Effectiveness of Cognitive Behavioral Therapy in Avoidant Personality Disorder: A Systematic Review

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ABSTRACT

Cognitive behavioral therapy (CBT) is a commonly applied therapy process for personality disorders; however, studies investigating its use in avoidant personality disorder (AvPD) are relatively limited. This systematic review aims to inquire about studies assessing the effectiveness of CBT in treating AvPD and examine its impact on functional improvement and overall well-being. A literature search was conducted using the databases Web of Science, PubMed, and Scopus, encompassing data available up to October 2025. The Preferred Reporting Items for Systematic Reviews and Meta-Analyses framework guidelines were used. Ultimately, 9 studies applying CBT as the treatment for AvPD were reviewed. Among the analyzed studies, 1 was an open trial, 1 was a comparative longitudinal design, 4 were randomized control trials, and 3 were experimental studies. The findings showed that CBT interventions provide statistically significant reductions in AvPD symptoms, in some cases, even to the extent of failing to meet the diagnostic criteria. Effect sizes have generally been reported in the moderate-to-large range (d=0.50–0.80). CBT interventions that target avoidance behavior, social anxiety, and interpersonal difficulties have shown promising results even with a limited number of sessions. While some studies have shown complete recovery rates of 40%, others have reported this rate as high as 68%. Although CBT appears to work effectively, a CBT protocol specifically tailored for AvPD may produce more stable results.

Keywords: Avoidant personality disorder, cognitive behavioral therapy, effectiveness, symptom reduction.

ÖZ

Kaçıngan Kişilik Bozukluğunun Tedavisinde Bilişsel Davranışçı Terapinin Etkinliği: Sistematik Bir İnceleme

Bilişsel davranışçı terapi (BDT), kişilik bozuklukları için yaygın olarak uygulanan bir terapi yöntemidir, ancak kaçıngan kişilik bozukluğunda (KKB) kullanımını araştıran çalışmalar nispeten sınırlıdır. Bu sistematik derleme, KKB tedavisinde BDT'nin etkinliğini değerlendiren çalışmaları sentezlemeyi ve bu terapinin semptomlar ve genel iyi oluş üzerindeki etkisini ortaya koymayı amaçlamaktadır. Web of Science, PubMed ve Scopus veri tabanlarında Ekim 2025'e kadar olan çalışmaları kapsayan bir literatür taraması yapıldı. Sistematik derlemeler ve meta-analizler için tercih edilen raporlama ögeleri (PRISMA) çerçevesi kullanıldı. Sonuç olarak, KKB'nin tedavisi olarak BDT'yi uygulayan dokuz çalışma incelendi. Analiz edilen dokuz çalışmadan biri açık çalışma, biri karşılaştırmalı uzunlamasına tasarım, dördü randomize kontrollü çalışma ve üçü deneysel çalışmadır. Sonuçlar, KKB semptomlarında, bazı durumlarda tanı kriterlerini artık karşılamayacak düzeye kadar bir azalma olduğunu gösterdi. Etki büyüklükleri genellikle orta-büyük aralığında (d=0,50-0,80) bildirildi. Bazı çalışmalar %40 oranında tam iyileşme gösterirken, diğerleri bu oranı %68'e kadar çıkarmaktadır. Kaçınma davranışı, sosyal kaygı ve kişiler arası sorunları hedef alan BDT müdahaleleri, az sayıda seansla bile umut verici sonuçlar gösterebildi. BDT'nin KKB ile etkili bir şekilde çalışabildiği görülmektedir; ancak KKB için özel olarak hazırlanmış bir BDT protokolü daha stabilize sonuçlar üretebilecektir.

Anahtar Kelimeler: Bilişsel davranışçı terapi, etkinlik, kaçıngan kişilik bozukluğu, semptom azaltma.

INTRODUCTION

Several personality disorders (PDs) are clustered with diagnostic criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM), and one of them is avoidant personality disorder (AvPD) (APA, 2022). According to the literature, AvPD is one of the most prevalent PDs (Torgersen, 2009). AvPD can make individuals struggle in circumstances that require substantial interpersonal interaction because it is characterized by a specific fear of being negatively evaluated. It is characterized by the poorest social skills among the PD categories, consequently diminishing the quality of life, as humans are social creatures by nature (Cramer et al., 2007). The detriment includes overall functional impairment in occupational and social circumstances caused by social isolation. Hence, anxiety and avoidance of social situations are key manifestations of AvPD.

PDs show significant comorbidities not only with other diagnostic categories but also among one other (Stuart et al., 1998). The highest comorbidity of SAD is observed with AvPD because these two disorders are based on common diagnostic criteria, such as social isolation (Friborg et al., 2013; Reich, 2009). Distinguishing between SAD and AvPD can be difficult because both diagnoses share significant overlap in clinical features related to intense anxiety, discomfort, and accompanying avoidance behaviors in social situations. However, AvPD is defined not merely as an anxiety pattern specific to certain social situations but rather as a pervasive, persistent, and continuous personality pattern that encompasses an individual's self-perception, interpersonal relationships, and behavioral repertoire. In contrast, SAD is an anxiety disorder limited to specific social interactions or performance situations.

Individuals experiencing symptoms such as intense anxiety and a debilitating fear of interpersonal relationships often seek therapeutic interventions at some point in life (Sørensen et al., 2019). According to Alden (1989), AvPD treatment has shown positive outcomes, such as reduced symptoms and improved interpersonal functioning. Although this dated study suggests the effectiveness of treatment for AvPD, there is an ongoing controversy regarding the most effective therapeutic approach for treating AvPD. Understanding the most effective treatment is important for several reasons, such as cost-effectiveness for the individual undergoing treatment. Over the years, individual therapy, based on one-to-one sessions, has been the traditional approach for psychotherapy (Sanislow et al., 2012). However, no definite argument exists that a single therapy protocol would be equally beneficial for every individual with the same disorder. Owing to the nature of AvPD, exposure-based group therapy might also be effective

because it requires social interaction during sessions. Wilberg et al. (2023) suggested that combined group and individual mentalization-based and metacognitive therapy methods are effective in reducing AvPD symptoms and improving overall well-being. However, no consensus has been reached on which therapy protocol is more effective than others (Weinbrecht et al., 2016).

Individual therapies for AvPD include behavioral interventions and social skills training. As outlined by Alden (1989), behavioral interventions assume that systematic exposure to feared situations can ultimately lead to symptom reduction. Therefore, behavioral interventions are designed to confront the client with feared and avoided situations. Social skills training assumes that individuals with AvPD may experience difficulties in relationships due to a lack of adaptive skills; therefore, it aims to improve these skills. These therapeutic approaches offer different strategies to address the specific challenges associated with AvPD and highlight the importance of CBT tailored to the specific needs of each PD.

Determining which approach is more effective for AvPD in the existing literature is difficult. Alden (1989) showed that therapeutic interventions are effective in addressing AvPD; however, the limited duration of short-term treatments may not be sufficient to fully return individuals to the normative range. Redesigning treatments to address factors such as content, duration, and whether they are individual- or group-based, with protocols specifically designed for each diagnosis, may be more effective in achieving full recovery. The need for further empirical research is undeniable.

Behavioral therapy, cognitive behavioral therapies (CBTs), and psychopharmacological treatments are commonly used for AvPD (Sanislow et al., 2012; Weinbrecht et al., 2016). The core focus of this review, CBT, is an effective approach for addressing various and enduring challenges faced by individuals with several PDs. CBT is used as an umbrella term for the family of cognitive and behavioral therapies, including Beckian CBT, cognitive therapy (CT), and third-wave CBTs (i.e., Schema therapy). The relationship between adverse childhood experiences and PDs aligns with the core CBT assumption that early childhood experiences shape core beliefs about people and the world (Davidson, 2008). Inflexible and relatively rigid thought patterns are core belief characteristics (Görmez, 2016). In turn, beliefs shape cognitive and behavioral responses to daily events. The core logic of CBT is based on the interrelatedness of these beliefs and thoughts and their ability to influence emotions and behaviors, because certain events or situations can trigger beliefs, potentially leading to the emergence of psychiatric disorders (James et al., 2009; Davidson, 2008). In short, thoughts influence behavior by

influencing emotions. In CBT, thought change is aimed at through various techniques, such as Socratic questioning (Scott & Beck, 2008). Along with addressing thoughts and schemas, synchronous or asynchronous techniques for behavioral change are also employed (Scott & Beck, 2008).

The sessions in CBT encompass elements such as psychoeducation, homework tasks, behavioral experiments (i.e., graduated exposure), and relaxation techniques (Beck et al., 2015; Matusiewicz et al., 2010). The characteristics of AvPD, anxiety, and avoidance can be targeted in CBT by working with cognitive structures, thoughts, beliefs, and behaviors (Zhou, 2024). The duration of therapy is typically up to 30 sessions (Balje et al., 2024) for both individual and group therapy methods. Therapy sessions in CBT are well-organized and have a fixed approximate duration, allowing for the focused exploration and modification of beliefs and maladaptive behavioral patterns (Davidson, 2008). These components are considered integral to an individual's mental health and, therefore, the treatment process. Specifically, cognitive restructuring involves exploring the thoughts underlying the individual's fears of being criticized or rejected and reconstructing them in a more adaptive manner (Sanislow et al., 2012), which is why it is effective in AvPD treatment.

Although AvPD is a common issue in practice and has been studied in the literature, the most appropriate treatment method remains a matter of debate (Lampe & Malhi, 2018). Conducting a review study 15 years after Matusiewicz's study (2010) is anticipated to contribute substantially to the literature. Matusiewicz reviewed CBT for PDs broadly and found that short-term group CBT (CBGT) is specifically effective, but multi-component ingredient therapies do not lead to better outcomes. According to Matusiewicz, while the compiled studies demonstrate effectiveness, complete recovery from symptoms has not been achieved for some patients in various studies. Therefore, further research is necessary to make informed decisions in determining effective treatment methods. Although Matusiewicz's study allows us to draw a general conclusion regarding PDs, the fact that it is a review conducted 15 years ago and that it did not examine CBTs specifically for AvPD highlights the importance of the present review for current literature. This systematic review aimed to evaluate the effectiveness of CBTs for treating AvPD by determining their effect on symptom reduction and general well-being. This will ensure a timely addition to the literature, incorporating current evidence reflecting the application of CBTs to AvPD. There are two hypotheses in the current review. First, classical CBTs are effective in treating AvPD. Effectiveness was measured by symptom reduction and functional improvement. Second, the effect sizes of classical CBTs in treating AvPD are medium to large.

LITERATURE STRATEGY

This systematic review follows the guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses framework (Page et al., 2020). The Web of Science (WoS), Scopus, and PubMed databases were searched for the last time on October 25, 2025. The search was conducted with the following grouped terms: (CBT* OR CBT*) AND APD. The inclusion criteria were the use of at least one of the classical CBTs, studies conducted with people with AvPD, and reporting effective outcomes. The exclusion criteria were as follows: studies that were books, reviews, commentaries, or therapy protocols; studies published in languages other than English; those with an AvPD comorbid diagnosis rate of less than 50% in the sample; and CBT studies involving other psychopathologies. The literature search results were collected, and duplicates were removed using reference management software. The study selection was conducted in two stages by two independent reviewers (D.N.C.O. and O.Y.A.). Any inconsistencies or disagreements regarding compliance were resolved through discussion until a consensus was reached. All articles were evaluated by the authors using the appropriate risk-of-bias tools. The included non-randomized studies were subjected to a risk-of-bias assessment using The Risk-of-Bias in Non-randomized Studies – of Interventions, Version 2 (ROBINS-I V2) (Sterne et al., 2024). The Cochrane Risk of Bias Tool for Randomized Trials (RoB 2) was used to assess the risk of bias in the included randomized control trials (RTCs) (RoB 2, 2019). The overall risk of bias for the four included RCTs was moderate. Despite these bias findings, this review was conducted because there are very few studies in the literature, but it serves a much-needed purpose in both practical application and theoretical formation. The methodological quality and risk of bias of the three included case studies were assessed using the Joanna Briggs Institute Critical Assessment Checklists (Munn et al., 2015), which are appropriate for case studies. These studies are case reports or case series; thus, their internal validity is naturally limited. However, these studies provide valuable qualitative evidence regarding CBT's applicability and potential benefits in AvPD. Most studies were of moderate to high quality; however, case studies are naturally limited by sample size.

OVERVIEW OF THE INCLUDED STUDIES

Figure 1 depicts the search and selection processes. The initial search yielded 314 records. 156 were sourced from WoS, 140 from Scopus, and 18 from PubMed. Subsequently, duplicated studies were removed, resulting in the removal of 108 studies. A total of 206 studies remained for title and abstract screening. Afterward, 159 studies were excluded because they did not meet the predetermined inclusion criteria. The remaining 47 studies underwent a full-text scan. Of these, 38 were considered unsuitable for this review due to the exclusion criteria. Ultimately, 9 were synthesized.
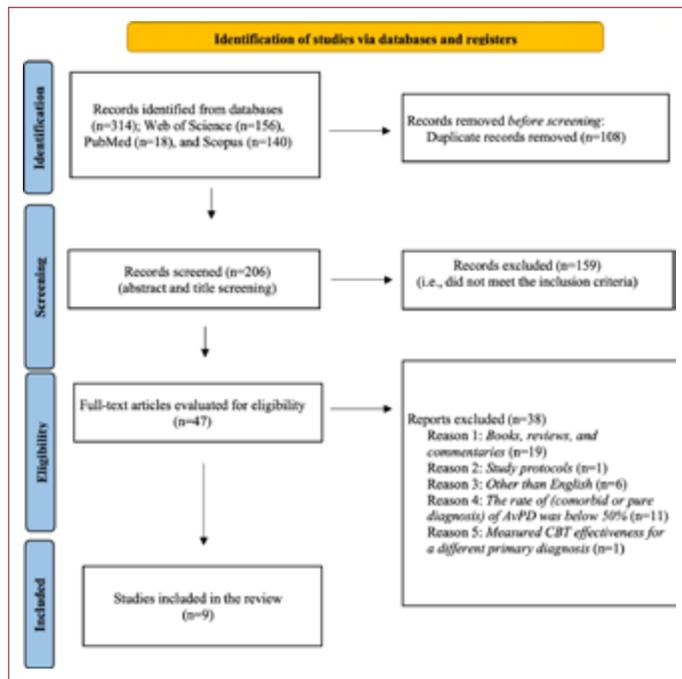
Figure 1. Flowchart of the article search and selection process (Source: PRISMA, Page et al., 2020).

Of the 9 studies covered, 1 was an open trial, 1 was a comparative longitudinal design, 4 were RCTs, and 3 were case studies (Appendix 1). The studies were conducted in 4 different countries: the United States, Australia, the Netherlands, and Norway. Although the sample sizes varied across the studies, the RCTs generally had larger sample sizes. The total sample size across all studies was 457 adults. Cognitive therapy (CT), brief dynamic therapy (BDT), CBT, CBGT, group schema therapy (GST), pharmacological interventions, and placebo were the treatment methods used in the studies. CT resembles the basis of traditional CBT techniques; therefore, in this review, CT studies cannot be distinguished from CBT studies that question the effectiveness of traditional CBT in PDs. Some studies incorporated control or comparison groups, resulting in the inclusion of multiple treatment methods. The findings indicate that the average number of sessions for CBT ranges from 12 to 43. Emmelkamp et al. (2006) reported that the average number of CBT sessions was approximately 18.5. The treatment duration was 12 weeks for CBT in the study by Nordahl et al. (2016). Another study also consisted of 12 sessions (Rees & Pritchard, 2013). In the study by Hofmann (2007), 27 CBT sessions were conducted. In Balje et al. (2024), 30 CBGT sessions were conducted. Strauss et al. (2006) found that the average session count for CBT was even higher at 43.28. Changes in CBT session counts across studies potentially imply differences in treatment duration. The treatment duration

and number of sessions may depend on factors such as the therapeutic approach, condition severity, treatment goals, and individual client needs.

Cohen's d value was accepted as a small effect at 0.20, a medium effect at 0.50, and a large effect at 0.80 and above (Cohen, 1977). Emmelkamp et al. (2006) showed a large effect size for CBT, and the effect size of the comparison group was medium to large, whereas the effect size of the control group was small. In the study by Nordahl et al. (2016), both CT and SSRI interventions showed large effect sizes. However, CT exhibited a larger effect than SSRI. According to Balje et al.,(2024) CBGT had a large effect on AvPD symptoms at both 3- and 12-month follow-ups. The effect size was greater in patients who completed the treatment. Overall, CBT, GCBT, and CT showed significant therapeutic effects with large effect sizes. CBT approaches appear to have larger effect sizes than comparison treatment interventions. Balje et al. (2024) found that both GST and CBGT were effective for AvPD, yet no significant difference was found between them. Among those who completed the protocol, the recovery rate from AvPD at diagnosis at the 12-month follow-up was 22% for both GCBT and GST, again not statistically significant.

Emmelkamp et al. (2006) found that CBT showed notable improvements compared with the control group, which received no therapeutic intervention. The study showed that CBT has higher effectiveness rates than BDT on various measures at follow-up. Only 9% of the individuals in the CBT group still met the diagnostic criteria for AvPD. This suggests that CBT is promising in maintaining positive treatment outcomes. The findings suggest a potential ranking of effectiveness for symptom reduction and improvement between CBT, BDT, and no therapy, respectively.

The focus was on comparing the responses of individuals with AvPD and obsessive-compulsive personality disorder (OCPD) to CT in the study of Strauss et al. (2006). At the end of treatment, the diagnostic rates of AvPD and OCPD decreased from 100% to 7%. These findings demonstrate the success of CT in reducing AvPD symptoms. Hope et al. (1995) reported that 42% of participants with comorbid SAD and AvPD experienced complete recovery from social phobia. Similarly, Nordahl et al. (2016) showed that CBT demonstrated significantly higher rates of recovery than placebo. The post-test fear of negative evaluation (FNE) decreased significantly across all treatment methods. The order and significance of FNE reduction were as follows: CT>SSRI and CT>placebo. No significant difference was observed between the CT and combined treatment groups. No significant difference was observed between the combined treatment and SSRI alone. Based on the post-test results, the complete recovery rate

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from SAD and comorbid AvPD was 68%, 23%, 45%, and 4% in the CT, SSRI, combined, and placebo groups, respectively. CT demonstrated significantly higher recovery rates than other treatments. Additionally, CT showed better results for social anxiety compared with SSRI treatment based on the post-test scores. Furthermore, CT demonstrated greater effectiveness for social anxiety than placebo. Even at the 12-month follow-up, CT maintained higher effectiveness than the combined treatment, SSRI, and placebo. Notably, the study revealed that the combination of CT and psychopharmaceuticals did not yield any additional advantages compared to using either alone (Nordahl et al., 2016) (Appendix 1 shows the significance values for all of the above-mentioned).

CBTs are effective in reducing various psychological symptoms and thus improving the overall well-being of individuals. According to the data from an open trial, significant changes were observed in SCID-II and in the scores of several other psychological disorders symptoms, indicating greater overall psychological well-being (Strauss et al., 2006). Hyman and Schneider (2004) reported significant improvements in depression, anxiety, social discomfort, and low self-esteem. Hope et al. (1995) demonstrated reductions in social anxiety scores. Emmelkamp et al. (2006) reported positive outcomes for CBT when considering social anxiety symptoms; hence, these findings collectively suggest that CBT approaches can address a range of symptoms associated with AvPD. Current evidence suggests that therapeutic effectiveness extends beyond cognitive-behavioral frameworks and includes other modalities, such as schema therapy (Balje et al., 2024). The existing literature does not support the clear superiority of any single approach. Rees and Pritchard (2013) found that therapy led to decreased anxiety and stress levels, contributing to an overall improvement in quality of life. Therefore, when describing the effectiveness of CBT, it is important to mention that receiving therapy, regardless of the specific approach, can yield positive outcomes for individuals with AvPD. In a study by Hyman and Schneider (2004), a patient received brief CBT for AvPD, and scores on various measures improved significantly from pretest to posttest. The improvements in the scores of depression, anxiety, adjustment, marital problems, obsession, low self-esteem, and social discomfort scales suggest that the participant would experience fewer daily difficulties after CBT. In Hofmann's study (2007), a patient underwent CBT for AvPD and also experienced symptom reduction. The case no longer met the diagnostic criteria in the follow-up assessments. Rees and Pritchard (2013) reported that FNE symptoms, a core feature of AvPD, decreased significantly after the treatment course. Hope et al. (1995) demonstrated that among participants diagnosed with both AvPD and SAD, 42% showed significant improvement, with 42% achieving full remission from their

symptoms, highlighting the effectiveness of CBGT. However, a small percentage (16%) did not experience any improvement or showed only mild improvement. Notably, the presence of AvPD did not show a statistically significant relationship with treatment response compared with comorbid conditions. Overall, CBT has promising outcomes for treating AvPD.

DISCUSSION

Given the negative impact of PDs on various aspects of an individual's life, their extensiveness, and longevity, determining which treatment approach is more effective and has a higher cost-benefit ratio is crucial. This systematic review aimed to evaluate the results of studies on AvPD treatment using CBT. Nine studies were evaluated using a systematic review approach to estimate the impact of CBTs on AvPD. The results support the first hypothesis, confirming the efficacy of CBT in reducing AvPD symptoms. There is an ongoing controversy regarding which therapy method is more effective for AvPD in terms of symptom reduction or full recovery. Within the CBT approaches, CT was found to be more effective than medication treatments (Nordahl et al., 2016). The findings challenge the assumption that combining psychotherapy with pharmacological treatments in AvPD necessarily leads to superior clinical outcomes. Indeed, Nordahl et al. (2016) showed that SSRIs did not provide any additional contribution to the effectiveness of CT. The addition of psychopharmaceuticals to therapy does not seem to increase CBT effectiveness. The combination of CBT and SSRI does not appear to yield additional therapeutic benefits. Strauss et al. found similar outcomes to Nordahl et al. (2016); CT is effective for AvPD treatment. In another comparison of BDT and CBT, CBT had a greater effect size (Emmelkamp et al., 2006). No significant difference was found between the group schema and group CBT treatments, demonstrating that both treatments were effective (Balje et al., 2024). However, Balje et al.'s study also showed the effectiveness of GCBT for treating AvPD. It can be said that any treatment is more effective for AvPD than no treatment, and CBT often demonstrates robust effects compared with some alternative therapies. However, other structured approaches, such as GST, have also shown similar effects. Further research is still needed in this field. Definitive conclusions cannot be drawn, especially considering the varying number of sessions and effect sizes across all CBT protocols.

CBT is a promising treatment approach for PDs (Beck et al., 2015; Matusiewicz et al., 2010). Some reviewed studies provided results supporting the effectiveness of CBT compared with the control or placebo conditions. CBT seeks to facilitate positive changes in PDs by targeting maladaptive beliefs and skill deficiencies to improve overall outcomes. This is congruent with how the DSM approaches PDs, as it places particular emphasis on treating the cognitive and behavioral patterns associated with PDs and suggests that the ultimate aim may be to reduce

symptoms and improve psychological well-being (Davidson, 2008). The effectiveness of CBT in these conditions stems from its effective reduction of symptoms associated with FNE.

The number of therapy sessions varies according to the therapy goals and adopted approaches. Some researchers believe that AvPD requires a long therapy duration (Alden, 1989). Some studies empirically supported the necessity of a longer treatment duration for AvPD by implementing protocols of 30 or more sessions (Strauss et al., 2006; Balje et al., 2024). However, AvPD can be treated effectively in a shorter duration (Emmelkamp et al., 2006; Hofman, 2007; Nordahl et al., 2016; Rees & Pritchard, 2013). Extensive therapy may not even be necessary for PDs, yet this subject requires more studies. Among the studies reviewed, although some lasted for 43 sessions, others lasted for around 12 sessions (Strauss et al., 2006; Rees & Pritchard, 2013). Studies demonstrating symptom reductions in a shorter time emphasize the urgent need for a tailored CBT protocol for this disorder, highlighting the potential for a more efficient treatment process targeting specific challenges and symptoms of AvPD in a shorter duration. Further research is warranted, particularly through additional studies focusing on determining the relationship between CBT effectiveness and the number of sessions. However, regardless of the number of sessions, CBT is a useful therapy approach in reducing symptoms and improving general well-being in patients with AvPD.

The effect sizes provide significant information about the effectiveness of a therapy approach. The findings of this review support the second hypothesis, that is, CBT has medium-to-large effect sizes for treating AvPD. The effect sizes of CBT interventions in the treatment of AvPD have consistently been reported as medium-to-large, resulting in reduced symptoms and increased well-being (Emmelkamp et al., 2006; Nordahl et al., 2016; Balje et al., 2024). Furthermore, comparative studies have shown that CBT has larger effect sizes than alternative treatments (Emmelkamp et al., 2006; Nordahl et al., 2016). The greater efficacy of CBT compared with control conditions and its ability to maintain long-term positive outcomes support its effectiveness for AvPD treatment (Emmelkamp et al., 2006). Consequently, the effect sizes of CBT are considered optimal and, therefore, CBT is a suitable therapeutic approach for PDs.

Studies consistently demonstrate significant improvements in quality of life (i.e., marital distress), depression, anxiety, and social phobia symptomatology in individuals receiving CBT (Strauss et al., 2006; Emmelkamp et al., 2006; Rees and Pritchard, 2013). CBT also appears effective in alleviating social anxiety symptoms, regardless of the presence of AvPD (Hope et al., 1995). Reductions in social anxiety levels positively impact overall well-being by facilitating interactions, as humans are inherently social beings. This provides strong evidence for

the effectiveness of CBT in reducing AvPD symptoms and improving the overall quality of life.

Hyman and Schneider (2004) and Hofmann (2007) also demonstrated the effectiveness of CBT for AvPD. Hyman and Schneider reported significant improvements in several measures of depression, anxiety, and social discomfort after a brief CBT session. In Hofmann's case, AvPD was severe enough that education was interrupted before beginning treatment. AvPD symptoms, such as extreme shyness and avoidance of social situations, prevented him from participating in academic activities or forming social networks. Individuals with AvPD can develop more adaptive mechanisms to continue their education with appropriate treatment (Skewes et al., 2015). Individuals with AvPD who recognize the potential for positive change in daily functioning and educational activities have a greater chance of developing adaptive mechanisms through personalized therapy, education, and appropriate interventions. A similar situation occurred in the case of Hofmann. In conclusion, CBT has a significant effect in reducing symptoms associated with AvPD and leads to improvements in overall well-being.

The main findings of this systematic review can be summarized as follows: CBT methods are effective in reducing AvPD symptoms and improving overall functionality. The effect sizes of CBT interventions for AvPD mostly range from moderate to high, indicating clinically significant change. Comparative studies have shown that CBT produces stronger symptom reduction than other treatments, such as SSRIs or BDT. While most studies have used existing CBT protocols, developing a standardized, disorder-specific CBT protocol that targets specific cognitive schemas (e.g., fear of rejection) and behavioral patterns (e.g., social avoidance) related to AvPD could make treatment outcomes more beneficial and sustainable.

This review contributes to the literature by synthesizing recent evidence on CBTs for AvPD, which have received limited synthesis despite growing clinical relevance. Unlike the review by Matusiewicz et al. (2010), the present study focuses solely on AvPD, allowing for a more nuanced understanding of how CBT interventions target the core features of this disorder. Furthermore, the inclusion of contemporary randomized controlled trials, comparative outcome studies, and longitudinal follow-up data provides up-to-date evidence that can better inform clinical practice and future research directions.

This review included studies with varying methodological rigor, ranging from RCTs to non-randomized open trials and case studies. While RCTs provide the highest level of evidence for efficacy, findings from other studies should be interpreted cautiously in terms of generalizability and causal inference strength. It is important to emphasize that this evidence hierarchy must be clearly acknowledged and the

results interpreted accordingly. This systematic review has several limitations. First, only three databases were searched. However, no date restrictions were imposed, and the most widely used databases in the healthcare field were searched. Second, studies may have been overlooked because of the similarity between the diagnostic criteria for SAD and AvPD. The inclusion and exclusion criteria were established a priori, and a careful, long-term review was conducted. A limitation was that studies were only searched in English. This was due to the language limitations of the authors.

A literature review was conducted using a predefined, focused, and repeatable search strategy related to CBT and AvPD. This approach ensured a systematic and manageable review process, while the search was conducted in the topic (title, abstract, and keywords) to capture relevant studies using different terminology or indexing. It also allowed the use of the asterisk plural suffix and different sentence-ending structures. However, future reviews may still consider additional search methods and strings, such as citation tracking, browsing specific journal archives, or searching separately for various therapies mentioned in this study, to reduce the possibility that the narrow string may have missed some studies. A limitation of this study is that some studies are case studies and do not provide data such as effect sizes. A similar limitation is the inability to conduct a meta-analysis due to the lack of sufficient numbers and quality of studies in the relevant field. However, future meta-analyses with new studies will provide a better understanding of the topic.

As mentioned earlier, a tailored protocol proposal can be developed based on this study's findings. While further studies are needed to detail and finalize the protocol and test its effectiveness, summarizing how the common findings of the included studies can be drawn upon to determine the cornerstones of the protocol is beneficial. The protocol should emphasize the therapeutic alliance's strength. Studies have shown the importance of a good alliance when in therapy with this disorder, which is characterized by problems in interpersonal relationships. Cognitive restructuring, beliefs, and behavioral experiments (exposure) should be worked on together. In the context of both a strong alliance and behavioral experiments, considering group therapies where exposure is necessary would be meaningful. Keeping the number of sessions as short as possible will increase individual cost-effectiveness and access to therapy. Studies have shown a success rate of as few as 12 sessions. Therefore, the protocol to be developed can be planned in the shortest possible time. Finally, AvPD screening should be mandatory at the beginning of therapy in patients with SAD. Undiscovered and untreated AvPD can increase recurrence in these two frequently comorbid conditions. Therefore, conducting PD screening is important.

CONCLUSION

In conclusion, the literature provides evidence supporting the effectiveness of CBT for AvPD treatment. CBT is a viable and promising intervention for improving the overall quality of life, reducing symptoms, and enhancing interpersonal functioning. The comorbidity of AvPD with other disorders, such as social anxiety disorder, highlights the importance of considering comorbidity and adopting a comprehensive approach to AvPD treatment. CBT is emerging as a viable therapeutic approach for AvPD, offering the potential for significant improvements in interpersonal relationships, career opportunities, and overall well-being. While CBT appears to be a feasible and plausible treatment, nearly every study has modified the guidelines. Therefore, a CBT guideline specifically tailored for AvPD is needed. Further studies are needed to contribute to the still limited literature.

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