PERSONALITY DISORDERS

Avoidant Personality Disorder

AvPD

DSM-5-TR 301.82 | ICD-10-CM F60.6

Pervasive social inhibition, felt inadequacy and hypersensitivity to negative evaluation, with avoidance despite genuine longing for closeness.

PREVALENCE	TYPICAL ONSET	SEX RATIO	COURSE
~2.4% US adults (NESARC)	Childhood shyness; adult dx	Roughly equal male:female	Chronic; slow partial remission

CLINICAL PICTURE

- The patient wants relationships and grieves their absence, which separates avoidant pathology from the indifference of schizoid detachment.
- Social situations are scanned continuously for signs of disapproval, and neutral faces or brief pauses are read as evidence of rejection.
- Intimacy is restrained for fear of being shamed or ridiculed, so disclosure stays shallow even in long-standing partnerships.
- Occupational avoidance is common: promotions, presentations and team roles requiring interpersonal contact are declined or sabotaged.
- Self-description centers on being socially inept, unappealing or inferior, and compliments are discounted as politeness or error.
- Presentation is usually via depression, social anxiety or somatic complaints rather than any spontaneous report of the personality pattern.

DIAGNOSTIC CRITERIA AT A GLANCE

- Four or more of seven features are required, spanning occupational avoidance, need for guaranteed acceptance before engaging, and restraint in intimacy.
- Remaining features cover preoccupation with criticism or rejection, inhibition in new interpersonal settings, felt ineptness, and reluctance to take risks.
- The pattern must be pervasive across contexts, present by early adulthood, and produce clinically significant distress or functional impairment.
- Shyness normative to an immigrant or minority experience, and avoidance explained by a medical condition or substance, are exclusions.
- The Section III alternative model rates self-esteem and intimacy impairment plus anxiousness, withdrawal, anhedonia and intimacy avoidance traits.

NEUROBIOLOGY & PHYSIOLOGY

- Twin studies place cluster C heritability near 27-35%, with substantial genetic overlap between avoidant personality disorder and social anxiety disorder.
- Behaviorally inhibited temperament identifiable in infancy predicts adult social avoidance, giving the disorder one of the clearest developmental precursors.
- Amygdala and insula hyperreactivity to faces and social evaluative threat parallels findings in generalized social anxiety disorder.
- Blunted ventral striatal response to social reward is reported, so approach behavior is weakly reinforced even when interactions go well.
- Cloninger temperament profiling shows high harm avoidance with low novelty seeking, consistent with serotonergic and dopaminergic constraint.
- Exaggerated cortisol and autonomic reactivity to the Trier Social Stress Test tracks the anticipatory dread patients describe before any social contact.

PSYCHOLOGICAL MECHANISMS

- Beck's cognitive model centers on core beliefs of defectiveness plus conditional assumptions that exposure of the true self guarantees rejection.
- Avoidance is negatively reinforced by immediate relief, and safety behaviors such as scripted talk prevent disconfirming feedback from registering.
- Post-event processing keeps failures alive for days, and self-imagery is encoded from an observer perspective that exaggerates visible anxiety.
- Developmental histories commonly include parental criticism or rejection, peer victimization and teasing about appearance or performance.
- Shame rather than performance failure organizes the fear, so reassurance about competence rarely changes the underlying self-concept.

DIFFERENTIAL & COMORBIDITY

- Generalized social anxiety disorder overlaps so heavily that most data favor a severity continuum rather than two categorically distinct conditions.
- Schizoid personality disorder lacks the longing for closeness and shows indifference to criticism, whereas avoidant patients are wounded by it.
- Dependent personality disorder frequently co-occurs; both fear abandonment, but avoidant patients withdraw while dependent patients cling.
- Depression, dysthymia, generalized anxiety, agoraphobia and alcohol use disorder are the leading comorbidities and often the presenting complaint.
- Risk comes from chronic depression, isolation and alcohol misuse; treatment dropout is high because attending sessions is itself an exposure.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- No agent is approved for the disorder, and evidence is extrapolated from generalized social anxiety trials with modest effect on core traits.
- First-line SSRIs include **sertraline 50-200 mg/day**, **escitalopram 10-20 mg/day** and paroxetine 20-60 mg/day, titrated slowly to limit early activation.
- **Venlafaxine XR 75-225 mg/day** is a reasonable second step; monitor blood pressure at doses above 150 mg and taper slowly given discontinuation effects.
- MAOIs such as **phenelzine 45-90 mg/day** remain effective for severe social anxiety but the dietary and interaction burden limits routine use.
- Avoid benzodiazepines and as-needed alcohol substitutes; beta blockers help discrete performance anxiety only, not pervasive social avoidance.

PSYCHOTHERAPY

- **CBT** with graded in vivo exposure, dropped safety behaviors and social skills practice has the strongest trial support, typically 15-25 sessions.
- **Schema therapy** over one to two years targets defectiveness, social isolation and abandonment schemas when brief CBT leaves core beliefs intact.
- Short-term psychodynamic and interpersonal therapies show comparable symptom gains, supporting a structured, alliance-focused frame over any single brand.
- Group therapy supplies live exposure plus corrective feedback, but early dropout is high, so prepare the patient and expect attendance lapses.
- Treat in-session avoidance, cancellation and vagueness as the disorder appearing in the room rather than as resistance or poor motivation.

ADJUNCT & SUPPORTIVE

- Video feedback after role plays corrects the distorted observer-perspective self-image that verbal reassurance alone consistently fails to shift.
- Track progress with the **LSAS** or SPIN plus a count of completed exposures, since subjective distress lags behavioral change by weeks.
- Behavioral activation and scheduled social contact prevent the between-session drift back into isolation that erodes exposure gains.
- Vocational counseling with graded workplace exposure addresses the underemployment that drives much of the long-term functional cost.
- Treat comorbid depression and alcohol use concurrently, since both blunt exposure learning and predict premature termination.

CLINICAL PEARLS

- Wants closeness but fears it; the schizoid patient does not want it at all.
- AvPD and generalized social anxiety look like one dimension at different severities.
- Medication supports exposure; without exposure the avoidance stays fully intact.

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NOTE

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