Distancing

Avoidant Personality Disorder

Revised and Expanded

MARTIN KANTOR

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PRAEGER

Westport, Connecticut
London

Library of Congress Cataloging-in-Publication Data

Kantor, Martin.
Distancing : avoidant personality disorder / Martin Kantor. — Rev. and expanded
p. cm.
ISBN 0–275–97829–X (alk. paper)
1. Avoidant personality disorder. 2. Avoidance (Psychology). 3. Remoteness
(Personality trait). I. Title.

RC569.5.A93K35 2003
616.85′8—dc21 2003052894

British Library Cataloguing in Publication Data is available.

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reproduced, by any process or technique, without the
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Library of Congress Catalog Card Number: 2003052894
ISBN: 0–275–97829–X

First published in 2003

Praeger Publishers, 88 Post Road West, Westport, CT 06881
An imprint of Greenwood Publishing Group, Inc.
www.praeger.com

Printed in the United States of America

The paper used in this book complies with the
Permanent Paper Standard issued by the National
Information Standards Organization (Z39.48–1984).

10 9 8 7 6 5 4 3 2 1

To M.E.C.

Let us not forget that the motives behind human actions are
usually infinitely more complicated and various than we assume
them to be in our subsequent explanations . . .

—Dostoyevsky, *The Idiot*

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Preface

In today's world, avoidance, distancing, removal and isolation have become so widespread that people assign greater importance to their possessions than they assign to their relationships. This is not surprising. What will startle us, however, is the extent to which laypersons, clinicians, and researchers alike have overlooked, misunderstood, or downplayed avoidance, even though, like sex or hunger, it serves as a primary determinant of behavior, creates as much interpersonal difficulty as schizoid remoteness, depressive withdrawal, and borderline ambivalence, and causes as much social distress as ignorance and poverty. Avoidants themselves (I use the term *avoidants* to refer to patients with an Avoidant Personality Disorder) think they are happy as things stand, or, if they feel unhappy, blame their unhappiness on their stars or on their fate. Victims of avoidants remain convinced that something is wrong with them, and try to do better, when it is the avoidant who has the problem and should be the one making the improvements. Psychotherapists treating avoidants often have too narrow a view of what causes and constitutes avoidance. In the realm of what causes avoidance, they often focus exclusively on the avoidant's fear of criticism, humiliation, and rejection, without considering other equally important reasons to be avoidant, such as the paranoid tendency to assume criticism, humiliation and rejection in their absence, or the histrionic tendency to rage mightily over the most insignificant and unimportant of interpersonal events. In the realm of what constitutes avoidance, they focus almost exclusively on two groups of avoidants: individuals who are timid and shy in their relationships, and individuals with a Social Phobia such as public speakers with stage fright. Virtually

overlooked are avoidants whose social anxiety is displayed in other ways. Particularly overlooked are those avoidants who are neither shy nor phobic but who form unstable relationships characterized by a fear of closeness, intimacy, and commitment.

In its turn the scientific literature overlooks much of the valuable work already done on avoidance, often simply because it is otherwise labeled. For example, what scanty literature there is on avoidance fails to mention that as early as 1945 Otto Fenichel described a group of individuals who suffer from "social inhibitions consisting of a general shyness . . . [that may lead to withdrawal] from any social contact [because] they anticipate possible criticisms to a degree that makes them hardly distinguishable from persons with paranoid trends" (p. 180), or that in 1953 Harry Stack Sullivan devoted substantial portions of his text *The Interpersonal Theory of Psychiatry* to the subject of avoidance. Karen Horney's contribution to the concept of Avoidant Personality Disorder (as outlined in Chapter 2) is generally downplayed, and Eric Berne's (1964) *Games People Play*, although it describes a number of what are essentially avoidant transactions substituting for real intimacy, is not as renowned as it should be as a treatise on interpersonal distancing. As usual, although Sigmund Freud has done much of the seminal work on avoidance, he gets little, or none, of the credit. For example, in *Totem and Taboo*, Freud (1950) was one of the first to use the term "avoidance," trace the "ancient history" or "phylogenetic" origin of "avoidance" (his word), and analyze "avoidance," in this case as it took the form of that notorious negativity we so often see between a man and his mother-in-law.

My book *Distancing* makes a break from tradition in order to provide a fresh, in-depth descriptive, dynamic and therapeutic look at avoidance and Avoidant Personality Disorder (AvPD). *Descriptively,* I delineate four types of avoidants. Collectively, all primarily suffer from social or relationship anxiety leading to distancing. Individually, each is distinguished by the specific way they distance.

Type I avoidants are removed avoidants who distance by withdrawing. There are two subtypes depending on the specific nature of the withdrawal: shy social isolates and social phobics. Shy social isolates stay at home living by themselves or with their family, either rarely socializing or socializing but within limits—making a few distant contacts and keeping a few old friends while having great difficulty meeting new people and even more difficulty sustaining close, intimate relationships. As Theodore Millon and Roger D. Davis (1996) say, these are the "*conflicted avoidants* [who] would like to be close and show affection but anticipate experiencing intense pain and disillusionment" (p. 268). Therefore they "precipitate disillusionment through obstructive and negative behaviors" (p. 268). In contrast, social phobics package their social anxiety into discrete quanta. Their anxiety appears in specific situations where they are

called upon to perform, for example, when they are called upon to speak in public. They then withdraw, but they do so only in these special circumstances, in the main sparing other, more intimate, aspects of their relationships. As Millon and Davis (1996) say, these phobic avoidants "disposed to find highly specific phobic precipitants" (p. 269) "turn their attentions to finding a symbolic substitute, some object or event onto which they can displace and funnel their anxieties" (p. 270) by "a psychic displacement and condensation of [their] internal and generalized anxiety onto a symbolic external object" (p. 270).

Type II avoidants are ambivalent avoidants who distance by having numerous superficial but few or no close intimate relationships. Typical Type II avoidants include my mingles avoidants, serial daters who meet new people easily but have difficulty sustaining and developing old relationships due to a fear of closeness, intimacy, and commitment.

Type III avoidants are also ambivalent vacillating avoidants who, however, distance by first forming what at least appear to be satisfactory relationships that seem to do well (if only superficially) and last. Then, after a shorter or longer period of time, they do an about-face and demean, devalue, and disavow those relationships—even when, or just because, they seem to be working. These are the seven year itch avoidants who form a long-term relationship with a lover, then one day announce "I need a hiatus from this relationship." Or they get married, then one day either file for a divorce out of the blue or just disappear forever out of the life of a significant other, often one who truly loves them.

Type IV avoidants are dependent individuals who distance by becoming deeply involved with, or immersed in, a regressive relationship with one other person or with a closed group of individuals. These individuals are exemplified by the codependents described by Melody Beattie (1987). Their goal is to get close to one in order to reduce or eliminate worldly contact with all. (All of these types and subtypes will be discussed more fully in Chapter 4.)

Dynamically, I view the distancing of Type I–IV avoidance as the product of multiple social/relationship anxieties—not just one. In addition to anxiety about criticism, humiliation, and rejection (the official avoidant dynamic), avoidants suffer from anxiety about being flooded by out-of-control instincts rushing out should they open up their inner Pandora's box full of dark sexuality and anger; anxiety about being depleted of life-energy as a result of letting go of their feelings; and, the *opposite* of anxiety about rejection, anxiety about the possibility of *acceptance.* This latter anxiety—a most important, and often downplayed, anxiety—is in turn due to one or more component anxieties: anxiety about becoming dependent; anxiety about being controlled, and as a result being overwhelmed by, trapped in, and engulfed by the closeness and intimacy of a committed relationship; and anxiety both about winning (a fear of success)

and about losing (a fear of failure). My definition of AvPD is therefore much broader than the narrow definition of AvPD found in the *DSM-IV*: "AvPD is a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation . . . present in a variety of contexts" (p. 662).

In *Distancing* I supplement clinical material gleaned from the avoidant in the therapist's office, on the structured psychological test, and in the research lab to include a perspective on the avoidant that the serious student of personality disorder too often discounts because of its informal, anecdotal, and so supposedly unscientific nature—a study of the avoidant in the real world, in his or her native habitat, in a place where he or she acts spontaneously, thereby producing material useful for bringing the scientific approach to the patient into line with the normal proband. I observe avoidant behavior in everyday life. I watch avoidants doing real, avoidant things without necessarily being aware that they are being studied. This way they reveal themselves without posing and without playing up to an audience, presenting a fleshy and true picture, not one that is suitable only for framing. I observe avoidants at home, on the dock on a summer's day in a singles' resort, at the rail on a winter's morn in a singles or gay bar, and in the supermarket, missing the people around them as they obsessively shuffle their two-for-one coupons. I also observe them in the gym, doing precisely three sets of twelve reps each, deliciously contemplating how their body will look six months from now when they should be even more deliciously contemplating the person at hand, the one right before them, the one waiting impatiently for the machine. I watch them fight for the machine, not for the person about to take it away from them, as they tell the interloper, "Go away and come back when I'm done," instead of turning the situation around to their nonavoidant advantage by saying, "Come here; let's not fight over gym machines; let's talk about us, and our getting together for a date, perhaps tonight."

My goal is to evolve a dedicated, eclectic, holistic, action-oriented therapeutic approach to treating the avoidant/AvPD patient, a therapeutic approach I call *avoidance reduction.* My therapeutic approach is *dedicated* because it is focused on the distancing process in all its aspects. It is *eclectic and holistic* because it deals with a broad range of core avoidant issues, including but not limited to the developmental, psychodynamic, cognitive-behavioral, interpersonal and existential-philosophical basis of avoidance, that is, it covers the main components of avoidance that go into making up the whole avoidant picture—the avoidant gestalt. It is *action-oriented* because it emphasizes doing as much as thinking. It goes beyond the more passive techniques such as those that emphasize developing understanding into the psychodynamics of avoidance, its developmental origins, and its basis in cognitive illogic, to include and emphasize the more active techniques such as exhorting patients to con-

vert from avoidance to nonavoidance by facing their fears now, as best they can, by exposing themselves directly to situations that make them anxious so that they can make that all-important leap from understanding to action.

My approach contains little that is new. I have scanned the various schools of thought for proven techniques that might be helpful for isolated remote patients having difficulty becoming meaningfully interrelated. I have come up with a compendium of relevant methods and techniques borrowed from the major schools of psychotherapy in use today, and cut and pasted them together to form a collage dedicated to helping patients become less shy, more outgoing, and increasingly comfortable with closeness, commitment and intimacy.

My text is intended for at least three audiences:

Therapists and other mental health workers who want their descriptions and dynamics rooted not merely in psychological test protocol/associative anamnesis but in everyday behavior in the real world, less tethered to theory than to earth, and who are looking for a practical, step-by-step guide they can use to help patients with Avoidant Personality Disorder conquer their distancing.

Avoidants themselves, stuck in heterosexual or homosexual distancing patterns, who can learn from its pages how to get beyond self-defeating, painful avoidance to extend a pseudopod to at least one other person in life: a friend or, to quote the personals column, “perhaps. . . . more?”

The victims of avoidants, who can infer from its pages what is troubling and eating at their potential or actual avoidant partners. Now they can make an intelligent decision about whether to try to turn a difficult relationship around to become one that is pleasurable, rewarding, satisfying, and even permanent, or to stay out of or get away from a problematical relationship that is unlikely to be salvageable. Victims who choose the former course can adapt my methods to help the avoidants in their lives become less distant. Victims who choose the latter course can make a more informed decision to either stay or go and, if they decide to stay, can infer methods for better coping with the avoidants in their lives who cannot or will not change.

I especially dedicate this book to a group of avoidants mostly ignored by a psychological literature preoccupied with shyness and specific social phobic symptoms such as an inability to speak or sign one’s name to a check in public. My book has a special place for avoidants whose problems consist of fear of attachment, intimacy, closeness and commitment: straight men and women, gay men and lesbians, whose social anxiety is characterized in the main not by shyness or anxiety aroused by specific, identifiable trivial prompts such as having to speak in public, use a public rest room, or enter a crowded room where there is a party going on, but by a deep, ongoing, pervasive, multilayered *relationship anxiety* that makes

it difficult for them to meet, connect with, and get close to someone, to form meaningful permanent relationships, and to then maintain and sustain them over time. To date, scientists just do not seem to take their problems seriously. They do not seem to find them sufficiently worthy of their attention and study. They dismiss people with such problems by calling them, pejoratively, the "walking well," then, relegating a discussion of their problems to the self-help literature, banishing the discussion to that inferior place on the bookshelf where they believe treatises on people with mere problems of living belong. In contrast, I view such avoidants, though survivors, as survivors with significant deficit. I take their problems seriously, and attempt to develop a useful, accessible, doable approach to solving them. My goal is to help those who suffer from avoidance, in whatever form, free themselves from their painful shyness and self-destructive distancing, to emerge from the dark shadows of isolation and loneliness into the bright light of warm, close, satisfying, loving relationships, relationships that can even last for a lifetime.

PART I

Description

CHAPTER 1

Why Has Avoidant Personality Disorder Received So Little Attention?

Avoidant Personality Disorder, along with Passive-Aggressive Personality Disorder, might be called a stepchild, or orphan, personality disorder. The aptness of this label is revealed by the attitudes of all-concerned—their friends and family, psychotherapists treating them, their victims; the avoidants themselves, and the scientific literature on avoidance and AvPD—towards the avoidants. Friends and family tend to discount and minimize avoidant behaviors in those close to them. One avoidant teenager had no friends and never said hello to his fellow students. At home, he regularly failed to even make eye contact with the neighbors. His fellow students, the neighbors, and even his parents did not think him at all remote. Instead they discounted his behavior as "typical of teenagers" and confidently predicted that he "would just grow out of it."

Psychotherapists treating patients with AvPD often fail to identify the problem and so overlook the diagnosis. The tendency to do so is revealed in an experienced colleague's remark, "I have never made the diagnosis of AvPD in my life," and by Frances and Widiger's (1987) observation that "several distinguished colleagues find themselves making the AvPD diagnosis rarely or never at all" (p. 279). Avoidants who apply for treatment run the risk of having the therapist view their presenting problem as insignificant, dismissing their avoidance as normal shyness, reticence, unfriendliness, cliquishness, just part of growing up, or even as socially accepted bigotry to be condoned as normal, justified, and even romantic. The psychotherapist then sends the avoidant off with reassurance that all is well, and that no therapy is necessary.

The victims of avoidants, uncomprehending and unprepared, remain

in the dark about the nature of and reasons for their loved-ones' remoteness. When a Type III avoidant told a partner "out of the blue" that "our relationship is over," the partner, who until that very moment thought that things were going well, was so surprised and stunned that she took to bed for a month and was not able to resume working for almost half a year. As she put it, "I still cannot believe it. He just fell apart—and took me down with him."

Avoidants themselves, unaware that they have a problem, continue to annoy, frustrate, and hurt themselves and the others in their lives. Some avoidants are isolated individuals who, unmindful of the pathological nature of their avoidance, cite, and live by, its presumed advantages, and eventually even come to believe that their isolation from family, friends, and potential intimates is a good thing.

A big-city man did not speak to his neighbors because "not talking to them is the one and only way to handle living in such close proximity." He believed that to be a social success he must first cut all ties with his family of origin deemed socially inferior so that he would not be embarrassed by them in the circles in which he hoped and planned to travel. Though he knew that his mother, to make him dependent on her so that he would devote his life to caring for her, isolated him from the rest of the family by repeating everything negative he said in passing about his relatives to his relatives, instead of putting a stop to her misbehavior by telling the relatives his side of the story, he allowed, and even encouraged, her disruptive ways. He reasoned that what she was doing was in the long run actually a good thing "because it's unhealthy for a young man to be too involved with his family."

Other avoidants, less isolated, get involved in relationships that are unstable and dysfunctional, like the man who married a remote and unattainable partner because he found her more challenging and consequently more alluring and desirable than he found partners who were interested in, involved with, warm towards, and available to him.

A good part of the "responsibility" for this stepchild or orphan status of AvPD belongs to the scientific literature and its tendency to diminish the status of AvPD or threaten its very existence as a syndrome by obsessively questioning whether or not AvPD is a discrete, identifiable personality disorder with inclusive and exclusive syndromal boundaries. The mighty struggle is not, as it should be, against AvPD as the common enemy. Rather it is between *believers* who identify a discrete syndrome, and *nonbelievers* who do not. The nonbelievers form into two camps. The *first* camp claims that there is no discrete Avoidant Personality Disorder because in their view avoidance is little more than a pathological personality trait or defense mechanism. (As they see it, avoidance may either be primary, that is, may occur de novo as a fundamental behavior in its own right, or be secondary, that is, may be a manifestation of another person-

ality disorder, so that avoidance is really paranoid anger or obsessive-compulsive uncertainty—e.g., a kind of final common pathway response found in anyone who fears or distrusts other people for any reason whatsoever.) The *second* camp claims that there is no discrete Avoidant Personality Disorder because in their view avoidance is a nonpathological trait or even a useful defense mechanism, both of which are to be found in almost everyone in certain stressful situations. In this view avoidance is a healthy, justifiable, self-protective response whose admirable goal is warding off anticipated humiliation or rejection by critics, and protecting oneself from the intrusive threats of overeager suitors. Unfortunately, such an ongoing struggle does not provide refinements that strengthen, deepen, or broaden the concept. Rather, with all concerned sidetracked onto clarifying secondary issues, the primary issue—the avoidant's interpersonal angst—is almost completely overlooked.

Of course, some of the "responsibility" for the stepchild or orphan status of AvPD resides in the nature of the disorder itself. First, since AvPD causes only relatively mild impairment, it is unlikely to be responsible for the hospitalization that so often brings patients into close proximity to researchers. Second, because AvPD is inherently undramatic in its presentation—more a chronic diathesis than an acute encapsulated symptom, it is more elusive and less startling in nature, and so less attention-getting, than its sister disorder, Social Phobia—the disorder that these days seems to garner all the attention.

Third, avoidants do not present for evaluation and treatment because they avoid therapeutic contact just as they avoid all relationships, and essentially for the same reasons. When they do present for evaluation and treatment, they keep their avoidance to themselves during the clinical interview. They hesitate to reveal intimacies due to embarrassment and shame, because past criticisms have caused them to fear new disdain, ridicule, and humiliation at the hands of everyone, therapists included, and because previous therapists treated them as bad, not sick, and gave them punishment instead of offering them help. One avoidant was "thoroughly tired," as he put it, of having people call him names like "compulsive loser, wallflower, and wimp," and of having his therapist tell him that he was too passive for his own good. If they do reveal the intimacies of their avoidance, they make excuses for them and for themselves. They often do this by blaming their biology, not their psychology, closing off an in-depth discussion of psychological factors with a statement like, "It's inherited, I was born this way," or "It's my chemical imbalance." Therapists often share the view of avoidance as purely biological. Pharmaceutical companies, for obvious reasons, successfully convince therapists that a chemical imbalance is the main cause of Social Phobia. Therapists arrive at the same conclusion on their own, though via a different route: a form of von Domarus or "similar-things-are-the-same" illogical thinking where

they equate two things with each other because of their resemblance to a third thing. Some therapists think specifically, "Biological processes are bereft of psychic representations; avoidants are often silent about the psychology of their avoidance; therefore avoidance is a biological process."

Fourth, symptoms of AvPD clinically resemble, overlap with, and so are often misidentified as symptoms of another disorder such as depressive withdrawal; hysterical frantic gregariousness characterized by "hypomanic pseudorelatedness"; hysterical sexual anesthesia when the anesthesia is created primarily to drive a partner away; the dependency of dependent personality disorder, a diagnosis that emphasizes less the withdrawal from mature than the attachment to immature relationships; and the narcissism of Narcissistic Personality Disorder where self-love more than interpersonal anxiety is the main mover in the distancing process, as illustrated by the following story, told by one of my patients:

A narcissistic woman decorated the public hall in her apartment building with drawings by her 2 year old, doing so in spite of the neighbors' complaints that, as one put it, "I dislike primitive art." Pressured to take the drawings down, she complied, only, however, to start the process over again by replacing the drawings with a basketball hoop for her son's practice shots. As she later confessed, "People say I'm just thinking of myself. I am."

Fifth, and partly as a result of the clinical overlap just mentioned, avoidance is often diluted in mixed syndromes like Millon's (1981) "avoidant-borderline mixed personality" (pp. 314–315). In the AvPD/BPD (Borderline Personality Disorder) admixture, avoidance and the distancing that results is subsumed diagnostically into the characteristic distancing of the object satiation/emerging phase of borderlines, the kind that is in turn cyclically undone by the overly close intense relationships characteristic of the object hunger/merging phase of borderlines.

A borderline individual in the emerging phase confined himself to behaviors that had little inherent interpersonal interest—dull, lonely things, like watching television from the couch, or self-destructive lonely things like excessive drinking and/or taking drugs. In contrast, in the merging phase he instead indulged in frantically promiscuous party-time excesses such as constant bar-hopping. This cycling between emerging and merging was both diversionary for him and off-putting for others, the latter because it kept people at bay by keeping them off-guard, not knowing what to expect from him next.

In the recent literature AvPD has been subsumed into, and really swallowed up by, the diagnosis of Social Phobia. As I will elaborate further in Chapters 2, 4, 10, and 12, I believe that while all social phobics are avoidant, not all avoidants are social phobics. For example, a patient with a Social Phobia that takes the form of a fear of public speaking is technically

an avoidant because he or she avoids relating to others, if only in a limited way. But many patients who are shy and withdrawn do not complain of being afraid of speaking in public, or of anything like that. Indeed, as many actors point out, as shy people they actively come alive when on stage, only to revert to type when the play is over. Henry P. Laughlin (1956) called this anti-phobia, the converse of a phobia, a "soteria" (pp. 198–201). In contrast, I emphasize not the descriptive and dynamic overlap but the descriptive and dynamic differences between the two disorders, and hence the distinctiveness of AvPD. As first mentioned in the preface, AvPD patients primarily are not bothered, as are social phobics, by reactive situational anxiety attached to discrete "trivial prompts"—that is, by situations not particularly meaningful in themselves that become meaningful only because they are invested with catastrophic implications. Rather, the life of the typical patient with AvPD primarily is consumed by diffuse, ongoing dysfunctional relationships characterized by remoteness, shyness, and/or a tendency to recoil from closeness and intimacy. Therefore, while social phobics and patients with AvPD both avoid out of fear, the social phobic's fears mainly arise in the clinical context of feeling, or actually being called upon to perform in ways ranging from giving a speech to urinating in a public washroom. In contrast the avoidant's fears generally arise in the context of interpersonal relationships, the main marker I look for in making the diagnosis of AvPD.

Sixth, avoidance tends to be illusory because it can be transient, selective, intermittent, reactive, or age-related. As for *transient*, avoidance can improve so rapidly on its own that the problem disappears before it is identified; or it can be mastered by an act of will, a possibility familiar to anyone who has been able to talk his or her way through the initial phase of stage fright or of meeting someone (though this is both difficult to do and often temporary in its effect).

As for *selective*, the avoidant is often bold when relationships don't count, but shy when they do:

> One timid had no problem with positive feelings as long as he could express them to a third party, or have them about a stranger where there was no possibility of consummation, as when he had them about women he merely passed on the street. A single man, he readily admitted, "I like her" to his friends, but never to the people he liked. With people he really liked, to use his own words, when he "got past first base" and was "in a position to score" he "completely froze up." Also, timid and shy with friends and family, he was bold and forceful with waiters and hat-check girls—comfortable with those whom he perceived to be "less threatening" because "from a lower social order, from an underclass."

As for *intermittent*, avoidance can appear and disappear cyclically for no seemingly apparent reason (endogenously)—so that for what appear

to be indeterminable reasons avoidants have some days when they are less avoidant than they are on other days. As for *reactive,* avoidance often comes and goes in response to external provocation (exogenously)—so that avoidants are more avoidant in some than in other situations. Typically, avoidance thrives when others are rejecting and diminishes when others are accepting and give positive feedback. Vicious cycles to which others contribute often affect the presence and severity of avoidance. Perhaps the most devastating vicious cycle for the avoidant is the one surrounding fear of rejection. The avoidant's withdrawal is the result of this fear of rejection, and the counterhostile response of others, who take the withdrawal personally (often properly so). Therefore, the avoidant actually becomes rejecting, and more fearful of relating due to more and more fear of rejection.

As for *age-related,* there can be marked differences between early (acute) and late (chronic) AvPD. Late AvPD is early AvPD altered and transformed by maturity, adaptation, syndromal admixtures, resignation, and therapeutization.

AvPD can diminish with *maturity,* with or without treatment. In one pattern, an increasing self- and other-forgiveness that comes (at least with nondepressives) with mellowing over the years allows an asocial, offputting, fearful, angry youth/adult to go on to become a self-confident, related, sociable elder. (Not all personality disorders improve with maturity. As Henry Pinsker suggests, antisocial/psychopaths such as CEOs out to raid their own corporations for personal gain may get worse as they grow older as they become simultaneously needier and cleverer [personal communication, July 2002].)

Adaptation can occur through changes in the defensive structure. In the life of all avoidants defenses against the fear of rejection soon appear. We might see defensive misanthropy that in essence says, "Who cares if you reject me—I have already rejected you," or a frantic desperation to connect manifested by panicky, often futile, attempts to "meet someone before it's too late." Sometimes the avoidant, instead of frantically searching for new relationships, strives for familiarity and sameness, avoiding rejection by retreating into routines with the same few, old friends, as Frances and Widiger (1987) note, "going to the same restaurant, the same table, and eating the same entrée" (p. 280), developing what Jerome Kagan as quoted by Ruth Galvin (1992) calls a fear of the unfamiliar (p. 43). (This fear of the unfamiliar, or of newness, is discussed further in Chapter 2.)

Often defensive acting-out develops. In one form of defensive acting-out the avoidant provokes others to get annoyed with him or her so that he or she can abandon them, and thus look not like an avoidant but like the victim of avoidance. A husband wants to go drinking, but his wife disapproves. He has no trouble antagonizing her by picking on her for small things like vacuuming when he is trying to watch television. She

gets defensive, saying, "Who else is going to clean around here?" and now he has the reason he was looking for to go out. She looks to the world like a harpy. He looks to the world not like an avoidant but like a henpecked husband.

In another form of defensive acting-out, avoidants get others to display their avoidance for them. It was pets for the patient who kept a half-dog, half-wolf that he taught to snarl at passers-by, and for the man who let his dog off the leash so that it might wander about and soil and uproot his neighbors' lawns and gardens. It was the spouse for the man who appeared to the world to be the "perfectly delightful one" while he egged his wife on to be the troublemaker of the family. It was the children for the avoidant who publicly played the role of "pillar of the community" while privately encouraging his children to cut the neighbor's flowers (by wishing aloud for a certain bouquet) and to shout anti-gay epithets (by criticizing homosexuals within the children's hearing range). It was the underlings for the boss who used them to live out his own petty interpersonal antagonisms, taking A into his confidence, making nasty comments to A about B, then behind A's back making nasty comments to B about A, getting them fighting. It was colleagues for an employee who provoked fights among his coworkers by misquoting them by "quoting" passing comments out of context and without qualifiers, and by otherwise subtly changing in the telling the meaning of a comment from positive to negative. It was a patient for a therapist who, unable to get the divorce he longed for, fulfilled his wishes in fantasy by encouraging the patient to act out against her own spouse instead of encouraging her to smooth things over and attempt reconciliation.

This therapist took sides with his patient based on material she deliberately skewed to have an antagonistic effect. He encouraged her to see to it that her husband, an alcoholic, was sentenced to jail for a behavioral peccadillo, not let off on psychiatric grounds, because "it isn't wise for him to constantly evade the consequences of his behavior." The therapeutic principle was good in theory—alcoholics must face the consequences of their alcoholism—but the real intent showed in the results—the husband started drinking again and, unable to forgive his wife for her heartlessness, filed for divorce.

It was the mother for a psychiatrist with marked self-destructive tendencies:

The mother of a psychiatrist who was about to join the staff of a psychiatric hospital was best friends with the mother of an inpatient currently admitted to the psychiatric ward that the son would soon administrate. Just before the psychiatrist was to arrive at the hospital to begin his tenure, he discovered that his mother planned to go through the entire ward and introduce herself to all the patients, telling them, "I am the mother of your new doctor," an action that was likely to

create transference problems for the patients and countertransference problems for the son. Not only did he do nothing to discourage/stop her, he thought aloud in her presence, "Maybe it's a good idea—perhaps they will respect me even more when they see what a fine family I come from."

The appearance of second-line defenses is also discussed in Chapter 8.

In the realm of *syndromal admixtures,* as previously suggested, in time most avoidants bring other personality disorders into play to coexist with their AvPD, transforming the classical syndrome. Here I cite two of the commonest syndromal admixtures: the above-mentioned Borderline Personality Disorder, which adds a dimension of "now you see it, now you don't" unpredictability to the avoidance (as the individual swings between separation-individuation or emerging, and nonseparation-nonindividuation or merging); and Passive-Aggressive Personality Disorder—Millon's (1981) "avoidant-passive-aggressive personality" (pp. 313–314)—which adds a new dimension of thinly disguised hostility to the thinly disguised hostility already expressed in distancing patterns. Comorbid disorders and the mixed personality pattern that results are discussed in detail in Chapters 9–11.

In the realm of *resignation,* timid-shy avoidants commonly give up after months or years of fear of, and actual, negative feedback, replacing fear, timidity, and shyness with a general sense of doom associated with existential hopelessness and pervasive anhedonia. Paraphrasing Berne (1964), who refers to the lonely consequences of playing off-putting games, because they are "not stroked [their] spinal cord . . . shrivel[s] up" (p. 14).

Finally, in the realm of *therapeutization,* avoidance often yields to the treatment of other, related disorders, such as chronic fatigue or sexual impotence, if only because therapists, friends and family rally round, take pity, and cheer on. Unfortunately, avoidance can also worsen if the therapist neglects the avoidant component of another clinical or personality disorder, or offers treatment that helps overcome a primary disorder at the expense of intensifying the avoidance—a common, unfortunate, and generally unavoidable complication of treating schizophrenics with high-dose pharmacotherapy.

In conclusion, my experience accords with that of Frances and Widiger (1987), who suggest that AvPD "does appear with some frequency in systematic studies . . . and seems to be a frequent diagnosis in our own outpatient departments and in our private practice" (p. 279). As I hope will become clear, I believe that there is a discrete, identifiable, Avoidant Personality Disorder, and that it is a diagnosis that is both appropriate and useful for those individuals whose lives are marred by social/relationship anxiety in the form of distancing, a problem that I believe to be as important as any other significant mental health problem patients, their real or potential loved-ones, and their therapists face today.

CHAPTER 2

The Literature

While at first glance the scientific literature on avoidance/AvPD appears scanty, in fact many authors have contributed, though in writings that are manifestly on other topics. Once we think to look for a discussion of avoidance/AvPD in the works of personologists like Ernst Kretschmer and Timothy Leary, in Freud's (1950) *Totem and Taboo,* in Sullivan's (1953) *The Interpersonal Theory of Psychiatry,* and in Berne's (1964) *Games People Play,* we find a great deal of value, little of which has found its way into the mainstream.

DESCRIPTIVE ASPECTS

The Historical View

Historically, many personality classification systems have included a personality type that closely approximates AvPD. According to Millon (1981), Kretschmer's asthenic individuals are "inclined toward an introversion, timidity, and a lack of personal warmth—that is, lesser intensities of the more withdrawn and unresponsive schizophrenics to whom they were akin" (p. 34). Of Kretschmer's four fundamental reaction types, one, the sensitive type, is "distinguished by a brooding, anxious, restricted, and unconfident behavioral style" (p. 35). William H. Sheldon describes cerebrotonia, which he defines as a "tendency toward restraint, self-consciousness, introversion, social awkwardness, and a desire for solitude when troubled" (p. 35). Henrik Sjobring describes subvalid personalities defined as "cautious, reserved, precise, industrious and scrupulous"

(p. 36). Eugen Kahn describes dysphoric types, whom he characterizes as anxiously timid and peevish (p. 37). Moritz Tramer describes a hypothymic personality whom he characterizes as "withdrawn and schizoid" (p. 37). Raymond Cattell uses the term *schizothymia* for those who are "reserved, detached, aloof" (p. 40). Hans Eysenck's dimensions of personality include "introversion-extroversion" (p. 41), which is founded in concepts of "autonomic nervous system reactivity and ease of conditionability" (p. 41). Eysenck also states that "those who readily form conditioned responses are inclined to introverted behavior" (p. 41), and that "people at the high end of both conditionability and autonomic reactivity are disposed to develop fears and compulsions" (p. 41). Maurice Lorr and Leslie Phillips categorize personality types according to the dimensions of "socialized-unsocialized," (p. 41) and one of their interpersonal styles is characterized by "avoidance of others . . . withdrawal behaviors, fantasy preoccupations, or other indices of social detachment" (p. 42). Henry J. Walton and his associates specify a withdrawn type "noted [for] being socially isolated and emotionally inhibited" (p. 44). Leary presents an "interpersonal typology [that is] based on two dimensions, dominance-submission and hate-love" (p. 55). He defines a rebellious-distrustful personality who handles "anxiety and frustration by active distancing from others and by displays of bitterness, cynicism, and passively resistant behaviors. . . .Experience has taught [the rebellious-distrustful personality] that it is best not to trust others, to be skeptical of the so-called goodwill of others, and to be alert to and rebel against signs of phoniness and deceit" (p. 55). The New York Medical School, collaborating with the Menninger Foundation, notes that some children "reached out for everything presented, others avoided anything new . . .[They] exhibited withdrawal reactions to new stimuli, showed minimal flexibility in response to change, and expressed intense and often negative moods" (p. 38).

Modern Formulations

Fear of Newness

John M. Oldham and Lois B. Morris (1995) describe comfort with routine, Lorna Smith Benjamin (1996) notes that avoidants "don't often try new situations" (p. 297), and, as previously mentioned in Chapter 1, Kagan, as quoted by Galvin (1992), emphasizes how some patients strive for familiarity and sameness, for example, "the same restaurant, the same table, the same entrée" (p. 280). In my experience, this fear of newness can readily change over to become an equally avoidant fear of sameness as patients go from being Type I avoidants, who fear the new, to become Type II avoidants, who feel a discomfort with the old.

A patient kept the same routine for months or years, not only eating in the same restaurant every night but also ordering the same food and drinks. Then after-

wards he would do an about face and, fearing stagnation, suddenly and without warning change restaurants on a slim, slightly paranoid pretext, once, for example, because, "The waiter hustled me for drinks, and the baked potatoes today were smaller than the baked potatoes yesterday."

Codependency

In Beattie's (1987) *Codependent No More* the syndrome called codependency is an "odd mixture" of nonavoidant and avoidant traits reflecting the tragic conflicts of real life Type IV avoidants with their strange, ambivalent admixture of dependency and withdrawal—avoidants who sink into one relationship in order to hide out from all others. They hide out for the same reasons other avoidants hide out: shame, low self-esteem, a paranoid tendency to take things too personally, fear of rejection, depression due to the lack of compliments and praise (stroke deprivation), and the pessimistic view that there is no sense trying to relate widely since the chances of being loved are at best narrow.

Social Phobia

The modern literature devotes considerable (some would say excessive) attention to differentiating Social Phobia and AvPD. David H. Barlow (1992) notes that the distinction between Avoidant Personality Disorder and Social Phobia is not clear. He suggests that the two disorders may actually represent points on a continuum of severity (most observers consider AvPD to be more severe than Social Phobia). In contrast, Millon and Davis (1996) distinguish Social Phobia from AvPD, as follows: First, in AvPD "there is a pervasiveness and diffuseness to the personality's socially aversive behaviors, in contrast to the [social phobic's] specificity of the phobic object and the intensity of the phobic response. Second [in Social Phobia] the phobic symptom is not associated with the broad range of traits that characterize the [avoidant] personality, such as 'low self-esteem' [or] the 'desire for acceptance'," (p. 274), or, as Benjamin (1996) notes, the AVD's (AvPD's) sense of being "socially inept [and] personally unappealing, or inferior to others" (p. 297). As a result, as Benjamin suggests, the patient with AVD "is less likely to be married, [and more likely to be] content (even relieved) to stay home by himself or herself" (p. 298).

I suggest that the problem of differentiating Social Phobia from Avoidant Personality Disorder is partly a specific instance of the wider problem of determining the relationship between any Axis I (Clinical Disorder) and its related Axis II (Personality Disorder), not only Social Phobia and AvPD but also Obsessive-Compulsive Disorder and Obsessive-Compulsive Personality Disorder or Conversion Hysteria and Histrionic Personality Disorder. The core dynamics of an Axis I and its related Axis II disorder are

very similar. The distinction between the Axis I and the Axis II disorder resides in the way that these similar dynamics present clinically. In both Social Phobia (an Axis I disorder) and AvPD (an Axis II disorder) social anxiety is the "core lesion" with withdrawal a key defense mechanism used to cope. But while social phobics choose to express their social anxiety indirectly and symbolically in the form of withdrawal from specific trivial prompts, avoidants choose to express their social anxiety more directly, in the form of ongoing interpersonal withdrawal behaviors including shyness, as well as problems with meeting, mingling with, moving close to, and remaining intimate and involved with, actual people.

DYNAMIC ASPECTS

The Historical View

Karen Horney

According to Isidore Portnoy (1959), Horney identified a group of individuals with "'basic anxiety'" (p. 315), individuals who "feel helpless, isolated, and afraid in a potentially hostile world" (p. 315). Horney believed that "parental neurosis [is] the major factor determining [how] the child seeks safety" and if the child seeks safety through "detachment" (p. 316). Horney "noted the frequency with which such [safety-seeking] children grow up in the shadow of an adored parent, self-sacrificing mother, or preferred sibling [and how] affection of a kind was attainable at a price: that of a self-subordinating devotion" (p. 316). Many such individuals as adults "soon adopt as their basic safety pattern a compulsively compliant attitude toward their human environment. Their dominant needs focus on being loved and lovable, being protected and taken care of, being inoffensive, pleasing others, avoiding all friction and conflict with others. Here the groundwork is laid for the dependent pattern and the need to repress assertive and aggressive as well as autonomous strivings. The major possibilities of anxiety come to be rejection or disapproval by others and hostile impulses from within the self" (p. 316).

Clara Thompson

Thompson (1959) states, "Problems of intimacy are among the most disturbing interpersonal difficulties. [A] form of interpersonal difficulty is that of isolation. The inability to make contact may be due to a hostile or even a destructive attitude. The individual feels so threatened by others that he must either drive them away or destroy them altogether" (p 239–240). Thompson is in effect describing my Type II avoidants when she notes "there are also detached people who are not particularly hostile, who live as onlookers to life. They have an impersonal warmth so long

as no closeness is involved, but they fear any entanglement of their emotions. They are lonely people, but unable to remedy their state through their own efforts. Again, the solution must come from a radical exploration and alternation of the character pattern" (p. 239–240). Thompson adds, "Many of these people get along very well in more superficial relationships. In fact, they may be the 'life of the party' or 'the hail fellow well met' so long as no permanent warmth or friendliness is demanded. However, some have difficulty in even these tenuous contacts and succeed either in making enemies through their arrogance or hostility, or in withdrawing so completely that no one feels the urge to seek them out" (pp. 239–240).

Eric Berne

Berne (1964) describes a number of interpersonally off-putting games such as the essentially sadomasochistic "Why Don't You—Yes, But" (pp. 116–122). In this game, interpersonal intimacy is avoided via a process of asking for specific suggestions, then rejecting one after another as unacceptable, in order to wear the other person down and out. A significant advantage of Berne's "game," or "transactional," analysis, is that each member of a dyad is asked to own up to his or her role in creating interpersonal difficulty. As such, Berne's transactional analysis is particularly therapeutic for those avoidants who blame others for their loneliness and isolation without acknowledging the active role their off-putting behavior plays in causing their own rejections.

Sigmund Freud

Freud's contribution to understanding avoidance/AvPD generally goes unappreciated by both the scientific and by the lay literature. One difference between the scientific and the lay literature is that the former, as exemplified by the *Diagnostic and Statistical Manual of Mental Disorders,* 4th edition (*DSM-IV*), and Martin M. Anthony and Richard P. Swinson (2000), eschews Freudian dynamics almost entirely, believing them either unverified or unverifiable, or both. In contrast, the lay literature freely borrows from Freudian concepts such as mother fixation and incest taboo, usually, however, without giving Freud much credit.

A review of Ernest Jones (1953–57, vols. 1–3) and Freud's original writings indicates that Freud made a number of contributions to the science of avoidance and AvPD.

Transference Trauma. In many of his writings Freud emphasizes the central role early experience plays in the development of emotional disorder later in life. For example, a fear of rejection now might originate in an actual or imagined rejection in the past, revived by a current prompt that resembles, and so reminds of, an old rejection.