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ORIGINAL PAPER

Specialized Treatment for Patients with Severe Avoidant Personality Disorder: Experiences from Scandinavia

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Abstract
Avoidant personality disorder (AvPD) is a common and heterogeneous disorder. In spite of this, few studies have focused on treatment, and treatment guidelines have not been developed. In Scandinavian countries many patients with low levels of AvPD are treated sufficiently in private practices or in briefer psychiatric treatments, often for anxiety or depression. However, patients with higher levels of personality dysfunction are often not helped sufficiently by such treatments. In this paper we describe a longer and more intense treatment for severe AvPD based on a combination of Mentalization-Based Group Psychotherapy and Metacognitive Interpersonal Individual Therapy. This treatment has been piloted in Norway and Denmark, and we provide a case example of a successful treatment of a patient, "Julie" treated at Stolpegaard Psychotherapy Centre in Denmark. Based on our review of the literature and experiences from the pilot studies, we also provide some observations and general guidelines about important aspects of treatment of severe AvPD.

Keywords Avoidant personality disorder · Mentalization · Metacognition · Specialized treatment · Anxious personality · Detached personality

Introduction

Avoidant personality disorder (AvPD) is a prevalent disorder associated with a high degree of heterogeneity and extensive psychiatric and socioeconomic impairments (Skodol et al. 2005; Torgersen et al. 2001; Verheul et al. 2007; Wilberg et al. 2009; Zimmerman et al. 2005). Further, the personal and health economic burden of AvPD is considerable (Cramer et al. 2007; Eikenaes et al. 2006, 2013; Jackson and Burgess 2004; Kvarstein et al. 2013; Soeteman et al. 2008). In light of this situation, surprisingly few studies have focused on treatment for AvPD. Generally, these studies are small, use different outcome measures, exclusion criteria and follow-up examinations. Thus, the purpose of this paper is first to present an overview of the existing literature of treatment studies; on AvPD, and on Cluster C Personality Disorders (PDs) (Avoidant, Dependent, and Obsessive–Compulsive PDs) in which more than 50% of the participants were diagnosed with AvPD. Afterwards, we briefly describe typical and more specialized treatments in a Scandinavian context. We then provide a case example of the patient "Julie" who was treated in a specialized treatment setting at Stolpegaard Psychotherapy Centre. Finally, we will attempt to extract some common treatment principles based on the existing empirical literature and the case findings demonstrated.

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Overview of Existing Literature

Four randomized controlled trials (RCTs) testing the efficacy of psychotherapy for AvPD have been published (Alden 1989; Emmelkamp et al. 2006; Stravynski et al. 1989, 1994). In addition, several case studies have reported favorable results treating AvPD, including Metacognitive Interpersonal Therapy (MIT) (Dimaggio et al. 2015a, 2017; Gordon-King et al. 2018), Interpersonal Therapy (IT) (Gilbert and Gordon 2013), acceptance and commitment therapy (ACT) in combination with dialectic behavioral therapy (DBT) (Chan et al. 2015), and emotion-focused therapy (EFT) (Pos 2014). Moreover, some recent treatment studies have shown promising results for Cluster C PDs (Bamelis et al. 2014; Bartak et al. 2010; Skewes et al. 2015; Svartberg et al. 2004). See Tables 1 and 2 for details.

It is difficult to compare outcome across the studies due to too large diversities. However, it is interesting and promising that the RCT by Svartberg and colleagues found effect sizes for improvement of symptoms as high as 1.76 and for personality score to be 1.67 (MCMI; Millon Clinical Multiaxial Inventory) (Millon and Davis 1997) after a 40-week period of individual treatment, and that most patients maintained their treatment gains during the long follow-up period. Though, 45 percent of the patients remain unchanged or deteriorated at follow-up (Svartberg et al. 2004). The RCT by Bamelis et al. (Bamelis et al. 2014) also found large effect sizes over the 3-year period, most prominently for schema therapy (ST) on Global Assessment Score (GAF) (ES: 1.76). Almost all the studies had follow-up assessments, and found that improvements were maintained. These findings are in contrast to several treatment studies that have identified AvPD as a negative prognostic factor and found it to be associated with increased risk of relapse after treatment (Gude and Vaglum 2001; Huppert et al. 2008; Karterud et al. 2003; Robinson and Safer 2012; Seemüller et al. 2014; Vrabel et al. 2010). The main difference is that the latter studies were not designed specifically for treating AvPD. Additionally, starting off more severe, the patients also terminated treatment at a more dysfunctional level than patients without AvPD (Weinbrecht et al. 2016). In order to capture whether AvPD should be considered a negative prognostic factor, one should compare the degree of change during and after therapy, or the study should control for status at the beginning of treatment, which was not done in many of the studies mentioned above.

In summary, studies designed for treating AvPD or cluster C have found promising results regarding improvement for patients with AvPD. It has been demonstrated that behavioral therapy and CBT generally lead to some improvement, but short-term interventions are insufficient to overcome the longstanding dysfunctional patterns of patients with AvPD (Alden 1989). Social skills group training as a treatment component for patients with AvPD did not seem to have any additional effect, neither in groups or individual treatment (Stravynski et al. 1989; Zimmermann et al. 2013). Brief psychodynamic therapy has shown contradictory results compared to CBT, and ST has shown promising potential for treating AvPD. However, it remains unclear whether ST actually provides treatment benefits compared to traditional CBT or psychodynamic therapy, and whether an individual, group or combined format is superior (Weinbrecht et al. 2016). MIT has also demonstrated promising results, but sample sizes are still too small to draw any firm conclusions (Popolo et al. 2018). Thus, the literature gives good reason to be optimistic regarding treatment for AvPD, although optimal treatment duration and psychotherapy modality remain uncertain.

Scandinavian Treatment Models

In Scandinavian countries mental health treatment is generally funded by the state based on a relatively high level of taxation. In Norway, mental health services are organized as public psychiatric outpatient clinics, day hospitals, and inpatient clinics. Treatment is also offered by psychiatrists and psychologists who have a special contract with the regional health authorities, here referred to as private specialist practice. Treatment expenses are usually covered by the State Health Insurance Fund. Patients diagnosed with AvPD are notably dissimilar regarding personality resources and social adaptation, with various levels of dysfunction and treatment needs. Despite the lack of documentation, there is reason to believe that patients with milder forms of AvPD or AvPD traits are treated in private specialist practice with good outcomes, even if their avoidant pathology is not explicitly recognized or diagnosed. Patients with moderate to severe dysfunction are usually referred to public outpatient clinics, but there are few treatment programs specifically targeting this type of pathology. The patients might be offered individual or group therapies with various outcomes (Kvarstein et al. 2017; Lorentzen et al. 2015; Narud et al. 2005). Due to limited institutional resources, individual treatments are typically short-term, whereas group therapies may be somewhat longer, usually including patients in diagnostically heterogeneous groups (Kvarstein et al. 2017; Lorentzen et al. 2015). For many patients in need of specialized or long-term psychotherapy, current treatment options are insufficient in many regions of the country, and there are no official guidelines for the treatment of AvPD. However, in Norway, specialized treatment units for patients with PDs have been

Table 1 Treatment studies for AvPD

Author, year, design	Therapy	Sample size Diagnostic Intake criteria	Duration: number of sessions	Drop-out %	Follow-up	Results Assessments
Stravyski et.al. (1989) RCT Cross-over	Group discussion (GD) + homework, individual targets + social skill training (SST)	28 DSM-III No medication or major clinical syndrom	10 (5 + 5) á 90 min Cross-over	25	No	No group difference ↑Social Functioning «blind» assessment ↓Sympt BDI, SAD, HAM
Stravyski et.al. (1994) RCT	GD with SST «in clinic» sess. versus comb. «in clinic» + «in vivo» sess	31 DSM-III No medication	14 á 90 min	10	3 months	No group difference ↑sos.funct. ↓ sympt. (SAD, SSQ, STAI, HAM) Improvements maintained at follow-up
Alden (1989) RCT 4 groups Alden and Capreol (1993)	1.Gradual exposure (GE) + relaxation 2. GE + Interpersonal skill training (IST) 3. GE + IST + intimacy focus 4. Control group = Waiting list	76 DSM-III Unmarried 20y < age < 40y No hospitalization	10 weekly sessions á 120–150 min	5	3 months	No group difference ↓Sympt./↑Sos.funct.; SORT, SRI, SQ Improvements maintained at follow-up IIP-C Cold negative predictor
Renneberg et al. (1990) Pilot, controlled	Group therapy, behavioral training Individual therapy before and after 3 months waiting list	17 DSM-III-R	32 × 60 min 4 days over 2 weeks	0	3 months 1 year	↓sympt (FNE, PSS, SAD, GRAI, BDI, STAI) ↑ funk SAS-SR, 55% norm. FNE
Barber et al. (1997) Naturalistic	Time-limited indiviual therapy «Supportive-Expressive-Dynamic Therapy» Core Conflict Relationship Theme	24 DSM-III-R	Max. 52 Mean (SD) 35 (20)	46%	No	61% no UPF, ↓sympt (BAI, BDI, IIP, HARS, HARSD) ↓WISPI
Emmelkamp et al. (2006) RCT	Cognitive behavioral therapy (CBT) versus brief dynamic therapy (DBT) versus. Waiting list	62 DSM-IV	20 6 months	CBT: 15 BDT: 0	6 months	CBT > BDT; SPAI, PDBQ CBT: 91% no UPF, BDT: 64% no UPF at follow-up BDT ≠ Waiting list
Eikenæs et al. (2006) Pilot Quasi experimental	Combined group and indiv. therapy, incl. physical training (CC) versus CC + wilderness therapy = Integrated wilderness therapy (IWT)	**53** 37 (CC) versus 16 (IWT) DSM-IV (DSM-III-R)	Inpatient 12 weeks	0	1 year	No group diff.: GSI, BDI, IIP, PDQ-4 BDI and GSI at follow-up Men: IWT > CC *, Women: CC > IWT IWT: 50% no UPF at follow-up (87% answered)
Zimmermann et al. (2013) Naturalistic Military Hospital	Indiv.therapy 2 sess./week, daily phys. training, relaxation versus additional SST in group	192; AvPD traits **110 (57%);** AvPD ICD-10	Inpatient 30 days	0	6 months	No group difference ↓sympt. (SCL-90; FKK) Improvements maintained at follow-up (46% answered)

developed as part of the Norwegian Network of Personality-Focused Treatment Programs, which includes several units throughout the south of Norway, treating patients with a broad range of PDs (Karterud et al. 2003). Previous studies from the Norwegian Network, typically step-down programs consisting of short-term day hospital treatment followed by long-term group analytic outpatient group therapy, found that AvPD was associated with a poor course compared with borderline PD (BPD). Many patients with AvPD were treated in long-term outpatient group therapies with little gain (Kvarstein and Karterud 2013; Wilberg et al. 2003). These findings concur with other research documenting that patients with more severe AvPD have a poor prognosis in many different treatment settings (Chiesa and Fonagy 2007; Gude and Vaglum 2001; Seemüller et al. 2014; Vrabel et al. 2010). In response to the rising awareness that AvPD patients may need specialized treatment approaches, some units are beginning to organize special programs for these patients, mostly group therapies. So far, these emerging efforts have not been evaluated.

In Denmark, mental health treatment in hospitals is organized into two different levels of treatment: (1) basic hospital service, in which patients receive a standardized treatment package, and (2) regional hospital service, defined as more individually tailored treatment. The aim is to treat approximately 80% of patients in the basic program and 10–20% in the regional program. For personality disorders, standardized treatment packages only exist for BPD and AvPD. The current standardized treatment package for AvPD is 34 h, of which approximately 27 h are reserved for psychotherapy (Simonsen et al. 2017). Remaining hours are spent on, e.g., intake assessment and medication review. AvPD patients may receive treatment consisting either of individual therapy only or of a combined group and individual format with fewer sessions of each. Most hospitals provide treatment based on a CBT modality, but due to the lack of clear treatment guidelines there seems to be a considerable integration of different theoretical models, including ACT and metacognitive approaches. If the basic treatment package is insufficient, patients can be referred to a regional treatment package. Upgrading to a regional treatment package is not based on systematic assessment, but will often be based on continued high symptom levels and/or an anticipated need for more individual support.

Specialized Treatment Formats

Both the Personality Disorder Unit at Ullevål, Oslo University Hospital (Ullevål) and Stolpegaard Psychotherapy Centre, Capital Region of Denmark (Stolpegaard) offer specialized treatment formats combining modified versions of Mentalization-Based Group Therapy (MBT-G) (Karterud

Table 1 (continued)

Assessments Tables 1 and 2: *Results* ↓, ↑: significant reduction and increase; *BDI* Beck Depression Inventory (Beck et al. 1961); *BAI* Beck Anxiety Inventory (Beck et al. 1988); *EQ-5D* Health status (The EuroQol group 1990); *FKK* Questionnaire of Competence- and Control Beliefs (Krampen 1991); *FNE* fear of negative evaluation (Watson and Friend 1969); *GRAI* Gambrill and Richey Assertion Inventory (Gambrill and Richey 1975); *HAM* Hamilton Anxiety Scale (Hamilton 1959); *HARS* Hamilton Anxiety Rating Scale (Hamilton 1959); *HARSD* Hamilton anxiety Rating Scale (Hamilton 1959); *IIP* Inventory of Interpersonal Problems (Alden et al. 1990); *PDQ-4* Personality Diagnostic Questionnaire for DSM-IV (Hyler 1994); *PDBQ* Personality Disorder Belief Questionnaire (Arntz et al. 2004); *PSS* Personal Self Scale (Fitts 1965); *SAD* Social Avoidance and Distress (Watson and Friend 1969); *SAS-SR* Social Adjustment Scale (Weissman and Bothwell 1976); *SCL-90, GSI* Symptom Check List; Global Symptom Index (mean score) (Derogatis 1994); *SORT* Social Reticence Inventory (Jones and Russels 1982); *SPAI* Social Phobia Anxiety Inventory (Beidel et al. 1989); *SRI* Self Report Inventory (O'Brien 1980); *SQ* Shyness Questionnaire (Alden and Cappe 1986); *SSQ* Social Situation Questionnaire (No Ref. is given in the paper); *WISPI* Wisconsin Personality Disorders Inventory (Klein et al. 1993)

Table 2 Treatment studies for Cluster C

Author, year, design	Therapy	Sample size diagnostic intake criteria	Duration: number of sessions	Drop-out %	Follow-up	Results Assessments
Svartberg et al. (2004) RCT	Indivdual therapy cognitive therapy (CT) versus short term dynamic psychotherapy (STDT)	50 (25 + 25) (31; 62% AvPD) DSM-III-R	40 weekly	2	2 year	No group difference ↓Sympt. SCL-90-R ↓IIP ↓MCMI Recovered at 2 y follow-up: sympt: STDT: 54%, CT 42% IIP and personality: 40%
Bartak et al. (2009) Naturalistic Multisenter	Short outpatient treatment (SOT) versus long (LOT) versus Short dayhospital treatment (SDHT) versus long (LDHT) versus short inpatient treatment (SIT) versus. long (LIT)	371 (63% AvPD) DSM-IV	Short versus long < 6 mounths > 6 mounths	SDHT 34 LOT 10	1 year after inclusion	Controlled for status at intake SIT > LOT, SDHT, LDHT, LIT GSI, IIP, EQ-5D, OQ-45 soc.role
Bamelis et al. (2014) RCT Multicenter	Individual therapy: schema therapy (ST) versus clarification-oriented therapy (COT) versus treatment as usual (TAU)	323 (51% AvPD) ST: N = 147 COT: N = 41 TAU: N = 135 DSM-IV	50 Median ST: 50 COT: 51 TAU: 22	ST: 26% COT: 22% TAU: 38%	3 year	Drop-out and diagnostic recovery: ST > TAU No group difference in self-report
Skewes et al. (2015) Pilot	Group schema therapy	8 (6; 75% AvPD) DSM-IV	20	25% (AvPD: no drop-out)	6 mounths	5 of 6: No AvPD at Follow-up ↓Sympt GSI ↓Depression ↓ Schema Mode (40%)

2015) and Metacognitive Interpersonal Therapy (MIT) (Dimaggio et al. 2007, 2015). In the following sections, we describe the basic common format and points of divergence. Both Ullevål and Stolpegaard are specialized in mentalization-based therapy (MBT) for patients with BPD (Bateman and Fonagy 2006). Both facilities have also initiated pilot projects for patients with AvPD. Currently, Ullevål runs a 2-year treatment program offered to 19 patients as part of a pilot study. At Stolpegaard, a 12–18 month treatment program has been offered to 30 patients since 2014. Inclusion criteria at the two sites differ somewhat, but both programs select patients who have suffered from AvPD and have previously been insufficiently treated, and both programs exclude patients with comorbid BPD and/or autism spectrum disorders. All patients are evaluated with a broad range of clinical measures before, during, and at the end of treatment. The major aim of the pilot projects is to examine treatment processes and outcomes and to generate hypotheses for further larger-scale controlled investigations of a specialized treatment format designed specifically for AvPD.

Before entering, or in the initial treatment phase, the patient agrees with the individual therapist on a written case formulation that includes the patient's main problems and focus areas in group and individual therapy. As mentioned above, group therapy at both Ullevål and Stolpegaard is MBT-oriented, manualized by Karterud (2015), and is run by experienced MBT therapists. The treatment groups meet for one-and-a-half hour weekly and only include patients with a confirmed AvPD diagnosis. Consistent with the MBT-G approach, therapy is focused on the patients bringing interpersonal situations from their lives to the group for a shared mentalizing investigation. Attending group therapy with the aim of sharing personal material constitutes a significant exposure for AvPD patients. Clearly, the challenges facing both patients and therapist when including only AvPD patients are quite different from the challenges facing groups

consisting of mainly BPD patients, for whom MBT groups where originally developed (Bateman and Fonagy 2016). Spontaneous sharing of stories, feelings, and thoughts is scarce in AvPD groups. On the one hand, this avoidance needs to be taken into account in the group structure to ensure that each patient's tendencies to use avoidant strategies are challenged. On the other hand, the patients may easily be overwhelmed by anxiety and negative self-evaluations, particularly in the early therapy phase. Hence, the MBT-G format is adapted to take the interpersonal guardedness and high levels of anxiety of AvPD patients into account, e.g., by requiring therapists in the AvPD groups to be more structured and active validating than prescribed by the original MBT-G manual. Also, as the patients often show significant difficulties with monitoring, labeling, and expressing their inner mental states (Moroni et al. 2016), the focus is primarily on mentalizing self-states rather than exploring the mental states of others.

A main difference between the therapies at the two sites is that Stolpegaard has structured the first part of the group sessions as a "training" format. Training is typically organized in modules running five to eight times, but may also be brief exercises, e.g., mindfulness, attention, or small-talk exercises. One training module designed specifically for promoting sharing is a "Tell your life story" exercise. One patient is interviewed by another about his or her life story in front of the group. A therapist positioned behind them draws a simple line of life on the board and fills in the personal details as they are told by the patient. Afterwards, feedback is given to both patients about content and process. Other examples of training modules include video feedback and basic emotions.

The 45-min weekly individual therapy is a modified version of MIT (Dimaggio et al. 2015). The treatment exposure varies at the two sites. At Ullevål, individual therapy is provided weekly throughout the treatment period, whereas individual therapy at Stolpegaard is weekly during the first 6 months and is then stepped down, typically to fortnightly sessions. In MIT, compared to MBT, the focus of individual therapy is more on maladaptive interpersonal patterns and schemes regarding self-states and beliefs about other's responses to self (Dimaggio et al. 2015). A main aim is to stimulate the patient's ability to differentiate between rigid representations and alternative views of self and interpersonal relations. In concordance with MIT, the individual therapists explore and validate the patients' interpersonal wishes as normal human motives which include attachment but also other motives such as the needs for belonging and for competing. Exploring the patients' affects and emotional reactions, including positive affects, is seen as a major task that may help the patients to be better able to identify and regulate inner states. The therapists also look for the patients' areas of interests, engagements, and healthy resources and encourage the patients to subject themselves to gradual exposure to anxiety- provoking interpersonal situations at a tolerable pace.

Both treatment programs are run by teams of two group therapists and two to four individual therapists with video-based supervision of group and individual therapies.

A Case from the Stolpegaard Program

At the time of referral to the Stolpegaard program, Julie was a 26-year-old university student living in a dorm with her boyfriend. Julie grew up in a privileged part of Copenhagen with her parents and three siblings. Julie presented her story as follows: She took care of her younger brothers during their upbringing, often acting as their guardian, cleaning the house, cooking, and looking after them while the parents were either mentally or physically absent. As a child, Julie would often go to the beach, wanting to drown herself, but the caring for her brothers kept her from acting on this urge. Julie competed with her older sister about gaining attention and praise from their mother, trying to "do right", working hard in school and at home. Even so, their mother would often create a split between the two sisters, favoring one over the other. There were often high levels of conflict between the parents, episodic violence, followed by days of punishing silence, periodical alcohol abuse and suicidal threats. When Julie reached the age of 17, her parents "kicked her out" of the family home after discovering that Julie had asked the public social security system for psychological help and help to get her own apartment. Julie moved into her own apartment and did not speak to her family for almost 2 years. She suffered from suicidal ideation and developed alcohol abuse. She did not profit sufficiently from the psychotherapies she had received which included briefer cognitive behavioral treatments aimed at reducing suicidality and depression, typically lasting 3–4 months. She moved in with her boyfriend, but nevertheless suffered from feelings of loneliness, with her boyfriend computer gaming most of the time and also abusing cannabis. At the initial intake interview at Stolpegaard, Julie was assessed using the Structured Clinical Interview for DSM-IV Axis-II Disorders (SCID-II) (First et al. 1995) and the Mini International Neuropsychiatric Interview (Lecrubier et al. 1997). She met the diagnostic criteria for a full AvPD diagnosis and some criteria for obsessive–compulsive PD (3) and BPD (3), thus fulfilling a total of 16 PD criteria. Applying the alternative DSM-5 model for personality disorders, on criterion A, she was rated as level 2 using the CALF interview (Thylstrup et al. 2016), and on the brief version of the Personality Inventory for DSM-5 (PID-5) (Krueger et al. 2012), high scores were found for Negative Affectivity and Detachment. She also suffered from comorbid panic disorder.

In the past, Julie had suffered from alcohol abuse and recurrent depressions, and she had one suicide attempt and regular contacts with the psychiatric emergency ward because of suicidal ideation. On several occasions she had been hospitalized due to sudden cramps. Further, epilepsy was suspected, but no physical etiology was found. At the time of referral, Julie was struggling with sadness, anxiety, and high levels of mistrust, as indicated by scores on the Symptom-Checklist-90-R (Derogatis 1996). On the Global Severity Index (GSI) her score was 2.28. Especially, she was confused about the validity of her own experiences and whether or not her feelings were justified, and she lacked an inner compass or a sense of values. Short glimpses of certainty about thoughts and feelings were almost instantly transformed into doubts and hypermentalization, leaving her with severe agency issues. Interpersonally, Julie had trouble expressing feelings and needs. A typical interpersonal schema would be based on a wish to connect combined with a fear that if she attempted to express her needs and wants, she would not be understood, and would ultimately be abandoned. Therefore, Julie kept people at a distance. Often, she took on too much responsibility without being able to make much demand on others, indicated by very high scores on, e.g., the Avoidance and Non-assertiveness subscales of the Inventory of Interpersonal Problems (Horowitz 1988). She often felt that others talked to her in condescending ways, which left her angry and subsequently shameful and guilty about her own anger. Julie attended the combined program of MIT (individual therapy) and MBT (group) for one-and-a-half year with five individual follow-up sessions.

Treatment Process

Lost in Confusion

In the early therapy sessions, Julie presented with a monotonous tone of voice, modest facial expressiveness, a cautious, suspicious, critical, and at times even judgmental appearance. She would speak in short sentences, offering very sparse descriptions with long breaks and a lack of spontaneity or simply answering questions with monosyllabic replies. In the group sessions, some group members managed to express that they sensed that Julie seemed critical of others.

The individual therapist experienced Julie as cold, distant, and difficult to read emotionally and difficult to make sense of. Often, the therapist would feel annoyed and confused, with a sense that Julie was withholding her inner world, frequently feeling "lost in confusion" when trying to understand Julie, with a sense of being unable to connect emotionally. The therapist felt frustrated and rejected, especially by the absence of non-verbal emotional markers.

After receiving supervision on these countertransference reactions, the individual therapist shared her experience of being "lost" (confused, insecure, frustrated) with Julie, expressing that she felt it was difficult to tell whether she was being of any help to Julie, as Julie did not show any emotions in her face and tone of voice. Julie reacted with surprise but recognized the sense of confusion and insecurity from herself: Julie would feel quite lost about what was "real", what sorts of emotions and opinions she actually held—and the therapist's "hounding" her for answers (emotions and thoughts) only made her feel more inadequate.

This intervention seemed to improve the relationship, as the therapist was now able to explicitly state every time she experienced this sense of "being lost" with Julie. That made it possible for her to help Julie focus on and express her emotions more clearly, often using a bodily focus that created a more genuine sense of sharing in the therapeutic relationship. Julie would often smile and say, "Argh, do we really have to do this again… it's so annoying!", when the therapist asked her to attend to her bodily responses during the therapeutic dialogue. This changed the countertransference feelings of the individual therapist, who now felt able to connect, with a sense of caring, to Julies experience and her painful feelings of doubt.

Based on this development, Julie discovered that her usual way of handling her confusion was to seek (cognitive) confirmation from others (one close girlfriend or her boyfriend), i.e., to seek their opinion on whether she was entitled to think in a certain way about a certain subject. However, their opinion (confirmation or not) did not actually help her much, because it would not alleviate her constant emotional doubt, her sense of "is my experience real?" It became clear to both Julie and the therapists that the strategy of relying solely on (cognitive) confirmation only seemed to intensify the hypermentalization that was an almost constant state of mind for Julie.

Looking at Things from Both Sides

In individual therapy, Julie was now able to identify two distinct self-states, an insight that emerged during a chair-work exercise. In one self-state, Julie experienced a harsh, critical, and perfectionist inner voice that would tell her to "get a grip" and "stop whining", associated with feelings of annoyance/anger and contempt as well as a need for autonomy and status/success. In the other self-state, she experienced a more vulnerable side which felt hurt, sad, inadequate, and insecure, associated with feelings of sadness and a longing for love, acceptance, and belonging to a group.

The harsh side initially came across to Julie as an important part of herself, a part that was able to put aside the hurt, "solider on", succeed, especially in regard to her studies. However, the two self-states would also create a fundamental

confusion and incoherence in Julie's own understanding of herself. The "harsh side" would push aside the vulnerable emotions, failing to integrate them into her sense of self, which resulted in a sense that her subjective experiences were not real. Julie's profound sense of doubt became evident when she was asked to describe narrative episodes from both her present and her past: Despite distinct visual and sensory memories, Julie had persistent difficulty distinguishing phantasy from reality, asking herself "whether it actually happened" or "Am I making it up?". This was particularly evident regarding childhood memories. Despite the individual therapist's focus on collecting detailed narrative episodes, it was only towards the very end of the treatment that Julie allowed herself more fully to remember and share important emotional episodes from her childhood. For example she would access memories of her father's violent behavior and herself protecting her younger brother, locking the door to her room to keep the father out. Likewise, towards the end of the treatment she was able to share and reflect upon violent/abusive episodes with her boyfriend with him shouting and throwing things at her.

In the group therapy, the "strong" self-state was often the more apparent one. Julie would most often adopt a critical position, easily feeling "talked down to" by the therapists and feeling annoyed with fellow group members, who in her opinion were being "weak" and acting like "victims". Alongside this stance, however, something else began to happen during the group sessions: Julie gradually became able to share and express her vulnerable feelings more openly and spontaneously and, as a consequence, receive emotional support from the group (instead of only cognitive inputs). She also gained access to feelings of empathy towards the other members and would often feel angry on their behalf. Towards the end of the treatment she commented that "maybe I should have been angrier myself" when thinking about her own background. Directing her anger outwards instead of inwards also seemed to take place in the group therapy, as Julie at one point refused to comply with the instructions of the male therapist (during a video exposure). She was surprised at his reaction (lack of anger) and his ability to accommodate her protest, and the experience became a turning point for her. She was now able to voice her criticism and disagreement more openly in the group.

In individual therapy, Julie gradually became aware of and gained a spontaneous sense of her own thoughts and feelings as arising within herself, relieving her of the constant effort to evaluate the truth veracity of her subjective experience. She would become increasingly able to report on her own inner states and experiences in therapy. She was now able to associate her physical responses with emotions, for example, she realized that her fainting at the university was not due to a sudden illness but was an expression of anxiety. During the follow-up period Julie left her abusive boyfriend. She found a new boyfriend (a former friend), to whom she felt mentally close, moved into an apartment with her younger brother, and worked on finishing her thesis, despite the stress of receiving threats from her ex-boyfriend.

Quantifying Julie's Development

Julie filled out questionnaires at baseline, throughout the treatment process and at the 1-year follow-up. Several of the results from the baseline measures were aligned with the observations of the therapists. Thus, on the ECR-R (Fraley et al. 2000), Julie scored 4.27 on attachment anxiety and 3.66 on attachment avoidance, indicating both the presence of a fear of losing attachment figures and also difficulties with approaching others for consolation. On the Toronto Alexthymia scale (Bagby et al. 1994), the total score was relatively high (57) but below cut-off score for alexithymia. Problems were especially pronounced within the areas of identifying and describing feelings, as also pointed out by the therapists. On the SIPP-118 (Verheul et al. 2008) which measures personality functioning, she scored particularly

Table 3 Development in Working Alliance Inventory (WAI) scores during 11/2-years treatment

	Session 3	Session 6	Session 21	Session 30	Session 40	Session 48
Bond						
Therapist	19	21	21	24	27	24
Patient	20	20	20	22	22	22
Task						
Therapist	20	19	18	24	25	21
Patient	19	19	19	23	23	22
Goal						
Therapist	23	20	22	24	26	23
Patient	22	22	22	24	24	23
General						
Therapist	5.2	5.0	5.1	6.0	6.5	5.7
Patient	5.1	5.1	5.1	5.8	5.8	5.6

Table 4 SCL-90-R from baseline to 1-year follow-up

	GSI	Som	OC	IS	DE	AX	Ho	Ph	Pa	PS
Start	2.28	2.17	2.60	2.78	3.38	2.80	1.00	2.14	2.00	1.00
6 months	1.78	2.00	2.90	2.33	2.54	2.10	.33	.86	1.00	.70
12 months	2.21	2.92	3.20	2.56	3.15	2.60	1.00	.71	1.17	.80
End	1.66	2.33	1.70	2.22	2.46	1.90	1.00	1.00	1.33	.50
1 year FU	1.21	1.83	1.90	1.11	1.69	1.50	.50	.14	.50	.30

Symptom Checklist 90-Revised

low on facets of identity integration, such as self-respect, lack of purpose, enjoyment, and self-reflection and on feeling recognized and intimacy, both facets of relational capacity. This profile closely mirrors the harsh self-states and negative beliefs about other people discussed above and suggests that the difficult self-fulfilling prophecies described in previous sections are personality-based problems.

Both the individual therapist and the patient filled out the Working Alliance Inventory (WAI) (Tracey and Kokotovic 1989) throughout the treatment. As shown in Table 3 the alliance was relatively high and congruent at all measurement points. There was a marked increase after session 30, around 8 months into the treatment, which may have been related to the therapist's ability to handle countertransference better after receiving supervision. Ogrodniczuk et al. (2011) found that therapists' negative reactions towards patients with high levels of alexithymia is not caused by the patient's high levels of expressed negative emotions but rather by low levels of expressed positive emotions. Thus, the increase in alliance scores might be understood as sequential: Improvement in the therapist's countertransference reactions increases the patient's levels of expressed positive emotions, which in turn strengthens the therapist's ability to handle the patient's high level of alexithymia.

With regard to treatment outcome, an interesting pattern emerged. With a reliable change criterion set at .34 on the SCL-90-R GSI (reliability = .84 and standard deviation .31) Julie improved reliably after 6 months, with her GSI dropping to 1.78. This improvement after 6 months can probably be understood as an initial positive sign of entering a supportive and benign treatment environment, particularly evident in lower scores on phobic anxiety, paranoia and psychotic ideation. However, her symptoms reliably recurred after a year (GSI = 2.21), followed by a reliable improvement at the end of treatment (GSI = 1.66), which was then sustained and further enhanced at follow-up (GSI = 1.21), a score that is close to the normal population of women in Denmark. One might speculate that in AvPD cases, such as Julie's, status quo or even increases in symptoms during treatment should be seen in the context of the patient's life narrative, attachment pattern, and difficulties with describing emotions. Julie cried out for help in her youth, but was condemned by her family for this, which led to a more avoidant pattern and high attachment anxiety. It might be viewed as an emotional corrective experience when Julie was able, within a secure therapeutic relationship, to report high levels of distress without being kicked out or criticized for this by the therapists. This speculation is in accordance with the observed pattern of scores, where improvements in working alliance and interpersonal functioning (especially in the form of reduced problems with distancing and vindictiveness) preceded substantial improvements in symptoms (Table 4).

Evidently, there are numerous limitations in the case study presented, and the patterns of symptom change and alliance identified should primarily be considered as preliminary findings. Although the patient filled out many questionnaires it would have strengthened the study if additional sources and domains of information had been included, e.g., clinician-rated outcomes and a measure of treatment satisfaction. Also, it would have been interesting to include a group climate questionnaire in order to test some of the assertions we have claimed, e.g., that Julie was perceived as critical by other group members.

Clinical Practices and Future Directions

As initially noted, the evidence base for treatment is limited and the optimal psychotherapeutic approach, length, and treatment modality are unsettled questions when it comes to AvPD. In Scandinavian countries we suspect that many patients with relatively low levels of AvPD, which might not even be formally diagnosed, are treated sufficiently in private practices or in briefer psychiatric treatments for anxiety and depression. However, some patients, such as Julie, who is discussed above, do not receive adequate treatment in these very time- and resource-limited interventions and require more specialized treatment. Because of the limited evidence base, pilot projects have been set up at both Ullevål and Stolpegaard to gain experience with longer treatments based on a combination of MBT and MIT. This has been done primarily with reference to successful case studies and the ability of these models to provide some theoretical and clinically helpful answers to aid clinicians in the treatment of patients at the more severe end of the AvPD spectrum. With this case

report we continue this line of work and would like to end by offering three observations that seem pertinent to the case and to long-term treatments based on MBT-G and MIT more generally: (1) A main difference between traditional MBT for BPD and the MIT/MBT-G treatment is the emphasis on interpersonal schemas and motives, often conceptualized within a core conflictual framework and worked through by more experiential methods, such as chair-work, than is prescribed in MBT treatment. (2) Avoidance of emotion and novelty is a major obstacle, and clinicians probably need strategies in order to avoid unintentionally colluding with this aspect of the AvPD personality. Explicit training may provide one helpful way for clinicians to provide a structure where they themselves and the patients are reminded and gently nudged towards new experiences of social sharing (see also Colle et al. 2017). However, as we saw in Julie's case, challenges arise when structuring such exercises, including the possibility of stimulating pseudomentalization and a judgmental group climate. (3) As discussed by Bender (2005), clinicians forming alliances with AvPD patients are faced both with the patient's extreme sensitivities, avoidance, and shame proneness and with the patient's intense desire for attachment and an authentic human connection. As in Julie's case, high or increasing WAI scores are not uncommon with AvPD patients (Muran et al. 1994; Stevens et al. 2007), and as discussed by Tufekcioglu et al. (2013), self-reported alliance may be more indicative of compliance or pseudo-alliance than actual working alliance. As in Julie's case, supervision and careful attention to the emotions and counter-transference reactions of the therapist seem to be a necessary supplement to self-report measures. There is a considerable gap in the evidence literature when it comes to the treatment of AvPD. Larger-scale randomized controlled trials are urgently needed, especially for patients at the more severe end of the AvPD spectrum without BPD comorbidity. In the future we hope to report more data from our pilot studies, and we strongly encourage the PD field to set up randomized controlled trials with comparisons of traditional CBT to SFT as well as, comparisons of new approaches, such as MBT/MIT to treatment as usual. Such trials will ultimately be the key to creating better treatments for the patients.

Compliance with Ethical Standards

Conflict of interest All authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in this study involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. This article does not contain any studies with animals performed by any of the authors.

Informed Consent Informed consent was obtained from the patient presented in this article.

References

Alden, L. (1989). Short-term structured treatment for avoidant personality disorder. *Journal of Consulting and Clinical Psychology, 57*(6), 756.

Alden, L., & Cappe, R. (1986). Interpersonal process training for shy clients. In W. H. Jones, J. M. Cheek, & S. R. Briggs (Eds.), *Shyness* (pp. 343–355). Boston: Springer.

Alden, L. E., & Capreol, M. J. (1993). Avoidant personality disorder: Interpersonal problems as predictors of treatment response. *Behavior Therapy, 24*(3), 357–376.

Alden, L. E., Wiggins, J. S., & Pincus, A. L. (1990). Construction of circumplex scales for the Inventory of Interpersonal Problems. *Journal of Personality Assessment, 55*(3–4), 521–536.

Arntz, A., Dreessen, L., Schouten, E., & Weertman, A. (2004). Beliefs in personality disorders: A test with the Personality Disorder Belief Questionnaire. *Behaviour Research and Therapy, 42*(10), 1215–1225.

Bagby, R. M., Parker, J. D. A., & Taylor, G. J. (1994). The twenty-item Toronto Alexithymia Scale—I. Item selection and cross-validation of the factor structure. *Journal of Psychosomatic Research, 38*(1), 23–32.

Bamelis, L. L., Evers, S. M., Spinhoven, P., & Arntz, A. (2014). Results of a multicenter randomized controlled trial of the clinical effectiveness of schema therapy for personality disorders. *American Journal of Psychiatry, 171*(3), 305–322.

Barber, J. P., Morse, J. Q., Krakauer, I. D., Chittams, J., & Crits-Christoph, K. (1997). Change in obsessive-compulsive and avoidant personality disorders following time-limited supportive-expressive therapy. *Psychotherapy: Theory, Research, Practice, Training, 34*(2), 133.

Bartak, A., Spreeuwenberg, M. D., Andrea, H., Holleman, L., Rijnierse, P., Rossum, B. V., & Emmelkamp, P. M. (2010). Effectiveness of different modalities of psychotherapeutic treatment for patients with cluster C personality disorders: Results of a large prospective multicentre study. *Psychotherapy and Psychosomatics, 79*(1), 20–30.

Bateman, A., & Fonagy, P. (2006). *Mentalization-based treatment of borderline personality disorder: A practical guide*. New York: Oxford University Press.

Bateman, A., & Fonagy, P. (2016). *Mentalization-based treatment for personality disorders: a practical guide*. New York: Oxford University Press.

Beck, A. T., Epstein, N., Brown, G., & Steer, R. A. (1988). An inventory for measuring clinical anxiety: Psychometric properties. *Journal of Consulting and Clinical Psychology, 56*(6), 893.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*(6), 561–571.

Beidel, D. C., Turner, S. M., Stanley, M. A., & Dancu, C. V. (1989). The Social Phobia and Anxiety Inventory: Concurrent and external validity. *Behavior Therapy, 20*(3), 417–427.

Bender, D. S. (2005). The therapeutic alliance in the treatment of personality disorders. *Journal of Psychiatric Practice®, 11*(2), 73–87.

Chan, C. C., Bach, P. A., & Bedwell, J. S. (2015). An integrative approach using third-generation cognitive-behavioral therapies for avoidant personality disorder. *Clinical Case Studies, 14*(6), 466–481.

Chiesa, M., & Fonagy, P. (2007). Prediction of medium-term outcome in cluster B personality disorder following residential and outpatient psychosocial treatment. *Psychotherapy and Psychosomatics, 76*(6), 347–353.

Colle, L., Pellecchia, G., Moroni, F., Carcione, A., Nicolò, G., Semerari, A., & Procacci, M. (2017). Levels of social sharing and clinical implications for severe social withdrawal in patients with personality disorders. *Frontiers in Psychiatry, 8*, 263.

Cramer, V., Torgersen, S., & Kringlen, E. (2007). Socio-demographic conditions, subjective somatic health, Axis I disorders and personality disorders in the common population: The relationship to quality of life. *Journal of Personality Disorders, 21*(5), 552–567.

Derogatis, L. R. (1994). *Symptom checklist 90-R: Administration, scoring and procedures manual*. Minneapolis: National Computer Systems Inc.

Derogatis, L. R. (1996). *SCL-90-R: Symptom Checklist-90-R: Administration, scoring, and procedures manual*. Minnesota: NCS Pearson.

Dimaggio, G., D'Urzo, M., Pasinetti, M., Salvatore, G., Lysaker, P. H., Catania, D., & Popolo, R. (2015a). Metacognitive interpersonal therapy for co-occurrent avoidant personality disorder and substance abuse. *Journal of Clinical Psychology, 71*(2), 157–166.

Dimaggio, G., Montano, A., Popolo, R., & Salvatore, G. (2015). *Metacognitive interpersonal therapy for personality disorders: A treatment manual*. New York: Routledge.

Dimaggio, G., Salvatore, G., MacBeth, A., Ottavi, P., Buonocore, L., & Popolo, R. (2017). Metacognitive interpersonal therapy for personality disorders: A case study series. *Journal of Contemporary Psychotherapy, 47*(1), 11–21.

Dimaggio, G., Semerari, A., Carcione, A., Nicolò, G., & Procacci, M. (2007). *Psychotherapy of personality disorders: Metacognition, states of mind and interpersonal cycles*. New York: Routledge.

Eikenaes, I., Gude, T., & Hoffart, A. (2006). Integrated wilderness therapy for avoidant personality disorder. *Nordic Journal of Psychiatry, 60*(4), 275–281.

Eikenaes, I., Hummelen, B., Abrahamsen, G., Andrea, H., & Wilberg, T. (2013). Personality functioning in patients with avoidant personality disorder and social phobia. *Journal of Personality Disorders, 27*(6), 746–763.

Emmelkamp, P. M., Benner, A., Kuipers, A., Feiertag, G. A., Koster, H. C., & van Apeldoorn, F. J. (2006). Comparison of brief dynamic and cognitive-behavioural therapies in avoidant personality disorder. *The British Journal of Psychiatry, 189*(1), 60–64.

EuroQol, G. (1990). EuroQol—A new facility for the measurement of health-related quality of life. *Health Policy, 16*(3), 199.

First, M. B., Spitzer, R. L., Gibbon, M., Williams, J., Davies, M., Bonis, J., et al. (1995). The Structured Clinical Interview for DSM-III-R Personality Disorders (SCID-II). Part II: Multi-site test-retest reliability study. *Journal of personality disorders, 9*(2), 92–104.

Fitts, W. H. (1965). *Tennessee (Department of Mental Health) Self Concept Scale*. Nashville: Counselor Recordings and Tests: Counselor Recordings and Tests.

Fraley, R. C., Waller, N. G., & Brennan, K. A. (2000). An item response theory analysis of self-report measures of adult attachment. *Journal of personality and social psychology, 78*(2), 350.

Gambrill, E. D., & Richey, C. A. (1975). An assertion inventory for use in assessment and research. *Behavior Therapy, 6*(4), 550–561.

Gilbert, S. E., & Gordon, K. C. (2013). Interpersonal psychotherapy informed treatment for avoidant personality disorder with subsequent depression. *Clinical Case Studies, 12*(2), 111–127.

Gordon-King, K., Schweitzer, R. D., & Dimaggio, G. (2018). Metacognitive interpersonal therapy for personality disorders featuring emotional inhibition: A multiple baseline case series. *The Journal of Nervous and Mental Disease, 206*(4), 263–269.

Gude, T., & Vaglum, P. (2001). One-year follow-up of patients with cluster C personality disorders: A prospective study comparing patients with "pure" and comorbid conditions within cluster C, and "pure" C with "pure" cluster A or B conditions. *Journal of Personality Disorders, 15*(3), 216–228.

Hamilton, M. A. X. (1959). The assessment of anxiety states by rating. *British Journal of Medical Psychology, 32*(1), 50–55.

Horowitz, L. M. (1988). Inventory of interpersonal problems: Psychometric properties and clinical Applications. *Journal of Consulting and Clinical Psychology, 56*(6), 885–892.

Huppert, J. D., Strunk, D. R., Ledley, D. R., Davidson, J. R., & Foa, E. B. (2008). Generalized social anxiety disorder and avoidant personality disorder: structural analysis and treatment outcome. *Depress Anxiety, 25*(5), 441–448.

Jackson, H. J., & Burgess, P. M. (2004). Personality disorders in the community: Results from the Australian National Survey of Mental Health and Well-being Part III. Relationships between specific type of personality disorder, Axis 1 mental disorders and physical conditions with disability and health consultations. *Social Psychiatry and Psychiatric Epidemiology, 39*(10), 765–776.

Jones, W. H., & Russell, D. (1982). The social reticence scale: An objective instrument to measure shyness. *Journal of Personality Assessment, 46*(6), 629–631.

Karterud, S. (2015). *Mentalization-Based Group Therapy* (*MBT-G*): *A theoretical, clinical, and research manual*. London: OUP Oxford.

Karterud, S., Pedersen, G., Bjordal, E., Brabrand, J., Friis, S., Haaseth, O., et al. (2003). Day treatment of patients with personality disorders: Experiences from a Norwegian treatment research network. *Journal of Personality Disorders, 17*(3), 243–262.

Klein, M. H., Benjamin, L. S., Rosenfeld, R., Treece, C., Husted, J., & Greist, J. H. (1993). The Wisconsin Personality Disorders Inventory: Development, reliability, and validity. *Journal of Personality Disorders, 7*(4), 285–303.

Krampen, G. (1991). *Competence and control questionnaire*. Göttingen: Hogrefe.

Krueger, R. F., Derringer, J., Markon, K. E., Watson, D., & Skodol, A. E. (2012). Initial construction of a maladaptive personality trait model and inventory for DSM-5. *Psychological Medicine, 42*(9), 1879–1890.

Kvarstein, E. H., Arnevik, E., Halsteinli, V., Ro, F. G., Karterud, S., & Wilberg, T. (2013). Health service costs and clinical gains of psychotherapy for personality disorders: A randomized controlled trial of day-hospital-based step-down treatment versus outpatient treatment at a specialist practice. *BMC Psychiatry, 13*, 315.

Kvarstein, E. H., & Karterud, S. (2013). Large variation of severity and longitudinal change of symptom distress among patients with personality disorders. *Personal Mental Health, 7*(4), 265–276.

Kvarstein, E. H., Nordviste, O., Dragland, L., & Wilberg, T. (2017). Outpatient psychodynamic group psychotherapy—Outcomes related to personality disorder, severity, age and gender. *Personal Mental Health, 11*(1), 37–50.

Lecrubier, Y., Sheehan, D. V., Weiller, E., Amorim, P., Bonora, I., Sheehan, K. H., et al. (1997). The Mini International Neuropsychiatric Interview (MINI). A short diagnostic structured interview: Reliability and validity according to the CIDI. *European Psychiatry, 12*, 224–231.

Lorentzen, S., Ruud, T., Fjeldstad, A., & Hoglend, P. A. (2015). Personality disorder moderates outcome in short- and long-term group analytic psychotherapy: A randomized clinical trial. *British Journal of Clinical Psychology, 54*(2), 129–146.

Millon, T., & Davis, R. (1997). National computer systems. In *Millon Clinical Multiaxial Inventory-III Manual*. Minneapolis: In: Inc.

Moroni, F., Procacci, M., Pellecchia, G., Semerari, A., Nicolo, G., Carcione, A. et al. (2016). Mindreading dysfunction in avoidant personality disorder compared with other personality disorders. *Journal of Nervous and Mental Disease, 204*(10), 752–757.

Muran, J. C., Segal, Z. V., Samstag, L. W., & Crawford, C. E. (1994). Patient pretreatment interpersonal problems and therapeutic alliance in short-term cognitive therapy. *Journal of Consulting and Clinical Psychology, 62*(1), 185.

Narud, K., Mykletun, A., & Dahl, A. A. (2005). A comparison of gains after treatment at a psychiatric outpatient clinic in patients with cluster A + B, or cluster C personality disorders, and non-psychotic axis I disorders. *Nordic Journal of Psychiatry, 59*(5), 331–338.

O'Brien, E. J. (1980). The self-report inventory: Development and validation of a multidimensional measure of the self-concept and sources of self-esteem.

Ogrodniczuk, J. S., Piper, W. E., & Joyce, A. S. (2011). Effect of alexithymia on the process and outcome of psychotherapy: A programmatic review. *Psychiatry Research, 190*(1), 43–48.

Popolo, R., MacBeth, A., Canfora, F., Rebecchi, D., Toselli, C., Salvatore, G., & Dimaggio, G. (2018). Metacognitive Interpersonal Therapy in group (MIT-G) for young adults with personality disorders: A pilot randomized controlled trial. *Psychology and Psychotherapy: Theory, Research and Practice*. https://doi.org/10.1111/papt.12182.

Pos, A. E. (2014). Emotion focused therapy for avoidant personality disorder: Pragmatic considerations for working with experientially avoidant clients. *Journal of Contemporary Psychotherapy, 44*(2), 127–139.

Renneberg, B. G., Alan, J., & Phillips, D. (1990). Intensive behavioral group treatment of avoidant personality disorder. *Behavior Therapy, 21*, 363–377.

Robinson, A. H., & Safer, D. L. (2012). Moderators of dialectical behavior therapy for binge eating disorder: Results from a randomized controlled trial. *International Journal of Eating Disorders, 45*(4), 597–602.

Seemüller, F., Meier, S., Obermeier, M., Musil, R., Bauer, M., Adli, M., et al. (2014). Three-Year long-term outcome of 458 naturalistically treated inpatients with major depressive episode: Severe relapse rates and risk factors. *European Archives of Psychiatry and Clinical Neuroscience, 264*(7), 567–575.

Simonsen, S., Heinskou, T., Sørensen, P., Folke, S., & Lau, M. (2017). Personality disorders: patient characteristics and level of outpatient treatment service. *Nordic Journal of Psychiatry, 71*(5), 325–331.

Skewes, S. A., Samson, R. A., Simpson, S. G., & van Vreeswijk, M. (2015). Short-term group schema therapy for mixed personality disorders: A pilot study. *Frontiers in Psychology, 5*(1592), 1592. https://doi.org/10.3389/fpsyg.2014.01592.

Skodol, A. E., Oldham, J. M., Bender, D. S., Dyck, I. R., Stout, R. L., Morey, L. C.,.. . Gunderson, J. G. (2005). Dimensional representations of DSM-IV personality disorders: Relationships to functional impairment. *American Journal of Psychiatry, 162*(10), 1919–1925.

Soeteman, D. I., Hakkaart-van, R. L., Verheul, R., & Busschbach, J. J. (2008). The economic burden of personality disorders in mental health care. *J.Clin.Psychiatry, 69*(2), 259–265.

Stevens, C. L., Muran, J. C., Safran, J. D., Gorman, B. S., & Arnold, W. (2007). Levels and patterns of the therapeutic alliance in brief psychotherapy. *American Journal of Psychotherapy, 61*(2), 109.

Stravynski, A., Belisle, M., Marcouiller, M., Lavallée, Y. J., & Eue, R. (1994). The treatment of avoidant personality disorder by social skills training in the clinic or in real-life settings. *The Canadian Journal of Psychiatry, 39*(8), 377–383.

Stravynski, A., Lesage, A., Marcouiller, M., & Elie, R. (1989). A test of the therapeutic mechanism in social skills training with avoidant personality disorder. *The Journal of Nervous and Mental Disease, 177*(12), 739–744.

Svartberg, M., Stiles, T., & Seltzer, M. (2004). Effectiveness of short-term dynamic psychotherapy and cognitive therapy for Cluster C personality disorders: A randomized controlled trial. *American Journal of Psychiatry, 161*, 810–817.

Thylstrup, B., Simonsen, S., Nemery, C., Simonsen, E., Noll, J. F., Myatt, M. W., & Hesse, M. (2016). Assessment of personality-related levels of functioning: A pilot study of clinical assessment of the DSM-5 level of personality functioning based on a semi-structured interview. *BMC Psychiatry, 16*, 298.

Torgersen, S., Kringlen, E., & Cramer, V. (2001). The prevalence of personality disorders in a community sample. *Archives of General Psychiatry., 58*(6), 590–596.

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the Working Alliance Inventory. *Psychological Assessment: A Journal of Consulting and Clinical Psychology, 1*(3), 207.

Tufekcioglu, S., Muran, J. C., Safran, J. D., & Winston, A. (2013). Personality disorder and early therapeutic alliance in two time-limited therapies. *Psychotherapy Research, 23*(6), 646–657.

Verheul, R., Andrea, H., Berghout, C. C., Dolan, C., Busschbach, J. J., van der Kroft, P. et al. (2008). Severity Indices of Personality Problems (SIPP-118): Development, factor structure, reliability, and validity. *Psychological Assessment, 20*(1), 23–34.

Verheul, R., Bartak, A., & Widiger, T. (2007). Prevalence and construct validity of personality not otherwise specified (PDNOS). *Journal of Personality Disorders, 21*(4), 359–370.

Vrabel, K. A. R., Hoffart, A., Ro, O., Martinsen, E. W., & Rosenvinge, J. H. (2010). Co-occurrence of avoidant personality disorder and child sexual abuse predicts poor outcome in long-standing eating disorder. *Journal of Abnormal Psychology, 119*(3), 623–629.

Watson, D., & Friend, R. (1969). Measurement of social-evaluative anxiety. *Journal of Consulting and Clinical Psychology, 33*(4), 448–457.

Weinbrecht, A., Schulze, L., Boettcher, J., & Renneberg, B. (2016). Avoidant personality disorder: A current review. *Current Psychiatry Report, 18*(3), 29.

Weissman, M. M., & Bothwell, S. (1976). Assessment of social adjustment by patient self-report. *Archives of General Psychiatry, 33*(9), 1111–1115.

Wilberg, T., Karterud, S., Pedersen, G., & Urnes, O. (2009). The impact of avoidant personality disorder on psychosocial impairment is substantial. *Nordic Journal of Psychiatry, 63*(5), 390–396.

Wilberg, T., Karterud, S., Pedersen, G., Urnes, O., Irion, T., Brabrand, J., et al. (2003). Outpatient group psychotherapy following day treatment for patients with personality disorders. *Journal of Personality Disorders, 17*(6), 510.

Zimmerman, M., Rothschild, L., & Chelminski, I. (2005). The prevalence of DSM-IV personality disorders in psychiatric outpatients. *American Journal of Psychiatry, 162*(10), 1911–1918.

Zimmermann, P., Alliger-Horn, C., Kowalski, J. T., Plate, S., Wallner, F., Wolff, E., & Strohle, A. (2013). Treatment of avoidant personality traits in a German Armed Forces inpatient psychiatric setting. *Military Medicine, 178*(2), 213–217.