), the ordering of criteria does reflect how central each of the criteria for AVPD were viewed by the *DSM-IV* committee members who crafted the diagnosis.

Across *DSM-III*, *DSM-III-R*, and *DSM-IV*, the core features of AVPD have persisted throughout each of the revisions, even though certain changes were made. Consistent features of the diagnosis include social withdrawal, sensitivity to criticism, and a devalued view of self. Functional impairment is emphasized in *DSM-IV*, with occupational difficulties resulting from social withdrawal as the first criterion. Social withdrawal becomes more specifically operational by breaking it down into components, first in *DSM-III-R* to vocational and social, and then in *DSM-IV* to vocational, intimate, and social relationships. The desire for affection and acceptance was dropped after *DSM-III*, but it remains in the (p. 553) text description: “They desire affection and acceptance and may fantasize about idealized relationships with others” (APA, 2000, p. 719). Other aspects of earlier criteria are evident in the text description as well but no longer detailed in the actual criteria (e.g., blushing or crying). This suggests that even though criteria sets have been revised, historical features of the disorder may persist as diagnostic interviewers

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rely on the text descriptions to elaborate the clinical context of the actual diagnostic criteria.

Avoidant Personality Disorder and DSM Diagnostic Co-occurrence

Like other personality disorders, comorbidity of AVPD with other diagnoses is generally considered the norm rather than the exception (see also Trull, Scheiderer, and Tomko, Chapter 11, and Links, Ansari, Fazalullasha, and Shah, Chapter 12, this volume). There are a number of disorders that frequently co-occur with AVPD. In some cases, diagnostic co-occurrence results from diagnostic overlap where criteria are similar. In other cases, co-occurrence may indicate shared mechanisms or etiology.

Disorders Frequently Co-occurring With Avoidant Personality Disorder

In a clinical sample of outpatients presenting for treatment for depression, one-third of the sample met *DSM-III-R* criteria for either AVPD or social phobia, or both disorders (Alpert et al., 1997). Devanand (2002) reported 11.8% comorbid *DSM-IV* AVPD among older adults being treated for major depressive disorder. Examining the relation of anxiety disorders and AVPD, Skodol and colleagues (1995) found both panic disorder and social phobia to occur with much greater likelihood (up to eight to nine times more likely) among those with AVPD. In the Collaborative Longitudinal Study of Personality Disorder (CLPS), among patients recruited for *DSM-IV* AVPD as the index disorder, McGlashan and colleagues (2000) reported baseline diagnostic co-occurrence for *DSM-IV* Axis I and II disorders. The Axis II disorders most frequently co-occurring with AVPD were depressive (30.3%), obsessive-compulsive (22.9%), and borderline (16.6%). Among Axis I disorders most frequently occurring with AVPD in the CLPS sample were major depressive disorder (81.5%) and dysthymic disorder (21.7%); for anxiety disorders, social phobia (38.2%), posttraumatic stress disorder (28.0%), panic disorder (22.9%), and generalized anxiety disorder (21.7%) frequently co-occurred with AVPD. Interestingly, 44.6% of patients in the CLPS met criteria for alcohol abuse or dependence, and 32.5% for abuse or dependence of another substance. In a large outpatient sample, Zimmerman and colleagues (2005) reported that AVPD occurred in 20.3% of the cases of major depressive disorder, 26.1% of the cases of generalized anxiety disorder, and 21.8% of the cases of panic disorder.

Overall, AVPD frequently co-occurs with a spectrum of anxiety and depressive disorders. The frequency of co-occurrence with depressive disorders varies widely and is likely somewhat dependent on the sample. Among personality disorders, social phobia is noteworthy because features of that disorder are similar in many respects to AVPD criteria. It also appears to be most related to the Cluster C personality disorders, based on frequency of co-occurrence. The base rate of schizoid personality is very low, typically less than 2% in large clinical samples (e.g., McGlashan et al., 2000; Zimmerman, Rothschild, & Chelminski, 2005), and so the lack of findings for AVPD and schizoid co-occurrence are not surprising. That said, AVPD and schizoid personality disorder share a long history in their diagnostic development, and this merits a closer look at the potential overlap and distinctiveness of the two disorders.

Avoidant Personality Disorder and Schizoid Personality Disorder

The insertion of Criterion 2 (“has no friends or close confidants...”) into the *DSM-III-R* AVPD diagnosis reflects the controversy around the decision to include separate diagnostic categories in the *DSM-III* for schizoid personality disorder and AVPD. Consistent with the possibility that this amendment may have narrowed the schizoid diagnosis too much, senior clinicians have been heard to joke that schizoid personality disorder is so rare that it does not actually exist. Livesley and West (1986) criticized the schizoid-avoidant split in *DSM-III*, arguing that it deviated inappropriately from the traditional concept of schizoid personality, which included the apparently contradictory qualities of superficial insensitivity or aloofness and underlying hypersensitivity (Livesley & West, 1986; Livesley, West, & Tanney, 1985).

The focus of *DSM-III* on desire or motivation for socialization to distinguish between schizoid personality disorder and AVPD was also criticized. Some clinicians with experience working with schizoid individuals noted that schizoid patients often have deep and powerful longings for attachment and acceptance (Guntrip, 1969). As a result, (p. 554) schizoid was refined in the *DSM-III-R* to correspond more closely with the concept of the “phobic character” that had been described previously in analytic literature (Fenichel, 1945). In contrast, an essential feature of AVPD in the *DSM-III-R* included a pervasive pattern of social discomfort, fear of negative evaluation, and timidity. In *DSM-III-R*, the desire for “affection and acceptance” was removed from the criteria list and placed in the

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text description.

In the end, deleting the criterion about desire or motivation for social acceptance and affection aimed to more clearly distinguish AVPD from schizoid, but it compounded the difficulty of distinguishing between AVPD and social phobia (Millon, 1991). To address this new problem, the *DSM-IV* committee focused on refining the social phobia diagnosis to be related to specific performance situations.

AVPD and Social Phobia

The *DSM-IV-TR* diagnosis of social phobia is characterized by a fear or avoidance of social situations that is presumably more circumscribed than AVPD. In studies of comorbidity between AVPD and social phobia prior to *DSM-IV*, considerable overlap was found (Alnaes & Torgersen, 1988; Brooks, Baltazar, & Munjack, 1989; Fahlen, 1995; Heimberg, Hope, Dodge, & Becker, 1990; Jansen, Arntz, Merckelbach, & Mersch, 1994; Sanderson, Wetzler, Beck, & Betz, 1994; Turner, Beidel, Borden, Stanley, & Jacob, 1991). Earlier studies that have compared patients with the generalized social phobia with and without AVPD argued for quantitative, not qualitative, differences between the two groups (Boone et al., 1999). Still, some have argued that widening the assessment scope of AVPD to include nonsocial domains (introversion, passivity, fear of novelty, for example) might clarify qualitative differences (e.g., Rettew, 2000). Others have raised questions about the “breadth” of the AVPD definition (e.g., Perugi et al., 1999). In general, however, studies have found that social phobia patients with comorbid AVPD experience more anxiety and more impairment compared to those with the generalized type of social phobia alone.

Revisions to the AVPD criteria made for the fourth edition of the *DSM* do not appear to have clarified the situation. Data from the CLPS supported the argument that AVPD represents a more chronic form of social phobia (Ralevski et al., 2005). In another, more recent study, also based on *DSM-IV*, impairment and distress were assessed among participants with the generalized type of social phobia with and without AVPD using self-report and observation. No significant differences were found between the groups when the researchers controlled for social phobia, supporting the continuum hypothesis (Chambless et al., 2008).

Overall, comparisons of the characteristics of patients with AVPD and the generalized type of social phobia, defined as the fear of most social situations, have yielded very few differences other than severity. The majority of studies have supported the idea of a continuum model, that AVPD is a more chronic and thus severe form of social phobia (Chambless, Fydrich, & Rodebaugh, 2008; Ralevski et al., 2005; van Velzen, Emmelkamp, & Scholing, 2000). This, along with the high co-occurrence rates for these two disorders, has continued for nearly two decades to provide support for the hypothesis that the primary difference between social phobia and AVPD is merely quantitative and not qualitative in nature (Widiger, 1992). Nonetheless, to fully evaluate the continuum model, it is important to consider features that distinguish AVPD and social phobia.

Interpersonally, AVPD traits are at least moderately associated with excessive social inhibition and nonassertiveness, as well as with problems related to self-sacrifice and being overly accommodating, along with coldness. Davila and Beck (2002) reported that those with AVPD evidenced higher levels of social anxiety along with interpersonal styles reflecting less assertion, more conflict avoidance, more avoidance of expressing emotion, and greater interpersonal dependency. This illustrates a style of behaving with others that, after repeated and extreme attempts to ward off social anxiety, may be a more entrenched and thus severe extreme of social anxiety. In other words, in the case of AVPD, the maladaptive interpersonal style to manage social anxiety may be more integral to personality than less severe or more episodic forms of anxiety (i.e., social phobia). Some data suggest that the breadth of AVPD pathology relative to social phobia represents more severe personality dysfunction for AVPD, leading to the contention that qualitative features cannot adequately be accounted for with the continuum hypothesis (e.g., Hummelen, Wilberg, Pedersen, & Karterud, 2007).

Personality traits may therefore be an important distinction. For example, one study found higher levels of social avoidance, depressive symptoms, neuroticism, introversion, and social and occupational impairment in participants with the generalized type of social phobia and AVPD than in those with the generalized type of social phobia alone (van Velzen et al., 2000). These authors postulated (p. 555) that AVPD differs from social phobia because it manifests itself in more severe cases of depression, introversion, and social and occupational impairment. However, whether these features are qualitatively distinct or merely representative of a more severe anxiety disorder is still a matter of debate among those in the field.

Other Comorbid *dsm* Conditions

Not unlike schizoid, those with schizotypal or paranoid personality disorder may also react to negativity from others, but more often from paranoia rather than the self-deprecation common in AVPD. Another personality disorder that overlaps or may share features with AVPD is dependent personality disorder. Dependent personality disorder also rests in the anxious or fearful Cluster C of *DSM-IV-TR* Axis II personality disorders. Characteristic of both are low self-esteem, rejection sensitivity, and an excessive need for reassurance. Both may be defined in terms of attachment anxiety; however, the key distinction of AVPD, again, is that the anxiety is driven by a fear of being rejected for being unworthy, whereas the anxiety in the case of dependent personality disorder stems from separation fear and of being rejected, but after a relationship has been established (Trull, Widiger, & Frances, 1987). Thus, with dependent personality disorder, distress is clear in the midst of a close relationship or when one ends, whereas people who suffer AVPD are slow to find or enter into new relationships. In further contrast, those with dependent personality disorder are likely to enter in new relationships indiscriminately and with a sense of urgency. Interestingly, revisions of the *DSM-III* to *DSM-III-R* appeared to increase the overlap between AVPD and several other personality disorders. Morey (1988) reported increased co-occurrence between AVPD and borderline, paranoid, and dependent personality disorders.

Avoidant Personality Disorder and the Five-Factor Model

Work integrating personality disorders with the Five-Factor Model of Personality (FFM; Costa & Widiger, 1994) has had a strong influence in the remaking of personality disorder diagnosis for the *DSM-5*. Thus, before turning to the proposed features of the *DSM-5* AVPD diagnosis, we first consider the FFM (see also Widiger, Samuel, Mullins-Sweatt, Gore, and Crego, Chapter 5, this volume). Briefly, the FFM is composed of five “domains” (neuroticism, extraversion, openness to experience, agreeableness, and conscientiousness) and thirty “facets,” six per each domain. The two domains that are relevant to AVPD, that is, that capture avoidant traits in their extreme ratings are neuroticism and extraversion. Neuroticism is composed of the facets anxiety, angry hostility, depression, self-consciousness, impulsiveness, and vulnerability. Extraversion is composed of the facets warmth, gregariousness, assertiveness, activity, excitement seeking, and positive emotions.

Broadly, AVPD is characterized at the domain level by high neuroticism and low extraversion. To describe avoidant traits in detail, and to more clearly differentiate AVPD from other disorders such as schizotypal, facet-level descriptions are appropriate (see Axelrod Widiger, Trull, & Corbitt, 1997). FFM facet-level traits that capture AVPD are high levels of anxiety, depression, self-consciousness, and vulnerability in the neuroticism domain, and in the extraversion domain, there are low trait levels on the facets gregariousness, assertiveness, and excitement seeking (Widiger, Trull, Clarkin, Sanderson, & Costa, 1994).

Avoidant Personality Disorder Comorbidity Revisited in the Context of the Five-Factor Model

As described earlier, the normatively high rates of comorbidity present a challenge for the *DSM-IV-TR* categorically defined personality disorders, and AVPD is no exception. The high rates of comorbidity raise questions about whether AVPD constitutes a distinct entity. An alternative explanation is that the level of description of the AVPD construct is not useful to make discriminations between AVPD and the disorders that frequently co-occur with it. According to proponents of the dimensional approach, these data do not provide such an intrinsic problem for dimensional models such as the FFM because the comorbidity can be understood as occurring due to overlap of certain personality traits, or facets (Lynam & Widiger, 2001). The extent to which disorders co-occur should therefore be proportional to the extent that they share common levels on the FFM domains and facets. The conceptual overlap of AVPD and schizoid personality disorder can be clarified with the FFM. Both involve high levels of introversion and therefore most cases involve behavior patterns that are shades of each disorder (Lynam & Widiger, 2001; Widiger et al., 1994). However, the disorders may be easily differentiated based on neuroticism, with AVPD characterized by high neuroticism and schizoid characterized by low neuroticism, the latter (p. 556) suggesting a splitting off of affect for the schizoid that is more in line with Bleuler's (1911/1950) original conception.

Avoidant Personality Disorder Comorbidity and the Axis I/II Distinction: Commentary

Widiger and Trull (2007) have argued that having sets of diagnostic criterion in the *DSM-IV-TR* were meant to help clinicians correctly diagnose and differentiate disorders with similar characteristics. Many criteria are similar for

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different disorders and co-occurrence of disorders with similar criteria (diagnostic overlap) is common, particularly between Axis I and Axis II disorders (Widiger, Shea, & Klein, 1992). This co-occurrence may be due to excessive criterion overlap in the *DSM-IV-TR* as in the case of social phobia and AVPD. Characteristics of each disorder may also be manifestations of the same pathology, or personality structure (Shea et al., 2004).

When making considerations about comorbidity and diagnostic co-occurrence, it is important to keep in mind that AVPD is a diagnostic construct, a useful explanatory tool to help understand and communicate among professionals, and to develop, implement, and guide treatments. Though they provide clinical utility, our diagnostic systems are not perfect, in part because they are not “real” or natural kinds, but approximations of a hypothetical construct that itself is not directly observable or tangible. One of the imperfections of these approximations includes the frequent co-occurrence. When there are shared mechanisms or etiological questions that tap similar traits or behaviors, the question arises as to whether the two disorders of interest are really separate disorders, or manifestations of a different level of severity or capturing a different point in the course of the disorder. The earlier discussion on the historical roots of the AVPD diagnosis in relation to schizoid personality disorder illustrates the issue of overlap.

The continuities hypothesized to span from personality traits, to personality disorders, to clinical syndromes, are also an important consideration. Constructs across these levels will have similarities that represent the continuity, and differences that reflect the level of observation. Pathoplasticity is a useful theoretical concept, or heuristic, to understand the relation of co-occurring disorders, and it is particularly useful for understanding the relation of Axis I and II disorders. Pathoplasticity “does not assume a shared etiology but [emphasizes] the influence of one condition on the presentation or course of the other” (Shea et al., 2004, p. 500). In other words, the presence of one disorder impacts the course and treatment outcome of the other, but they do not stem from the same pathology. With CLPS data, Shea and colleagues (2004) tested the longitudinal associations of Axis I and Axis II disorders. Among these, the relation between AVPD and Axis I anxiety disorders was examined. The link between AVPD and anxiety disorders was specific; although AVPD was related to major depressive disorder, it was found that borderline personality disorder captured the significance of this association when the effect of borderline on depression was controlled. Findings held for the grouping of all anxiety disorders, and also for tests examining the relation of AVPD with social phobia, and AVPD with obsessive-compulsive disorder (Shea et al., 2004). Using the same CLPS data, Warner and colleagues (2004) tested the relations of personality traits to *DSM-IV-TR* symptoms using a cross-lagged structural modeling approach. Results indicated that the changes in avoidant personality traits defined with the FFM (c.f. Lynam & Widiger, 2001) preceded changes in the AVPD *DSM-IV-TR* criteria. The Warner results support the conceptual link between personality traits and personality disorders implied by the *DSM*. Together, these studies support the addition of personality traits in the *DSM-5*.

Proposed Avoidant Personality Disorder Diagnosis for *DSM-5*: 2011 and Beyond

In contrast to the polythetic criteria sets of essential features in *DSM-IV-TR*, a prototype model for personality disorders was initially proposed for *DSM-5* that included a descriptive prototype followed by specific domains or facets that may or may not to a continuous degree be characteristics of various personality disorders (Skodol, Chapter 3, this volume). Five to six of the ten *DSM-IV-TR* personality disorders are likely to be retained, among them AVPD.² It was intended for the *DSM-5* diagnostic system to be changed from a categorical to a hybrid prototype-dimensional system based on a five-(or six-)domain trait dimensional diagnostic system. Ratings would also be made for “Self” (Identity Integration and Self-directedness) and “Interpersonal” (Empathy and Intimacy) functioning to capture general personality disorder.

AVPD was reformulated as the “Avoidant Type,” characterized by a “negative sense of self, associated with a profound sense of inadequacy, and inhibition in establishing intimate interpersonal relationships” (APA, 2010, 2011). It was originally (p. 557)

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Table 25.1 Avoidant Prototype Proposed for *DSM-5* (APA, 2010)

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.

proposed to be diagnosed with respect to a narrative description of a prototypic case, which emphasized typical deficits and features shown in Table 25.1. However, in the subsequent revision of the proposals for *DSM-5*, this narrative description was replaced by a diagnostic criterion set that combined the self and interpersonal level of functioning with the traits.

The original trait description of AVPD included 10 lower order traits from three domains (see Table 25.2). However, based on a factor analysis, the original list of 37 traits (within six domains) was reduced to 25 (within five domains). Six of the original 10 traits assigned to AVPD were deleted (and/or shifted from AVPD). For example, in the original proposal the diagnosis of AVPD included five traits from the domain of negative emotionality: anxiousness, separation anxiety, pessimism, low-self esteem, and guilt/shame (APA, 2010; see Table 25.2). In the revised version, only anxiousness is now included from this domain for the diagnosis of AVPD (APA, 2011; see Table 25.3). From the second domain, detachment (originally titled introversion), the associated facets were intimacy avoidance, social withdrawal, restricted affectivity, anhedonia, and social detachment (APA, 2010; see Table 25.2). In the revised version, only intimacy avoidance, social withdrawal, and anhedonia are included (APA, 2011; see Table 25.3). Finally, in the original proposal, there was also risk aversion from the domain of compulsivity (APA, 2010; see Table 25.2). However, risk aversion has since been eliminated (APA, 2011; Krueger et al., 2011). Of course, it is possible that further revisions will occur prior to the final decision.

Inspection of Table 25.2 reveals that many of the specific features of the *DSM-IV-TR* AVPD criteria were captured in trait ratings, at least within the original proposal. For instance, the criterion that an individual is “usually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing” was reflected in the *DSM-5* trait of risk aversion. A new trait/feature for AVPD present in the *DSM-5* rating system is anhedonia (see Tables 25.2 and 25.3).

Stability and Course of Avoidant Personality Disorder

A primary distinction between Axis I and Axis II personality disorders is the chronic and enduring course of personality disorders relative to clinical syndromes on Axis I. This long-held assumption is really part of the definition of personality disorders, and it has been challenged with recent empirical studies that have examined the prospective course of personality disorders, the CLPS (Skodol, Gunderson, et al., 2005) and the McLean Study for Adult Development (Zanarini, Frankenburg, Hennen, Reich, & Silk, 2006). The general finding from both of these longitudinal, naturalistic studies is that personality disorders remit diagnostically much more often than was originally assumed (see also Morey and Meyer, Chapter 14, this volume). This pattern has been demonstrated specifically with AVPD (Grilo et al., 2004; Sanislow et al., 2009). However, functional impairment, including social and occupational, appears to be more stable relative to diagnosis for AVPD (and other personality disorders)

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(Skodol, Oldham, et al., 2005; Skodol, Table 25.2 Personality Traits Proposed for DSM-5 (APA, 2010) 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 risktaking; 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 Pagano, et al., 2005). Thus, even though there is a drop below diagnostic threshold, clinically significant impairment remains evident over the long run.

Given that *DSM-IV-TR* personality disorder criteria are a mixture of traits, symptoms, and behaviors (see Sanislow & McGlashan, 1998), it is reasonable to query whether certain AVPD symptoms tend to persist more than others. McGlashan and colleagues (2005) reported the frequency that AVPD criteria persisted in the CLPS clinical sample at an assessment conducted 2 years later (by clinical interviewers blind to the baseline diagnoses) as follows: "Feels inadequate" (62%), "socially inept" (62%), "preoccupation with rejection" (53%), "need to be liked first" (51%), "avoid risks for fear of embarrassment" (p. 559)

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Table 25.3 Diagnostic Criteria for Avoidant Personality Disorder Proposed for *DSM-5* (APA, 2011)

- A. Significant impairments in **personality functioning** manifest by:**
- 1. Impairments in **self-functioning**:**
 - a. Identity:** Low self-esteem associated with self-appraisal as socially inept, personally unappealing, or inferior; excessive feelings of shame or inadequacy.
 - b. Self-direction:** Unrealistic standards for behavior associated with reluctance to pursue goals, take personal risks, or engage in new activities involving interpersonal contact.
 - 2. Impairments in **interpersonal functioning**:**
 - a. Empathy:** Preoccupation with, and sensitivity to, criticism or rejection, associated with distorted inference of others' perspectives as negative.
 - b. Intimacy:** Reluctance to get involved with people unless being certain of being liked; diminished mutuality within intimate relationships because of fear of being shamed or ridiculed.
- B. Pathological **personality traits** in the following domains:**
- 1. Detachment**, characterized by:
 - a. Withdrawal:** Reticence in social situations; avoidance of social contacts and activity; lack of initiation of social contact.
 - b. Intimacy avoidance:** Avoidance of close or romantic relationships, interpersonal attachments, and intimate sexual relationships.
 - c. Anhedonia:** Lack of enjoyment from, engagement in, or energy for life's experiences; deficits in the capacity to feel pleasure or take interest in things.
 - 2. Negative affectivity**, characterized by:
 - a. Anxiousness:** Intense feelings of nervousness, tenseness, or panic, often in reaction to social situations; worry about the negative effects of past unpleasant experiences and future negative possibilities; feeling fearful, apprehensive, or threatened by uncertainty; fears of embarrassment.

(44%), "fears ridicule and shame" (38%), "avoids jobs with interpersonal contact" (31%). Thus, the top two most persistent criteria include 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 the more global, general personality constructs, whereas the least persistent are based on behaviors (interpersonal jobs) and symptoms (fear). Like AVPD'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.

The CLPS has also reported two studies that examined the structure of the covariation among the AVPD criteria, relative to the other index disorders in the CLPS. In the first, a confirmatory factor analysis performed on baseline diagnoses and replicated on the assessment conducted 2 years later by clinical interviewers blind to the baseline diagnoses, provided support for the AVPD diagnosis (Sanislow et al., 2002). Factor loadings varied from the baseline to the 2-year assessment suggesting differential weighting of the criteria with "preoccupation with being rejected," "views self as socially inept," and "feels inadequate" loading highest in the 2-year model. Testing the stability and latent structure of AVPD over 10 years of follow-up, Sanislow and colleagues (2009) found that the AVPD diagnostic construct was stable, and this stability leveled off after 5 years. It also became more highly correlated with other disorders, suggesting greater comorbidity of personality disorder symptoms in chronic cases.

Mechanisms and Theories

As is evident from the diagnostic history of AVPD and related psychopathological conditions, any attempt to discern mechanisms or explain the theoretical underpinnings of avoidant pathology is dependent on the particular iteration of the construct (or its predecessor). Thus, this presents particular challenges. On the other hand, there are opportunities to consider areas where there is the possibility for integration, or not, to clarify the disorder.

Psychodynamic Perspectives

Psychodynamic theories, broadly including psychoanalytic and object relations theory, focus mainly on the idea of “phobic character.” The phobic character is more prototypically schizoid than what has become of the more modern definition, wherein AVPD has been split off from schizoid and is now more in line with anxiety and depressive spectra. For psychoanalytic and object relations theorists, the labels “schizoid” and “false-self” correspond (p. 560) not only to the socially detached character of the avoidant type but are also key representations of their developmental history (e.g., Fairbairn, 1952). In particular, the pattern of avoidance is a defense against potentially painful or overwhelming affect, seeking security while attempting to manage catastrophic fears of being exposed (see also Fonagy and Luyten, Chapter 17, this volume).

Horney (1945, 1950) focused on the avoidant style as one avenue to resolve inner conflicts revolving around attachment. Interestingly, she described the degree of “estrangement” in continuous terms: “The extent of the estrangement depends more on the severity of the disturbance than on the particular form the neurosis takes” (Horney, 1945, p. 74). For the detached character, Horney (1945) emphasized the anxiety that comes with relatedness and thus drives a need to be self-sufficient, not relying on anyone else for meaningful help. This sets up the need for hypercompetence, a standard that is so high that, chances are, it will lead to disappointment in one’s own abilities. In schizoid personality, it is often the case that the affected individual is able to develop self-sufficiency despite the presence of other deficits (Masterson & Klein, 1989). For the avoidant, “internalized” critical self-object attacks are experienced unrelentingly, stemming back from early experiences. Thus, more modern analytic explanations presume the development of a superego, suggesting a distinction more neurotic than related to the psychotic spectrum of *DSM* Cluster A personality disorders such as schizoid, paranoid, or schizotypal. In addition, a history of physical or sexual abuse may exacerbate masochistic personality traits and intensify the shame characteristic of the avoidant (van der Kolk, Perry, & Herman, 1991).

Interpersonal Origins and Maintenance of Avoidant Personality Disorder

As with other personality disorders, interpersonal problems are a critical feature of AVPD. In fact, almost all of the *DSM-IV-TR* criteria for AVPD describe aspects of the interpersonal problems generated and encountered by an individual with AVPD (see also Pincus and Hopwood, Chapter 18, this volume). The most articulate description of the interpersonal features of AVPD symptoms are derived from Benjamin’s Structural Analysis of Social Behavior (SASB; Benjamin, 1974). The SASB codes patterns of interpersonal behavior of both the self and the other, and it also codes for the patterns of interpersonal behavior that one has repeatedly experienced as they relate to how a person perceives or thinks about himself or herself. Benjamin has applied this model to the *DSM-IV-TR* personality disorders, including AVPD, and has linked characteristic interpersonal patterns to AVPD criteria (Benjamin, 1996). From there, it is possible to trace back characteristic interpersonal experiences of the person suffering AVPD and to infer how the person “talks to” or otherwise treats oneself.

According to Benjamin’s (1974; 1996) interpersonal theory, AVPD persons 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, as well as a reliance on safety at home that can sap the resources of the few individuals with whom the AVPD person does have a relationship. The origins of this pattern of behavior suggest that the person had enough love and nurturance to form a good sense of self, and that the difficult interpersonal transactions came later. For instance, “exhortations combined with degrading mockery” (Benjamin, 1996, p. 292) put a premium on the need to occlude any personal failings. For Benjamin (1996), the sine qua non for AVPD is a “defensive withdrawal out of fear of humiliation, attack, and rejection, and the wish for acceptance” (p. 298). Benjamin (1996) has characterized the interpersonal stance of AVPD as follows:

There is an intense fear of humiliation and rejection. Feeling flawed, the [avoidant] withdraws and carefully restrains himself or herself to avoid expected embarrassment. He or she intensely wishes for love and acceptance, but will become very intimate only with those few who pass highly stringent tests for safety. Occasionally, the [avoidant] loses control and explodes with rageful indignation. (p. 294)

In the interpersonal view, the person suffering from AVPD expects to be degraded, humiliated, and rejected by people for being socially inept or inferior. According to interpersonal theory, the person suffering AVPD behaves in ways that ensure rejection and criticism from others, largely in the service of reducing anxiety by making his or her

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interpersonal world a certain place with predictable responses from others. Thus, he or she keeps quiet and “invisible,” minimizing interpersonal contact and the associated likelihood of mockery or rejection, unless there are repeated and generous offers of support and nurturance, or others pass unrealistic and often covert tests to demonstrate uncritical (p. 561) acceptance. Subtle, veiled, or unintended cues from others that suggest mockery or derision will likely have adverse consequences for the AVPD, who may lash out in anger, projecting his or her hurt onto the deserving other.

Biological and Cognitive Processes

AVPD per se is rarely the focus of experimental studies of psychopathological mechanisms (see also Roussos and Siever, Chapter 15, this volume). On occasion, AVPD is studied co-incidentally as a contrast group. One study of borderline patients examined autonomic and startle response to emotional pictures and involved AVPD patients as a psychopathology contrast group (Herpertz et al., 2000). AVPD patients reacted similarly to the normal control group on autonomic measures to negative material, interpreted as an “appropriate” signal to avoid unpleasantness that was not present among the participants in the borderline group. Interestingly, the AVPD group demonstrated an eye-blink startle response across all conditions, suggesting an overgeneralized reactivity.

While there have not been neuroimaging studies directed at AVPD, there has been work done on related psychopathology such as social phobia that may provide clues to better understanding cognitive features of AVPD. Campbell and colleagues (2007) compared those with the generalized type of social phobia to healthy controls on a task where participants viewed pictures of human faces depicting anger, fear, contempt, happiness, and neutral expressions during functional magnetic resonance imaging. The study design allowed the researchers to examine the temporal characteristics of response. Interestingly, there was a delayed amygdala response to the angry, fearful, and happy faces for the patient group relative to the healthy controls, suggesting a problem with orienting toward emotion for those with generalized social phobia. The authors went on to suggest that circuits involved in self-evaluations may be taking precedence, for instance, medial-temporal regions of prefrontal cortex (Gusnard, Akbudak, Shulman, & Raichle, 2001).

In a more recent neuroimaging study by Blair and colleagues (2008), increased activation was found in response to fearful expressions for patients with both generalized social phobia and generalized anxiety disorder, but there was a direct relationship to their level of self-reported distress. Here, however, the generalized anxiety disorder patients evidenced less amygdala activity. Other work has shown that patients with generalized anxiety disorder fail to engage brain regions associated with cognitive control (e.g., anterior cingulate) and thus are less able to regulate emotional response than healthy controls (Etkin, Prater, Hoefl, Menon, & Schatzberg, 2010). Perhaps these patient groups rely on other strategies. Whatever the case, these findings are not consistent, in part because methods vary, and raise more questions than answers. Among the questions are whether there is a one-to-one correspondence between neural circuits and diagnoses based on clinical description.

Another strategy is to examine experimentally the relevant components or potential intermediate phenotypes to AVPD (and social anxiety). The construct of rejection sensitivity, characterized by a sensitivity and expectation of interpersonal rejection, is relevant to AVPD (Downey & Feldman, 1996). Downey and Feldman have shown experimentally that those who are sensitive to rejection, based on the measure that they developed, perceive rejecting behaviors from others in ambiguous interpersonal situations. Low self-esteem has been associated with a defensive motivational system as demonstrated by disruptions in attentional control using a startle eye-blink paradigm (Gyurak & Ayduk, 2007). In an analog study, “rejection-sensitive” individuals who experienced being rejected were then presented with the opportunity to allocate hot sauce to the offender to express their aggression in response to being rejected. Those higher on rejection sensitivity were more likely to respond more aggressively to the person who rejected them as inferred by the amount of hot sauce that they gave them (Ayduk, Gyurak, & Luerssen, 2008). This finding persisted after controlling for neuroticism, suggesting that the hostile reaction was based on rejection sensitivity, and not to more general distress.

Neuroimaging studies of rejection sensitivity have also shown differences in brain activation in limited cortical areas. In a task where participants high and low on rejection sensitivity viewed images suggesting themes of rejection versus other themes of acceptance, those who were less rejection sensitive showed greater activity in left prefrontal cortex, along the inferior frontal gyrus and the right dorsal superior frontal gyrus (Kross, Egner, Ochsner, Hirsch, & Downey, 2007). These regions are implicated in cognitive control of both behavior and

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emotion. Behavioral work combined with cognitive neuroscience approaches may offer advantages by working with well-developed constructs such as rejection sensitivity or self-esteem over more complex diagnostic formulations.

(p. 562) Conclusion

Writing a chapter on a diagnosis that is in the process of being revised presents certain challenges and the possibility of new discovery. Whatever the final formulation of AVPD is in *DSM-5*, there are several important things to bear in mind. First, AVPD is a construct, or organization of traits, behaviors, and symptomatic distress that has explanatory power aiding in understanding and treating a form of psychological distress. In this sense, it is not a “real” thing existing in nature and hence is subject to change based on our views and understanding of psychopathological processes and personality. Second, the evolution of the diagnosis is informative in that it provides a trajectory that hints at potential possibilities beyond *DSM-5*. Third, the distress and dysfunction captured by AVPD may be described by trait components from personality theory, for instance, the FFM. The effort to integrate trait components into the *DSM-5* is laudable, and it may set the stage for future empirical work based on the *DSM-5* to clarify personality traits from major clinical syndromes.

Our present understanding of descriptive models of psychopathology strongly suggests that diagnostic constructs of mental disorders are best represented dimensionally (see Eaton, Krueger, South, Simms, & Clark, 2010, and also Krueger, 2005), and the evidence that neurobiological dimensions underlie many psychiatric disorders is growing (Cuthbert, 2005; see Larson, Nitschke, & Davidson, 2007). The case of AVPD and the *DSM-IV-TR* Axis I disorder social phobia appear to exist on a continuum with the construct AVPD capturing more severe and debilitating forms of social anxiety that has progressed to the point of becoming more integral to the person. Perhaps there is utility in identifying a subset of those individuals for whom chronic anxiety has become *who they are* and not simply *what they experience* to help clinicians recognize an entrenched maladaptive interpersonal style that will require a qualitatively different treatment approach. Regardless, the continuum model is very useful in allowing the identification of the mechanisms—interpersonal, psychological and biological—that operate to instigate and maintain social anxiety.

Future Directions

These are times of the potential for exciting advances in the area of personality pathology and psychiatric diagnosis. However one regards the post-1980 editions of the *DSM*, they have facilitated a burgeoning of empirically based diagnostic studies over the last three-plus decades. Together with the advancements in personality theory, including the FFM, the study of personality and psychopathology has at its disposal an unprecedented wealth of data. At the same time, advances in neuroscience are being organized in new ways aimed to clarify mechanisms of psychopathology (Sanislow et al., 2010), and there are hints of relationships between personality traits and brain structure (see DeYoung et al., 2010). The issue of chronic social anxiety becoming personality pathology, or *who the person is*, also underscores the importance of developmental mechanisms. As epigenetic factors unfold, the identification of windows of vulnerability related to the experience of social anxiety may give rise to protective strategies for early intervention before anxiety becomes chronically dysfunctional and complicated with multiple forms of psychopathology. For this, work in the area of personality traits and affect vulnerability will be important (see Schmidt & Jetha, 2009). Finally, it has become clear that functional impairment, if more clearly conceptualized, may provide opportunities to improve our approach to diagnosis (see Mullins-Sweatt & Widiger, 2010). The coming years, including *DSM-5* and beyond, promise to be a very interesting time as understanding increases across all of these areas and is integrated to further clarify, refine, or reorganize the diagnostic constructs we use to describe a strong sense of feeling bad about oneself in combination with chronic social anxiety (and other disorders).

Author's Note

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Notes:

- (1.) For DSM-III (APA, 1980) and DSM-III-R (APA, 1987), passive aggressive Personality disorder was also classified in Cluster C, prior to being moved from the formal diagnostic scheme to research a diagnosis.
- (2.) In addition to avoidant, the other types include antisocial/psychopathic, borderline, obsessive compulsive, narcissistic, and schizotypal (albeit schizotypal may no longer be classified as a personality disorder; a possibility being considered as well for antisocial/psychopathic, avoidant, obsessive-compulsive, and borderline; see Skodol, Chapter 3).

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