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Stability or instability in avoidant personality disorder:Mode fluctuations within schema therapy sessions

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ABSTRACT

Background and objectives: Avoidant personality disorder (APD) is among the most prevalent personality disorders, but has received relatively little empirical attention. This study aims to characterize the frequency, intensity, and fluctuation patterns seen in the modes (self-states) of APD clients over the course of schema therapy (ST), a psychotherapy approach developed especially for personality disorders.
Method: The newly-developed client mode rating scale (CMRS) was used to code every 5-min segment (n = 645) of 60 ST sessions. Each segment was coded by two independent raters, achieving adequate reliability.
Results: The avoidant/detached mode was present in 74% of therapy segments and was the most intense and unstable mode; the vulnerable child mode was present in 58% of segments and was the second most intense and unstable mode; the dysfunctional parent mode was present in 40% of segments, and was the third most intense and unstable mode; the over-compensator, compliant-surrenderer, and healthy adult modes were present in around 33% of segments, but the healthy adult mode was significantly more stable than all others.
Limitations: Although 645 segments were coded, they were drawn from only 15 APD clients with no control group. Further studies are needed to established specificity to APD.
Conclusions: This study demonstrates the utility of the mode concept as a lexicon for capturing personality states and their instability. It highlights the use of in-session segment-by-segment ratings to assess client change within psychotherapy. Although DSM5 fails to address instability as a criterion for avoidant personality disorder, the APD clients in the current study were characterized by considerable mode instability.

1. Introduction

Instability is one of the common facets of personality disorders (PDs) (APA, 2013). It encompasses fluctuations in affect, behavior, cognition, and interpersonal relations (Dimaggio, Nicolò, Semerari, & Carcione, 2013). The most common form of instability studied to date is emotional lability (EL), which is defined as instability of intense emotional experiences or moods which are easily aroused. EL is often attributed to difficulties in emotional regulation, and these are a common target of most evidence-based models for the treatment of PDs such as mentalization based treatment (Bateman & Fonagy, 2006), dialectical behavioral therapy (Linehan, 1987), transference focused psychotherapy (Levy et al., 2006) and schema therapy (Young, Klosko, & Weishaar, 2003). EL has been tied, prospectively, to poor social functioning (Bagge et al., 2004). In addition, EL has been discussed as a possible predictor of therapy outcome (Dimaggio et al., 2013; Gratz, 2007; Newton-Howes, Clark, & Chanen, 2015). Initial evidence supporting this possibility comes from studies targeting emotion dysregulation in the treatment of borderline personality disorder (BPD) symptoms, including self-injury behaviors: Gratz, Bardeen, Levy, Dixon-Gordon, and Tull (2015) demonstrated that emotional regulation (i.e., reduced emotional lability) was the mechanism of change leading to symptomatic improvement and reduced self-harm.

Importantly, the role of EL or other forms of instability in personality disorders has been studied extensively only with regards to BPD; research regarding its role in other PDs remains quite

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sparse (Dimaggio et al., 2013; Newton-Howes et al., 2015). One disorder within which the concept of instability merits further attention is avoidant personality disorder (APD; see Snir, Bar-Kalifa, Berenson, Downey, & Rafaeli, 2016). APD is among the most prevalent personality disorders, affecting about 10–20% of patients in psychiatric clinics and 1–2% of the general population (Sanislow, Bartolini, & Zoloth, 2012; Zimmerman, Rothschild, & Chelminski, 2005). Nonetheless, it has received relatively little empirical attention (Alden, Laposa, Taylor, & Ryder, 2002; Sanislow et al., 2012), possibly due to the ongoing debate about its overlap with other disorders, particularly social anxiety (see Chambless, Fydrich, & Rodebaugh, 2008). People with APD are socially withdrawn, have great trouble initiating and maintaining interpersonal relationships because of low self-esteem and an excessive need for assurance or acceptance. They often avoid making decisions, refrain from sharing intimate feelings, and avoid experiencing intense bodily sensations as well as positive or negative emotions (Arntz, 2012). APD impedes occupational, educational, and social functioning, and hinders people from realizing their potential. APD is associated with severe dysfunction and subjective distress, at a level comparable to that of BPD (Wilberg, Karterud, Pedersen, & Urnes, 2009).

Though individuals with APD often display negative affectivity (APA, 2013), only a handful of studies have examined instability in APD. It appears that APD is often assumed to be an exaggeration of normal personality (Alden et al., 2002), quite stable, and restricted behaviorally, to the strategy of avoidance. Studies that have considered instability in APD have typically compared it to that found in individuals with BPD or in healthy controls (HC). Herpertz et al. (2000) found few differences between individuals with APD, BPD, or HCs in either self-reported or psychophysiological reactivity to emotional pictures. Lobbestael and Arntz (2010) found that the physiological response pattern of Cluster C PD participants (which contained individuals with APD, dependent PD, or obsessive-compulsive PD) was comparable to that of a BPD group and these two groups were more reactive on a psychophysiological level to abuse-related stimuli (a film scene) compared to antisocial PD or HC participants, but did not differ from the HC group on self-report scales (Lobbestael & Arntz, 2015). Results from an fMRI study (Koenigsberg et al., 2014) indicated that whereas healthy participants habituated to negative emotional pictures, neither BPD nor APD participants did; additionally, the failure to increase neural activity in certain brain structures was associated with greater affective instability among both BPD and APD participants.

In a recent experience-sampling study, Snir et al. (2016) asked participants to report their momentary affect several times each day. Following the recommendations of Ebner-Priemer, Eid, Kleindienst, Stabenow, and Trull (2009), they computed mean-squared-successive-difference (MSSD) scores as an index of temporal instability. Using this index, they found APD participants to show greater temporal instability in negative affect compared to the HCs, though less temporal instability compared to BPD participants.

As the studies reviewed above illustrate, a common focus on instability in personality disorders (and other disorders: e.g., Henry et al., 2001; Hollander, Pallanti, Allen, Sood, & Rossi, 2005) has been that of EL. Yet instability can manifest itself in other phenomenological aspects. Indeed, as recent advances in personality psychology (Dunlop, 2015; Fleeson, 2007; Mischel & Shoda, 2010) have illustrated, personality itself – including traits, goals, and even life-narratives, is often contextual. These contextualized "selves" or parts of an individual's personality are, by definition, state-like. The identity of these states, and the shifts between them, may be just as important as the fluctuations in emotions.

To be able to discuss fluctuations among self-states as a clinical phenomenon, we must adopt a clinical view of the self as multi-faceted. Several clinical theories adopt such a view (e.g., Bromberg, 1996; Greenberg, 2004; Stone & Stone, 2011). One theory that offers a promising approach for mapping the multi-faceted terrain of the self is schema therapy (ST; Edwards & Arntz, 2012; Young et al., 2003), and particularly the concept of *modes*.

The mode concept was developed by Young et al. (2003) in order to capture the instability reflected by rapid changes in behaviors, cognitions, and feelings of clients with PDs. A mode is said to reflect the individual's state at a given moment. Each mode has its unique combination of schemas and coping strategies. We can anticipate the way an individual will think, feel, and act when a specific mode becomes active in a given moment, and we can often predict the interpersonal responses that this mode will elicit in others. For instance, when an APD client who is eager for an emotional connection reverts into an avoidant mode (e.g., by declining a social invitation and instead opting for an evening of internet gambling) they may temporarily feel emotional relief and have some reprieve from the onslaught of self-critical automatic thoughts; interpersonally, the repeated activation of this mode is likely to turn others (e.g., the friend who extended the invitation) away in the long run.

According to ST (Young et al., 2003), all individuals inhabit several modes over time. They differ, however, both in the identity of these modes, and in the degree of integration or dissociation between them. In terms of their identity, modes fall into four categories. Some modes reflect a sort of regression into intense child-like emotional states (child modes; e.g., the lonely/inferior child); others have a self-protective function (maladaptive coping modes; e.g., the avoidant protector mode); still others reflect negative aspects of internalized object relations (dysfunctional parent modes; e.g., the critical parent mode); and one reflects the positive aspects of the internalized object relations (the healthy adult mode). These four categories have been further divided, with more and more specific modes identified as ST is applied to various patient populations (Bernstein, Arntz, & Vos, 2007; Gross, Stelzer, & Jacob, 2012; Lobbestael, van Vreeswijk, & Arntz, 2007, 2008).

Studies using the Schema Mode Inventory (SMI-1, SMI-2; Bamelis, Renner, Heidkamp, & Arntz, 2011; Lobbestael et al., 2008) have posited that individuals with avoidant PD are characterized by the following modes within each of the categories: vulnerable, lonely, abandoned and abused, angry, and undisciplined *child modes*; compliant surrender, detached protector, detached self-soother, avoidant protector, and suspicious over-controller *coping modes;* and punitive as well as demanding *parent modes*. They also posited that these individuals are particularly low in the happy *child mode*, attention and approval seeking *coping mode*, and the *healthy adult mode*.

Whatever the specific modes inhabited by an individual are, the transition between the modes can be thought of as falling on a continuum. At one end, modes could be like transient moods (e.g., one may feel a bit anxious early in the day, but gradually feel more content and energetic as the day progresses); such moods may fluctuate in a relatively healthy way, allowing the person to maintain a sense of consistent selfhood, an overarching "I". At the other end, extreme separation and dissociation among modes can lead to a very fragmented sense of self, with each mode presenting as a different personality – i.e., distinct and seemingly unrelated "I"s – which may characterize various forms of severe psychopathology (Rafaeli, Maurer, Lazarus, & Thoma, 2016). Theoretically, some disorders (e.g., BPD) are characterized by sudden and abrupt shifts between modes whereas others (e.g., obsessive compulsive personality disorder) are characterized by greater rigidity (Lobbestael et al., 2007). However, few studies have empirically investigated mode shifts or fluctuations.

Most studies on modes, their shifts, or their fluctuations have relied on clients' self reports (e.g., on the Schema Mode Inventory –