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THE AVOIDANT PERSONALITY DISORDER AS A VULNERABILITY FACTOR IN MIXED ANXIETY AND DEPRESSIVE DISORDER: A CASE REPORT

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ABSTRACT

Background: The prevalence of Avoidant Personality Disorder has been estimated at approximately 3.3%, with one study reporting a lifetime prevalence of 9.3% among women older than 25 years. Avoidant Personality Disorder is an enduring personality pattern characterized by social avoidance, feelings of inadequacy, and hypersensitivity to negative evaluation. These characteristics may function as psychological vulnerability factors for affective psychopathology, particularly Mixed Anxiety and Depressive Disorder. Methods: This study employed a qualitative descriptive case report approach. Data were obtained through comprehensive psychiatric history-taking, mental status examination, clinical observation, and psychometric assessment using the Hamilton Anxiety Rating Scale (HARS), Hamilton Depression Rating Scale (HDRS), Minnesota Multiphasic Personality Inventory-2 (MMPI-2), and Millon Clinical Multiaxial Inventory-IV (MCMI-IV). Diagnosis was established in accordance with the Indonesian Classification and Diagnostic Guidelines for Mental Disorders, Third Edition (PPDGJ III). Results: Mrs. RM, a 29-year-old woman, presented with complaints of anxiety, marked difficulty engaging in social interactions due to fear of rejection, impaired concentration, and difficulty initiating sleep, accompanied by palpitations, tremulousness, and cold extremities for the preceding three months. The patient experienced significant psychosocial stressors, including family dysfunction and marital relationship difficulties, which were exacerbated by underlying avoidant personality disorder pathology. Psychometric evaluation revealed moderate anxiety and depressive symptoms, while personality assessment demonstrated a persistent avoidant personality pattern. The patient was diagnosed with Mixed Anxiety and Depressive Disorder with comorbid Avoidant Personality Disorder. Clinical improvement was observed following treatment with fluoxetine 20 mg once daily, clobazam 10 mg once daily, supportive psychotherapy, and Cognitive Behavioral Therapy (CBT). Conclusion: Avoidant Personality Disorder served as a major vulnerability factor and enduring personality pattern contributing to the development and persistence of Mixed Anxiety and Depressive Disorder, thereby prolonging and complicating the therapeutic course. Appropriate psychotherapeutic intervention, particularly CBT, is therefore essential in the management of such cases.

Keywords: Avoidant Personality Disorder; Mixed Anxiety and Depressive Disorder; Cognitive Behavioral Therapy; vulnerability factor

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INTRODUCTION

The World Health Organization defines health as a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity. Mental health nables individuals to cope with life stressors, maintain interpersonal relationships, function productively, and contribute to society. Conversely, psychiatric disorders are associated with substantial impairment in social, occupational, and interpersonal functioning, as well as reduced quality of life. Anxiety and depressive disorders are among the most prevalent psychiatric conditions worldwide and frequently coexist, producing greater symptom severity, more persistent impairment, and increased treatment complexity (World Health Organization, 2024). According to Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision, Avoidant Personality Disorder (AvPD) is characterized by a pervasive and enduring pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation, resulting in marked avoidance of interpersonal situations because of fears of rejection, criticism, or humiliation.

One condition that commonly underlies anxiety and depressive symptoms is personality pathology. Personality disorders are enduring patterns of inner experience and behavior that deviate from cultural expectations, are inflexible and pervasive, and lead to clinically significant distress or dysfunction. Among these conditions, Avoidant Personality Disorder (AvPD) is particularly relevant because it is characterized by pervasive social inhibition, feelings of inadequacy, hypersensitivity to criticism, and marked fear of rejection. According to the DSM-5-TR, Avoidant Personality Disorder (AvPD) classified as a Cluster C personality disorder, reflecting a predominance of anxious and fearful traits.

Avoidant Personality Disorder (AvPD) is increasingly conceptualized not only as a comorbid condition but also as a vulnerability factor for the development of mood and anxiety disorders. The present study is theoretically grounded in the concept of "personality disorder as a vulnerability factor," which proposes that enduring maladaptive personality traits constitute a predisposing condition that increases susceptibility to subsequent psychiatric disorders when individuals encounter psychosocial stressors. The Worldwide, the pooled prevalence of Avoidant Personality Disorder ranges from 0.8% to 5%, with an average prevalence of approximately 3.3%. One epidemiological study reported a lifetime prevalence of 9.3% among women older than 25 years (Fariba et al., 2024; Rees & Pritchard, 2021).

Mixed Anxiety and Depressive Disorder (MADD) is defined as a clinical condition in which symptoms of anxiety and depression occur concurrently, are present nearly every day for at least two weeks, and are sufficiently severe to cause significant distress or functional impairment; however, neither symptom cluster independently meets the full diagnostic threshold for an anxiety disorder or a depressive disorder when considered

separately (ICD-11; World Health Organization, 2018). Mixed Anxiety and Depressive Disorder, commonly conceptualized as the coexistence of anxiety and depressive symptomatology, is frequently observed among individuals who also meet criteria for Avoidant Personality Disorder. This association reflects the substantial clinical overlap between Cluster C personality pathology, characterized by anxiety and behavioral inhibition, and Axis I anxiety and depressive disorders.

The relationship between AvPD and MADD may be explained through the cognitive vulnerability model and the diathesis–stress model. Individuals with AvPD typically develop persistent maladaptive core beliefs such as "I am inadequate," "I will be rejected," or "others will criticize me." These beliefs heighten sensitivity to interpersonal stressors and increase the tendency to interpret social situations as threatening or humiliating. Consequently, when individuals with AvPD encounter rejection, criticism, or interpersonal conflict, these pre-existing vulnerabilities may precipitate both anxiety and depressive symptoms. Furthermore, chronic social avoidance limits corrective interpersonal experiences and perpetuates emotional distress (Yan-Min Xu et al., 2022).

This comorbidity has important clinical implications. First, the coexistence of Avoidant Personality Disorder and Mixed Anxiety and Depressive Disorder often complicates diagnosis because clinicians may focus primarily on acute anxiety or depressive symptoms while overlooking the underlying personality pathology (Rees & Pritchard, 2015). Second, patients with comorbid personality disorder generally have a poorer prognosis, more severe functional impairment, higher relapse rates, and slower recovery than patients without personality pathology (ter Meulen et al., 2021; Altaweel et al., 2023). Third, the presence of Avoidant Personality Disorder may contribute to a more complex therapeutic response because avoidance, fear of criticism, and difficulties forming trust may interfere with treatment adherence and the therapeutic alliance (Banyard et al., 2021).

Despite increasing recognition of the association between AvPD and emotional disorders, the available literature remains limited. Most previous studies have focused on prevalence and comorbidity rates rather than examining the psychological mechanisms through which AvPD functions as a vulnerability factor for MADD. In addition, there are relatively few case reports that explore the causal relationship between avoidant personality traits, psychosocial stressors, and the subsequent emergence of mixed anxiety-depressive symptoms.

This research gap provides the rationale for the present case report. A case report approach is particularly relevant because it allows an in-depth exploration of the developmental history, psychosocial context, personality structure, symptom progression, and therapeutic response of an individual patient. The present case was managed in a mental health clinic at a private hospital and illustrates how longstanding avoidant personality traits, family dysfunction, and interpersonal stressors contributed to the emergence of Mixed Anxiety and Depressive Disorder. Through this case, the study aims to clarify the role of Avoidant Personality Disorder as a vulnerability factor, emphasize the importance of early identification of personality pathology, and demonstrate the value of psychometric assessment and integrated treatment planning in clinical practice.

This case report aims to describe the clinical manifestations of mixed anxiety and depressive disorder in an individual with avoidant personality disorder and to analyze the role of avoidant personality disorder as a psychological vulnerability factor underlying, triggering, and maintaining anxiety and depressive symptoms. Furthermore, this report emphasizes the clinical value of psychometric testing in comprehensive treatment planning.

RESEARCH METHOD

This paper uses a qualitative approach with a descriptive case report. Data were obtained through a comprehensive psychiatric history, mental status examination, clinical observation, and psychometric testing using the Hamilton Anxiety Rating Scale (HARS), Hamilton Depression Rating Scale (HDRS), Minnesota Multiphasic Personality Inventory-2 (MMPI-2), and Millon Clinical Multiaxial Inventory-IV (MCMI-IV). The HARS score was 27, HDRS score was 25, MMPI-2 indicated moderate anxiety and depressive symptoms, and MCMI-IV demonstrated avoidant, paranoid, and melancholic personality traits.

Case report

A 29-year-old woman with the initials Mrs. RM came to the Mental Health Clinic of a Private Hospital in Bandung upon a referral from the Community Health Center. The patient complained of frequent heart palpitations, trembling and cold hands and feet, and a fear of being in crowded places. When in a crowd, the patient tends to immediately move away, has rapid breathing and feels shaky, has difficulty concentrating, and sometimes goes to the toilet because it feels safer. Initially, the patient thought the complaints were related to heart disease, but after anamnesis at the Community Health Center, after an examination by the Community Health Center doctor, the complaints pointed to a mental problem, so the patient was referred to the Mental Health Clinic. These complaints have been felt for the past three months.

The patient complained of feelings of anxiety when thinking about her children and husband. She feared that something bad might happen to them. She also felt a sense of purposelessness in life, as no one understood her feelings. Furthermore, she often felt unwilling to do any activities around the house, as evidenced by a loss of interest in previously enjoyed hobbies.

When in crowded places, the patient feels shaky and often looks for a place to hide for fear of being judged. The patient also complains of easily tiring, even without engaging in strenuous activity. When washing in the bathroom, the patient often feels as if he is about to fall. The patient experiences sleep disturbances, sleeping approximately two hours per day. The patient reports trying to fall asleep by closing his eyes, but his thoughts continue to wander. He typically falls asleep around 3:00 a.m. and wakes up again around 5:00 a.m. Sometimes he goes to bed earlier, but wakes up in the middle of the night and cannot fall back asleep until morning.

According to the patient, her symptoms began when her relationship with her best friend soured about three months ago. This was the first time she felt like she had a close friend to confide in, having developed a friendship through their children attending the same school. Previously, she had never had a close friend or close companion from childhood through adulthood. One time, a patient told a friend about his financial problems, but the patient felt belittled because of his family's financial situation. Feeling misunderstood, the patient decided to distance himself, withdraw into himself, and refuse to see the person he previously considered a friend again. The patient felt disappointed after the incident. Following the incident, the patient feared rejection and misunderstanding.

The patient is the second of six children, consisting of one older sister, two younger sisters, and two younger brothers. The patient's parents divorced when the patient was nine years old. After the divorce, the patient lived with her mother, grandmother, and five siblings. The patient reported that her father frequently cheated and changed partners during her marriage to her mother. The patient once witnessed her father being intimate with another woman on public transportation. The patient's father works as a public transportation driver. Since the divorce, the patient's father has never provided financial support to the patient, her mother, or her siblings. Since childhood, the patient often helped her mother look after her four younger siblings. The patient's relationship with her mother is relatively good, but the patient feels she lacks warmth or emotional closeness, especially because the patient's mother is closer to her son. The patient reported that she was never asked about her feelings as a child and feels she received insufficient attention from her parents.

The patient was born normally, full-term, cried immediately, had no congenital abnormalities, and was delivered by a midwife. She was breastfed for two years and grew and developed appropriately for her age. She received a good education up to vocational high school (SMK). Since childhood, she was known as a quiet child and lacked close friends until adulthood. After graduating from vocational high school, she worked at the village office for four years.

The patient has been married for approximately ten years. After marriage, she worked until her child was three years old, then decided to quit to care for her child, who was about to enter school. This decision was approved by her husband because the family's needs were still met. Currently, the patient feels that her relationship with her husband has become cold. The patient also reports a lack of transparency regarding the family's financial situation, including her husband's salary. The patient feels that her husband often lies about his income and uses it for gambling, which the patient believes is influenced by his work environment, which she feels is unhealthy. The patient feels that communication with her husband is very limited and she rarely discusses her feelings for fear of causing arguments. The patient feels that her husband is indifferent and unwilling to listen to her complaints.

The patient stated that she currently lives her life solely for her child, despite feeling a lack of personal purpose. She has an 11-year-old child. She deeply loves her child and enjoys spending time with him. She enjoys the moment when her child comes home from school and tells her about his activities. She doesn't want her child to experience the same childhood experiences she did. The patient is Muslim and regularly performs the five daily prayers. However, he rarely attends religious study groups in his neighborhood. He used to enjoy cooking, but for the past three months, he has lost interest in any activity, including cooking. He also complained of darkness and discomfort in the bathroom while washing.

On physical examination, the patient's general condition was found to be good, the patient's blood pressure was 40/95 mmHg, pulse rate was 90x/m, respiratory rate was 20x/m, temperature was 36.5ºC. General and neurological status were within normal limits. On mental status examination, the patient's consciousness *was compos mentis, and* his attitude during the interview was cooperative. During the interview, the patient appeared anxious. He maintained good eye contact with the examiner. He cried halfway through the interview when he discussed his feelings of inferiority. He spoke spontaneously, with occasional *remorse* , moderate intonation, adequate volume, adequate quality, clear articulation, and adequate quantity. His mood was anxious with harmonious affect. His thought patterns were realistic, and his thoughts contained preoccupation with low self-

esteem and no suicidal ideation. Cognitive function assessment showed intelligence commensurate with his educational level, good concentration, and good orientation to time, place, and person. His memory was good. He felt ill but did not know the cause.

Psychometric Examination

Psychometric Test The HARS showed a score of 27 (moderate anxiety), and the HDRS showed a score of 25 (moderate depression). *The Minnesota Multiphasic Personality Inventory* (MMPI-2) showed moderate anxiety and depression. This is consistent with the patient's complaints. ***Millon Clinical Multiaxial Inventory*** (MCMI–IV) indicates an *avoidant, paranoid, melancholic personality.*The patient's diagnosis was made multiaxially with diagnoses on Axis I: Mixed Anxiety and Depressive Disorder (F41.2), Axis II: *Avoidant Personality Disorder*, Axis III: no diagnosis, Axis IV: Relationship conflict, lack of emotional support, dysfunctional family history, Axis V: Global Assessment of Functioning (GAF) 70-61.

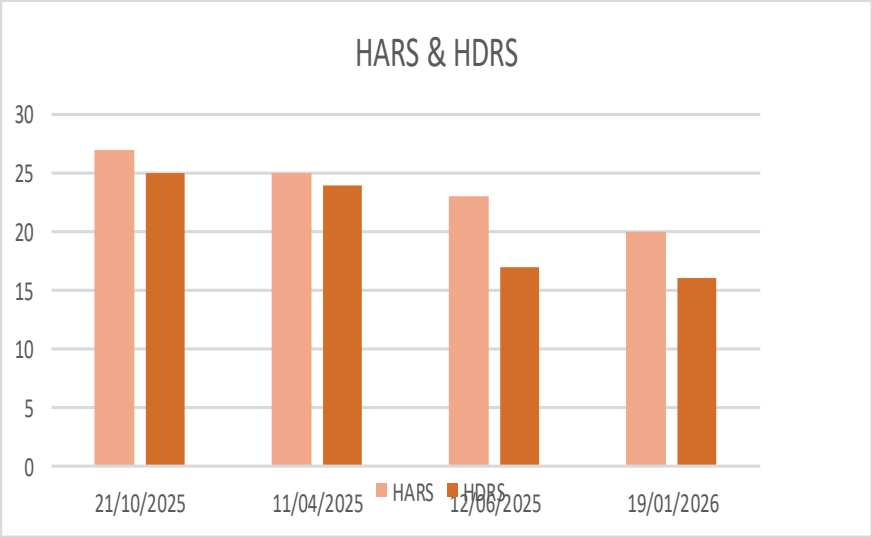

Figure 1. Psychometric Test The HARS

RESULT AND DISCUSSION

In this patient, the characteristics of avoidant personality disorder were clear and persistent, as reflected in the developmental history and family parenting patterns that indicated risk factors. The symptoms that emerged in the patient were caused by the patient being raised with a lack of attention from both parents were busy with their own affairs, such as the mother working and the father ignoring the family. Neither parent was ever involved in overseeing the emotional and social development. This is consistent with previous research that suggests that the group with avoidant personality disorder reported a lack of parental participation and support during their childhood and adolescence (Birgenheir & Pepper, 2011) . The patient grew up in a family with an unstable structure due to parental divorce at an early age, accompanied by the emotional and financial absence of a father figure. These conditions have the potential to hinder the formation of a sense of emotional security needed for personality development and healthy interpersonal relationships (Reichborn-Kjennerud et al., 2007).

Entering adulthood, the patient's need for emotional closeness remains evident, as evidenced by his attempts to establish what he considers close and meaningful friendships for the first time. However, the experience of feeling devalued and unappreciated in these relationships triggers profound disappointment. The patient then responds with a complete withdrawal from social settings as a form of protection against potential rejection and negative evaluation. This response pattern aligns with the primary mechanism of avoidant personality disorder, namely relationship avoidance as a strategy to reduce threats to self-esteem (Rees & Pritchard, 2015).

Following this interpersonal experience, the patient exhibited a marked worsening of anxiety symptoms, such as heart palpitations, trembling hands and feet, and feeling cold, particularly in social settings. This suggests that interpersonal stressors perceived as threatening to self-esteem play a role in triggering anxiety symptoms in individuals with avoidant personality vulnerability. This finding aligns with the literature indicating that individuals with avoidant personality disorder are highly sensitive to experiences of negative evaluation and social rejection (Holt et al., 1992).

Based on the Guidelines for the Classification and Diagnosis of Mental Disorders (PPDGJ III), the patient met the criteria for mixed anxiety and depressive disorder (F41.2), which is characterized by clinically significant symptoms of anxiety and depression that are not dominant enough to warrant a diagnosis of a single disorder. A dysfunctional family history, limited emotional support, and a tendency to internalize stress contributed to the patient's clinical condition, as reported in the literature on avoidant personality disorder (Alnæs & Torgersen, 1989; Tükel et al., 2013).

Pharmacological

The patient was given fluoxetine 1x10mg po taken in the morning as basic therapy, and in the 3rd week the patient's dose was increased to fluoxetine 1x20mg po, and clobazam therapy 1x10 mg at night to reduce anxiety and help improve sleep quality, with a plan for a gradual dose reduction (tapering off) given 5-6 weeks if the clinical condition improves.

Non-Pharmacological

The patient was educated about her condition, the planned treatment, the medications to be prescribed, the benefits and side effects of the medications, and the importance of regular check-ups. The patient's husband was also educated on how to act as a support system, helping to reassure her when anxiety symptoms arose, and reminding her to have regular check-ups and take her medications.

Supportive psychotherapy

What is done in the initial stage is to develop a therapeutic alliance to build a good relationship with the patient, in addition to that, psychotherapy interviews are also conducted to increase the patient's self-esteem and reduce the patient's anxiety.

Cognitive Behavior Therapy (CBT)

CBT therapy is an excellent first-line treatment for anxiety disorders. It has good patient acceptance, a relatively rapid onset of action, strong maintenance of treatment gains, and strong cost-effectiveness. CBT offered in individual or group settings has been shown to benefit these patients for both short-term and long-term outcomes. CBT focused on anxiety disorders is generally delivered in 8–12 weekly sessions. Some evidence suggests that condensed therapy (i.e., several hours of therapy over several days) can be

effective, and this approach may be useful for patients who are unable to attend standard weekly sessions.

CBT was selected because the patient demonstrated persistent maladaptive cognitions and avoidant behaviors that maintained her anxiety and depressive symptoms. In accordance with Beck's cognitive model, the patient tended to interpret interpersonal situations negatively and to assume rejection or criticism without adequate evidence. The dominant cognitive distortions included catastrophizing, overgeneralization, mind reading, and negative self-evaluation. CBT was integrated with pharmacotherapy and supportive psychotherapy and conducted in four sessions. The initial sessions focused on psychoeducation, establishment of a therapeutic alliance, relaxation techniques, and identification of automatic thoughts. The patient was encouraged to recognize the relationship between triggering situations, maladaptive thoughts, emotional reactions, and physical anxiety symptoms.

The patient's core belief identified during therapy was "I am helpless." Therefore, the primary therapeutic intervention was cognitive restructuring. The patient was guided to examine evidence supporting and contradicting her assumptions, distinguish between facts and interpretations, and develop more realistic and adaptive thoughts. For example, the patient initially believed that other people, including her husband and friends, judged and rejected her, despite the absence of direct confirmation.

Behavioral interventions were also implemented to reduce avoidance. The patient was gradually encouraged to communicate more openly with her husband, remain in situations that usually triggered anxiety, and participate in daily and social activities rather than withdrawing. After four sessions, the patient demonstrated meaningful clinical improvement. Anxiety, palpitations, trembling, insomnia, and fear of social situations decreased, while sleep quality, communication, and daily functioning improved. These findings suggest that CBT targeting maladaptive beliefs, rejection sensitivity, and avoidant behavior may be an effective component of integrated treatment in patients with Avoidant Personality Disorder and Mixed Anxiety and Depressive Disorder.

The patient's CBT sessions only lasted until the fourth session. At that point, the patient's core belief was "I am helpless." Cognitive Restructuring: In the cognitive model, anxiety disorders are based on misinterpretations (automatic thoughts) of excessive fear. To better understand the patient's situation, automatic thoughts , and behavior, the patient was given the task of filling out an automatic thought form.

Table 1. CBT session

Situation	Automatic thought	Emotion	Behavior	Physical Signs
Check in to the Mental Health Polyclinic by going alone / being in a public place	I feel like people are watching and judging me.	Anxious, 50% Fear, 50%	Avoid crowds, look for a quieter place like a toilet.	Heart pounding, a cold sweat

Seeing husband playing games on his cell phone	Husband must be playing online gambling.	Anxious, 60% Sad, 30%, Annoyed, 10%	Repeatedly observing her husband's activities, but not daring to ask or confirm directly.	Dizzy, pounding
Received a message that the husband has a debt at the cooperative	If I ask directly, there will be an argument and my husband will be angry.	Anxious (30%), S sad (30%), M direction (25 %), annoyed (10 %).	Not having open communication directly with her husband, choosing to avoid it.	Dizziness, heart palpitations.
Invited to hang out with friends	My friends don't like me.	Fear (60%), Anxious (40%)	The patient did not confirm the directly through open communication with husband	Dizzy, pounding

An example of the fourth interview session is presented below (January 16, 2026)

- Evaluate clinical progress and reexamine persistent automatic thought patterns, especially fears of negative judgment when expressing feelings.
- Perform further cognitive restructuring by examining supporting and opposing evidence against automatic thoughts.
- Design behavioral experiments in a gradual and safe manner according to the patient's capacity.
- Set specific, measurable, and realistic behavioral goals.
- Provide reinforcement for patient efforts and emphasize the gradual process of behavioral change.

Interview Excerpts

Doctor: Good afternoon, Mrs. R. How has Mrs. R been since the last meeting?

Patient: Good afternoon, Doctor. I feel calmer than before. I still have occasional anxiety, but it's much less intense and more manageable.

Doctor: Okay. Has Mrs. R had a chance to try the task we discussed earlier, which was communicating directly with her husband in a calmer setting?

Patient: Yes, Doc. I tried talking to my husband before bed, when the house was quieter. I was very anxious at first, but I tried to calm myself and express my feelings without blaming him.

Doctor: How did your husband respond at that time?

Patient: My husband responded quite well, Doc. He explained that the money he borrowed was used to pay off his monthly motorcycle installments. He said he didn't mean to hide anything, just didn't want to burden me with his difficulties.

Doctor: Did your husband also explain about the use of his salary and the money he borrowed from Mrs. R?

Patient: Yes, Doc. My husband said that part of his salary and the money he borrowed from me were used to pay off the motorcycle installments. He thought he could manage it himself, but it turned out to be quite a burden.

Doctor: How did Mrs. R feel after hearing the explanation directly?

Patient: I feel relieved, Doctor. My thoughts immediately changed. I'd been thinking the worst, but it turned out not to be the case. My anxiety immediately lessened after receiving a clear explanation.
Doctor: Compared to Mrs. R's previous thoughts, what are the main differences that Mrs. R feels now?
Patient: Now I realize that I've been making assumptions without asking directly. Now that I know the facts, I feel calmer and no longer immediately think negatively.
Doctor: That was a crucial shift in thinking. By asking direct questions and getting clear information, Mrs. R was able to distinguish between assumptions and reality. How did this impact the physical symptoms of anxiety?
Patient: Symptoms such as heart palpitations and dizziness still occur occasionally, Doc, but they are much milder and subside quickly after I relax.
Doctor: Very good. Based on Mrs. R's experience yesterday, we can draw one important conclusion. Mrs. R should not immediately think negatively or judge something negatively before knowing the facts. What is Mrs. R's opinion on this?
Patient: Yes, Doc. I just realized that I often immediately think the worst, even though it's not necessarily true.
Doctor: That's right. Therefore, going forward, Mrs. R needs to train herself to ask questions directly about any problems that arise, in a calm and open manner, without being filled with anxiety beforehand. That way, Mrs. R won't have to keep guessing or harboring suspicions.
Patient: Yes, Doc. After I tried asking directly, it turned out that my feelings were much lighter and not what I had imagined.
Doctor: Very good. This attitude is important so that Mrs. R can carry out her daily activities more comfortably. When Mrs. R is no longer filled with negative thoughts, her fear of rejection, excessive worry, anxiety, and sadness will decrease.
Patient: I feel the same way, Doc. Now I'm more willing to participate in activities and don't immediately avoid them like I used to.
Doctor: That's significant progress. With a more realistic mindset and more open communication, Mrs. R can better navigate her roles and activities without the burden of unnecessary suspicion or negative thoughts.
Patient: Yes, Doc. I want to keep practicing so I don't fall back into my old habits.
Doctor: Very good. This shows that our CBT strategies are starting to be effective. We will continue to practice more realistic thinking and open communication so that Mrs. R's anxiety can become more manageable and prevent it from returning to its previous state.
Patient: Okay, Doc. Now I feel more confident in dealing with situations like this.

Thus, early identification of avoidant personality disorder traits is a crucial aspect in the management of mixed anxiety and depressive disorders. A therapeutic approach that focuses not only on improving acute symptoms but also considers underlying personality patterns is expected to improve clinical outcomes, prevent relapse, and sustainably improve patients' social functioning and quality of life (Sadock et al., 2017).

Prognostic perspective, the presence of Avoidant Personality Disorder may contribute to a more chronic and recurrent course of Mixed Anxiety and Depressive Disorder. Patients with comorbid Avoidant Personality Disorder generally demonstrate

slower improvement, greater interpersonal dysfunction, poorer treatment adherence, and a higher risk of relapse than patients without underlying personality pathology. Nevertheless, early recognition of Avoidant Personality Disorder and the implementation of integrated treatment, including pharmacotherapy and Cognitive Behavioral Therapy, may improve prognosis by reducing maladaptive cognitions, interpersonal avoidance, and vulnerability to future anxiety-depressive episodes."

CONCLUSION

This case report demonstrated that Avoidant Personality Disorder contributed significantly to the development and persistence of Mixed Anxiety and Depressive Disorder in a 29-year-old woman with longstanding fear of rejection, low self-esteem, and interpersonal avoidance. Interpersonal conflict with a close friend and chronic marital difficulties acted as the precipitating stressors; however, the severity and persistence of symptoms were strongly influenced by the patient's pre-existing avoidant personality structure. The dominant clinical manifestations included marked fear of negative evaluation, social withdrawal, insomnia, impaired concentration, autonomic anxiety symptoms, depressed mood, and loss of interest in daily activities. The psychometric findings supported this formulation. HARS and HDRS demonstrated moderate anxiety and depressive symptoms, whereas MMPI-2 and MCMI-IV identified a persistent avoidant personality pattern accompanied by maladaptive cognitive styles, including catastrophizing, overgeneralization, and heightened rejection sensitivity. These findings suggest that the patient's anxiety-depressive symptoms occurred within the context of longstanding personality pathology rather than an isolated mood disorder.

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