Personality Disorders
Avoidant Personality Disorder

DSM-IV-TR Diagnostic Code: 301.82 Avoidant Personality Disorder

Diagnostic Guidelines:

1. Establish Diagnostic accuracy as defined in DSM-IV-TR/ICD-9.

2. Identify differential diagnoses and co-morbid problems: Rule out social phobia, substance abuse, organicity, dysthymia, anxiety disorders, post traumatic stress disorder. Use psychological testing, including the use of objective and projective personality assessment instruments, to assist with rule outs when treatment based on standard clinical evaluation and treatment approaches are ineffective or fail to improve the client's mental status and related life experiences. It is important to note that Avoidant Personality Disorder often presents as a co-morbid factor with Axis I diagnoses such as Generalized Anxiety Disorder, Social Phobia, or Panic Disorder with Agoraphobia. In fact, some experts estimate that rates of co-morbidity of Avoidant Personality Disorder with one or more of these disorders can be as high as 50%.

3. Establish accurate diagnosis through continued assessment of diagnosis over time and rule out of other diagnoses as necessary.

4. Obtain external corroboration of diagnosis when possible through review of past treatment history, legal history, etc.

5. Review previous treatment episodes to determine efficacy of treatment interventions and therapeutic gains.

Treatment Guidelines

1. Behavioral and/or cognitive approaches are the most useful in treating this disorder. The focus of therapy must first be directed at solidifying an alliance with the clinician to prevent early termination of therapy. Assertiveness training along with behavioral rehearsal techniques may be useful and may be employed in either individual or group therapy modalities. The clinician should be cautious when giving assignments to exercise new social skills outside of therapy, because failure may reinforce the client's already poor self-esteem. Explore client's desired behaviors revolving around social interactions. Utilize role playing scenarios, modeling and behavioral rehearsal to increase client's sense of self efficacy in social situations. Cognitive approaches of helping the client to identify and manage distorted beliefs about self and others may be beneficial. Together

examine supporting evidence for and against distorted perceptions. The tracking of irrational beliefs by the use of a journal may assist to reinforce lasting change.

2. Therapy is usually most effective when it is relatively short-term and oriented toward finding solutions to specific life problems (e.g., engaging in social interactions in specific settings). The negative self-perception is a life-long, pervasive cognition and is typically not conducive to regular methods of increasing one's self-esteem. A solid therapeutic relationship founded with good rapport and listening to the client is important to the clinician's effectiveness.

3. It is necessary to take a more detailed evaluation than usual, while doing so in an unobtrusive fashion in an effort to identify when information is withheld or overlooked. The client may tend to minimize symptoms or the actual degree of disability in an effort to please the therapist. The clinician should be sensitive to nonverbal cues of the client as part of this evaluation.

4. The clinician needs to maintain a middle ground between inadvertently cooperating with the client to minimize complaints versus being overly intrusive which may threaten the client's sense of privacy and modesty and possibly contribute to non-compliance to treatment.

5. A low-key approach that emphasizes the clinician's friendliness and availability and includes prompt return of phone calls, respect for punctuality at appointments, and periodic reassurance of the clinician's personal interest and commitment will counter the client's normal inclination to see himself or herself as unimportant or undeserving of the clinician's attention. Explore assumptions that the client may have regarding the therapist in comparison to those held in previous significant relationships. Identify how projection can reinforce our perceptions of self and others.

6. Structured group therapy may be useful to increase socialization and interactional skills as well as desensitize the client to the exaggerated threat of rejection. Consider assertiveness training.

7. Family and conjoint therapy are appropriate modalities to explore patterns and themes of distancing and rejection. Family members are encouraged to identify their own behaviors and distorted thoughts that reinforce unhealthy boundaries and interactions. Increase the client’s sense of self esteem by teaching assertion and communication skills starting with low risk issues and working towards more threatening concerns.

8. Utilize relaxation techniques to increase self-awareness of bodily sensations, both in and out of stressful situations. Aid the client through desensitization exercises in learning self-regulation of physiological responses.

9. A medication evaluation is valuable for relief of symptoms during acute phases,

however, medications such as anti-anxiety agents and antidepressants should only be prescribed for specific and acute Axis I diagnoses or problems suffered in conjunction with the personality disorder. Clinicians should avoid overprescribing to someone with this disorder, because they often present with complaints of anxiety in social situations or a feeling of disconnectedness with their feelings. Long-term medication maintenance is usually contraindicated.

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