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Avoidant Personality Disorder: The Case of Maria

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ABSTRACT

Failure to develop a secure attachment leads to rigid and insecure internal working models, increasing the risk of developing personality disorders, such as avoidant personality disorder, in adulthood. This disorder is characterised by a consistent pattern of avoidance of relationships and situations in which the individual may be subject to evaluation by others, feeling constantly inadequate and exhibiting an intense fear of criticism and disapproval from others.

These characteristics are summarised in the clinical case described in this paper, in which intervention was carried out using a new cognitive-behavioural psychotherapeutic approach: treatment focusing on 'leverage points'.

Keywords

Avoidant personality disorder, Leverage points, Attachment systems, Emotions, Cognitive-behavioural intervention.

Introduction

The ways in which people relate to one another vary greatly: some seem disinterested or superficial, others appear anxious and in constant need of reassurance, whilst others tend to be 'all over' the person they are talking to. All these patterns have specific underlying reasons that fall within the scope of attachment styles: that is, the ways in which a person enters into and maintains an emotionally significant relationship with their parents, their primary attachment figures during childhood [1-5]. These styles tend to remain stable throughout life, as the individual internalises them as Internal Working Models; in other words, they become mental representations of these relational patterns dating back to childhood. Indeed, the child has an innate predisposition to seek physical and emotional closeness with an adult attachment figure (mother) whenever they experience distress, fear or are in difficulty: this seeking behaviour is made possible by the attachment system, a biologically based motivational system, which finds its natural complement in the caregiving system, responsible for the adult's display of attentive and caring behaviour towards the child [6-8]. How does the attachment system develop and how is it organised?

The attachment system originates in relationships with significant figures and has been studied and described by various authors [6,7,9,10]. For example, Ainsworth, Blehar, Waters & Wall [10] used an experimental procedure known as 'The Strange Situation', in which the behaviour of a one-year-old child was observed at various times with their mother – both during moments of closeness and separation – and in interaction with a stranger. The data obtained from this allowed them to conceptualise the following four types of attachment (Table 1):

1. The secure attachment style: this is the most common type, found in just over half of children, characterised by the child's ability to interact calmly with their mother, to protest by crying when she leaves, and to rejoin her joyfully, allowing themselves to be soothed and comforted, whilst also engaging in periods of solitary play;

2. The insecure-avoidant attachment style: this type is found in around a quarter of children; it is characterised by a scarcity or, more often, an absence of pleasant and/or playful interactions between the child and the mother, by the child showing no distress or confusion when the mother leaves, and by the prevalence of moments in which the child is absorbed in some solitary activity, appearing detached and disinterested in the mother;

3. The insecure-ambivalent attachment style: this type is also found in around a quarter of children; it is characterised by the child's strong emotionality, whereby, in the mother's presence, the child sets aside their play and interacts actively with her, whilst upon her departure and return, the child initially displays

distress, anxiety and agitation, then protests furiously and cries inconsolably; and despite being reunited with their mother, they are unable to calm down or find comfort;

4. The disorganised attachment style: this type is rarer, occurring in only a small percentage of cases, and is characterised by the absence of consistent and structured behaviour in the child, who instead displays such distress that they engage in chaotic, incoherent behaviours, such as moving in a stereotyped manner or approaching their mother upon her return, whilst avoiding eye contact or physical contact, or remaining motionless as if paralysed.

Table 1: Summary of childhood attachment styles.

ATTACHMENT	CHARACTERISTICS	EMOTIONAL RESPONSE
Secure	Confident, open, well-balanced	Comfortable with closeness
Anxious	Clingy, afraid of abandonment	Overly dependent on their partner
avoidant	Emotionally distant, self-sufficient	Struggles with vulnerability
Disorganised	Conflicting and inconsistent behaviour	Fear of both intimacy and abandonment

What happens if the attachment system does not activate or is inhibited?

This leads to serious consequences for emotional and relational development, which can be summarised in the following scenarios [11-14]:

- **Reactive Attachment Disorder (RAD):** the child displays extreme and constant emotional withdrawal, avoiding or rejecting any form of comfort (for example, the 'uninhibited type', may exhibit 'dangerous' indiscriminate sociability, i.e. they may seek affection and physical contact indiscriminately from anyone, including strangers);
- **Reversed attachment:** the child inhibits their own attachment to take on the parent's suffering or vulnerabilities (for example, with a depressed parent, the child becomes 'overly mature and sensible', repressing their own needs);
- **Emotional regulation disorders:** the child experiences constant anxiety and fails to develop the ability to calm themselves independently, increasing the risk of developing emotional disorders in adulthood);
- **Developmental and cognitive stagnation:** the energy expended on repressing emotions and managing the environment without a reliable attachment figure diverts resources away from learning and the natural exploration of the world.

Could these serious consequences for emotional and relational development, in some way, influence the individual's personality in adulthood? Given that attachment styles tend to be self-perpetuating throughout the lifespan, this is highly likely [15-21]; indeed, the preferred way in which people engage in interpersonal relationships as adults mirrors the attachment style they developed in childhood with their parents, the characteristics of which could be summarised in the types listed below:

1. **The secure style:** the individual places equal value on both their need for autonomy and their relational needs, experiencing and building emotionally meaningful relationships and feeling worthy of love, respect, pleasure and trust;
2. **The avoidant style:** the person places greater value on their need for autonomy, devaluing their relational needs – which they equate with dependence on others – and either avoiding relationships or forming brief, occasional or superficial ones, characterised on the one hand by a light-hearted and playful atmosphere, and on the other by emotional detachment. This stems from the belief that 'they do not need anyone, because their needs cannot be met or understood by others' and that, therefore, they must fend for themselves, just as they did with their parents when they were children;
3. **The anxious style:** the person places greater value on their own needs for dependence, devaluing both their own and others' needs for autonomy; they demand constant reassurance from others, harbour a strong fear of abandonment, and believe that others are unreliable and must be continually encouraged to satisfy their own relational needs;
4. **The disorganised style:** the person lives in a perpetual conflict between their needs for autonomy and those for relationship, alternating between phases of solitude and phases of involvement, without ever finding a balance.

Consequently, the failure to develop a secure attachment creates rigid and insecure internal working models, increasing the risk of developing personality disorders, such as avoidant personality disorder, in adulthood (Bretaña I, Alonso-Arbiol I, Recio P, & Molero F [22]; Wardecker B, Chopik W, Moors A, & Edelstein R [23]. This disorder, as we shall see in the next section, is characterised by a consistent pattern of avoidance of relationships and situations in which the individual may be subject to evaluation by others, feeling constantly inadequate and exhibiting an intense fear of criticism and disapproval from others [24-39] Shaver PR & Mikulincer M [34].

Avoidant Personality Disorder

As we have seen, this disorder, which is characterised primarily by relationship problems associated with a deep-seated sense of inadequacy and a fear of others' judgement, affects approximately 1.5–2.5 per cent of the general population, with clinical estimates reaching as high as 10 per cent [40,41]. Does this clinical picture, in addition to the 'signs' described, also have neurobiological implications? Beyond clinical contexts, the 'avoidant' brain processes the experiences described and reaches a logical conclusion: being oneself causes pain, revealing oneself to others leads to rejection, and being vulnerable equates to danger; it therefore devises a specific strategy to safeguard the individual's psychological well-being:this strategy is *avoidance* (negative reinforcement), which becomes the default pathway that the brain automatically follows, suppressing anything that causes distress ('public speaking', 'giving a hug', 'exchanging messages', etc.). Consequently, the amygdala – the part of the brain responsible for processing threats and emotions – is activated as if facing

a real physical threat, even though it is merely an emotional response. At the same time, the prefrontal cortex, responsible for rational thought, is overwhelmed by this alarm system, which is so invasive that the person completely loses control of the situation and is unable to assess it more appropriately, failing to react, and becoming specialised solely in detecting, encoding and remembering any episode that confirms their worst fears (enhanced negativity bias). The brain's reward systems are also altered: for most people, a hug and physical contact trigger the release of dopamine and oxytocin, making the interaction pleasant and reinforcing; whereas for these individuals, avoidance itself has become their primary reward: if they escape the threat, they are safe, and this sensation is pleasurable, and their brain remembers it.

These neurobiological difficulties often manifest as the following clinical characteristics:

- **Inhibitory control:** this is a fundamental executive function, regulated by the prefrontal areas of the brain, which enables the suppression or delay of impulsive or contextually inappropriate responses and drives the individual towards obsessive risk assessment and chronic avoidance reactions;
- **Molecular dysregulation:** this involves alterations in *neurotransmitter systems* (specifically the serotonergic system – responsible for mood and the modulation of anxiety – the dopaminergic system – linked to the reward and motivation system – and the noradrenergic system – which plays a crucial role in the 'fight-or-flight' response and in the regulation of attention; this results in hyperactivity of the behavioural inhibition system associated with risk assessment and hypoactivity of the behavioural activation system) and in *amygdala reactivity* (which is overactivated, particularly during the *anticipation* phase of judgement, triggering reactions of anxiety and freezing);
- **Functional disconnection:** describes the way in which the mind disconnects from relational or emotional situations perceived as unbearable, reducing anxiety and preserving a sense of security; this mechanism acts as an unconscious defence to protect the individual from criticism, failure or humiliation and to prevent them from feeling overwhelmed by vulnerability.

In summary, these characteristics can all be traced back to incessant and repetitive thinking (overthinking) which leads the individual to analyse every detail in an extreme attempt to prevent criticism or rejection, thereby paralysing action. Overthinking stems from a deep sensitivity to rejection and low self-esteem and is used as a shield with the illusory aim of gaining total control over reality, to avoid humiliation. This mechanism blocks behavioural coping, increasing isolation and anxiety; it takes specific forms and operates on three levels:

- **Before an action (pre-emptive analysis):** analysing possible mistakes, creating catastrophic scenarios in which the individual thinks of phrases such as: "What if I say the wrong things …?" or "What if they notice my embarrassment … what will they think of me?";
- **During the behaviour (mind reading):** continuous monitoring of one's own performance and others' reactions in search of the slightest signs of disapproval or criticism; for example, they might think: *"That person grimaced; perhaps they think what I'm saying is uninteresting and that I'm not up to scratch". The other person might simply have been showing their own discomfort;*
- **After the behaviour (retrospective rumination):** following an event, the person examines the words spoken, the gestures and the looks of others to find 'evidence' of inadequacy, thereby fuelling feelings of inferiority and shame; for example, they might have constant thoughts such as: "I didn't express myself as well as I would have liked!", " I was anxious and didn't give a good presentation; what must they have thought of my preparation!".

These characteristics influence the way an individual perceives and organises the world around them and the way they behave towards others; these mechanisms will be analysed through Maria's case.

Maria's case

Maria is a brilliant woman of around twenty-nine, with an organised and functional life, capable of smooth and pleasant relationships, although these are essentially a highly effective form of personal branding: her *overt* relational style has developed as an adaptive response to an emotional environment in which closeness is safe, needs are met, dependence is not dangerous, there is no need to ask for anything, and she does not need to feel vulnerable, thus avoiding situations of rejection or indifference. In fact, she has several friends, but almost none of them really know her: there's the friend she goes to the gym with, the one she talks to about work, the one she shares some books with, and so on, but with all of them she still finds it very difficult to talk about her feelings.

Maria is not a person without emotional needs, but these needs have been pushed so deep, suppressed so consistently, and denied with such conviction, that they have become almost unrecognisable to her (even simply thinking of someone to buy them a present, missing them, or remembering a special occasion relating to them can trigger a sense of vulnerability in her). In reality, these emotional needs do exist; they continue to be felt and manifest themselves, albeit often indirectly and frequently in contradictory ways: interest is followed by a sudden withdrawal; a warm approach is followed by a cold retreat; active involvement is followed, from a specific moment when things come to a halt, by emotional 'coldness' or disinterest. She manages all her relationships like an archive: everything is catalogued and in its rightful place, accessible up to a certain point beyond which access is denied.

All these behaviours could be labelled with the term 'fear', even though Maria identifies them with different expressions ('I need space', 'I have to do it on my own', 'I don't need others', etc.);
as the relationship develops with greater emotional continuity, fear inhibits emotional closeness by triggering a sense of threat and danger, causing her to distance herself from the person, who becomes a source of stress. At the same time, her most recurring

thoughts of constant self-criticism ("I'm inadequate!", "I can't cope with things!", 'I have so many flaws!', etc.), together with the automatic thoughts that negatively anticipate what will happen ('I'll make a complete fool of myself!', 'I'll be criticised!', 'I won't have anything interesting to say!', etc.), create considerable distress and tension for her, leading her to prefer to keep her distance from social situations and relationships, with the exception of those that are reassuring.

On the surface, Maria appears to have a very strong sense of identity: she knows who she is, she knows what she wants, she does not get lost in other people's expectations, she does not change to please anyone, etc., but in reality this is a sign that her identity has become 'fixed in rigid patterns', rendering her impervious to change; and it cannot be questioned, because if it were to crack, it risks bringing down the entire edifice of beliefs upon which she has built her world to protect her vulnerability: for example, becoming too emotionally close to someone or expressing their feelings. To counteract all this, they begin a cycle of drawing closer (initially there is greater closeness: questions, messages, meetings, etc.) which alternates with avoidance behaviours (when the emotional intensity rises, there is withdrawal: failure to reply to messages, avoiding meetings, indifference, etc.), triggering emotional disengagement or sabotage (any behaviour that makes the other person feel unwanted), in which the emotional response is drastically reduced if the emotional relationship is perceived as a threat to their own vulnerability. For example, her way of handling remote digital communication is quite peculiar: she does not disappear because that would require an explanation; she does not always reply straight away because that would show too much availability and create expectations she does not wish to meet; instead, she finds an alternative approach: she replies when it suits her, with a fairly consistent irregularity – sometimes straight away, sometimes after hours, sometimes one or more days later, but always without giving an explanation; in this way, she keeps the other person in a state of uncertainty about what might have taken priority: work, a family commitment, tiredness, the need to be on her own for a while, etc.

Why has someone as extraordinary as Maria, with excellent professional and interpersonal skills, developed an avoidant personality?

Avoidant behaviour is evidence that at some point in her life – certainly when she was very young – Maria learnt that people, even those closest to her, could hurt her without even realising it. The brain, in fact, is a highly efficient pattern-recognition machine; it constantly scans the surrounding environment for threats, analyses situations and makes predictions based on past experiences; for example, if her family was emotionally distant, teaching her that her feelings and needs did not matter and that she had to learn to fend for herself at all times and in all circumstances, she was inevitably forced to manage her life independently despite any difficulties. In other words, her parents may have provided her with food, shelter and education, fulfilling all the requirements of a proper upbringing, but by being emotionally absent (that is, they were not attuned to her feelings), they did not regard her as a person with her own inner world; they did not respond to her requests for comfort, did not teach her to express her emotions, and did not offer her secure attachment figures to cling to.

Another coping mechanism used to temporarily escape stress, anxiety or the fear of failure and restore emotional balance is such a hectic lifestyle (the constant 'jumping' between commitments, errands, housework, etc.), which provides immediate relief but, in the long term, hinders emotional processing and impairs productivity.

This is particularly evident in one of the most recent meetings Maria had with one of the authors (G.M.G.):

M.: Could I take a test for hyperactivity?

G.M.G.: Why would you want to take this test?

M.: A friend told me I'm hyperactive!

G.M.G.: This hyperactivity thing is only the third or fourth self-diagnosis you've made: 'I'm anxious', 'I probably have OCD', 'I have imposter syndrome', 'I often think I have a personality disorder', 'Can we do a test to find out what the problem is?', and so on. In reality, you're not hyperactive, just as you didn't have all the other disorders you've identified with.

M.: So what is my problem, then?

G.M.G.: You're like a volcano with very strong internal tension which, instead of erupting (dysfunctional thoughts, anger, etc.) through the main vent, opens up smaller, secondary craters, allowing the accumulated tension to be released and the system's balance to be restored, by focusing your attention on household chores, family or work commitments, or possible tasks to be carried out, etc.; these behaviours are so intrusive and sudden that they might be labelled 'hyperactive' by an outside observer. From a physical point of view, yours is a 'static equilibrium' – that is, it does not change over time and, despite your attempts to 'distract yourself', you return to your starting point with your doubts, your assumptions about your personality, and your distress, etc.

M.: So will I always find myself in the same situation? Will I never be able to change my state and will I always have to live with my distress?

G.M.G.: No! The very aim of our psychotherapy journey is to help you move from a 'static equilibrium' to a 'dynamic' one, by managing your emotions (without avoiding them, but by trying to observe what you are feeling, but without passing judgement) and your own thoughts (not letting yourself be dominated by intrusive thoughts by suppressing them, but instead trying to 'observe them from the outside'), adapting to change and moving continuously between extremes without ever falling, just as a surfer 'rides' the wave.

In summary, from the transcript of this brief interview, and from the previous description of the case, it is clear that Maria: 1) does not show her emotions, 2) displays discomfort at even simple physical contact or emotional intimacy, 3) tries to do everything on her own without asking for help, even when facing difficulties,

4) tries not to show her vulnerability to others, 5) suppresses her emotions by never talking about herself, her feelings or her thoughts, 6) tends to avoid dealing with different or new situations for fear of making mistakes or looking foolish. With regard to this last point, the following conversation speaks volumes.

M.: "I've been invited to give a short presentation at a conference. It would be an important experience for my professional and career development. But… I'm terrified of making a mistake and/or making a fool of myself in front of everyone. So I'm thinking of turning it down".

G.M.G.: "I see. I imagine this situation is causing you a great deal of stress. What exactly are you afraid might happen if you accepted this invitation?" .

M.: "I'm afraid others will think I'm incompetent, that I've been bluffing by pretending to be competent. For example, if I'm speaking at a meeting with several people, I'm always afraid my voice will tremble or that I'll freeze up, or that what I'm saying is wrong. Just thinking about it, I'm already starting to feel my face getting hot … 'Am I blushing?' … , my heart starts racing, I'm sweating now and I tend to look away from you to hide myself. … In a real-life situation, I might even faint. … I'm overcome by a sense of shame".

G.M.G.: "It's a very strong fear, which leads you to consider giving up something you want, to protect yourself from possible negative judgement."

M.: "Yes, that's exactly it. I prefer to stay in my place, do my job without 'showing off', so I can be sure I won't make a mistake or make a fool of myself."

G.M.G.: "Of course, avoiding confrontation makes you feel safe in the short term. But it also prevents you from putting yourself out there and achieving professional fulfilment. Would you like us to try to work out together what lies behind this fear of not being up to the task, and to overcome it?"

M.: "I don't know… maybe that's just how I am – why should I change if I'm happy the way I am?"

G.M.G.: "The fact that you fall short of your own ideal does not define your overall worth; and sharing your insecurities with people you trust lightens the burden of judgement. During psychotherapy, we could work on this aspect, step by step, in a safe and stress-free environment for you, to help you replace your 'harsh inner critic' with self-compassion – that is, with understanding and kindness towards yourself)."

It is clear from the consultation that Maria, driven by a fear of shame and a deep-seated belief that she is not good enough – which lie at the very heart of her way of functioning – constantly anticipates catastrophic scenarios ("I'll make a fool of myself", "I won't be able to …", "I'll be criticised", etc.), in which making a mistake is experienced as public confirmation of her own inadequacy and incompetence; to protect herself from these 'negative judgements', she tends to turn down new job opportunities and chances for professional growth, but also to hide her feelings and distance herself from potential romantic relationships.

This behaviour allows the person: 1) to avoid distress (sudden interruption usually occurs when an activity, even a mental one, requires sustained effort, concentration or potential evaluation, triggering a sense of inadequacy); 2) to seek easy gratification (shifting to simpler, repetitive tasks or to a pleasant and safe activity helps to numb frustration and the fear of not being up to the task); 3) to create a vicious circle (the short-term relief reinforces the behaviour, leading to the postponement of commitments, which in turn fuels low self-esteem).

Avoidance has worked, becoming not only a protective strategy but an addiction which is now imprisoning her and preventing her from experiencing her emotions freely, with awareness and without protective armour. In fact, one of the most destructive aspects of avoidant personality disorder is the way it distorts one's sense of identity, preventing the thinking self (identifying with the disorder) from being separated from the observing self (the set of learnt responses) and leading her to think, 'I don't need anyone!', 'I am a completely self-sufficient person!'; "Trusting someone often turns to disappointment", "I'm fine as I am, I don't need to change a thing!". These thoughts represent their 'comfort zone', which makes them feel at ease; however, as they are a natural defensive reaction, they become particularly intrusive and painful when conflicts arise in the relationship or when the relationship becomes too affectionate too quickly for their liking [42-44].

Maria is not an avoidant person, but someone who has learnt to avoid in order to protect herself from an environment she perceives as threatening; that is, she is adopting a behavioural pattern she has developed in response to specific circumstances, which means it can be unlearned.

What, then, can be done to help Maria overcome her avoidant disorder? Psychotherapy is undoubtedly the best option to help her overcome her avoidant disorder. To this end, a new cognitive-behavioural psychotherapeutic approach has been introduced, which we have termed – drawing on the concept from Systems Theory – 'Leverage Points' treatment [45-47].

'Leverage Points' refer to a specific area within a complex system, such as our brain, where a targeted intervention can generate profound changes capable of bringing about the emergence of a new form of self-organisation [48-50]: neurons form connections based on the stimuli they receive, and the brain changes as a result of experience (neuroplasticity). This also occurs through psychotherapy, which acts as a biological treatment capable of physically altering the brain. Through the therapeutic relationship and dialogue, the nervous system's capacity to create new connections and reorganise itself is stimulated, and this enables one to overcome dysfunctional thought patterns and behaviours at three different levels: 1) Immediate solution (low level of leverage; for example, resolving an immediate problem such as reducing anxiety levels, which requires considerable effort but may ultimately have only a superficial and temporary impact); 2) Deep-rooted change (medium level of leverage; for example, modifying dysfunctional thoughts through cognitive restructuring within

the system to prevent the problem from recurring); 3) Systemic transformation (high level of leverage; for example, changing the system's primary objective, that is, helping you to examine your underlying beliefs – *"I'm inadequate!", 'If they really knew me, they wouldn't accept me!', etc.*— as protective strategies rather than self-deprecating judgements: an inability to express one's emotions or a tendency to be highly self-critical; this is the most challenging intervention, but it brings about the most radical and lasting transformation) [15,52].

The intervention

The first two levels were used in the initial phase (Mindfulness, Cognitive Restructuring, Graded Exposure, etc.) both to reduce the rather high levels of anxiety relating to certain social aspects and to change some deeply ingrained beliefs: not needing others [53-62].

As regards, on the other hand, the beliefs typical of avoidant personality disorder (for example, difficulty confiding one's emotions to others, relying solely on oneself to deal with certain problems, feeling uncomfortable when someone expresses their feelings towards them, distracting oneself with work or hobbies rather than facing one's emotions, etc.), we opted to use the 'systematic transformation' level, initially focusing on recognising the behavioural signs of avoidant attachment [63]. These signals, in fact, are not permanent; they are learnt responses that can be unlearned through self-awareness (learning to identify and deal with her emotions in a healthy way), effort (engaging in an atmosphere of unconditional acceptance to alleviate deep shame and the fear of others' judgement) and support (accepting dysfunctional thoughts without forcing through resistance).

Identifying the various levels of self-organisation of thought that were addressed, to guide Maria in overcoming her difficulties, made it possible to modify the system without acting on the outcomes, but rather on the processes, information and paradigms that generated those outcomes. From an operational perspective, the following strategies were employed:

1. **Modifying reinforcement mechanisms:** moving away from negative reinforcement (avoiding situations and thoughts that caused distress) and positively reinforcing every small step forward: for example, replacing the thought 'I'm not satisfied with my performance' with the thought 'On closer analysis of the whole process, my performance went better than last time; all things considered, I did well but I still need to improve'. In this way, the system reorganised itself around the new framework (improved self-perception).
2. **Working on information flows:** we intervened in the way Maria acquired, processed, stored and interpreted external stimuli (input) to generate emotions (fear) and avoidant behaviours (protecting her own vulnerability), breaking the vicious circles (very rapid and automated information flows) that had influenced the functioning of her emotional system and, consequently, her behaviours ("My thoughts cause me suffering and distressing emotions, to the extent that they prevent me from doing what is important to me").
3. **Modifying the system's organisation:** the change took place through specific phases and operational methodologies (analysis of emotional regulation style and belief system, recognition of automatic thoughts and associated emotions in specific situations, and adaptation of the individual's organisation to relational and interpersonal contexts) to alter the emerging behaviour, transforming the system through a new phase of self-organisation. The latter is a process in which a disordered system (Maria's avoidant way of thinking) spontaneously generates a structured order through the interaction of its parts, without any voluntary control, making the system extremely resilient, in which past experiences are integrated with external disturbances to maintain its identity, whilst adapting to changes. This process describes how change never occurs in a linear fashion, but through various stages in which the system self-organises, finding a more functional and adaptive equilibrium, whilst learning to generate its own well-being autonomously [64-66].
4. **Changing the system's objectives:** redefining the purpose, shifting the focus to objectives that are easier to achieve but which are situated within the individual's hierarchical scale of values (1. Family, 2. Well-being, 3. Career, 4. Friendships) and starting from their awareness of what is truly important and a priority for managing avoidant disorder.
5. **Working on paradigms:** changing the deep-rooted beliefs that underpin the individual's way of thinking (the paradigm), by challenging them (for example, 'Not being up to the task in a particular situation', 'Being unable to cope with uncomfortable situations', 'Being afraid to show affection', etc.) and guiding them towards a different, more mindful interpretation of reality, without falling into automatic emotional reactions.
6. **Accepting events and their unpredictability:** encouraging adaptation, whilst avoiding the imposition of pre-determined solutions (attempts to force change often lead to resistance) that restore the previous state; whereas acceptance of events, even the most negative ones, involves opening up to one's own emotional responses without judging or fighting them, making room for the unexpected and allowing unpleasant emotions to flow naturally.

Conclusions

The initial consultation with Maria required an atmosphere of unconditional acceptance to alleviate the deep shame and fear of judgement typical of this condition. Indeed, the patient felt a strong sense of nervousness, which was acknowledged and 'normalised' verbally, as can be seen from the first consultation:

G.M.G.: "I can see you're feeling a bit uncomfortable; that's perfectly normal and an excellent starting point for psychotherapy").

[The primary aim was precisely to build a secure therapeutic alliance, exploring dysfunctional thoughts without forcing through her resistance. At this stage, direct questions were kept to a minimum so as not to make her feel 'under scrutiny', whilst exploratory questions were asked to understand the origin of the problem].

G.M.G.: "During the initial phone call to arrange this appointment, you told me that you always feel uncomfortable in social situations where you are expected to demonstrate your abilities. Could you explain to me what would happen if you allowed these emotions to surface?".
M.: "I'd feel very intense anxiety, so much so that I'd feel my strength draining away and might even faint."
G.M.G.: "It's as if your mind had told you: 'If I speak, I'll make a fool of myself and be mocked. That's a very critical thought; in your opinion, how likely is it that things really do always turn out that badly?'
M.: "For me, it's a certainty, and by not exposing myself, I avoid the danger of making a complete fool of myself."
G.M.G.: "Certainly, avoidance protects you from immediate suffering, but does it make you feel at peace and fulfilled?"
M.: "No, it makes me feel increasingly incapable; I've often thought that's just the way I am and that I can't change I have to accept myself as I am!"
G.M.G.: "Shall we try to understand together where this feeling of inadequacy comes from?"
M.: "I'd like to, but I don't know if I'll manage it".
G.M.G.: "This constant tendency to put yourself down ('… I don't know if I'll manage it') is the first step towards realising that the idea of being worthless is merely an echo of the past and that today it is being used as a defence mechanism".

As we have seen, the avoidant attachment style causes people to find it difficult to confide their emotions to others, to feel inadequate, to rely solely on themselves to deal with certain problems, to feel uncomfortable if someone expresses their feelings towards them, to distract themselves with work or other interests – including household chores – rather than facing their emotions, and so on.

These behaviours and others were also characteristic aspects of Maria's personality; after about a year and a half of treatment, she became aware of her emotions (she learnt to identify and deal with them in a healthier way), managed to change certain automatic thought patterns (being less self-critical), to reduce her fear of others' judgement (feeling less inadequate in situations she previously avoided, and feeling able to be accepted without fear of criticism), to manage vulnerability (tolerating others' emotional closeness better) and to engage constructively with them (without fear of losing her autonomy or suffering disappointment) [67-70].

This approach, therefore, based on 'leverage points', led to the rewiring of Maria's neural connections, resulting in very positive outcomes and benefits, albeit not exhaustive: 1) replacing old habits with new ones, improving learning and stress management; 2) shifting focus from the problem to the solution, developing a success-oriented mindset; 3) activating the self-organisation system in relation to the patient's current situations, limiting the interference of past experiences; 4) overcoming certain dysfunctional traits, whilst strengthening the patient's resilient aspects.

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