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Therapists' experiences with mentalization-based treatment for avoidant personality disorder

Mona S. Pettersen, Anne Moen, Elin Børøsund and Theresa Wilberg

Registered nurse, Clinic for Mental Health and Addiction Treatment, University Hospital of North Norway, Tromsø, Norway *Email*: m.i.s.pettersen@medisin.uio.no

Abstract: Recent research points to significant mentalizing difficulties in individuals with avoidant personality disorder (AvPD). A mentalization-based approach in psychotherapy with avoidant patients is emerging. The aim of this study is to contribute to an understanding of the therapeutic issues such work might entail with our research questions being: a) What are therapists' experiences of using mentalization-based treatment (MBT) to treat patients with an AvPD diagnosis? and b) What do therapists perceive as therapeutic challenges when conducting MBT with avoidant patients? Semi-structured, in-depth interviews were conducted with six therapists from a MBT team treating patients with AvPD. The data were analyzed using thematic analysis. Two main themes emerged. The first 'Scarcity of explicit personal narratives' encompasses 'Engaging the withdrawn patient' and 'Capitalizing on the treatment structure'. The second main theme – 'On being a patient' - incorporates 'Stimulating but emotionally challenging work' and 'Making use of experience with other therapeutic approaches'. Participants' responses about their experience suggests that MBT targets much of the AvPD core pathology. The use of some techniques, however, warrants active consideration, and there may be a need to adjust MBT treatment for use with AvPD patients. Our study reveals more nuances in therapists' emotional reactions than earlier reported. Future studies should investigate the effect of MBT on AvPD patients and examine treatment processes and interventions that may facilitate change.

Keywords: Mentalizing; mentalization-based treatment; avoidant personality disorder; psychotherapy; qualitative methods

Avoidant personality disorder (AvPD) is characterized by feelings of inadequacy, hypersensitivity to negative evaluations, and fear of criticism and rejection, resulting in extensive avoidance of social interaction. The disorder is associated with considerable subjective suffering, impairment of work and social functioning, and high rates of co-occurring psychiatric disorders (American Psychiatric Association, 2013; Lampe & Malhi, 2018). Several studies have identified AvPD as being associated with a modest treatment outcome or an increased risk of relapse after treatment (Gude & Vaglum, 2001; Karterud et al., 2003; Kvarstein & Karterud, 2012; Seemüller et al., 2014; Vrabel et al., 2010). AvPD is among the most frequent personality disorders; the mean reported population prevalence in Western countries is 3.7% (range 1.2–9.3%) (Lampe & Malhi, 2018; Quirk et al., 2016; Winsper et al., 2020).

Despite the prevalence of AvPD and the considerable impact on those who are affected by it, research into treatment and efforts to develop specialized treatment programs have been scarce (Bo, Bateman & Kongerslev, 2019; Simonsen et al., 2019; Sørensen, Wilberg, Berthelsen & Råbu, 2019; Weinbrecht et al., 2016). According to Weinbrecht et al. (2016), cognitive behavioural therapy and schema therapy are the treatments for which the strongest empirical evidence exists. Other psychological treatments that have been reported to be helpful are psychodynamic psychotherapy, graded exposure, social skills training, supportive–expressive psychotherapy, and metacognitive interpersonal therapy (Alden, 1989; Barber et al., 1997; DiMaggio et al., 2017; Kvarstein, Nordviste, Dragland & Wilberg, 2017; Stravynski et al.,1994). However, the number of studies is small, and large randomized controlled studies focusing on AvPD are rare (Lampe & Malhi 2018). At this point, it is unclear whether any kinds of psychotherapeutic treatment are more favourable than others (Sørensen et al., 2019). Moreover, AvPD is a heterogeneous condition with varying levels of severity. To be better able to tailor treatments to patients with AvPD, we need more knowledge of psychotherapeutic processes and the particular challenges or problems that therapists face when adapting or modifying different psychotherapies to this particular patient group.

In their review of research and insights in AvPD, Lampe and Malhi (2018) view research in the area of social cognition as especially promising. Social cognition concerns an individual's understanding of others' mental states. Mentalization is a broader construct that includes both the capacity to understand one's own and others' minds. It refers to the ability to (implicitly and explicitly) understand and interpret one's own and others' behavior as expressions of mental states, such as, thoughts, feelings, fantasies, intentions, and wishes (Fonagy, Gergely, Jurist & Target, 2002). Other related but only partly overlapping concepts are psychological mindedness and theory of mind. The capacity to mentalize is gradually developed from infancy through attachment to a secure caregiver Bateman & Fonagy, 2004). It is assumed that a good mentalizing ability is important for the development of a coherent self-image and relational functioning. Mentalization-based treatment (MBT) was originally developed to target mentalizing difficulties in patients with borderline personality disorder (BPD). However, insufficient, or unstable, mentalizing may play a role in many forms of mental disorders. MBT has captured broad interest, and therapies in which mentalizing is a central focus are currently being developed for other conditions as well (Bateman & Fonagy, 2013).

Recent research points to significant mentalizing difficulties in patients with AvPD. AvPD seems to be associated with a generally reduced awareness of and access to own mental states (DiMaggio et al., 2017; Johansen, Normann-Eide, Normann-Eide & Wilberg, 2013; Jordet & Ladegård, 2018). There are reports that individuals suffering from AvPD may have particular difficulties identifying, labelling, and expressing their inner experiences and feelings, as well as a limited understanding of what triggers affect and compromised ability to identify and explain the reasons and motives underlying their own behavior (Moroni et al., 2016; Nicolò et al., 2011; Salvatore et al., 2016). Notably, a recent study indicates that alexithymia, another concept to describe difficulties with identifying and expressing emotions, may represent an index of severity of personality dysfunction in patients with AvPD (Simonsen et al., 2020).

AvPD patients may also have difficulty taking other people's perspectives and reflect on the mental states and intentions of others as something independent of their own personal views and experiences. Self-focused and biased attention add to the problems with the realistic evaluations and interpretations of what goes on in others' minds. Individuals with AvPD are often driven by what is called maladaptive interpersonal schemes, which refer to rigid and poorly nuanced perceptions of oneself and others (Salvatore et al., 2016). It is assumed that such mentalizing difficulties are central to the interpersonal fear and avoidance that are typical of AvPD and may contribute to its maintenance.

In contrast to the typical mentalizing difficulties seen in patients with BPD, which seem mostly related to strong emotional activation in attachment situations, patients with AvPD appear to have more continuous mentalizing deficits based on generally poor access to mental states and low affect awareness which contribute to the severity of the disorder (Johansen et al., 2018). Thus, patients with AvPD, and especially those in the more severe end of the spectrum, may lack the very capacity that are central in many forms of psychotherapies aiming to help patients recollect and explore their emotions and inner states in order to better understand themselves and their relational problems. Alexithymic patients has been shown to evoke negative reactions in therapists (Ogrodniczuk, Kealy, Hadjipavlou & Cameron, 2018) and the mentalizing problems in patients with AvPD may contribute to difficult therapeutic processes and poor outcomes. It is therefore important to gain knowledge of how therapists experience conducting MBT with patients with such problems, a therapy specifically targeting their mentalizing difficulties. An increased understanding of what kind of therapeutic issues such work might entail may make us better equipped to adjust and adapt mentalization-based treatments to patients with severe AvPD pathology. The present study explores the experiences of therapists working in an MBT program for patients with AvPD. The research questions were: a) How do therapists experience treating patients diagnosed with AvPD with MBT? and b) What do therapists perceive as therapeutic challenges in conducting mentalization-based treatment with avoidant patients?

This research was particularly motivated by two of the researchers' interest in mentalizing and in therapeutic processes in the treatment of personality disorders. The first author, Mona Pettersen, is a registered nurse currently working with mentalization-based approaches within the addiction field. Co-occurring personality disorder is common among patients with substance use disorders. Theresa Wilberg is a professor in psychiatry with several years of clinical and research experience with personality disorders, including AvPD. She has a special interest in efforts to improve treatment conditions for this group of patients. Anne Moen, a registered nurse and professor in nursing, and Elin Børøsund, a registered nurse and senior researcher, both bring experience in qualitative methods and have been especially involved in the planning and designing of the study.

Materials and Methods

Design

The study employed a qualitative, descriptive design. Data were gathered through semi-structured, in-depth interviews and analyzed using thematic analysis (TA) (Braun & Clarke, 2006, 2019).

Mentalization-based therapy (MBT)

MBT is a specialized psychodynamic therapy that is focused primarily on enhancing and maintaining patients' ability to reflect on their own and others' thoughts, feelings, and intentions. Rather than being concerned with psychological insight, MBT is directed at the processes behind the insights and interpretations of one's own and others' behaviours. The main area of focus is the exploration of specific events—preferably current interpersonal episodes—in the patient's life. The therapist encourages the patient to actively mentalize such events and does so by clarifying and elaborating on the patient's affects, perceptions, and behaviors. The therapist should hold an open, not-knowing stance and stimulate the patient's curiosity about his or her own internal world and the mental states of others. By maintaining an empathic, curious, and not-knowing attitude, the therapist gently challenges rigid attitudes, perceptions, and beliefs and invites the patient to explore alternative perspectives. Interpretations are used with caution and are presented as an alternative perspective as part of the exploration. Special attention is given to the patient's affects within interpersonal relationships, including that between the patient and the therapist. MBT is typically a team-based treatment program that consists of a combination of individual and group therapies, psycho-educative groups, and regular supervision.

Setting and treatment program

The therapists were recruited from an MBT treatment program offered at a psychiatric outpatient clinic. The treatment is based on the original MBT program for patients with BPD, with local adjustments and written outlines of the AvPD treatment program. The program consists of a combination of individual and group therapies. Initially, the patients take part in a weekly psychoeducational group for eight weeks; each group session lasts one and a half hours. The psychoeducational groups focus on topics that are relevant to AvPD, such as the concept and manifestations of personality disorder and specifically AvPD, attachment and the importance of attachment relationships, emotions and emotion regulation, mentalizing and a mentalizing stance, anxiety, depression and psychotherapeutic treatment. Individual therapy is offered in parallel with the psychoeducational groups, the main focus being to further thematize the topics taught, explore the patient's experiences of taking part in a group, and establishing an initial working alliance. During these eight weeks, both patients and therapists assess whether the group therapy format seems manageable and potentially beneficial for the patients. If so, the patients are usually put on a group therapy waiting list. Patients' own motivations for therapy are emphasized, as many experience that people close to them have wishes and ideas on their behalf even though the patients do not feel ready.

The clinic offers regular MBT group therapy and expressive group therapy; the latter is also based on MBT principles. Patients participate in only one of them, and they are assessed on specific criteria regarding which type of group is more suitable. They are given information about both groups and invited to take part in the decision. Both the regular MBT groups and the expressive groups meet weekly for one and a half and two hours, respectively.

The regular MBT groups

The MBT groups are structured in line with guidelines for MBT group therapy for BPD (Bateman & Fonagy, 2004; Karterud; 2015). Each group session starts with the therapists giving a short summary of each patient's area of focus last time. This is followed by a "go-around," in which each patient is asked whether there is anything from the last time that he or she has been especially concerned about and what he or she wishes to work on today. Usually, three patients' current situations, events, or goals are chosen each time.

The expressive MBT groups

The structure of these groups is mainly the same as for the regular MBT groups, except that patients are given a concrete assignment in each session, such as representing a given feeling or creating an expression for how they feel today. The patients share their work—for example, a painting or a drawing—and reflections with the other group members.

Individual therapy

Individual sessions take place once a week during the first year of treatment and last for approximately 45 minutes. In the second year of treatment, the frequency of individual sessions is gradually reduced from once every two weeks to once every three. Some patients choose to participate in only group therapy for the last six months of treatment.

The MBT groups are led by two therapists, and all patients have one of the group therapists as their individual one. The therapists working with the AvPD patients are all part of the same clinical team. Some therapists in the AvPD team are also part of the clinic's BPD team. The therapists on both teams receive two hours of video-based supervision per week. Supervision is divided between group and individual therapy. The maximum length of treatment is two years. Individual assessments of the length of treatment are made within the team. Some patients choose to end treatment early. The treatment is rarely prolonged beyond two years.

Participants

Of the six therapists recruited for the study, two were male and four were female. Four therapists were clinical psychologists who specialized in mental health and/or addiction. Two therapists were registered nurses who specialized in mental health and family therapy. Most of the therapists had additional competences from various courses and educations (e.g., specific trauma therapies or dialectical behavior therapy). At the time of the interviews, two were certified MBT therapists, three were in the process of finishing training courses in MBT (individual therapy format), and one therapist had not yet started any formal MBT training. Participants reported having between 10 and 25 years of clinical experience as therapists. All the participants reported having experience working therapeutically with patients with BPD and/or mixed personality disorders in addition to patients with AvPD.

Procedures

Recruitment - Therapists practicing mentalization-based treatment with patients with AvPD were purposively recruited. We aimed to recruit therapists that were working in specialized MBT teams, of which, in Scandinavia, there are relatively few. The first author contacted the Norwegian National Advisory Unit for Personality Psychiatry (NAPP), and NAPP contacted two Norwegian clinics offering MBT to patients with AvPD. The first author, having received contact information from NAPP, contacted one additional clinic within the Nordic countries. Information about the project and a request for participation were distributed to all three clinics. One hospital was interested, and the first author contacted the hospital and gave additional information about the study. All six therapists from the hospital's AvPD team were finally recruited.

Interviews

One-on-one semi-structured, in-depth interviews were the method of choice. The first author developed the interview guide, and the co-authors reviewed and added to it. The guide, which consisted of open-ended questions with potential follow-up questions, assisted in structuring the interviews and addressed some predetermined themes while also giving the participants room to present and elaborate on their subjective experiences. We strived to avoid asking questions that would likely elicit responses that were founded in theoretical knowledge of what one should do, and instead asked questions that we perceived more likely to reflect actual experiences. Some questions aimed to get the therapists focused and to let various situations and relations come to mind; they included "Please tell me about the last therapy session you had with a patient with AvPD" and "I would like you to think about two different individual therapies or two groups. Can you please tell me what comes to your mind when you think about this?" Other questions were more specific—for example, "What is it like to conduct MBT group therapy with patients with AvPD?" The interview guide is available on request.

To receive feedback on the interview guide, the first author conducted a pilot interview with an MBT therapist working at another clinic. The guide was then adjusted slightly. The pilot interview also gave some sense of how an interview situation might unfold, thus preparing for data collection. Data from the pilot interview were not used in the analysis.

The first author conducted all the interviews, each of which lasted between 50 and 60 minutes. The interviews took place over two days 14 days apart: three interviews on the first day

and then three on the second. The interviews were conducted in the therapists' respective offices in keeping with their wishes. They were audio recorded and transcribed verbatim for analysis.

Analysis

Thematic analysis (TA) (Braun & Clarke 2006, 2019) was chosen to identify, analyze, and report patterns and themes within the data. TA is recognized as useful in psychotherapy process research and has been used in a number of important investigations in the counselling and psychotherapy field (Mörtl & Gelo, 2015; McLeod, 2011). The method's freestanding from pre-existing theoretical ground means that it is flexible and possible to use within different theoretical contexts and for different purposes (Clarke & Braun, 2018).

Our post-positivist-constructivist position rejects the idea that any of us can see the world as it really is. We acknowledge that, as researchers, we engage our subjectivity in our interpretations and this affects what findings are generated from the material. Underpinning our qualitative analysis is a hermeneutic philosophy, which is especially concerned with the interpretation of texts. The interpretation process involves a coming together of the worlds and understandings of the interpreter and the text, thus transforming the initial positions of both (McLeod, 2011). Hence, hermeneutic theory allows different understandings to be read from the text or the data set. For the first author, this entailed being actively attentive to her own pre-understandings of the theme and of thoughts and reflections arising after the interviews and being aware that these pre-understandings might colour her reading of the material. The involvement of three researchers in the analysis process implied the opportunity to discuss openly and reflect actively and critically upon the different readings and interpretations of the data material. Effort was made to be open to the text and get a sense of its meaning partly by keeping in mind the hermeneutic principle that McLeod (2011, p. 33) describes as the "use of empathy in respect of the author(s) of the text." In this case, this has mean reflecting on and trying to develop a sort of personal understanding of the therapists' world—for instance, their therapeutic responsibilities and rationales, the local cultural context in which they work, and organizational circumstances.

All interviews were done prior to analysis. In conducting the analysis, we followed the TA steps outlined by Braun and Clarke (2006) while adhering also to the aspect of reflexivity that they have since strongly emphasized (e.g., 2019, 2020). Prior to and during the analysis process, we regularly discussed our pre-assumptions, theoretical points of reference, and ways of understanding the data material. The transcription of the interviews was completed by Mona Pettersen, the first author, and represented the initial step in getting familiarized with the data. Theresa Wilberg read all the interviews, and Anne Moen read some of the interviews. Coding was done inclusively and in line with a bottom-up or data-driven approach. From the codes, tentative themes were developed. Figure 1 illustrates the initial organizing and naming of themes. Finally, defining and naming themes was a back-and-forth process of moving between the entire data set, candidate themes, coded data extracts, and initial codes and reviewing the evidence for and consistency of the themes. Emergent patterns and themes were frequently discussed with co-authors. Two main themes were finally defined and named, and each had two subthemes.

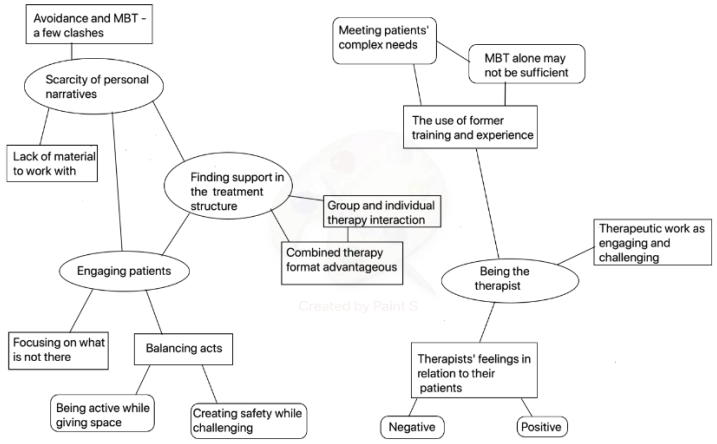

Figure 1 - *Thematic map* (idea from Braun & Clarke, 2006), showing the initial organizing of themes

Ethical considerations

All the participants gave their signed informed consent to participate. The project was approved by the Hospital Privacy Protection Officer and was conducted in accordance with the Declaration of Helsinki. The protocol was approved by the Norwegian Centre for Research Data (NSD), project identification code 272798. The study was exempt Ethics Committee approval, according to the Health Research Act, Norwegian legislation. As there are relatively few therapists delivering MBT to patients with AvPD, great care has been taken to ensure anonymity. Information about the participants' genders and ages have therefore been omitted. For the same reason, in the reporting of results and the use of citations, references to the participants' genders are random; for example, a male participant may be referred to as "she" and vice versa.

Results

The aim of this study was to inquire into therapists' experiences with MBT for patients with AvPD. Our analysis supported two main themes. The first, 'Scarcity of explicit personal narratives', comprises findings related to the therapeutic work of gaining access to material and engaging avoidant patients in therapy. The second theme, 'On being a therapist', encompasses the emotional reactions of the participants and the use of experience from other therapeutic approaches.

Main themes	**Scarcity of explicit personal narratives**	**On being a therapist**
Subthemes	Engaging the withdrawn patient. Capitalizing on the treatment structure	Stimulating but emotionally challenging work. Making use of experience with other therapeutic approaches

Table 1: Main themes and subthemes

Regarding the use of the frequency labels *all, most*, and *some* participants in the presentation of the findings, *all* refers to six participants—that is, the whole sample; *most* refers to four or five participants; and *some* refers to three participants. As the sample size of the study is small and the study focuses on a field that is little explored, it is considered expedient to also report findings that apply to only one or two participants. This is then referred to as one or two participant(s).

Theme 1: Scarcity of explicit personal narratives

This first main theme encapsulates two subthemes: 'Engaging the withdrawn patient' and 'Capitalizing on the treatment structure'. All the participants delineated therapy settings that are characterized by patients' avoidance and withdrawal. The patients were described as struggling both to talk about events and circumstances in their day-to-day lives and to express the emotional and cognitive content of their inner worlds. The participants found that the MBT approach makes sense by targeting the core problems of AvPD, but also that some interventions require care when used.

Engaging the withdrawn patient

All the participants conveyed a continuous effort in their therapeutic work to be about balancing the patients' needs for support and safety with challenging them, thereby making way for new experiences. Most described trying to shift tolerably between validating the patient's experience and pain and being curious about how the patient came to certain conclusions about him/herself and the world. Some pointed to how patients may find this exploration annoying or perceive it as criticism and thus shame-inducing, especially within a group setting.

> The mere act of mentalizing…being curious—like "Are you sure? Are there any other ways to understand it?"—may trigger insecurity and a feeling of shame related to having misunderstood. Such misunderstandings…so often come with mentalizing deficits. […] They withdraw: "Right…just another failure. I didn't understand that either…you're questioning…" This curiosity we wish to be positive. Curiosity may also trigger insecurity.

Exploring and asking questions must therefore be done "gently," as two participants expressed. This involves being clear about their intentions both there and then and related to exploration as a central aspect of therapy. All conveyed the value of being transparent in engaging patients. The transparency of one's own mind in the session was described to serve multiple functions: It has a reassuring effect; is a way of modelling and normalizing mentalizing activity; and is a way of demonstrating differences in perceptions, which can then be explored in a mentalizing fashion.

Some participants explained that they occasionally choose to share something from their personal lives with their patients, intending to normalize feelings and reduce shame, as well as to help the patients to dare to be open by demonstrating openness themselves. One example of this is sharing having experience of an emotion similar to what the patient is now trying to convey or manage. They emphasized the need to be aware when choosing this strategy and not sharing anything that they themselves find difficult to manage.

All the participants talked about what can be described as 'creating material of what is absent'. This refers in part to what they what they refer to as "non-events" - that is, events or situations that the patient was supposed to initiate or take part in but instead avoided. This concrete event of avoidance was then subjected to exploration. One participant shared how asking for events necessitates focusing both on the fact that there might have been an event that the patient avoids mentioning and on potentially exploring such non-events.

> "No, nothing special happened"; that's what they often say. "Nothing's happened. Really? I would say I guess a lot has happened. What is it that you're searching for in your head when I ask if something's happened?" […] And then I need to help them to search. […] "So, why didn't anything happen? Were there any situations in which you refused something? Have you avoided taking part in things?" You have to help them to search, because their condition makes nothing seem important enough or big enough.

All participants conveyed the therapeutic strategy of explicitly thematizing the patients' lack of response or sharing, especially in group therapy. Some explained that they sometimes share their own thoughts about what the silence might be about in order to demonstrate mentalizing activity and that they are actively thinking about the patients' minds. Some underlined the importance of challenging the patients to talk about what is happening within themselves as they sit there silently, helping them to direct their focus outward and connect to each other. As one participant explained, they try to ensure that if a patient has shared something without getting any response from the others, he or she is not left fantasizing about the reasons for the lack of response. Instead, they are given insight into what the others are thinking about, which might also offer validation and comfort.

All the participants also talked about engaging the patients by using the 'here-and-now' and trying to notice when the patients display avoidance in the therapy room—for instance, by distancing themselves or changing subjects. After pointing this out, they would invite the patient to explore what is going on. Some reflected on how it may be easy to fall into the trap of being too quick to interpret and suggest what is happening. The challenge here is to remark on what they observe and to give the patients time to reflect and express their own understandings. One participant conveyed the importance of awareness of how one responds to patients' silence:

> I myself need to be active in keeping my own mentalizing ability alive, for instance, when it becomes very silent or if I don't get any response. "Is it wise now to offer some suggestions, or should I wait and give you the chance to be aware and find out yourself?" I might be too quick sometimes, because the dynamics with some of the avoidant patients—not all of them, of course, but some of them are so quiet and withdrawn that it's hard sometimes to know if you've reached them.

Some described assessing rather continuously how active versus how awaiting to be in therapy more generally. They emphasized that long silences and having a therapist who is "too laid-back" exacerbates anxiety and discomfort, while, at the same time, patients may need time to recognize how they feel or react. Two participants mentioned that it can be easy to misinterpret a lack of immediate response as a sign that the patient "did not get" what was asked and to therefore feel the need to elaborate further. In group therapy, all the participants described being focused on actively inviting patients in, although they differ somewhat regarding how quick they are to do this.

Capitalizing on the treatment structure

Most participants suggested that they find support in the structure of the therapy program and/or groups when working to get to know the patients and gaining access to their minds and stories. Some explained that large proportions of the individual sessions are used to prepare and facilitate group therapy work, which is considered the primary part of the therapy program. Most mentioned that the fact that the patients they see individually are also part of their therapy groups provides opportunities to create therapy material and to help the patients to challenge their avoidant patterns.

> Many may need help to bring topics into the group, and sometimes, we use part of the individual sessions for this. "What are you going to talk about? You think that'll be too hard? OK. Then what would be a manageable place to start?" Negotiating and trying to give them some responsibility for this. And then they might show up for group having forgotten what we talked about, in which case I might say, "We talked about it…you and me. Remember? No? Is it all right if I mention it?"

Being present in the same group situations as the patient was delineated by some as facilitating the exploration of different perceptions of what happened, thus stimulating the patient's mentalizing activity. These patients, they described, often vividly remember having said something stupid or having thought that others felt bored. They may profit from being reminded or made aware of the supportive feedback they got but have forgotten or it did not register. Two participants indicated that seeing their patients both individually and in group therapy may facilitate alliance and attachment work. In individual sessions, they may ask for the patients' reactions to what the therapist said or did in the last group session, especially if the therapist had challenged or pushed the patients in any way. This checking out combined with the transparency of their own intentions creates opportunities to clear up misunderstandings and reduce relational insecurity.

Situations from the group or the patients' mere experiences of being in the group serve the function of events that can be mentalized about in individual therapy. According to some participants, this compensated, to a degree, for the patients' difficulties with introducing content from their own lives into therapy. The structure of the group sessions was referred to as helpful with regard to the patients' difficulties with sharing and their tendencies to withdraw. The therapists' summaries and

questions at the beginnings of sessions are given as one example. The participants pointed to how sitting silently in a group for a long time increases both their anxiety and their thresholds for sharing. Patients may be aware of this but may be unable to take the initiative themselves, thus needing therapeutic help with "breaking the sound barrier," as expressed by one participant.

The participants also mentioned that they mostly work in a headline fashion in the groups, as being in focus for a longer period can be too demanding for avoidant patients. Additionally, this ensures that more patients will have time to work on their themes in the sessions. In the participants' view, the period between each patient presenting some personal material should not be too long. One participant shared his reflections on how this structuring of the groups has both helpful and disadvantageous aspects:

> Sometimes I find the group structure somewhat limiting. […] I've heard that depth is achieved by working with something several times, and I do know that if, with this patient group, we had worked really in depth with some topic, the shame probably would've been much stronger—like "I've taken up all time and space." So, there's something good in having to divide the time the way we do. [...]. But, occasionally, it feels a bit superficial. I can hear myself saying like, "All right…now we've talked about that. Is there anything here that you can take with you and continue to work on and maybe bring back to the group some other time? Is it OK if we change the subject now?"

Another participant also mentioned how repetition makes for immersion and in-depth work. If a patient does not bring anything new to the group, the therapist might suggest working a bit more on previously talked-about topics, thus supporting the patient in not backing away from sharing. His experience is that a lack of new themes might also be a sign that the patient feels the need to work more on a previous theme and that it can be useful to ask the patient about this.

Theme 2: On being a therapist

This second main theme also encapsulates two subthemes: 'Stimulating and emotionally challenging work' and 'Making use of experience with other therapeutic approaches'. All therapists expressed being emotionally engaged with their patients and emotionally affected and challenged by therapeutic work. Related to diagnostic complexity and different therapeutic needs, some reflected on how they make use of former education and professional experience in therapy.

Stimulating but emotionally challenging work

All the participants described working with their patients as inspiring, meaningful, and interesting. Most mentioned their own urges and wishes to alleviate the patients' pain while simultaneously expressing a need to accept and tolerate the inner realities and emotions of their patients as something that cannot simply be changed and must be endured by both parties.

It's challenging for me as a therapist to not try to remove the sense of guilt that many of them carry. I need to work on that; I talk about it in supervision; this, they are so quick to feel guilt, and it's just totally disproportionate to the situation, looking at it from the outside. But to tolerate this—like, "Right…this is what it feels like for you"—and not try to remove it. Because I'm not able to do that, though I want to, because witnessing it really hurts.

Challenging the patients' long held and familiar perceptions of themselves and of the world may be emotionally demanding for the participants, as well as for the patients. One of the participants used the words "brutal" and "mean" to describe how he sometimes feels when having to help patients to challenge themselves and realize how many of their problems are actually caused by their extensive avoidance. He related this difficulty in part to his background as a trauma therapist, explaining that the trauma therapy tradition emphasizes support and emotional holding and containing to a larger degree than does MBT. Another participant expressed ambivalence related to the fact that already in the early phases of treatment and prior to achieving a solid treatment relationship, the MBT approach is concerned with making clear to the patient the need for him or her to change his or her negative notions and perceptions of him/herself. Observing how shame holds a central place in many of the patients' identities, the therapist wondered whether a focus on removing this shame might weaken their sense of identity and thus inflict further pain. She suggested that she occasionally gets a sense of "hammering loose on what's most vulnerable."

Other emotional reactions conveyed were frustration, irritation, and impatience. These seems especially related to the patients' silence and withdrawal during the group therapy. Two participants talked about feelings of irritation and provocation in situations in which a patient has shared something difficult and then gets little or no response from his or her fellow group members. They admitted to having moments of thinking of the patients as miserly and to failing to take responsibility and show concern for the others' well-being. When sharing these examples of their emotional reactions, the participants simultaneously emphasized patients' relational guardedness and lack of sharing as part of their reason for being in therapy in the first place.

> Sometimes, I get somewhat provoked or frustrated in a group. If someone holds back a lot or…Yes! That actually is one of the things I struggle with the most in groups…this scarcity of response and expressed support. […] When someone has shared something really difficult and…I do understand what happens in the other patients…that many are censoring themselves and feel like they have nothing of importance to say, but it feels like no one is offering anything. That might make me rather…impatient or provoked sometimes…like "Come on!"

Challenges related to the patients' rigid beliefs and resistance toward change were mentioned by one participant. She described how it often appears that the patients have decided that certain things are unachievable for them or impossible to change despite their efforts. While acknowledging the patients' perceptions as understandable, she indicated that feelings of frustration might arise in her. Two participants talked about sometimes experiencing a sort of emotional contagion of the patients' anxiety, resulting in instances of performance anxiety in the therapy setting. Remembering being new to the team and leading a psychoeducational group, one participant described how the patients' silence and lack of explicit participation in the group caused self-doubt and devaluation of his own work. He also tended to interpret the patients' passivity as a sign that they did not pay attention or did not understand what was taught. Another participant described that she sometimes feels affected by the patients' shame. This may cause her to feel uncomfortable talking about the topic in question, even though it is actually the patient who feels shameful about the topic. One participant explicitly pointed to the need to be aware that countertransference reactions might arise when working with patients with AvPD, having observed that therapists are more inclined to be attentive to these types of reactions when working with patients with BPD or antisocial personality disorder.

The value of being part of a team and receiving mandatory and frequent supervision was conveyed by most participants. Some underlined how when they are affected by their own emotions or by the avoidant patients' seemingly mental standstill or stagnation, they might lose their own ability to mentalize sufficiently, thus needing forums to remind and train them to keep their own mentalizing activity going. One participant expressed that working together in teams and having adequate treatment resources are important, as the patients' conditions and range of difficulties might be difficult to fully discover and understand. Another participant pointed to the value of outside observations, as "one might get lost in relations."

Making use of experience with other therapeutic approaches

Some participants talked about how they make treatment adjustments based on former experience and competences from other therapeutic orientations. One of them conveyed that she sometimes finds the MBT approach inadequate in meeting the patients' needs. She described how patients with AvPD often present with comorbidity and a wide range of symptoms that might require a different treatment approach or a combination of treatment approaches. Having been trained in dialectical behavior therapy (DBT), she explained that she makes regular use of DBT skills in her current work with patients with AvPD, especially in the treatment of those with severe anxiety. This participant explained how, for instance, treating anxiety disorders may require the active use of exposure activities and techniques, which is not inherent in the MBT approach. She emphasized the concepts of validation and radical acceptance, both of which are central to the DBT approach.

> Radical acceptance…that's really important to me. […] Like, everything happens for a reason, and when you don't understand everything… It's easy to start fighting ourselves when we don't understand ourselves. All we see is the tip of the iceberg, and to try to understand more of ourselves, it enables working together in better ways. These are the kinds of things I've brought from DBT, because it's an important part of… One might validate and understand oneself in light of one's story, or I might validate the other by the way I sit in the chair, changing position […] I could validate your strength by challenging you. Validation can be used in so many ways.

Two therapists with trauma treatment experience described making active use of emotion regulation techniques in their current work, such as making the patients hold onto small massage balls and do breathing exercises or rearranging the room to create more physical space, thereby enabling the patients to avoid sitting face to face. This is especially during the first phases of treatment or if the patient dissociates or has a background that includes severe trauma. One of these participants explained how 'the window of tolerance', a central concept in trauma therapy, is inherent in the navigation of his work, making him especially observant regarding whether a patient needs his help to regulate his or her emotions, for example, by changing the subject or using bodily techniques, such as breathing. He reflected on the degree to which this type of regulation work might be a temporary move away from the mentalizing project in a given session, pointing at the same time to the regulation of emotion being a clear constituent of a mentalizing approach. For the other participant with a trauma therapy background, this professional experience was conveyed as something that strengthens her ability to handle the patients' fear and

emotional pain: "I don't get stressed by…I don't feel helpless when the other gets scared, because I feel like I have a lot of competence from working with trauma and anxiety and the like. So, I don't get infected by that."

Discussion

The aim of this study was to inquire into therapists' experiences with MBT for patients with AvPD. Overall, all the participants expressed finding the MBT approach useful in treating patients diagnosed with AvPD. Engaging the patients and gaining access to their personal narratives appears to be a central therapeutic undertaking. The participants described how they apply certain strategies to bring forth therapeutic material, and they seem to find the treatment structure therapeutically helpful. The participants expressed being emotionally affected in different ways in relation to the patients, something that they seem aware of and focused on handling. For some participants, their previous professional experience seemed to aid them in their work.

Scarcity of personal narratives

The scarcity of explicit personal narratives appeared to be a significant challenge for the therapists but was interpreted as part of the patients' core problems. Approaching the patients' limited access to their own mental states and general experiential avoidance may be challenging for both the therapists and the patients. To help the patients talk about themselves, and to gain access to therapeutic material, the participants described using strategies consisting of basic mentalizing attitudes and MBT-related techniques. The use of some techniques, however, warrant active consideration. Central to the MBT approach is an explorative focus and a mentalizing stance of the therapist; there is "an attitude of openness, inquisitiveness, and curiosity about what's going on in others' minds and in your own," and such an attitude should be stimulated in the patient as well (Allen, Bateman & Fonagy, 2008, p. 320). However, adopting a curious attitude may not come naturally to AvPD patients. Persons with avoidant attachment styles have been found to report less curiosity than do securely attached persons and have a more rigid cognitive style with a tendency to reject new information that may cause confusion and ambiguity (Mikulincer, 1997). Correspondingly, AvPD is associated with low affect consciousness regarding the affect interest/excitement compared to BPD and lower self-report scores on the primary emotion seeking system (Johansen et al., 2013; Karterud et al., 2016). The basic MBT premise of an open-minded, curious, and inquisitive attitude on the therapist's part may thus be at odds with some basic tendencies in the patient. Based on our findings, this contrast may create the potential for the patients to misconstrue inquisitiveness as criticism. Instead of seeing the therapist's explorative questions as a way of engaging them both in a common effort to understand and clarify the patient's mental state, the patient may interpret the therapist's questions as signalling that the patient has misunderstood something or should have considered other options. Curiosity and inquisitiveness may thus add to the patient's negative self-image and shame, which is an effect that, if not dealt with, may cause further impairment of mentalization in this situation.

The therapists' comprehension of the patients' limited access to their own mental states as a core problem is in line with research showing that patients with AvPD often show significant difficulties with monitoring, labelling, and expressing their inner mental states (Fonagy et al., 2002; Bateman & Fonagy, 2013; Johansen, 2013). Yet, mentalizing involves mentalizing both self and others, and MBT recognizes that individuals with mentalizing difficulties may have more problems with any one or both of the two. MBT for BPD focuses on mentalizing both self and others. However, the severe problems with access to own mental states associated with AvPD suggests that focus should primarily be on mentalizing the self, particularly in early stages of therapy (DiMaggio, Montano, Popolo & Salvatore, 2015). An explicit priority on mentalizing the patients' self-states with limited focus on others' minds was not part of the local guidelines in the present study. Still the therapists seemed most concerned with helping the patients becoming aware of and sharing their own mental states.

As MBT entails an explicit focus on affect and actively explores emotional states, one could ask whether more cognitively or behaviourally oriented treatments may be more tolerable and easier for AvPD patients to engage in, as they often have poor affect awareness and tend to overregulate emotions (Johansen et al., 2013; DiMaggio, Popolo & Salvatore, 2019). However, at this point, for avoidant patients, there is no convincing evidence that cognitively oriented therapies are more helpful than psychodynamic or affectively oriented therapies (Emmelkamp et al., 2006; Schanche et al., 2011; Svartberg, Stiles & Seltzer, 2004). Nonetheless, the change processes and significance of an affect focus may be dissimilar in different therapies (Ulvenes et al., 2012). Interestingly, when the participants in the present study conveyed concerns about the patients' mental withdrawal and lack of sharing, they did not seem to differentiate between affective and cognitive content but referred to the patients' personal experiences more generally. A previous study found that there is a closer correlation between affect consciousness and mentalization capacity among patients with AvPD than among patients with BPD (Johansen et al., 2018). The affective and

cognitive components of inner mental states may be strongly interwoven and difficult to disentangle in patients with AvPD.

The group therapy format

The group therapy component of an MBT program represents extra challenges for AvPD patients. From a typical AvPD perspective, groups imply several people potentially holding critical attitudes, which may increase patients' self-consciousness and trigger extensive anxiety, thereby further blurring the capacity to mentalize and making it even more difficult to share personal information (Stangier et al., 2003; Colle et al., 2017). There has been discussion of whether some patients are too anxious to benefit from group therapy (DiMaggio et al., 2019; Scholing & Emmelkamp, 2003)]. However, groups may, if sufficiently regulated, offer an arena in which the individual has the possibilities to have new interpersonal experiences and to moderate his or her negative perceptions of him/herself and others (Boettcher, Weinbrecht, Heinrich & Renneberg, 2019). Yet, the question of whether individual or group therapy generally has more benefit for AvPD patients remains unanswered. The participants in our study are aware of the need to regulate anxiety within the groups to create a sufficiently safe environment for the patients to participate in. They describe various strategies they use, such as working in the here and now, thematizing the patients' lack of responses, and challenging silence in an open and curious manner in order to support group members who have exposed themselves. They also make efforts to create therapeutic material of what is absent (i.e., non-events), thus trying to limit the patient's withdrawal both individually and from the group.

Therapist transparency

The participants consider transparency to be a central therapeutic instrument. In the participants' view, transparency serves several functions: It has a reassuring effect, reducing insecurity; it's a way of modelling and normalizing mentalization activity; and it demonstrates differences in perceptions to be discussed in a mentalizing fashion. Being transparent means modelling openness and making one's own mind available to others (Robinson, Skårderud, & Sommerfeldt, 2019), for example, by sharing one's own thoughts and reflections with the patient, especially related to the here-and-now situation. This is in line with the MBT manual, which regards transparency as an important part of mentalizing the relationship between patient and therapist, particularly when something in the session or across sessions interferes with treatment progress (Bateman & Fonagy, 2016). MBT transparency is not to be confused with self-disclosure, which may be defined as "therapist statements that reveal something personal about the therapist" (Hill and Knox, 2001, p. 413) and to which "outside of therapy" might be added (Hill & Knox, 2001; Hill, Knox & Pinto-Coelho, 2018). We saw that some participants mentioned occasionally sharing something of this type of personal character with patients, intending to provide emotional support and model openness. The fact that they claimed to do this more toward AvPD patients than those with BPD indicates that the question of how personal one should be is present to a larger degree in therapy with AvPD patients. Reflecting on this, one might wonder whether it has something to do with therapists sensing a need to "convey themselves as subjects," as expressed by Sørensen, Wilberg, Berthelsen, and Råbu (2019, p. 10) in their article on the subjective experience of treatment by persons diagnosed with AvPD. An urge to be more personal could also be related to what therapists perceive as patients' lack of knowledge or confusion regarding normal emotional reactions due to the patients' limited social and relational experiences.

However, treatment approaches differ in their opinion on self-disclosure as a therapeutic tool. Whereas self-disclosure is not recommended in MBT (Bateman & Fonagy, 2016), for instance, Metacognitive Interpersonal Therapy for personality disorders (MIT) views self-disclosure as a particularly useful aspect of the therapeutic relationship (DiMaggio et al., 2015). In MIT, the aims of therapist self-disclosure are to promote a sense of sharing, similarity, and connection, allowing the patient access to a sense of being with a peer of the same rank, not feeling inferior or judged (p. 93-94). Still, according to MIT, self-disclosure is not without pitfalls and should be applied skilfully. Much in the same way as the participants report in the present study, MIT instructs therapists to avoid self-disclosure of private circumstances that are emotionally difficult for the therapist. Moreover, therapists should focus on similar feelings or situations and not on how they solved the problems, as providing solutions could add to the patients' feeling of inferiority. The possibility that the patients perceive self-disclosure of private material differently from the therapist's intentions is always present. Sharing private experiences could evoke a range of patient reactions, like feeling pity for the therapist, guilt for creating trouble or an uncomfortable sense that the therapist's life or needs invade the treatment. Accordingly, therapists should monitor the patients' reaction to any self-disclosure (DiMaggio et al., 2015). The therapists valued the combined group and individual therapy format, and parts of the individual sessions were used to stimulate the patients to expose themselves in the groups. MBT itself does not give any directions for combined (same therapist) versus conjoint (different therapists) therapy. A clear benefit of a combined format, as presented by the participants, is that the therapists' presence in both places contributes to the continuous pressure on the patients, thus limiting possibilities for avoidance and opportunities to explore different perspectives on what happens in the group. Considering the potential benefits of a

conjoint format, it might be that having a separate individual therapist would offer AvPD patients a sort of safe haven and a sense of being part of a relationship that is more "one's own." Additionally, a conjoint format represents more relationship experiences. However, working within a conjoint therapy format will likely necessitate close cooperation between therapists in order to counteract avoidant behavior. An empirical investigation of whether either format is more advantageous will be of clinical interest.

Countertransference reactions

Emerging from our data are the participants' feelings in relation to their patients—what is also termed countertransference reactions. Research has shown that patients' level of personality organization and type of personality pathology may affect therapists' emotional responses to the patients in typical ways (Stefana et al., 2020). However, to date, research on countertransference reactions in the treatment of patients with AvPD is scarce, and most studies have been performed at cluster level—that is, on cluster C (dependent, obsessive–compulsive, and avoidant) patients. Such studies have found that patients with cluster C disorders tend to evoke more positive and less negative emotional reactions—such as parental and protective responses—in their therapists (Betan, Heim, Conklin & Westen, 2005; Røssberg, Karterud, Pedersen & Friis, 2008). Meehan, Levy, and Clarkin (2012) found that cluster C symptoms in patients with BPD were associated with low negative affect, but the therapists also reported that they were not thinking much about the patients between sessions and found the treatments less stimulating. The authors speculate if aggression is defensively denied, resulting in less enlivened therapy. Research focusing on specific personality disorders partly support the findings from cluster C studies by reporting associations between AvPD or avoidant traits and parental and protective responses, over-involvement, and therapists' feelings of importance and helpfulness (Colli, Tanzilli, DiMaggio & Lingardi, 2014; Tanzilli, Colli, Del Corno & Lingiardi, 2016; Thylstrup & Hesse, 2008). In a study by Genova and Gazillo (2018), anxious personality patterns were associated with both a parental and a disengaged response.

In our study, we find a range of emotional reactions experienced by the participants. Urges to alleviate the patients' painful emotions and suffering, as well as their emotional discomfort when making them aware of the need to change and challenge their thoughts and beliefs, are expressed. This may be understood as conveying some of the same aspects as the abovementioned findings regarding parental and protective responses. Among the more negative feelings experienced by our participants are frustration, irritation, impatience, and provocation. This seems partly related to patients' general withdrawal and reluctance to share, and, for some, to instances in which patients in group therapy collectively fail to respond to someone's sharing, sitting quietly and appearing to be inwardly focused instead. Such reactions are in line with the clinical considerations of Cummings, Hayes, Newman, and Beck (2011), who state that AvPD patients' tendency to withdraw from therapy may be frustrating for therapists who are eager to help their patients. They discuss how therapists who become frustrated and try to shake patients out of their avoidance over time may feel ineffective and disengaged as a result of the slow pace of therapy. In the present study, the additional experiences of being infected by patients' anxiety, thereby causing performance anxiety and the devaluation of their own work, are reported. Thus, our results suggest that patients with AvPD may trigger a broader spectrum of emotional reactions than previously reported (Breivik et al., 2020). Previous studies of countertransference reactions associated with AvPD or cluster C disorders have been based on therapists' self-report questionnaires. The use of a qualitative method with in-depth interviews in the current study seems beneficial for bringing forth a more nuanced picture of therapists' feelings toward their patients.

Different findings across studies may also depend on variations in therapist samples (e.g., different professional roles and years of experience), patient samples (e.g., comorbidity), and treatments. We can only speculate on the degree to which our findings are related to MBT or any specific aspects of the MBT approach. Those of our findings that match others', such as the more protective reactions, may be interpreted as being primarily due to patient characteristics. However, Meehan et al. (2012) found that in the treatment of patients with BPD, therapists in transference-focused therapy reported experiencing more negative affect in the treatment compared to therapists in DBT and psychodynamically oriented supportive psychotherapy, thereby indicating that the type of therapy may affect the therapists' feelings. However, other research has found that therapists' emotional responses are not influenced by the therapists' orientation (Colli & Ferri, 2015).

Notably, in our study, no therapist reactions that resemble feelings of disengagement, emerged. On the contrary, the participants report that working with the patients is stimulating. Among many possible explanations is the fact that the therapists were recruited from a specialized treatment program for patients with AvPD. They were also experienced and might have had a special interest in this type of personality pathology. Moreover, the treatment is team-based with close collaboration between therapists, including regular supervision. In the interviews, the participants demonstrate an awareness of the fact that they react emotionally to their patients. Some of them convey how supervision helps them to notice and manage these reactions. MBT supervision aims to

support clinicians' mentalization capacities in relation to particular patients; that is, the focus is on mentalizing the relationship, which could counteract feelings of disengagement (Bateman & Fonagy, 2016). Supervision is generally recommended when working with patients with severe personality disorders, but for various reasons, this is a recommendation that may not be followed in ordinary clinical practice.

In managing their emotional reactions to patients, some participants also convey that they profit from the experiences of other treatment approaches. We might infer that competency from other types of treatment may sometimes contribute to a professional confidence that helps the therapists not to act on these reactions—for instance, by enabling them to withstand the urge to protect the patient and thus take part in his or her avoidance and instead dare to challenge the avoidance and tolerate the patient's anxiety as it unfolds. Related to their former professional experiences, some participants find it useful to employ strategies that are not specified within MBT. The degree to which one should adopt a more eclectic approach or shift between different therapeutic models when facing patients with a wide range of co-occurring psychiatric disorders is an important clinical question more generally. To date, there is little systematic research on this topic to guide clinicians who treat patients with personality disorders.

Strengths and limitations of the study

All the participants in our sample have lengthy experience as therapists, are presently working with patients with both AvPD and BPD and have witnessed a broad spectrum of personality pathology. In the interviews, all the participants seemed positive; engaged; and willing to share, elaborate, and reflect on their own therapeutic practices and emotional experiences, thus contributing to the richness and nuance of the data. The result is a detailed analysis of how practitioners value a therapeutic technique and, as such, contributes to the literature exploring therapeutic interventions and outcomes research.

However, it needs to be recognized that the participants were all recruited from a specialized outpatient clinic. Neither the therapists nor the patients are representative of the majority of therapists treating patients with AvPD with MBT or the patients suffering from AvPD in mentalization-oriented treatments. Additionally, all therapists were recruited from the same clinic, and the number of therapists was low. Consequently, this small qualitative study does not allow for generalizations of results or firm conclusions. Including a larger number of therapists from different hospitals or teams might have brought more variance and supplementary perspectives into the gathered data.

Regarding the thematic analysis, all steps in the analysis process were subjected to discussion and reflection, back and forth which we suggest increased the scientific rigor and integrity of our research. We strived to be consistent and meticulous in our work, resulting, we believe, in presenting findings that represent some essence of the gathered data. We acknowledge that other qualitative methodologies could have offered further depth and more nuanced perspectives on the matter. We also could have employed greater reflexivity to make ourselves and our subjective interpretations more transparent in our write-up as fitting our Reflexive Thematic Analysis and our claim to have engaged hermeneutic methodology. However, we chose to selectively prioritize more objective languaging given word space constraints.

Our post-positivist commitments led us to emphasize where only some, rather than all, participants expressed a certain view. We argue that this deepened the transparency and integrity of our research.

Conclusions

The participants find the use of mentalization-based with patients with AvPD to be stimulating. In their experience, MBT targets much of the AvPD core pathology. However, as patients with AvPD appear generally to have limited access to their own mental states and affects, the use of some techniques warrants active consideration, and there seems to be a need to adjust MBT for avoidant patients. This qualitative study has revealed more nuances in therapists' countertransference reactions and more negative affect than has been reported previously. When adapting therapies to this patient group, such knowledge may be clinically useful.

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About the Authors

Mona Skjeklesæther Pettersen is a registered nurse at the Department of Substance Abuse, Clinic for Mental Health and Addiction Treatment, the University Hospital of North Norway, Tromsø, Norway and a part-time research assistant at the Institute of Health and Society, University of Oslo. She is a registered nurse (RN) (2015) with a master's degree in nursing science (2020). She has done most of her clinical work within the fields of mental health and addiction treatment and has a special interest in developmental trauma, personality disorders and mentalization-based approaches. She has been engaged in several collaborative research projects based on data collected within the Network for Personality Disorders in Norway.

Anne Moen is professor at the Faculty of Medicine at the University of Oslo, Norway, and adjunct Professor, Norwegian Center for eHealth Research, Tromsø, Norway. Her focus is design and deployment of digital tools and accompanying services, emphasizing citizen empowerment and digital health literacy. Anne Moen is a registered nurse (1985), with a master's degree in nursing science (1996), and PhD in social sciences (Dr.Polit) – specialization in health informatics (2002). She has been Fulbright fellow (2002) and postdoc at University of Wisconsin-Madison and UiO (2002 – 2005). For this paper she oversaw the empirical work, qualitative analysis, and preparation of the manuscript.

Elin Børøsund is a senior researcher and head of Research and Education at the Department of Digital Health Research at Oslo University Hospital, Oslo, Norway. She is a RN (1992), with a master's degree in nursing science (2006), and a PhD within nursing and eHealth (2015). She has previously worked treating and following-up people with drug addictions and people with chronic conditions. Her research embraces studies on development of and effect studies of digital (eHealth) interventions and communication solutions for people with chronic and complex health challenges. For this paper, she oversaw the empirical work, qualitative analysis, and manuscript preparation.

Theresa Wilberg is a professor of psychiatry at the Institute of Clinical Medicine, University of Oslo and senior researcher at Department of Research and Innovation, Oslo University Hospital. She also works as a psychotherapist. Her main current areas of research are personality disorders, including quantitative and qualitative studies on avoidant personality disorder, social cognition, assessment of reflective functioning and change processes in mentalization-based, psychodynamic and cognitive psychotherapies. She has published several scientific articles and book chapters on assessment, treatment, and longitudinal course of patients with personality disorders, and has co-authored a textbook on personality psychiatry.