



Received: 11 February, 2021

Accepted: 01 March, 2021

Published: 02 March, 2021

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Review Article

Avoidant personality disorder: Definition, clinical and neurobiological profiles, differential diagnosis and therapeutic framework

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Abstract

This work focuses on the analysis of the general, clinical, neurobiological and therapeutic profiles of the disorder under examination, suggesting a particular attention to the elements that could make a difference in relation to healing or better management of symptoms, often aggravated by frequent comorbidities.

Contents of the manuscript

Definition and general profiles

The present personality disorder, disciplined by the DSM-V [1], in cluster C, is characterized by a penetrating pattern of behaviour of social inhibition, feelings of inadequacy, extreme sensitivity to negative evaluations towards oneself and the tendency to avoid social interactions. Most individuals sometimes use avoidance to relieve anxiety or to prevent difficult situations. Avoiding personality disorder, on the other hand, is characterised by a pervasive pattern of social inhibition, feelings of inadequacy and hypersensitivity to negative assessments. People with this disorder are concerned about being ridiculed by others, rejected or criticised. This leads them to avoid social situations in which they have to interact with others by limiting the normal development of social skills over time. People with personality avoidance disorder generally live in isolation, spectators of a world in which they would like to take part but which is too scary for them. They tend, in fact, to think that they are not good enough, that they can be rejected or hurt, that others do not like them, that they are unattractive and socially inadequate. These thoughts lead

to high states of anxiety in social situations, such as work, friends, intimate relationships, which they tend to avoid carefully for fear of being ridiculed, criticized and rejected. The pre-eminent condition is "social distress and anxiety" and a marked tendency to lead a routine life that shelters these people from the potential risks of novelty. In order to live positive and gratifying sensations, even if temporary, the avoiders cultivate solitary interests and activities. Finally, social withdrawal confirms their personal sense of social inadequacy, in an apparently endless spiral. People with avoidant personality disorder often consider themselves socially incapable or unattractive on a personal level and avoid social interactions for fear of being ridiculed, humiliated or objects of dislike. Despite the difficulties and strong inhibitions, however, people with this disorder would like to have social relationships; unlike other personality disorders in which the person avoids interaction but at the same time is not interested in it. However, the avoidance disorder is diagnosed at the beginning of adulthood even though the symptoms usually exist from childhood; it is no coincidence that strong associations have been found with emotional neglect, particularly rejection by one or both parents, or perceived rejection by the peer group [2-8].



The cause of the avoidant personality disorder is not clearly defined, and can be influenced by a combination of social, genetic and biological factors. Specifically, various anxiety disorders in childhood and adolescence have been associated with a temperament characterised by behavioural inhibition, including characteristics of shyness, fear and introversion in new situations. Many people diagnosed with the avoidant disorder have had previous painful chronic experiences of criticism and rejection by parents or peers, due to their psychological characteristics (shyness, conduct disorders, oppositional-provocative disorder, attention deficit/hyperactivity disorder) or physical defects that are not accepted. In particular, the need to bond with parents “prone to rejection” makes the person affected by the disorder “hungry” for relationships, but his great desire gradually develops into a defensive “shell” of self-protection against repeated parental criticism. Many others, on the contrary, claim to have had problems with ultra-protective parents that prevented him from developing his own personality [9-16].

The neural correlates

The interest in literature for this disorder has re-emerged only in recent years, with the advent of instrumental examinations in case of studying related neurobiological processes. In this perspective, the interest in the scientific literature has privileged the examination of multiple aspects and domains, including cognitive and attentional bias, coping strategies, metacognitive abilities, comorbidity with other disorders, general functioning, quality of life, and more. To these is added the current attempt in neuroscience to identify the neurobiological correlates and neural mechanisms involved in the emotional regulation of the disorder under analysis. The data emerging from a recent study, conducted through the use of functional neuroimaging, shows that a central role in the hypertrophy of the anxious response to social stimuli in subjects affected by this disorder can be traced back to a high reactivity of the amygdala both in the phase preceding the stimulus and in that of actual exposure. To this end, the authors have prepared an experimental task through which to measure the different reactions in front of the negative social stimulus. The subjects of the experiment are given an instruction on the behaviour to adopt towards the visually presented stimulus. The sequence is divided into 5 steps: listening to a recorded audio instruction (‘Look at the image’ or ‘Assume critical distance from the image’), 1-3 seconds interval, appearance of the stimulus, evaluation of the emotional intensity experienced and finally indication of the degree of detachment from the stimulus. Each subject was also given a questionnaire to evaluate anxiety of state and trait anxiety. The results of the study suggest that patients present a higher bilateral activity of the amygdala than the control group of healthy subjects during the early evaluation of the negative social stimulus. This observation is repeated in the negative stimulus exposure phase, although amygdala hyperactivity appears more intense in the right region. In the first case the level of amygdala activation correlates significantly with trait anxiety, while in the second case it correlates with state

anxiety. There are, instead, no differences between the group of patients affected by the disorder and the control sample in the critical distance attitude towards the negative stimulus; more in detail, the activity of the prefrontal areas involved in the cognitive regulation of emotions presents profiles very similar to those of healthy subjects. The effects on the clinical level, however, appear to be of extreme interest. If pharmacological intervention is an important and necessary action in cases of greater emotional intensity, the adoption of therapeutic techniques capable of favouring down-regulation of states of anxiety represents a decisive act in the modulation of early warning typical of the emotional experience of patients with this disorder. In any case, the small sample of the experiment (17 patients and 21 control subjects) must be underlined, which necessarily imposes an attitude of caution and reserve with regard to the data that have emerged, which are nevertheless promising and relevant for the future advancement of studies on neural correlates and on the regulation of the emotional structure in the disorder under examination [3,17].

Clinical profiles

With reference to the disorder in question, it should first be considered that in many cases there is an “avoidance style” rather than a real personality disorder: the substantial difference between the two conditions is determined by assessing how deeply these affect the normal “functioning” and performance of the individual in daily life. Think of a “bridge” between the healthy and the pathological. The avoidance style is found on the end of the healthy part, while the avoidance of personality disorder lies on the unhealthy part [3].

The characteristics of the avoiding style of personality are [1,3]:

- 1) Feel comfortable with habit, repetition and routine;
- 2) Prefer the known to the unknown;
- 3) Close fidelity to family and/or a few friends; tendency to have the house as a point of reference (and consequently go out little);
- 4) Sensitivity and concern about what others think; tendency to an awkward and apprehensive attitude;
- 5) Excessive discretion and prudence in social interactions
- 6) Behaviour that tends to be reserved and self-repressed around others;
- 7) Tendency to curiosity and attention considerably focused on hobbies and pastimes;
- 8) Counterphobic behaviour successfully adopted.

The characteristics of the avoidance of personality disorder are instead [1,3]:

- 1) Exaggeration with respect to their actual magnitude of potential difficulties, physical hazards and associated risks in acting routine, but outside the routine;

- 2) Total, or almost total lack of intimacy and confidence with individuals outside of close kinship; rejection of activities involving significant interpersonal contact;
- 3) Reluctance to get involved with other people without certainty of approval; excessive sensitivity to criticism and disapproval;
- 4) Fear of blushing, crying or anxiety in front of other people;
- 5) Reticence in social situations caused by fear of saying something inappropriate or silly, or not being able to answer a question;
- 6) Tendency to perform less than one's ability and difficulty in concentrating on one's professional activities and hobbies.

From DSM-V [1], the disorder under examination is classified as a pervasive pattern of social inhibition, feelings of inadequacy and hypersensitivity to negative judgement, which begins in early adulthood and is present in various contexts, as indicated by four (or more) of the following:

- 1) Avoid work activities that involve significant interpersonal contact for fear of being criticised, disapproved of or rejected.
- 2) It is reluctant to enter into a relationship with people unless it is certain of pleasure.
- 3) Shows limitations in intimate relationships for fear of being humiliated or ridiculed.
- 4) He is concerned about being criticized or rejected in social situations.
- 5) Is inhibited in new interpersonal situations for feelings of inadequacy.
- 6) He sees himself as socially inept, personally unattractive or inferior to others.
- 7) He is unusually reluctant to take personal risks or engage in any new activity, as this can be embarrassing.

From the point of view of differential diagnosis, the disorder under examination differs from [3]:

- 1) **Social phobia:** the differences between social phobia and avoidant personality disorder are subtle. Avoidant personality disorder involves anxiety and avoidance more pervasively than social phobia, which is often specific to situations that can cause embarrassment in public (for example, speaking in public, on stage). However, social phobia can lead to a broader model of avoidance and can therefore be difficult to distinguish. However, research suggests that people with avoidance disorder, in common with people with other social phobias, over-monitor their inner reactions when involved in social interactions. However, in contrast to

people with other social phobias, they also over-monitor the reactions of the people they are interacting with. The extreme tension created by this monitoring can justify the hesitant way of speaking and the taciturnity of many people with avoidant personality disorder. They are so concerned about monitoring themselves and others that producing fluent speech becomes difficult.

- 2) **Schizoid personality disorder:** Both disorders are characterised by social isolation. However, patients with schizoid personality disorder tend to isolate themselves because they are disinterested in others, while those with avoidant personality disorder tend to isolate themselves because they are hypersensitive to possible rejection or criticism of others.
- 3) Other personality disorders may be somewhat similar to avoidant personality disorder, but they can be distinguished by peculiar characteristics (for example, a need to be treated in dependent personality disorder versus prevention of rejection and criticism in avoidant personality disorder).

Finally, from the point of view of comorbidities, as we have already seen, there are often anxiety and mood disorders, depressive (up to the risk of suicide), obsessive and phobic, precisely because of the common symptomatology. Such comorbidities can aggravate the general picture, making it more difficult to solve problems [18-29], especially in terms of psychotherapy and for understanding the differences between awareness of one's clinical condition and the awareness of wanting to obtain a benefit by changing one's dysfunctional habits and behaviour [30,31].

Treatments profiles

The cognitive-behavioural treatment for avoidance personality disorder works in the first instance on the analysis of dysfunctional, distorted and inaccurate automatic thoughts, which are the basis of the disorder. These thoughts, once identified and shared with the patient, are challenged through refutation and replaced with new, more functional thoughts. For example, suppose that the patient strongly believes that he or she is inferior to others and that others would like him or her to leave the company where he or she works. The therapist, using various techniques, questions the validity of the thoughts by asking him/her the name of the people he/she likes to spend time with him/her or other experiences he/she has had fun with them. In this way the therapist demonstrates that there are people who want to be with him and with whom he has fun and that, in general, his fears and insecurities in social situations are irrational and unfounded. This is a simple example of a technique used in cognitive-behavioural therapy called cognitive restructuring. Interpersonal cycles are also shown to the patient, and thus how his personal beliefs also influence others with reactions that ultimately only confirm the basic belief. The aim is to show him/her possible strategies for dealing with the feared situations using behavioural techniques. The analysis of interpersonal cycles also makes it possible to improve the therapeutic relationship



itself, which is fundamental for the continuation and success of the therapy. For example, in this way the patient would know that due to his personality characteristics he can perceive the therapist as critical or judging, increasing the sense of security if this happens and eventually sharing it in real time and evaluating its truthfulness. Another therapeutic approach for the treatment of personality avoidance disorder is the interpersonal metacognitive therapy which, through the narration of one's own autobiography, attempts to solicit the patient's ability to differentiate between imagination and reality, in particular in considering negative representations of oneself with the other as hypothetical and not a mirror of an objective reality; evoke alternative representations that the patient possesses, but which are masked by the dominant problematic mental states; promote new behaviours to replace the usual ones; to form an integrated representation of oneself that takes into account psychological contradictions and errors in the patient's reasoning, such as systematically noticing hostile intentions in the other or strategies of the type "if I avoid them, I certainly do not suffer negative judgement"; to read the intentions of others with greater sensitivity; to distinguish expected signs of hostility from actual ones and to decentralise, that is, to assume the point of view of the other not influenced by one's own negative expectations. Finally, various classes of psychopharmaceuticals, such as tricyclic antidepressants, mono-Amino-Oxidase inhibitors, selective serotonin reuptake inhibitors and dual serotonin and norepinephrine inhibitors, as part of integrated therapy, can be useful in reducing individual sensitivity to fear of rejection, criticism and feelings of embarrassment and shame. Benzodiazepines are indicated for the treatment of anxiety or panic, nervousness and tension caused by having to deal with social situations usually avoided. β -blockers have been found to be effective in managing the hyperactivity of the autonomic nervous system (sweating, tremors, redness, etc.) that occur when facing dreaded situations [3].

Conclusions

The recent interest of the academic world for this disorder echoes the need for further investigation, especially in terms of neurobiological and psychopharmacological elements, able to better explain the internal relations with this disorder and to find the best strategic solutions to solve, according to a multifactorial approach, the problems described by patients.

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