Psychotherapy of personality disorders

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Psicoterapia de los trastornos de la personalidad

Summary

A review of classical psychodynamic concepts in the psychotherapy of personality disorders (PD) is carried out. New approaches, such as dialectic behavioral therapy or cognitive analytic therapy, are also studied. Whenever possible, evidence is given on the efficacy of these approaches. The article finishes with a PD by PD study of relevant psychotherapeutic issues.

Key words: *Psychotherapy. Personality disorders. Psychodynamic. Group therapy. Cognitive behavioral.*

Resumen

Se proporciona una revisión de los conceptos psicodinámicos clásicos en la psicoterapia de los trastornos de la personalidad (TP). Se estudian asimismo nuevos abordajes, como la terapia dialéctica conductual o la terapia cognitivo analítica. Cuando es posible, la evidencia sobre la eficacia de estos métodos es señalada. El artículo acaba con un estudio de los aspectos psicoterapéuticos más importantes de cada TP.

Palabras clave: *Psicoterapia. Trastornos de la personalidad. Psicodinámico. Terapia de grupo. Terapia cognitivo conductual.*

INTRODUCTION

Some children support great adversities without developing psychopathology. Many people have a bad time and do not necessarily go mad. There are persons with an identical type of stress, family education and social setting who develop different diseases. Others, on the other hand, do not develop them. Even more, there are many mental patients who never had any type of special stress as children or adults. Livesley[1] states that almost 50 % of the differences between individuals depend on complex polygenic genetic factors and, in fact, monocygotic twins living apart present similar personalities. The remaining 50 % of the differences are due to the environment. For the whole society, it is good to have personality differences, different talents that are complemented in favor of a common good. It is possible that what really exists is a complex genetic-environmental interaction, genotypephenotype and diathesis or predisposition-stress[2].

Predisposition or diathesis would be the personality traits in personality disorders (PD), the complex relationship between traits and environment being key to understanding this group of entities. A certain disease may or may not develop with similar genetic load, even under similar circumstances. Thus, the inutility of the reductionist approaches. One could be sarcastic and state that social and psychodynamic psychiatry lacks «brain» and that biological psychiatry lacks «spirit» and «heart».

Everyone has the genetic potential to become ill, which can be manifested under certain physical, social and environmental conditions. There is a *continuum* between health-normality and disease-abnormality and there is a «threshold» which, if crossed, means the passage from health to disease. This threshold is dynamic and is often determined by the surroundings. PDs are the paradigm of the complex genetic-environmental interaction and chronic stress (even mild or medium) seems to have greater influence than acute stress in this interaction. Thus, it is not the «great psychoanalytic trauma» that is so important but rather small and median traumas that are repeated and chronic, without solution in daily life. Social factors are as important as psychological ones[3] and can be subestimated in the dominant theoretical models. The bio-psycho-social interaction is very complex and we still know very little about it.

From the psychoanalytic point of view, there is the commonly accepted opinion that life history affects the subject's personality and that the present is determined by the past. However, Paris[4] states that this is true to a much smaller degree than believed. According to this author, the predominance of early childhood experien-

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ces has become a dogma that leaves other important influences in the personality structuring with no answer, these being, for example, constitution, adult life experiences and social setting. Due to these factors, knowledge of the past, by itself, would not be sufficient to produce changes in the present. Hillman[5], a Junguian psychoanalyst, even states that the future (the chosen destination) explains the past since the individual chooses a future, some goals, a destination, from a young age, using this to organize the subject's way of being.

GENERAL ASPECTS OF PSYCHOTHERAPY WITH PD AND GENERAL EVIDENCE OF ITS EFFICACY

After thirty years of psychotherapeutic practice with successes, failures and mediocre results, Paris[6] observes that the stories that arise in psychotherapy are not representative of that which has really occurred in the past. Thus, he reaches the conclusion that childhood experiences, by themselves, cannot justify the development of a PD. For Paris, the biopsychosocial model is the only one capable of adequately approaching the complexity of psychopathology. In his opinion, all psychotherapists begin by applying the technique they have learned; with time, they discover their limits and, by trial and error, begin to modify it and to make it more eclectic. Psychodynamics is focused less on interpretations and begins to be more confrontational and the behaviorists stop focusing so much on symptoms and become experts in treating the complete individual. In summary: the good therapists abandon their dogmas and do what works, what gives results. Paris believes that it is very likely that in the future, instead of speaking of «schools» of psychotherapy, an agreed upon psychotherapeutic method will be developed with a high degree of eclecticism that will be accepted by most of the clinicians.

The predominant approach, although not the only one, of this article will be psychodynamic, although eclectic. In this, we are supported by a revision on psychotherapy of PD performed by Shea[7] in which the utility of different types of psychodynamic psychotherapeutic approaches in the treatment of personality disorders is recognized. Until now, from an evidence based approach, most of the data come from cohort studies. Evidence based psychiatry (EBP) or factual psychiatry has used different methodology (self-questionnaires, observer scored scales, etc.) in an attempt to measure (which in psychotherapy is always difficult) aspects such as mental health or personal and/or social functioning. It is true that not much research has been performed from the EBP perspective in regards to PD psychotherapy. It does seem that there is improvement when patients with PD who have access to different forms of psychotherapy are compared with those having a natural history of personality disorder that has passed without any therapy[8,9]. Bateman and Fonagy mention the general characteristics that all PD psychotherapy must have to be moderately effective[10]:

1. Good structuring.
2. Considerable time dedicated to increase compliance and its promotion.
3. Clear objective, since this is a specific problem (for example, self-injuring behavior) or the patterns of interpersonal relationship.
4. Great theoretical coherence both for the therapist as well as the patient, which sometimes makes it necessary to eliminate some information incompatible with the theoretical model.
5. Long term (at least relatively).
6. Promotion of bonds and strong relationship between the therapist and patient with some well-defined limits permitting, at the same time, some flexibility.
7. Possibility of integration of psychotherapy with other services available for the patient.

All the individuals have a characteristic profile of personality traits. It has already been stated at the beginning that the traits are modulated both by genetic factors as well as by experience and tend to cause responses that reinforce them, especially in childhood. A useful conceptual model of PD would be understanding them as pathological exaggerations of normal personality traits[11]. PD would represent the non-adaptive exaggeration of these traits and psychosocial factors would be crucial in the transformation of traits in disorders. Going from trait to disorder will depend on genetics, on the psychosocial agents and on the different trait combinations[12].

According to these principles, the psychotherapy goals would be to invert the process by which the traits become disorders, demonstrate the non-adaptive use that they make of their traits to the patients and develop ways of using the existing traits more adaptively, extending the behavior repertoire. This method differs from the preexisting ones in several aspects:

1. It does not accept that all the patients with PD are psychotherapeutically treatable, so that it tries to locate a treatable subgroup that can benefit as much as possible from the therapeutic intervention.
2. It does not assume that introspection *(insight)* is the treatment goal but rather only the first step towards change.
3. It does not aim to be neutral to unadaptive behaviors and it recognizes that psychotherapy has the mission of increasing social integration and promoting specific changes.

Personality traits overlap with defense mechanisms. Paris considers that the defense mechanism concept is an erroneous way of describing behavior models. He proposes that it would be better to call them «adaptation styles» since there is no evidence of a psychodynamic constellation associated to each PD, as the classics believed.

Conversion of the personality traits into disorders is performed in a very non-specific way. An extroverted subject is sociable, gregarious, well integrated, however if the setting becomes stressing, he «adapts» seeking more contact and support from others, as he knows how to

do, but if this intensified and last for a long time, a histrionic type pathology probably occurs. An introverted subject lives well focused on himself and is autonomous, but if the setting becomes hostile, he becomes withdrawn and groups A or C pathologies appear (above all schizoid and avoidance). That is, the traits worsen with stress, especially with chronic and permanent stress and when the family and social surroundings are inadequate.

According to Paris, PD psychotherapy should be based on working with the traits, not against them. It tries to attenuate the traits, drawing the maximum benefit from them and extending the behavior repertoire. Thus, psychotherapeutic treatment should be aimed at reverting the already mentioned process of amplifying the traits. If the therapy works, the traits are maintained, but at a less dysfunctional level. That is, the traits do not disappear, but attenuate. Thus, it consists in readjusting an altered homeostatic system.

There are two basic ways of working with the personality traits. The first consists in modifying maladaptive behaviors, first identifying when the traits are applied poorly in order to manage them better. Some traits are easier to modify than others. For example, it is easier for an anancastic to work less than for an impulsive subject to find work. The second is to teach the patients to use their traits better, taking advantage of them, if possible, in the adequate settings.

The belief that psychodynamic transference is pure gold does not correspond with either practice or research[13]. What does work is when the patient has the sensation of being understood by the therapist. Regressive complications and the difficult task of «re-parenting» must be avoided, leaving the use of transference for specific points. Paris also does not believe that psychodynamic interpretations have been useful in practice or have been validated in research. He doubts that focusing on childhood is of much use since the present is the principal object of psychotherapy. By 1946, Alexander and French[14] stated how easy it was to look at the past as a justification to not change the present.

Therapy must include history taking, therapeutic alliance, therapist listening skills, confrontation of maladaptive behaviors, explanations and development of more mature behavioral alternatives. The 50 minute weekly hour continues to be valid. There is no evidence that twice a week is more effective and once a week makes it possible to analyze the weekly events. An alternative concept to long term therapy is intermittent therapy, also defined by Alexander and French[15], Silver[16] and McGlashan[17]. In any case, psychotherapy must be the art of the possible and not of the impossible.

The therapeutic community, except specialized units, does not seem to be the preferred method of psychotherapy of PD nowadays, although this approach was in force in the sixties and seventies in a clear way. It is true that there is little evidence that supports this therapeutic management and some authors even deny it validity in the case of PDs[18]. However, there is evidence in the cases of the borderline and antisocial PD.

The implementation of integrative models of psychotherapy[19] is already a clear tendency today. This psychotherapy called integrative has the flexibility to integrate hybrid models and also to perform different types of psychotherapy in each patient in different phases of their life. It should be stated that integrative psychotherapy is not a ragbag but that its approach has a foundation in coherent theoretic models. Well, in regards to the PD, there is certain evidence that integrative psychotherapy is useful[20,21].

PSYCHOTHERAPY OF GROUP A PD: PARANOID, SCHIZOID AND SCHIZOTYPAL

Paranoid PD

Paranoid thought is not by itself pathological. The schizo-paranoid position is a basic model of organizational experience that persists in the human psyche through the life cycle. In this way, dangerous thoughts or unpleasant feelings are split off, projected outside and attributed to others. Paranoid PD is not a transitory state of growth. It implies a study of thought, feelings and relationship with the others that is extraordinarily rigid and invariable.

As in most of the PD, the key traits of paranoid PD are egosyntonic. It is the family, friends or workmates who push them to seek treatment. Their thought style is characterized by a search for hidden meanings, of keys to discover the truth behind the face of a situation. The obvious, superficial, apparent mask reality. This endless search implies a state of intense hyperattention that includes incapacity to relax. They also show lack of flexibility. Not even the most persuasive arguments have an impact on the beliefs of the paranoiac. Thought is not delusional. There is no distortion of reality but rather of the meaning of the apparent reality.

Projection and projective identification are two key defense mechanisms in this PD. The need to control others reflects the extremely low self-esteem in the nucleus of paranoia according to Meissner[22]. In a deep plane, the paranoiac feels inferior, weak and ineffective. Thus, grandiosity or the feeling of being special, frequent in these patients, can be understood as a compensatory defense of the inferiority feelings. They are very concerned about humiliation from authority figures. They perceive their autonomy as threatened. They feel that anyone who approaches them secretly tries to make the most of it. The therapists who know this other dimension of the paranoid personality (weakness and low self-esteem) can empathize more easily with these difficult patients. Thanks to the knowledge that low self-esteem creates the need to see fault in others, the therapists can empathize with the point of view of the patient and look for suggestions on how to make the treatment more productive.

Due to their suspiciousness, group psychotherapy is not good for paranoiacs. Most come to treatment due to

external pressure and distrust all. Based on these obstacles, the first step in psychotherapy should be the construction of a therapeutic alliance[23]. However, this process is made even more difficult due to their tendency to evoke defensive responses and the therapist is not an exception. The patient treats the therapist as a bad persecutory object, so that he feels induced to defend himself and generally ends up making an interpretation that tries to make the projection return to the patient. Then the paranoiac responds by feeling attacked, misunderstood and disappointed. To avoid this escalation, the therapist should empathize with the projection needs of the patient as a means of emotional survival. According to Epstein[24] the therapist should serve as a container for the feelings of hate, evil, impotence and hopelessness. He should be capable of accepting the blame, even to the point of recognizing the lack of ability to help the patient[25].

Failed treatment or accusation of incompetence may cause a strong contratransferential reaction in the therapist. Defending oneself is also a natural reaction when accused of dishonesty. However, the defense can be misinterpreted as a confirmation that the therapist has something to hide. «Openness» is the best policy with paranoiacs. If the patient suspects the notes that the therapist is writing down, the therapists would do well sharing them with him since refusal to share them would lead to greater paranoia[26].

The therapists also have to empathize with the tendency of the patient to keep his intimacy. Allowing periods of silence instead of intrusively asking questions may help the patient to open up a little more. Another technique is to focus on the state of tension secondary to the intense observation necessary to maintain the paranoid cognitive style. When the patient wants to speak, the therapist should promote elaboration, which may reveal historical background of the present stress situation[27].

The main objective of psychotherapeutic work with paranoiacs is to help them change their perceptions, origin of their problems, from an external site to an internal one. This change can only follow a slow schedule which is unique for each patient. The therapist should support repeated accusations and suspicions without become exasperated. As the patient opens up more, the therapist can help him to distinguish between emotions and reality[28].

Through the therapeutic process, the therapist should hold back feelings more than act on them. This provides the patients with a different way of relationship that will become complemented with gradual changes in thought. The key is to achieve a «creative doubt» of his perceptions of the world and that things become «as if» they were true rather than really true.

Schizoid and schizotypal PD

Here they are considered together due to the dynamic and psychotherapeutic parallels of these PD. The inner world of the schizoid is often a source of contradictions. Akhtar[29] has grouped these contradictions into public and dissimulated manifestations: «the schizoid is publicly independent, self-sufficient, distracted, uninterested, asexual and idiosyncratically moral while he is secretly exquisitely sensitive, emotionally needing, markedly watchful, creative, often perverse and vulnerable to corruption». These polarities do not reflect conscious and unconscious personality traits. Rather, they represent a splitting or fragmentation of the *self* in different representations that remain disintegrated. From the psychodynamic perspective, the term «schizoid» reflects this fundamental splitting of the *self*. The result is a diffuse identity that makes relationship with others problematic. Perhaps the most pronounced trait of the schizoids and schizotypics is their apparent non-relationship with the others.

Schizoid patients who have allowed their therapists to have access to the inner worlds have often revealed fantasies of omnipotence. They use them to directly reach success in interpersonal relationships or careers. They often feel ashamed about these fantasies and resist sharing them with their therapists until they feel safe.

Schizoids and schizotypics may benefit from supportive-expressive individual psychotherapy, from a dynamic group psychotherapy or from a combination of both. As the interactional demands of the group generally cause great anxiety, most of the patients feel more comfortable beginning with individual psychotherapy. The therapeutic mechanism probably occurs more through internalization of the therapeutic relationship than from the interpretation of the conflict, according to the most modern literature[30]. The task of the therapist is to supply them with a new experience of relationship. The therapist should consider how to relate with the patients in a maturely corrective way.

However, stating that the objective of the therapy is to create a new relationship for internalization is too simple. This strategy has many obstacles. In the first place, the basic way of existence of the patient is that of non-relationship and the therapist aims to make him move in the opposite direction. This strategy comes up against emotional distance and importance silences. Patience is key because the internalization process is slow. The therapist should adopt a permissive attitude regarding the silence and must see it as something more than simple resistance. Silence is also a specific form of nonverbal communication that gives essential information on the patient. Gabbard[31] sustains that the behavior of the patient would evoke certain responses in the therapist that contain important diagnostic information on the inner world of the patient through projective identification. With this model, the emotional reactions of the therapist towards the patient, although subtle, are the primary source of information: the therapists receive the patients' projections and monitor them in themselves with-out the action of contratransference.

The decision to not interpret may be the most therapeutic strategy. If silence is interpreted as resistance, these patients may feel responsible and humiliated by their basic incapacity to communicate[32]. Respecting their silence may be the only feasible therapeutic approach to construct a therapeutic alliance[33]. Our natural tendency is to load the patients with expectations that they should be different from how they are. Specifically, we want them to speak to us and to relate with us. However, this expectation implies that we should ask the patients to confront the painfulness of their schizoid avoidance. This would paradoxically lead to greater withdrawal. Some patients would respond to tolerant and empathic acceptance with greater openness in their therapeutic relationship. Stone[34] suggested that the schizotypal patients who function best in psychotherapy have more depressive symptoms and some capacity for emotional warmth and empathy and warned the therapists of excessive expectations because only a limited progress can be expected. From the point of view of this author, schizoids need more than supportive-expressive psychotherapy. The schizotypal patients having lower functioning level also need training in social skills, reeducation and social supports.

These patients may benefit from group psychotherapy since it is oriented to helping patients with socialization, which is exactly what they are suffering from. They can benefit considerably simply by being exposed regularly to the others. As they begin to feel accepted and realize that their fears do not come true, they gradually begin to feel more comfortable with people. The reactions of the other group members may be a corrective experience regarding their previous experiences. There may be difficulties when the others continuously talk about their lives and miracles while they remain in silence. At these times, the therapist should support the schizoid and help the other members to accept his need for silence[35]. The other patients may also ignore the schizoid and act as if he was not there. In this case, the task of the therapist is to introduce the patient into the group, pointing out how that pattern he has outside the group is being repeated within.

Schizotypal patients tend to benefit from group therapy as much as the schizoids but those who have rare behavior or psychotic thought may become scapegoats simply because they are different from the other members. With these patients, individual therapy alone may be the preferred modality. For most of the schizoids, the combination of group and individual psychotherapy is the ideal because the social field found in the group can be discussed and processed with their individual psychotherapist. An important number of schizoids will feel, however, that group therapy is like «throwing them to the lions». They may even feel betrayed when their therapist makes the suggestion. A preliminary step is often working with their fantasies on what will occur in group psychotherapy.

PSYCOTHERAPY OF GROUP B PD: BOARDERLINE, NARCISIST, ANTISOCIAL, HISTRONIC

Borderline personality disorder (BPD)

Patients with BPD are difficult since they want immediate relief of their great malaise, dysphoria, impulsivity, psychotic microepisodes, unstable relationships and feelings of emptiness. In general, they improve somewhat after forty years, above all, due to decrease of their impulsivity. However, this is a chronic disorder and the risk of suicide in these patients is high.

Otto Kernberg[36] relates the BPD with fixation during the separation-individualization phase of Margaret Mahler, specifically with the rapproachement subphase that occurs between 16 and 30 months. According to him, these patients repeatedly relive the infant crisis in which they fear that their attempts to separate from their mother will end up in disappearance and abandonment. The reasons for the fixation are due, according to Kernberg, to an alteration in emotional availability of the mother during this period, either due to constitutional excess of aggression in the child or to maternal problems, or a combination of both. The important component of this fixation is the lack of object constancy that gives rise to intolerance to separation and isolation. The result is a condition that Kernberg[37] characterizes by the predominance of negative introjections. The Kernberg theory emphasizes the meaning of constitutional excess of oral aggression in borderline PD, which reduces their ability to integrate good and bad images of the *self* and of the others; evil destroys goodness. When the introjected is projected outwards, they feel at the mercy of the malicious pursuer and when it is reintrojected, the introjected bad makes them feel despicable and of little value, which sometimes leads them to suicidal thoughts.

Siever and Davis[38] stress affective lability, impulsivity and extroversion as traits in these patients. According to Paris, these traits should be «amplified» in an unfavorable setting, however, what would this unfavorable setting in BPD be? The research published has not demonstrated any specific pattern. Sometimes it deals with parents who neglect or traumatize their children or unorganized families who give them little support. But this is not sufficient to produce a BPD. According to Links[39], in this same setting, siblings of the borderline patient do not develop the PD and although (as Paris[40] says) children are very resistant, not all of them are and the one who has emotional lability and impulsivity is at a disadvantage to support misfortunes.

Stone[41] and Linehan[42] have already stated that both factors, predisposition plus stress, must exist for a BPD to exist. Linehan disagrees with Siever as he considers that the core in this PD is the «emotional deregulation», impulsivity being secondary. In any event, both emotional lability and impulsivity must be taken into account in psychotherapy. When they interact with each other and with the setting, they cause symptoms that are typical of these

patients. In addition, there are other characteristics of the borderline patients, based on impulsivity, affective lability and extroversion as, for example, the short psychotic symptoms that are not so easy to explain.

According to Paris[43], only a minority of these patients would be adequate for long duration psychotherapy. They would be those who have some force of the self, work and/or studies, present or past significant interpersonal relationships and more adaptive defense styles. Kernberg[44] also thinks that the load implied by treatment of patients with BPD should only be assumed when there is a reasonable probability of success. With the BPD patients who are less suitable for psychotherapy in the long term, intervention during the crisis (emergencies) and some supportive, individual or group psychotherapy can be used, as permitted by the available resources. There are schools such as that of Rockland[45] or Zetzel[46] that recommend only supportive therapy to borderline patients. Zetzel was perhaps the greatest defender of the supportive approach since he believed that interpretative psychotherapy was too disruptive of the therapeutic alliance. Although other schools such as that of Adler[47], Gunderson and Waldinger[48] and that of Kernberg[49] recognize that supportive therapy is better for patients with low functioning level, they recommend psychoanalytic therapy for selected cases. Shea[50] already mentioned in a revision of the subject that the behavioral approach of patients with BPD showed evidence of efficacy. Furthermore, some promising results are now beginning to be shown with the psychopharmacological approach of BPD[51].

In general, there is or has been little optimism in the psychotherapeutic treatment of BPD. Some more recent studies have begun to challenge this assumption somewhat. It is very probable that these patients abandon treatment, act self-destructively and make rare and excessive demands on the therapist. An important problem is the nature of the therapeutic alliance because it is very difficult for them to consider their therapist as a useful figure who works in collaboration with them towards mutual objectives. Stern[52] and successors as Hoch[53] have already said that the borderlines are not adequate for the traditional psychoanalytic methods since they tend to regression. Skodol[54] and Gunderson[55] state that two thirds of the patients who initiate psychotherapy abandon it within a few months. Other authors such as Stevenson and Meares[56] believe that the abandonment rates are less if the patients are chosen well. We mention, in passing, that the studies of Stevenson and Meares use a psychodynamic methodology of interpersonal orientation influenced by Kohut and that their study was open and well designed. Linehan[57] also says that only 16% abandon with his dialectic behavior therapy.

An essential aspect within the borderline PD is precisely the tendency to suicide and parasuicide behavior. Tony Bateman and Peter Fonagy carried out a randomized clinical trial (RCT)[58], trying to measure the results of the psychotherapy in this particular aspect. This RCT shows that a day hospital with analytic type psychotherapeutic approach decreases the parasuicide behavior of the patients with borderline PD. Linehan's dialectic behavioral therapy presents some evidence that it can help decrease parasuicide behavior[59-62] even in the cases where this problem is chronic. Linehan et al. have clearly stated another one of the few RCTs in the field of PD psychotherapy.

Due to the size and rigor (RCT) of the investigation, it is good to speak about this psychoanalytic orientation day hospital program developed by Bateman and Fonagy[63]. This approach to BPD was compared with normal psychiatric attention of the community mental health teams in Great Britain. The results in decrease of depressive symptoms, suicide and parasuicide behaviors, number of hospitalization days and improvement in the social and interpersonal functioning indexes were clear at the end of the therapy[64] and at 18 months, when a follow-up was performed on these patients[65].

Different studies show the utility of the psychodynamic approach in the treatment of BPD in both clinical[66] as well as economic[67] indexes, producing a significant saving in comparison with the standard community treatment.

The therapeutic community also has its place in borderline PD psychotherapy. There is already a classic study of Henderson[68]. This hospital has a therapeutic community of patients with serous PD (mostly borderline) in hospital admission regime. This investigation provides results of significant clinical improvements in almost half of the patients studied and, furthermore (in easily accessible language for managers and administrators) provides evidence that there is a decrease in the costs of mental care services at one year for these patients. In the Cassel Chiesa and Fonagy Center[69], the impact of this type of therapy on BPD has been analyzed, demonstrating improvement in these patients when they participate in a therapeutic community as hospitalized patients during one year. what is interesting in this study is that the patients who are admitted for a shorter period, but who continue outpatient work with community psychiatric nurses and group therapy in outpatient regime obtain even better results. Both groups improve more than those who are simply evaluated and followed-up by the standard community psychiatry teams.

Mechanisms of change in dynamic psychotherapy

1. *Work in the past.* Linehan[70] considers that the validation of feelings of these patients towards the past and their reconstruction is important since they have seen how their emotions were invalidated by their parents since they were very young. It also must be taken into account that if the patient remains anchored in the past, he can respond erroneously to the present context and it is aimed to change behavior in the present life.
2. *Establish a good therapeutic relationship.* Fromm-Reichmann[71] said that «therapy is not an explana-

tion but rather an experience», the emotional experience of feeling understood. The BPD problem is the difficulty of establishing a good emotional experience by splitting, violent negative transferences and the difficultness of the therapeutic relationship, which is always very fragile. Adler[72] considered the therapeutic alliance as a myth in the BPD psychotherapy. However if the therapist achieves the «attraction», the psychotherapy may work.

3. *Modification of defenses* with the aim that the patient adopts other more mature ones.

In a review of the literature, Waldinger[73] selected eight basic dogmas of different clinicians from the different technical approaches that have been agreed on in BPD psychotherapy:

1. Stable treatment framework: appointment times, completion of the sessions on time in spite of the insistence of the patient to prolong them, clear explanations on payment, etc.
2. Avoid a passive therapeutic posture since silence is often misinterpreted as lack of attention or malevolent denial of support.
3. Hold back the patient's anger.
4. Confront self-destructive behaviors.
5. Establish connection between feelings and actions. Action is often language. They feel controlled by the intense affective states and see action as the only way to relieve it, although they generally ignore that their actions are motivated by feelings.
6. Establish clear limits.
7. Maintain the focus of the therapeutic interventions in the here and now.
8. Monitor the contratransferential feelings.

According to Gunderson and Waldinger[74], even with experienced therapists, the treatment drop-out index is high. In their sample, approximately one third completed the treatment, although the patients who completed it improved substantially.

Special problems in the treatment of BPD

They are mainly four:

1. *Contratransference*[75] due to the intense anger that dominates them, which is difficult to endure and causes contratransferential feelings («that's your problem if you commit suicide»).
2. *Maintenance of* sexual and non-sexual limits between therapist and patient.
3. Chronic *suicidability* that is not merely manipulative. This wears out the therapist due to stress, calls with suicide threats and self-mutilations. Linehan[76] believes that when the borderline PD subjects cut themselves, they substitute unsupportable emotions for the blood flow that relaxes them and relieves their dysphoria, and they feel less empty and depersonalized («blood therapy»). The therapist should assume that he is not responsible if he cannot prevent the suicide since no one knows how to prevent a suicide; if the patient wants to, he commits suicide.
4. *Stories of child trauma*. Stories of child trauma have become fashionable, but are not true in many cases. Only one fourth of the children who suffered abuse have measurable levels of psychopathology. Furthermore, BPD patients are characterized by distorting their memories negatively, these being loaded with much fantasy. Paris[77] considers that the «recovered memories» are not very reliable and are sometimes induced by the therapists since these patients are very impressionable.

It should not be expected that therapy would solve all the problems. Few recover completely. The patients frequently improve with time, but they have difficulties, that are sometimes considerable, in intimate relationships and also in the relationship with their children[78]. Thus, improvement is bond to the development of professional competence[79] and not so much to the search for interpersonal intimacy. Paris[80] considers that patients with borderline PD will be vulnerable for life, especially in the most difficult phases of the life cycle, and may need intermittent or sporadic care.

Dialectic behavior therapy (Linehan)

Dialectic behavior therapy is a mixture of several methods[81] since it joins elements of cognitive therapy, of behavioral therapy, of psychoeducation and some psychodynamic type interventions. This conceptual model can be summarized as follows:

1. Borderline PD is a dysfunction of the emotional regulation that occurs as a result of a genetic tendency plus an «invalidating setting» in which the parents fail to help the child manage emotion. Thus, the goal is to help the patient to modulate and manage intense affects.
2. The patient and therapist should agree on the therapy goals.
3. The work of the therapist is «dialectic». The patient's disease is understood and accepted but he should change it.
4. Treatment focuses on problematic behaviors within the following hierarchies of priorities: decrease suicide behavior, decrease behaviors that interfere with the therapy, decrease behaviors that interfere with quality of life and increase behavioral skills.

These strategies are accompanied by original tactic maneuvers. Each patient needs a «coach» to change his maladaptive behaviors[82]. Lineham's «telephone strategy» is interesting. It consists in encouraging the patients to call the therapist when they have suicidal ideation, but does not allow them to call if they have made a suicidal gesture. The idea is to encourage the patient to call asking for advice to handle the dysphoric emotions, but

discouraging, simultaneously, them from putting these emotions into practice. The telephone contact is short and structured and consists in giving instructions that go from distraction methods to methods of asking the patient to consider alternative solutions to the problems that concern them.

Linehan[83] performed a controlled study with his method versus supportive therapy in the community. After one year of treatment, his group had comparatively fewer parasuicidal behaviors, fewer hospital admissions and fewer impulsive acts. The main limitation of this therapy is that the patients did not state that their feelings were less dysphoric at the end of the treatment. We also ignore if their interpersonal problems would be solved with longer treatment. It stands out that the patients of the group studied by Linehan presented chronic dysfunction and lived on pensions.

One year of follow-up is not much and several questions can be posed. Up to what point are the results of this therapy related with specific techniques, or with part of them, or with the strong program structuring and the establishment of a strong therapeutic alliance? Does the result of the therapy depend on the team's enthusiasm or is it generalizable to other teams? Would a similar treatment, but one lasting more years, be more useful? Or, is dialectic behavioral therapy indicated for all the borderline patients or only for the specific subgroups?

Stone[84] and Ryle[85] have similar integrating approaches to the dialectic behavior therapy.

Cognitive-analytic therapy (RYLE)

Cognitive-analytic therapy[86] is a short therapy (16 to 20 sessions, sometimes even more), that is very structured. Its theoretical bases draw from two sources: one psychodynamic (above all the object relationships) and another of more cognitive models. The method is very collaborative. The first three sessions are exploratory and they seek to identify:

1. Objectives based on the patient's complaints.
2. *Dilemmas* or false dichotomies.
3. *Traps*, mainly in the interpersonal relationships.
4. «Snags» or fear of the consequences of change, which may be related with the early experiences and are often rationalized.

Immediately, a re-expression is made in which the patient with BPD has an active participation and based on this, work is done on the previously identified mechanisms that are the cause of the problems in the client's life and where reciprocities and relationships with others are often presented in form of diagrams.

There is no clear evidence on the usefulness of this therapy, but there are studies that point in this direction[87,88]. In recent years, other investigators have performed middle (6 months) and long term (18 months) follow-ups in patients who have received this type of therapy and the results are quite promising although most of the patients do not have the diagnostic criteria of the BPD[89]. Measurement of the impact of the analytic cognitive therapy in BPD on the interpersonal relationships gives positive results.

Narcissistic personality disorder

The psychotherapy of this PD is a challenge as this disorder is the paradigm of the egosyntonic pathology.

Kohut[90,91] understands this pathology either as a lack of empathy associated to a parental failure in reflecting the child's feelings or as a failure in idealization as the child suffers an early and traumatic loss of the positive image of a parent. The child needs his feelings to be reflected, that is, that they are validated and approved, thus internalizing such responses. If this is lacking, the child feels alone, with lack of inner cohesion, and can develop grandiosity as a defense mechanism against this feeling of fragility. As an adult, he feels that if no one takes care of him, he will take care of himself, but in fact, he continues to need the constant reinforcement of the others. Kohut speaks of constant searching of approving and empathic figures. If the child lacks the idealization of the parent, they search for, lacking protection, a figure to idealize. The therapy proposed by Kohut would be to empathize with the patient and accept his idealizations. However, this therapy lacks empiric objectivation and does not take other psychological factors into account.

Kernberg[92] considers narcissism as aggressive more than defensive. His theory emphasizes distortions in the psyche of the narcissistic PD that would create an image of the world that is not compatible with empathy, concern for the others or love. The therapist has to confront this distorted view of reality. Kernberg does not give in to sentimentalisms and sees the narcissist not as misunderstood but as potentially hostile and exploiter.

We do not know the exact mechanisms by which the narcissistic traits are amplified with experience. Millon and Davis[93] believe that they could occur because the child is given all the pleasures, or on the contrary, because they have been too harsh and critical of them. Unfortunately, there is little investigation on the dynamics of the patient's families with narcissistic PD.

It must be kept in mind that, in many aspects, narcissism is an exaggerated individualism, a highly appreciated trait in the present society[94,95] and also that psychotherapy can reinforce narcissism. This gives these patients the attention and self-observation they need and thus many like psychotherapy. Any therapy used in this PD requires confrontation with the patient to reduce their grandiosity. The technical problem is to confront them without hurting their feelings and causing narcissistic anger. Kohut[96,97] believes that empathizing with the patient, internalizing the inner cohesion, and making the therapist the parent, would manage to reduce their grandiosity in the long term.

There are those who believe that grandiosity is caused by low self-esteem and that it therefore must be increa-

sed in the narcissist, since, according to the myth, if people feel better about themselves, they will behave better. However, as Dawes[98] states, there is no evidence that this hypothesis and thus people with low self-esteem can be a paradigm of virtue and that people with high self-esteem may behave very badly. If the narcissists behave badly, they must feel bad about it to be able to change and if they behave well with the others, this would give them true self-esteem in the long term. Healthy guilt is good, as long as it is not neurotic and unproductive.

The message should not be given that bad behavior is understandable when it is simply bad. Psychotherapists confront their patients little about their bad behavior because the Freudian myth was imposed that bad actions are motivated by negative experiences of the past and everyone is a type of victim. This is the Rousseau paradigm, it is the noble savage myth, that was adopted by the British school of psychoanalytic object relationships with Winnicott[99] who spoke of the true self, the good, and the false self, the bad, formed in the relationship with the parental and social expectations. It was also adopted by the American Carl Rogers with his client based therapy[100]. He believed in the essential goodness of the people that the therapist had to accept in an unconditional positive way. Freud[101] and Klein[102] were not so sentimental and knew how amoral and egoistic the child can be (San Agustin already had said that the innocence of the child arises from the weakness of his forces and not of his intentions).

According to previous principles in therapeutic work with the narcissist PD, an attempt must be made to reverse the amplification process of narcissistic traits. Patients must be selected among those who suffer enough to want a change and who are capable of forming a therapeutic alliance. Narcissism is very high in the youth and Kernberg[103] has even suggested that they are only treatable when they soften somewhat on reaching middle age.

Torgersen[104] showed that narcissistic PDs have a high level of dysphoria, largely caused by their failure in intimate relationships. There are successful narcissists who are in the external world and who only have problems in intimate relationships; others also are not successful in the external world and they are surprised when their bosses and work colleagues tell them so.

The first goal of the therapy is to make them understand and consider the needs of the others. In regards to the tactics to be used, it is very important to focus on the present conflicts with other persons and to identify maladaptive behavioral models. These patients should try to see their problems from the point of view of the people with whom they are talking to; they must be taught this skill in order to negotiate compromises, indicting that narcissism harms them in their relationships with the others.

The initial idealization of the narcissistic patients together with the devaluation of the previous therapists may activate the narcissism of the therapists, who believe that they have unique faculties that the previous therapists lacked. The therapist must know and accept his own narcissistic needs. Another frequent contratransferential problem is boredom derived from feeling ignored by the patient or simply being used as an object. The intense devaluation of the therapist by the patient can make him feel useless, impotent, as well as harmed and angry. When the therapist believes that these circumstances have passed his personal limit, confrontation is necessary, telling the patient how this can destroy the possibility of achieving an effective treatment.

Group psychotherapy is not recommended in the narcissistic PD as exclusive treatment[105-108]. The narcissist can feel attracted by the idea of having an audience in the psychotherapy group, but also upset because others take away time and attention of the therapist. He may feel offended by the simple suggestion of participating in the group psychotherapy, which can be interpreted as a lack of interest of the therapist and he may feel that the group is a situation that hurts his feeling of being special and unique. In the group, they generally behave by monopolizing the conversation and/or acting a «cotherapists», making observations on the problems of other patients and denying their own[109]. On the other hand, group therapy may have some advantages for these patients such as confronting them with the fact of not being the center of attention, that the others also have their own needs and allowing them to receive feedback that their interventions produce in the groups.

Some authors[110] suggest greater benefit when individual and group psychotherapy are combined. Wong[111] recommends a previous period of individual therapy along the line of Kohut to create a strong therapeutic alliance. This preparatory period also makes it possible to examine fantasies on the group psychotherapy. This author suggests that the same therapists should be used in both modalities. The therapist would rescue the patient during the group if necessary and could help the other patients to empathize with the needs of the narcissist to be recognized and admired.

Histronic personality disorder

Nestadt[112] states that the histrionic personality disorder can be as frequent in men as in women, although perhaps men may be diagnosed more as narcissists.

Functioning in the histrionic PD is better than in the BPD, but there may be a spectrum. Paris[113] believes that there can be the feminine and masculine version of the same disorder, respectively, in serious borderline and antisocial cases and in mild histrionic and narcissist cases.

There are several explanatory models of histrionic PD. Zetzel[114] describes one in which histrionic PD would be developed when the female (girl) is too attached to her father and distant from her mother in the family, that is, an edipic situation. Another important factor may be the absence of the father or a weak masculine figure. This is very common in the actual wave of divorces which, how-

ever, may have a very different impact on a girl with histrionic traits than in one having, for example, anxious traits. Many of the problems that histrionic female patients have are the men in their lives and perhaps paternal deprival leads them to search for an idealized substitute that cannot be filled adequately by any man. Another model is seen in female histrionic patients with an intimate relationship, that is devious and complicated with a mother who is also histrionic in which the daughter, if she is extroverted, seeks masculine attention histrionically. These models are not self-exclusive and there is no single mechanism of amplifying histrionic traits. Many girls grow up in this type of environment and do not become hysterical. Both biological base as well as a pathological setting are necessary to develop PD.

When working with histrionic traits, the most difficult is extroversion that constantly requires stimulus and attention. As Winnicott[115] stated, success in life requires the «capacity of being alone» and this capacity must also be developed by these patients. It is also necessary to work with the emotional lability which, together with the above, places the individual at the mercy of the environment since in this PD, each breeze is a storm, a hurricane.

On the contrary to other PD, the histrionic patient is characterized because he establishes a therapeutic alliance in which the therapist is assessed as «useful» from the onset. However, it becomes necessary to confront the unconscious expectations of the patient on the capacity of the therapist to intuitively know his intrapsychic world. To do so, the need for detail and to narrate thoughts and feelings versus vagueness of the universe of perceptions that tinge the speech of the histrionic subject must be explained[116]. Allen[117] recommends teaching the patient to identify, in depth, desires and thoughts versus the superficiality that would act as a defense. In an attempt to avoid anxiety produced by self-revelations, this author states how the patient can become interested in obtaining personal type information about the therapist as a defensive maneuver, a circumstance that should be avoided at all cost.

The change of cognitive styles is a previous step to any type of interpretation and the patient must understand the active role he plays in the relationships with the others instead of seeing himself as a passive victim.

Therapeutic work on transference constitutes the main tool for change as the problems that the patient has in his relationships outside of the therapy becomes reflected in this. Erotic transference, which Person[118] describes as a «mixture of erotic, sexual and fond feelings that the patient experiences towards the therapist», may sometimes be experienced ego-syntonically by the patient, who finally considers his expectations of sexual consumption as reasonable and desirable[119]. This erotic transference may be examined and understood in a safe relationship, without risk of abuse or exploitation and its adequate management requires:

1. The examination of the contratransferences such as seeing erotic transferences where none exist; silence, coldness, distancing and lack of empathy by the therapist; anxiety due to fear of losing control by the patient or by the therapist and permitting or even increasing it due to the personal satisfaction that it can mean.
2. Considering it as relevant material to be studied. There can be resistance to going deeper into the therapeutic process and sometimes acts as a type of mask behind which the patient hides sadism and aggressiveness towards the therapist's figure.
3. The interpretation of the connections between transference and present and past relationships (although in general it is not recommended to interpret transference until it becomes resistance).

These patients may benefit from group therapy. In general, they consider the group as an opportunity to receive the maternal affection that they believe they lacked during childhood and they frequently try to be the center of attention and obtain the affect of the other members. When the other members point to the distortions derived from the patient's cognitive style, this can be of help to them.

The cognitive-behavior approach also obtains good results.

Antisocial personality disorder (APD)

Patients with APD are not completely aware of the other persons as separate individuals with their own needs. They have not developed the capacity to feel guilt or depressive anxieties. They are not capable of suffering a true depression, although they may use the term to refer to the anger against the world because their desires are not satisfied accompanied by a sensation of emptiness and boredom[120-122].

The basic characteristic of psychopathy from the dynamic point of view is the deep alteration of the development of the superego. Lack of interest to justify or rationalize the antisocial behavior distinguishes the true psychopath from other pathologies that can have associated antisocial behaviors. Sometimes they use lying to avoid responsibilities for their behavior. They systematically locate their problems in the exterior.

Meloy[123] describes 5 clinical characteristics that contraindicate individual psychotherapy in these patients: background of violent and sadistic behavior towards others that had led to death or serious harm, total absence of remorse or rationalization of this behavior, intelligence much higher than the mean or, on the contrary, close to mental retardation, history of incapacity to develop affective bonds and a contratransferential reaction of intense fear in experienced clinicians, even in the absence of precipitating factors by the patient.

Hospitalization is advisable if it is considered that they are susceptible to psychotherapeutic treatment. Psychotherapy is not recommended in outpatients.

There are six basic principles in regards to the technique to be followed:

1. The therapist should be stable, persistent, uncorruptable and especially scrupulous.
2. It should repeatedly confront denial and minimization of antisocial behavior. Special attention should be made to stress to the patient the correct word that will help him avoid externalizing all the responsibility.
3. It should help the patient to connect actions with internal states.
4. Confronting the here and now is more effective than interpretation of the unconscious matter of the past.
5. It should detect any type of contratransference with the greatest rigor.
6. The therapist should avoid excessive expectations of improvement. The therapists whose self-esteem depends on the improvement of their patient should not treat these PD.

The therapist should not be neutral to the antisocial behaviors of the patient nor empathize with these behaviors.

From the point of view of evidence based psychiatry, the most classic study is that of Cambridge-Somerville[124]. This research evaluated the impact of counseling in the outpatient and voluntary regimen of antisocial PD. Unfortunately, the Second World War cut this project short. The results up to that time showed that there was no difference between this method and non-treatment of these subjects. In every case, most of the data came exactly from forensic or penitentiary psychiatry. Although there are many groups that state they have been successful with the psychodynamic management of these patients (as for example the Van der Hoeven Clinic in Utrecht, Holland), there is no proven evidence in the revised scientific literature. Marie Quayle and Estelle Moore[125], of the high security Forensic Hospital of Broadmoor, revised the efficacy of group psychotherapy in antisocial PD with inconclusive results. Other studies point to the fact that the multiple psychotherapeutic approach in this type of pathology is useful, but is less so in those antisocial subjects with sexual crimes committed[126]. A revision of the evidence of the efficacy of psychotherapy of the antisocial PD shows the prolificness, complexity and heterogeneity, aside from the lack of conclusive results, in this field[127]. In some hospitals, as the classic one of Henderson in England, it seems that positive results have been achieved in the treatment of APD (and of BPD)[128,129]. It is true that, in this case, the patients are only admitted as volunteers and after a very selective process.

Except in highly specialized units, the therapeutic community has fallen somewhat in disuse as a method of treatment of APD and this should be regretted. In the United Kingdom, it is common practice in the high security forensic hospitals, where there are a high percentage of patients with APD, and there is a meta-analysis[130] that supports this approach in spite of the methodological problems derived from the polymorphism of the therapeutic communities and the measurement of the impact. It does seem that there is evidence on different levels that this approach is therapeutically effective, even in the serious cases of APD.

PSYCHOTHERAPY OF THE GROUP C PD: OBSESSIVE-COMPULSIVE OR ANANCASTIC, AVOIDANT, DEPENDENT

Obsessive-compulsive or anancastic personality disorder

The first psychodynamic ideas related it with conflicts from the anal phase with a pathological predominance of control in the control-discontrol binomial. More modern contributions[131] focus it on interpersonal elements, self-esteem, management of anger and dependence, cognitive style and balance problems between work and emotional relationships. There is a child who does not feel loved and appreciated by his parents in all anancastic PD. The children grow up with the belief that they simply had not tried hard enough and as adults they continuously feel that they are not doing enough. The always unsatisfied father is internalized as a hard super-ego who expects more and more of the patient.

The cognitive style of these patients is the contrary to that of impulsivity. After studying pathological traits in normal twins, Livesley et al.[132] find that compulsiveness is inherited in 40%. And, even though there are no specific family models in the anancastic PD, they generally have parents who hardly praise and approve them.

The emphasis of the therapy in these patients is placed on the modification of perfectionist and unreasonable expectations. Psychotherapeutic work may be boring, because they are repetitive, rigid and can use psychotherapy as a means of hiding. However, it is good for many of them and they decrease their perfecionist demands.

On the contrary to the refractory nature of obsessive-compulsive disorder, anancastic PD often improves significantly with individual psychotherapy with expressive emphasis[133]. Common resistances of these patients are initial denial that the therapist is saying something new that they did not already know. In addition, there is affective isolation, which can present as a lack of knowledge of any feeling towards the therapist, above all of dependence or anger. The typical digressing discourse of these patients in psychotherapy is the frequent cancellation of thoughts or desires that they have just stated. Furthermore, thought overinclusivesness leads to their bring peripheral events that progressively digress beyond the main subject of the session.

Many anancastics aim to become the «perfect patient». They try to produce exactly what they believe the therapist wants to hear, with the unconscious fantasy that they will finally obtain the love and esteem that they missed as children. As they are sure that any expression of anger will be disapproved of, they may not experience anger consciously while their unconscious expresses it,

completely monopolizing the session. Other patients with anancastic PD will manifest their resistance, recreating their fight for power with their mother in the transference with the therapist.

Therapeutic approaches to manage these resistances characteristic of the anancastic PD begin with careful attention to contratransference. The therapist may feel a strong impulse to part with the meticulous and mechanical presentation of subject matter of events. He may begin to isolate the affect as the patient does rather than to experience irritation and anger as an important part of the process that needs to be interpreted to the patient. An effective strategy is to open up the way between the smoke screen of words to go directly to the feelings[134]. The anancastics will also avoid transferential feelings, withdrawing into long discourses on far-away historical events. The therapist must bring the patient to the here and now in the transference and try to establish what occurs in the present situation that leads the patient to seek refuge in the past[135-137].

A global objective of psychotherapeutic treatment of anancastic PD is the modification of the super-ego[138]. They must accept that their desire to overcome feelings of anger, hate, dependence, etc. is condemned to failure. These feelings should be integrated as part of his own personal experience more than suppressed, denied or repressed. To achieve this objective of making the super-ego a more benign structure, calming promises are rarely useful. Comments such as «you are not as bad as you think you are» or «you are being too hard on yourself» will sound false. It is more likely that the changes of the super-ego will occur through the detailed interpretation of the conflicts of the patients on dependence, aggression and sexuality and by the stable neutrality of the therapist over time. The patient will repeatedly try to see the therapist as critical, but he can provide the recognition that the patient is attributing his own critical attitude to him.

When these patients begin to understand that the others are not as critical as they are, their self-esteem may increase. When they experience acceptance by the therapist for what they are, their self-acceptance also increases. The therapist may use periodic confrontations on unrealistic expectations that the patients have on themselves. When they can finally experience and express their unhidden anger towards the therapist, they learn that this is not as destructive as they had thought. The therapist is a figure that is there, unharmed from the expressions of anger. In a similar way, they discover that their anger does not transform them into monsters.

Avoidant personality disorder (APD)

Both the APD as well as the dependent one are characterized by pathological anxiety that interfere with social competence. They are very common in the clinical practice[139,140] and there is much overlapping between both categories[141,142].

The individuals may be timid and avoidant for several reasons. According to Gunderson[143], they may have a constitutional predisposition to avoid stressing situations based on the innate temperament that is elaborated secondarily in their personality style. Some investigations suggest that the origin of timidity trait is genetic-constitutional, but that it requires a specific environmental experience to convert it into a complete trait[144]. Timidity or avoidance defends against humiliation, shame, rejection and failure. Psychotherapy often describes shame as a central affective experience.

In the APD, social situations are avoided because they allow their insufficiencies to be exhibited in the presence of everyone. They avoid them to hide the intensely unpleasant affect of shame when they are exposed to a group of people who mean a lot to them.

According to Kagan[145], one third of the children with important traits of behavior inhibition are cured and the other two thirds reach adolescence with these traits, which may then become Group C anxiety and personality disorders. Kagan observed that those who improved were the ones in whom their parents made then face social situations, that is, the anxiogenic phobic objects. This indicates that if the parents overprotect them or give an example of avoidance, the anxiety will persist.

Expressive or supportive psychotherapy may be very effective with these patients. The supportive elements imply an empathic appreciation of shame and humiliation associated with exposure and the conviction of not placing oneself again in the feared situations. The expressive elements of psychotherapy imply examining the underlying causes of shame and its association to passed experiences. Initial exploratory efforts may be frustrating because the avoidant subjects are not sure what they fear. The expressive aspect is reinforced, above all if the patient wants to take the risk of confronting the feared situations.

Robinson[146] says that the patient is immersed in a vicious circle. A situation of potential rejection is perceived and automatically causes negative thinking that includes cognitive distortions on one's self. This leads, in turn, to dysphoric emotivity, which tends to an avoidant behavior to decrease the dysphoria.

Millon[147] says that the therapeutic intervention in these patients aims to reestablish the balance between pleasure-pain and activity-passivity polarities, fostering «that the patients actively focus on the pleasant stimuli and decrease active avoidance of the potentially painful stimuli».

There is some evidence that the behavior approach of this type of patient is also useful[148]. The psychotherapeutic approach that generally gives the best results in these patients is the cognitive-behavioral one, together with relaxation techniques and promoting of competence in social skills[149]. Cognitive techniques focused on the slow change of maladaptive assumptions of the patient in relationship with subjective inefficacy have demonstrated their effectiveness. They are useful both in individual therapy - especially assertive training - as well as in that of the group, the latter part being especially valid

for the development of social skills, specifically maintaining homogeneous supportive groups. Furthermore, psychotherapy focused on learning and development of skills and social capacities is useful and is supported by the EBP[150].

Dependent personality disorder

Psychotherapy of these patients presents an immediate therapeutic dilemma since they must first develop dependence on their therapist. This dilemma is often elaborated into a specific form of resistance in which the patient sees dependence on the therapist as an objective itself more than as a means to the objective[151]. One rule in the treatment of these patients is to remember that what they say they want is probably what they do not need. They will try to make their therapist tell them what to do and finally avoid making decisions or reasserting their own desires. The therapist must be capable of frustrating these desires and promoting independent thinking and action in the patient.

Dynamic psychotherapy limited in time has been useful for some of them[152]. Knowing from the onset that the patient-therapist relationship will end after a certain number of sessions forces them to confront their deepest anxieties on loss and independence. However, there is also a subgroup of dependents who are not capable or do not want to make use of the short psychotherapy work. The perspective of losing the therapist after «hardly having begun» creates too much anxiety for them[153]. These patients need to develop a positive dependent transference with the therapist for a long time. However, with this supportive strategy, important therapeutic gains are possible according to the investigation of Wallerstein[154]. Some patients change as part of a «transferential deal» with the therapist. They are desiring to make certain changes in their lives to obtain the approval of the therapist. Some may feel well when the therapist decreases the number of sessions to one every few months, as long as there is no fear of the end.

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