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ORIGINAL PAPER

Treatment of Clients with Anxious and Over-controlled Personality Disorders: An International Accord

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Abstract
Personality disorders are common in most clinical settings and their presence can slow or disrupt the treatment process. The present paper examines central issues in the treatment of the anxious and fearful cluster of personality disorders. Treatment benefits from a strong focus on the therapeutic alliance, a sound plan for treatment, and a comprehensive approach that adjusts the focus and style of therapy across the various phases of treatment. Hopefully, with a continued integration of science and practice, the psychotherapy for personality disorders can become more effective as well as more efficient.

Keywords Psychotherapy · Personality disorders · Dependent · Avoidant · Obsessive-Compulsive Personality Disorders

Personality disorders (PD) can create a lifetime of social and occupational impairment for clients. Unfortunately, PD are often neglected from a treatment plan because of problems with the assessment and diagnosis of the different personality issues. Thus, many personality problems are not identified by the attending therapist, and therefore these problems remain untreated. Furthermore, personality problems may be neglected because the therapist lacks an adequate level of training in their identification or treatment. This creates a problem, especially because these persons can be successfully treated, as long as treatment is delivered with a clear understanding of PD problems and the needs of each patient. Finally, because many clients with PD doubt their ability to change, they may not seek treatment for their problems (Tetley et al. 2012) or they may fail to fully engage with their therapist (Jinks et al. 2012). When these clients seek treatment for their symptoms, it is up to the clinician to accept the presenting problem as a reasonable starting point, and engage the client in a treatment that is focused on the deeper, underlying personality dysfunctions.

Effective therapies are available mostly for borderline PD (e.g., Bateman and Fonagy 2009; Linehan et al. 2015), but this has created a bias in attention and allocations of funds (Dimaggio et al. 2013). The cumulative prevalence all other PD is much higher than BPD, yet these other PD have been largely neglected and under-investigated. In particular, only a few theoretical models are available to guide the treatment of clients with the anxious and fearful PD and only recently some approaches have provided evidence of effectiveness for these disorders (e.g. Bamelis et al. 2014; Popolo et al. 2018). Supported by these recent studies, we advocate for a pressing need to deliver effective treatments for PD whose main features include an inhibition of social behavior, a tendency to introversion, passivity, shyness, restricted expression of feelings, social anxiety and a tendency for social withdrawal and isolation. These clients are often diagnosed with avoidant, obsessive–compulsive, or dependent PD and they may seek treatment for prominent depressive or anxious symptoms. Failure to address the underlying PD may undermine the efficacy of treatments that focus on the presenting problems. Even when treatment helps to ameliorate these symptoms of depression or anxiety, the results are unlikely to be sustained.

Psychotherapy for clients with a dependent, avoidant, or obsessive–compulsive PD may require several components. First, because of the extended nature of treatment, therapy relies on a sound therapeutic alliance. Second, therapy will require a comprehensive treatment plan that adapts to the client's needs as therapy changes. Finally, therapy involves specific strategies designed to help clients gain insight and

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make changes that improve their functioning in most areas of their lives.

A sound therapeutic alliance relies on empathy, interpersonal warmth, and genuine interactions in all contacts with the client (Overholser 2007) and plays a prominent role in the treatment of clients with a personality disorder (Kushner et al. 2016). The therapist provides a supportive relationship that gives clients the freedom to explore their personal flaws, developmental struggles, and interpersonal sensitivities (Overholser 2010). When therapy sessions bring a compassionate approach to treatment, clients can reduce their feelings of shame and incompetence (Lucre and Corten 2012).

The supportive therapeutic bond requires effort, because most PD are driven by maladaptive schemas about the self and others. Furthermore, negative schemas often distort the client's perception of their therapist. Thus, a patient's personality traits can have a negative influence on the therapeutic alliance (Kushner et al. 2016). Therefore, therapists need to pay attention to schema-driven patterns that may underlie transference and countertransference reactions (Colli et al. 2014). In addition, maladaptive schema can help to understand the client's developmental history and unresolved issues. Consequently, therapy with these PD clients requires a sustained focus on the therapeutic relationship in order to detect client vulnerabilities, understand tendencies for relationship conflict, and repair ruptures in the therapeutic alliance (Dimaggio et al. 2015; Safran and Muran 2000). In particular these patients are prone to the "withdrawal" type of alliance rupture (Safran and Muran 2000). They tend to shut off communication, respond with clipped answers, and fail to engage in therapy homework. Therapists can attend to these ruptures and make them part of the therapy conversation in a way that restores alliance.

Because of the chronic course of a PD, a comprehensive treatment plan is needed to guide the treatment (Livesley et al. 2016). It can be useful to devise a treatment plan that addresses a broad spectrum of areas (Wood and McMurran 2013). The presenting problem of emotional distress or interpersonal conflict may hide the more persistent and pervasive problems of personality. Therapists often focus on problem areas that are not well aligned with the client's personality problems (Huband et al. 2014). A thorough understanding of the client will help to devise a more comprehensive approach to treatment.

Therapists must be cautious in their expectations for therapeutic gains. In spite of emerging evidence that positive outcomes can be achieved as short as in 10 sessions for BPD (Kramer et al. 2014) or 16 sessions for the PD (Popolo et al. 2018), personality problems tend to reappear and therapists have to confront the same problems many times. Therapists must keep a positive attitude and maintain motivation for therapy, even when the treatment is prolonged over many months or years.

It is often best to devise a plan for treatment that evolves across several phases to therapy (Gilbert and Gordon 2012; Livesley 2012). The plan for therapy should include a rational sequence of therapeutic elements (Clarkin 2012). Therapists need to remain gentle and supportive, yet doggedly persistent in their focus on movement toward change. If therapy becomes overly structured during the early stages of treatment, it will be more difficult later to shift to exploratory discussions (Clarkin 2012). As clients make progress in some areas, the therapist may need to shift the goals for treatment and the style of therapy (Livesley et al. 2016; Overholser and Fine 1994). Therapy can strive to help clients achieve a sense of balance in their approach to life, balancing acceptance of the good qualities in their life with a view for changing areas that are deficient.

When treating PD, a clear and thoughtful case formulation is essential (Clarkin 2012; Livesley 2012; Kramer in press). The pathology that underlies inhibited/fearful PD is best understood by dissecting it into domains (Dimaggio et al. 2006; Livesley et al. 2016), so the clinician has to evaluate the various issues and plan the treatment accordingly. Although a detailed description of the domains at stake in these PD is outside the scope of this introduction, we briefly describe some of the most relevant issues.

The central domains include maladaptive schemas pertaining to self and others; impaired capacity to understand mental states, both of the self and others'; maladaptive coping strategies; impaired emotion regulation; and a diminished capacity for meaningful social relationships.

Maladaptive schemas are at the core of virtually all models for PD, including cognitive, psychodynamic or humanistic approaches to treatment. Clients with a PD tend to appraise interpersonal relationships according to fixed, rigid and mostly negative views. These patients form predictions on the basis of their schemas, tend to interpret the others reactions in a schema-consistent way, and they tend to act on the basis of their negative expectations. For example, persons with avoidant PD hope to be appreciated, but instead they predict that others will criticize them harshly, they interpret ambiguous communicative cues as signs of impending negative judgment, and they use their own critical interpretations as evidence that confirms their core self-image is unworthy and inept (Dimaggio 2015). Attempts to change maladaptive schemas must follow a sincere validation of each client's perspective and wishes. Challenging the way clients perceive themselves and others might risk making them feel wrong, which would generate negative feelings such as shame. Consequently, even when therapy is focused in a specific moment on changing schemas, the therapeutic alliance remains important to the process of therapy (Seavey and Moore 2012). A supportive therapeutic environment will give clients the security needed to expose their weakness and

vulnerabilities, which is a preliminary step to accomplish before attempting to change schemas.

The second problematic domain is a reduced awareness of mental states, named metacognition or mentalizing (Semerari et al. 2003, 2014; Fonagy and Bateman 2016). When functioning properly, metacognitive skills include the capacity to identify and articulate one's own mental states, understanding that emotions are elicited by interpersonal events mediated by cognitive interpretations, and the capacity to realize that a person's subjective perspective does not necessarily mirror reality. Metacognition also includes the capacity to form a rich and nuanced understanding of the mind of the other people and a willingness to see the world from their perspective, realizing that others may see things differently from our own view. Finally, metacognition includes the capacity to use awareness of mental states to have a positive influence on emotional reactions and interpersonal relationships (Carcione et al. 2011). Patients with a PD have a diminished capacity to recognize their own mental states, and often have difficulties describing their feelings or connecting interpersonal events with a cascade of cognitions, affects, somatic reactions and behaviors. They have difficulties in taking a higher-order stance from which to observe one's own ideas and recognize their reactions are subjective. They also encounter problems in understanding the nuances of the mind of the others and tend to quick, stereotyped and schema-driven attributions of others' intentions and behavior (Fonagy and Bateman 2016). These aspects of inadequate metacognition or mentalizing provide a core feature of PD pathology and they serve as a key issue to confront when treating these persons (Bateman and Fonagy 2009; Dimaggio et al. 2015; Semerari et al. 2007; Livesley et al. 2016). Evidence is mounting that all these domains are impaired in PD (Semerari et al. 2014). For example, clients with Avoidant PD often display a poor capacity to recognize self-states and understand they are driven by maladaptive cognitions which disrupt their social interactions. Poor metacognition is correlated with overall PD severity, which cannot be explained by the presence of borderline PD alone (Semerari et al. 2014). Metacognitive impairments can underlie tendencies for social inhibition and emotional constriction. Clients with a PD often predict that others will reject, criticize or ridicule them (Dimaggio et al. 2015) and cannot resort to a flexible and accurate capacity to recognize different intentions. Thus, persons with dependent PD may believe that others will abandon them. In the moment in which they are afraid, clients cannot understand that signs of distress or fatigue on the other person's face could be unrelated to the relationship with the client.

Poor metacognition, and in particular a diminished capacity for being aware of these tendencies can make these persons more prone to enact maladaptive coping strategies (Ottavi et al. 2016), which is the third domain of psychopathology we consider here. When confronted with negative ideas or disturbing emotions, these patients lack effective strategies to cope effectively in attempts to soothe their distress or adopt appropriate behaviors.

When persons with PD fail to regulate their cognitions, negative ideas about self and others abound, such as: "I am vulnerable and the others will abuse me", "I am unlovable and the others will neglect me". When confronted with such pessimistic cognitions, clients tend to respond with a series of problematic strategies. These maladaptive strategies include suppression of feelings for fear of the negative reactions of the others; emotion dysregulation, emotional inhibition or avoidance (Popolo et al. 2014; Dimaggio et al. 2018), substance abuse, submissiveness, over-compliance, perfectionism, behavioral avoidance, or reactive aggression. All these coping and regulatory strategies contribute to the persistence of suffering and the social dysfunction of these persons. During cognitive therapy, it remains essential to create a safe environment free of judgment in order to help clients confront their negative automatic thoughts and core beliefs (Rees and Pritchard 2015). Only then can clients be expected to make changes in their habitual manner of viewing self and others.

A focus on problematic regulatory strategies is at the core of dialectical behavior therapy for borderline PD. Therapy can help clients to recognize their feelings, validate their emotional reactions, and interrupt dysfunctional behaviors like self-harm so they begin to use adaptive strategies. In cases of over-controlled PD, specific approaches to deal with maladaptive coping have been suggested. For example, schema therapy helps clients to recognize tendencies for avoidance and promote pro-active problem-solving skills. Metacognitive Interpersonal Therapy (MIT) puts a focus on repetitive thinking such as worry and rumination and then uses mindfulness exercises in order to help reduce worrying about interpersonal problems (Ottavi et al. 2016). Of note, MIT does not address maladaptive coping as the primary problem. Instead, MIT focuses on supporting core patients' wishes and validating them. Then, therapy can help clients to realize that when they encounter problems, conflict, or struggles, they often resort to maladaptive coping, which distracts them from pursuing their core wishes. For example, a person with avoidant PD may wish to be appreciated and usually fears criticism. When they think others are judging them, they avoid the person and the situation. MIT asks these patients to identify positive qualities in the self and then ask themselves: "Do you still need to avoid? Can you try next week to sustain your wish and remember you feel a sense of self-worth? If you feel tendencies to avoid try to stop them and then report back to me what passes though your mind?".

The treatment of over-controlled and anxious PD needs to include techniques that confront and reduce the power of a

person's cognitions. For example techniques from metacognitive therapy (Wells 2008) aim to reduce repetitive thinking. Thus, persons with obsessive–compulsive PD can be helped reducing their worries about perfectionism, avoidant PD can interrupt a cycle of worrying about public humiliation, and patients with dependent PD can learn how to interrupt rumination about past abandonment which led them to foster a self-image as an unlovable and abandoned reject.

A fourth problematic area is impaired capacity to form and sustain social bonds, including stable romantic relationships and mature occupational roles. Persons with PD have diminished agency, which means they have difficulties in setting goals and pursuing committed action that remains consistent with their own internalized goals. As a consequence, clients may feel overwhelmed and easily frustrated, and they may lack persistence in the face of adversity. Diminished agency in PD has been noted by some clinicians (Fonagy et al. 2002; Dimaggio et al. 2015; Links 2015; Ronningstam 2009) and it is included among the defining aspect of impaired functioning in DSM 5 (American Psychiatric Association 2013). When establishing a plan for treatment, clinicians need to address problems in agency and in social relationships.

Psychotherapy sessions can be planned according to an understanding of the common dysfunctional domains. The current special issue includes several valuable papers on the treatment of personality disorders. Specific intervention strategies can be used to promote insight and encourage change. Clients can learn to change their daily actions (i.e., what they do on a regular basis) and their persistent cognitive attitudes (i.e., how they interpret common life situations).

A central part of cognitive therapy involves helping clients to confront and shift their view of self, other people and the problems encountered in their typical week. In some ways, these strategies overlap similar interventions that are used to confront the client's presenting problems of depression, anxiety, or stressful life events (Overholser 1997). Behavioral strategies can be used to promote adaptive changes in daily action (e.g., Behavioral Activation) or help clients learn new ways of managing interpersonal difficulties (e.g., assertiveness, social skills training). Behavioral strategies can be used for a mix of purposes. For example, MIT adopts them in order to break automatism, that is schemas endorsed at a pre-verbal level. Moreover, maladaptive coping hampers access to the client's core pain and vulnerability. When persons avoid for a long time, they may lose the capacity to be in touch with their painful experience and then just say: "I don't want to feel distressed. It's better to not face problems". If the clinician involves them in behavioral homework, e.g. interrupting avoidance of perfectionism, their emotional arousal mounts so the core affects are more easily recognized and can become part of the treatment plan.

In a different vein, Transference Focused Therapy includes behavioral activation as part of the contract for borderline BP (Yeomans et al. 2017). The goal is preventing passivity and providing clients with opportunities to form different and healthier objective relationships.

Different strategies can be used to promote different views on self and others. Some clinicians work through the therapy relationships in order to let patients discover that their relationship with their therapist is different from their negative expectations (Clarkin et al. 2006). Other therapies invite patients to form connections between present and past events, until they understand that their view of self and others is not necessarily true but is a personal construction based on developmental history (Dimaggio et al. 2015a).

A long and sustained focus on behavioral homework is usually needed in order to sustain substantive changes in the client's views of self and others with repeated experiences of agency, self-efficacy, self-esteem and so forth. Many clients have spent a significant part of their lives avoiding, surrendering, or striving to reach unrelenting and unrealistic standards of performance. Therapy needs to create room in their everyday life where they experience new ways of being with others, until they internalize different and more benevolent ways to appraise self and others.

Conclusions

Psychotherapy for clients with an anxious or fearful personality style will benefit from a comprehensive plan for treatment that helps each client to make lasting changes in their daily action and cognitive tendencies. Because of the complex nature of personality disorders, an integrative approach to treatment is needed (Nelson et al. 2012; Livesley et al. 2016).

Therapy for PD requires patience and persistence on the part of the therapist. Time is needed to help clients gain insight into their problems and become willing to risk a variety of changes. Therapists remain active and responsive while helping to validate each client's views of self and others (Bateman et al. 2015). We hope that the papers in this special issue will provide clinicians with a set of approaches and techniques which will lead them first to realize that fearful/anxious/over-controlled PD can be treated indeed, deserve attention and then increase their ability to actually treat them successfully. Moreover our hope is that with this special issue we draw further attention to these understudied population and eventually contributes to attract more funding resources for a next generation of outcome studies. There is a lot to be known about how to treat these persons and, given their cumulative prevalence, which largely exceeds the prevalence of BPD alone, effective treatments are urgently needed.

Compliance with Ethical Standards

Conflict of interest The authors have no conflict of interest.

Research Involving Human and Animal Rights This article does not contain any studies with human participants or animals performed by any of the authors.

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