Review

Psikiyatride Güncel Yaklaşımlar-Current Approaches in Psychiatry 2022; 14(2):185-194

DOI: 10.18863/pgy.962588

Effectiveness of Cognitive Behavioral Therapy in Cluster C Personality Disorders

C Kümesi Kişilik Bozukluklarında Bilişsel Davranışçı Terapinin Etkililiği

Elif Ergin[1], Özden Yalçınkaya Alkar[2]

[1]Ankara Medipol University, Ankara, Turkey

[2]Ankara Yıldırım Beyazıt University, Ankara, Turkey

ABSTRACT

It is important to have knowledge about characteristics and treatment methods of personality disorders which affect people in many aspects and cause impairments in functionality. In this article, it is aimed to investigate Cluster C personality disorders (which includes avoidant, dependent and obsessive-compulsive personality disorder) and studies conducted about the effectiveness of cognitive behavioral therapy (CBT) in these disorders. Firstly, the definition of personality disorders and evolution of their classification in DSM over the years were explained. Later the reason of choosing Cluster C disorders and CBT for this article was mentioned. Then common characteristics of Cluster C personality disorders was reviewed. Afterwards these three disorders were discussed separately within the frame of their diagnosis criteria, their characteristics and researches conducted about CBT. Finally, in the discussion and conclusion section, findings obtained from these studies and suggestions for both making up the deficiency in the literature and gaining new perspectives were discussed.

Keywords: cluster C personality disorders, CBT and personality disorders, avoidant personality disorder, dependent personality disorder, obsessive compulsive personality disorder

ÖZ

Bireylerin hayatlarını birçok açıdan etkilediği bilinen ve işlevsellikte bozulmalara neden olan kişilik bozukluklarının özelliklerinin iyi bilinmesi ve tedavi yolları hakkında bilgi sahibi olunması önemlidir. Bu yazıda C kümesi kişilik bozukları olarak kategorilendirilen çekingen, bağımlı ve obsesif kompulsif kişilik bozukluğu ile bu bozukluklarda bilişsel davranışçı terapi'nin (BDT) etkililiği hakkında yapılan çalışmaların incelenmesi amaçlanmıştır. İlk olarak kişilik bozukluklarının tanımlanması ve DSM'deki sınıflandırmanın yıllara göre değişimi açıklanmıştır. Daha sonra çalışma için C kümesi bozukluklarının ve BDT'nin seçilme nedenine değinilip C kümesi bozukluklarının ortak özellikleri gözden geçirilmiştir. Devamında bu üç bozukluk ayrı ayrı ele alınmıştır. Bozukluklar hem tanı kriterleri ve genel özellikleri hem de BDT ile ilgili yapılan çalışmalar çerçevesinde incelenmiştir. Son olarak yazının tartışma ve sonuç kısmında ise tarama sonucunda elde edilen bulgulardan bahsedilmiş ve alanyazındaki eksikliklerin giderilmesi, ayrıca yeni bakış açıları kazanılması için yapılabilecekler tartışılmıştır.

Anahtar sözcükler: C kümesi kişilik bozuklukları, BDT ve kişilik bozuklukları, çekingen kişilik bozukluğu, bağımlı kişilik bozukluğu, obsesif kompulsif kişilik bozukluğu

Introduction

Personality is a concept whose first meaning is given as "the distinctive feature of a person, the whole of his/her spiritual and incorporeal qualities, the selfhood" in the dictionary of the Turkish Language Association. This concept has been discussed by Millon et al. (2004) as "a complex pattern of deeply embedded psychological characteristics that are expressed automatically in almost every area of psychological functioning ". Personality disorder, on the other hand, is described as "… enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, … and leads to distress or impairment (American Psychiatric Association [APA] 2013)". In International Statistical Classification of Diseases and Related Health Problems (ICD for short), which is the classification system of the World Health Organization (WHO 2021), personality disorders are discussed as follows: "Personality disorder is characterised by problems in functioning of aspects of the self (e.g., identity, self-worth, accuracy of self-view, self-direction), and/or interpersonal dysfunction (e.g., ability to develop and maintain close and mutually satisfying relationships, ability to understand others' perspectives and to manage conflict in relationships) that have persisted over an extended period of time (e.g., 2 years or more).

Address for Correspondence: Elif Ergin, Ankara Medipol University, Faculty of Economics, Administrative and Social Sciences, Department of Psychology, Ankara, Turkey **E-mail:** elif.ergin@ankaramedipol.edu.tr **Received:** 06.07.2021 **Accepted:** 24.10.2021

ORCID ID: orcid.org/0000-0002-5842-8363

The disturbance is manifest in patterns of cognition, emotional experience, emotional expression, and behavior that are maladaptive (e.g., inflexible or poorly regulated) and is manifest across a range of personal and social situations."

While in the previous version (ICD-10, WHO 2010), there was a classification of personality disorders similar to the DSM, in its 11th version (ICD-11, WHO 2021), which is the most recent one, it has been suggested that personality disorders should be evaluated according to the severity of personality dysfunction. It is seen that, in IDC-11, there are sub-titles as mild, moderate and severe personality disorders under the title of personality disorders. Also with the classification, it is possible to specify one or more prominent feature areas in individuals. These are negative affectivity, detachment, disinhibition, dissociality and anankastic features. In addition, the borderline pattern is among the titles that can be specified besides the severity level.

When we examine the history of the Diagnostic and Statistical Manual of Mental Disorders, it is understood that many efforts have been made to classify personality disorders from DSM-I (APA 1952) to the most recent version, DSM-5 (APA 2013). It is seen that personality disorders are mentioned under two main titles in DSM-I, namely Personality Disorders and Transient Situational Personality Disorder. The title of Personality Disorders is also divided into four sub-titles: Personality Pattern Disturbance, Personality Trait Disturbance, Sociopathic Personality Disturbance and Specific Symptom Reaction involving disorders such as speech and learning disorders. When the contents of these categories are examined, it is seen that there are many disorders that are addressed under other categories in the DSM-5 or that have been removed from the list. For example, while sleepwalking disorder is considered under personality disorders in DSM-I (APA 1952) and expressed as "somnambulism"; in DSM-5 (APA 2013), it is expressed as "sleepwalking", and it is a type of Non-Rapid Eye Movement Sleep Arousal Disorders, which is the subtitle of parasomnia.

It is seen that the personality disorders subcategories in the DSM-5, which experts refer to for diagnostic evaluations today, are quite different from DSM-I. Personality disorders are divided into three clusters by APA (2013), according to the similarity of their descriptive features. It is stated that people with one of the disorders in cluster A are usually seen as strange and eccentric; those with cluster B disorders are often seen as unstable, dramatic, and emotional; those with cluster C disorders are seen as anxious and timid (APA 2013). This grouping based on similar characteristics, brings one question to mind, that is whether the effectiveness of the treatment methods that have been tried for these disorders would be similar or not.

Therapies applied to people with personality disorders have been discussed since the beginning of the history of psychotherapy (Beck et al. 2004). When it comes to treatment, the psychoanalytic theory approach has been emphasized for years (Lazare 1971, Kernberg 1985, Lucas 1992, Bornstein 2006). In addition, it is seen that conceptualizations for personality disorders have been developed by also cognitive behavioral therapists (Beck et al. 2004). According to Beck (2011), when individuals evaluate their own thoughts in a more realistic and adaptive way, improvements are observed in their mood and behaviors. From this point of view, Beck (2011) stated that in cognitive behavioral therapy (CBT), various ways are sought by the therapist to produce cognitive change that will affect the client's thought and belief system. He stated that as a result of this, emotional and behavioral changes will also be achieved (Beck 2011). The main techniques used in CBT for this change are cognitive conceptualization, setting concrete goals, structured sessions, filling out the thought record form, identifying automatic thoughts, cognitive distortions and basic beliefs, finding evidence and contradictory evidence (Beck 2011). Basic beliefs and schemas that shape the attitudes and experiences of people with personality disorders are explained, thanks to the therapists emphasizing the influence of behavioral and cognitive techniques on symptoms of personality disorders and cognitive schemas (Beck et al. 2004). It is stated by Millon et al. (2004) that this cognitive therapy model created by Beck and colleagues, builds bridge between personality disorders and the strategies that are used by every person to adapt to life, but exaggerated in personality pathologies. The tendency in personality disorders to perceive life distortedly suggests that cognitive therapy focusing on cognitive distortions and automatic thoughts can be effective in the treatment of personality disorders (Beck et al. 2004, Millon et al. 2004).

Bender (2005) stated that establishing alliance, which is already difficult to do, is even more difficult especially with individuals who have severe paranoid, borderline or narcissistic personality disorder. Because it is explained that problematic interpersonal attitudes and behaviors may interfere between the client and the therapist, thus prevent establishing a therapeutic bond (Bender 2005). On the other hand, it is mentioned by Stone (Stone 1993, Bender 2005) that tendencies seen in Cluster C personality disorders, such as feeling guilty and internalizing the responsibility of current situations, will have a facilitating effect on the alliance to be established between the therapist and the client. It is stated that these individuals will be more willing to take responsibility for their problems and to communicate with the therapist to solve these problems, compared to Cluster A and B personality disorders (Stone 1993 cited in Bender 2005). Therefore, when considering these three personality disorder clusters, Bender argued that cluster C (which includes avoidant personality disorder [APD], dependent personality disorder [DPD], and obsessive-compulsive personality disorder [OCPD)]) is the most treatable cluster. Besides, as is known, the effect of CBT has been proven for many disorders such as anxiety disorders (Hofmann et al. 2012), bulimia nervosa (National Collaborating Center for Mental Health 2004) and insomnia disorder (Jungquist et al. 2010). Therefore, in this article, it is aimed to address cluster C disorders in detail and to examine the studies about the effect of CBT in these disorders. CBT and Cognitive Therapy (CT) will be considered together while conducting this review.

Maladaptive strategies and dysfunctional beliefs, which are characteristic features of personality disorders, make individuals impressionable to life experiences that will interfere their

cognitive vulnerabilities (Beck et al. 2004). Beck et al. (2004) stated that this cognitive vulnerability is based on rigid, extreme and inevitable beliefs. Again, the same researchers argued that dysfunctional beliefs are the result of the interaction between genetic predisposition of people and their exposure to the undesirable effects of people in their lifes or traumatic events.

In a study examining the prevalence rates of APD, DPD, and OCPD, these rates have been reported as 2.4%, 0.5%, and 7.9% respectively; also OCPD has been found as the most common personality disorder in the general population (Grant et al. 2004). In the same study, it has been stated that APD and DPD were found more common in women, but such a gender difference cannot be said for OCPD. In a previous study, in which 2053 people participated, the prevalence has been found to be 5% for APD, 1.5% for DPD, and 2% for OCPD (Torgersen et al. 2001). Although the rates are quite different from each other, it is seen that especially the rates of APD and OCPD are considerably high. Thus, it is considered very important to carry out studies about the treatment of these personality disorders, which, as stated in their definition, cause distress and which persist.

One of the studies aimed at understanding cluster C personality disorders has been conducted by Nordahl and Stiles (2000). In this study, individuals with cluster C personality disorders have been compared with people who do not have personality disorders but have Axis I disorders and healthy controls. This comparison has been made according to people's scores on dimensions such as sociotropy, autonomy and dysfunctional attitudes, which are cognitive-personality dimensions suggested by Beck (1983, as cited in Nordahl and Stiles 2000) about the etiology of depression. The concept of sociotropy is defined as an over-investment in one's relationships with others (Beck 1983 as cited in Bieling et al. 2000, Sato and McCann 2007) and the subscales of the concept are specified as anxiety about disapproval, need for attachment/separation anxiety, and pleasing others (Beck et al. 1983 as cited in Nordahl and Stiles 2000). As a result of the study, it has been found that people with cluster C disorders did not show a significant difference in terms of autonomy; however, it is seen that they get higher scores on scales related to both sociotropy and dysfunctional attitudes. Owing to these findings, it is possible to have an idea about the views of individuals with cluster C personality disorder about social relations. The higher level of dysfunctional attitudes in cluster C personality disorders than the disorders named Axis I by DSM-IV (APA 1994) such as anxiety disorders and eating disorders (Nordahl and Stiles 2000), arouses curiosity about the effectiveness of CBT in personality disorders.

When the literature on personality disorders is reviewed, it is seen that there are very few studies about the clusters of personality disorders. Personality disorders are generally studied when they are comorbid disorders to other disorders. (Farabaugh et al. 2005, Baljé et al. 2016, Nordahl et al. 2016). Studies based on personality disorder clusters also seem to have this tendency (e.g. Sato et al. 1994, Hardy et al. 1995, Farabaugh et al. 2005, Garno et al. 2005). Only study encountered that directly addresses the effectiveness of cognitive therapy in Cluster C personality disorders, is about comparison of Cognitive Therapy (CT) and Short-Term Dynamic Psychotherapy (STDP) (Svartberg et al. 2005). In this study, 50 participants with one or more cluster C personality disorders were randomly assigned to the 40-week STDP or CT group. As a result of the study, it has been found that there was a significant improvement on average for both groups during treatment and during the 2-year follow-up period. After 2 years of treatment, 54% of the participants in the STDP group and 42% of the participants in the CT group showed symptomatic improvement. In addition, when evaluated in terms of interpersonal problems and personality functionality, it was stated that 40% of all participants showed improvement (Svartberg et al. 2005).

In this article, it is aimed to examine avoidant, dependent and obsessive-compulsive personality disorders, which are categorized as cluster C personality disorders (APA 2013), and the effectiveness of cognitive behavioral therapy (CBT) in these disorders. It is thought that the article is important in terms of reviewing studies about effectiveness of CBT (whose, as mentioned before, effectiveness is proven for several disorders [Hofmann et al. 2012, National Collaborating Center for Mental Health 2004, Jungquist et al. 2010]) for the personality disorders which cause individuals to experience serious problems related to social life (Beck et al. 2004, APA 2013) and in terms of addressing the lack of literature about this topic. In the continuation of the article, these disorders, whose basic beliefs and strategies are given in Table 1, will be discussed separately. The disorders will be examined within the framework of both their characteristics and studies on CBT.

Avoidant Personality Disorder

APD is a personality disorder characterized by "a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation (APA 2013)". It is stated that for the diagnosis, at least four of the seven criteria of DSM-5 should be met in the assessment. These criteria are: "(i) avoids occupational activities that involve significant interpersonal contact because of fears of criticism, disapproval, or rejection (ii) is unwilling to get involved with people unless certain of being liked, (iii) shows restraint within intimate relationships because of the fear of being shamed or ridiculed, (iv) is preoccupied with being criticized or rejected in social situations, (v) is inhibited in new interpersonal situations because of feelings of inadequacy, (vi) views self as socially inept, personally unappealing, or inferior to others (vii) is unusually reluctant to take personal risks or to engage in any

Table 1. Basic beliefs and strategies associated with traditional personality disorders (Beck et al. 2004)

Personality Disorder	Basic Belief	Strategy
Avoidant	I may get hurt.	Avoidance
Dependent	I am helpless.	Attachment
Obsessive Compulsive	I must not err.	Perfectionism

new activities because they may prove embarrassing (APA 2013)."

It is stated that individuals with APD actually want to be close to other people and to reach their potential both intellectually and professionally, but they do not make an effort in this direction because they are afraid of being hurt, rejected and failed (Beck et al. 2004). These people who choose the avoidance strategy in this way have a distorted and negative view of themselves socially and tend to see themselves as inadequate academically and professionally (Beck et al. 2004, Hofmann 2007). The previously mentioned study by Nordahl and Stiles (2000) also supports this statement. In this study, APD has been found to be associated with "anxiety about disapproval" and "pleasing others" subscales of sociotropy, as well as dysfunctional attitudes.

About the development and process of APD, it is stated that withdrawn behaviors usually begin with shyness, isolation, and fear of new people or situations in infancy or childhood (APA 2013). Although childhood shyness is a sign for APD, it is said that this shyness disappears in many people as they grow up (APA 2013). On the other hand, it is emphasized that in people who develop APD, shyness and avoidance increase more and more in adolescence and early adulthood, when social relationships with new people are especially important (APA 2013). In addition, from the study conducted by Skodol et al. (2002), it is possible to obtain information about the impairment of functionality in APD. This study has been conducted to compare the impairment of functionality caused by avoidant, schizotypal, borderline, and obsessive-compulsive personality disorder with the impairment caused by major depressive disorder. Results showed that each of the personality disorders examined caused more impairment than major depressive disorder (Skodol et al. 2002).

When the studies on CBT for APD are reviewed chronologically, firstly the study by Alden (1989) draws attention. In this study, it was aimed to compare the 10-session behavioral short-term therapy which is structured in 3 different ways and the control group. Although for therapies, graduated exposure, interpersonal skills training and intimate relationships were chosen to focus on separately, no significant difference was found between these three groups. Besides this, it has been found that these structured therapies provided improvement for APD in general, compared to the control group. It has been reported that the participants enjoyed social activities more, also their withdrawal and social anxiety decreased. At this point, it is thought that it would be meaningful to focus on the common features of these three applications rather than their different features. For all groups, some aspects of cognitive therapy have been included in the treatment plan. Examples of these are identifying the fears underlying the avoidance pattern, raising awareness about the factors that cause anxiety, and shifting attention from fear-related thought to behavioral action. It is pointed out by the researcher that, besides the fact that the improvement was promising, the functionality of the participants still did not reach the normative level. The first reason stated for this is insufficient time period of the interventions for more effective change. As the second reason, it is suggested that perhaps an "upper limit" should be considered regarding the changes of people with APD. In other words, Alden stated that maybe one should not expect full benefit from the therapies, with bearing in mind that some biological factors also play a role. However, considering that there was a little focus on cognitive factors in the study, in general behavioral interventions were carried out, and this was only a ten-session application, we think that it is too early to put forward such a hypothesis. We think that more reasonable arguments about the treatability of APD can be obtained with studies where these conditions are met. At the same time, in a later study of the researcher, it is found that people with APD have different profiles from each other in terms of interpersonal problems, and this difference affects the responses of individuals to behavioral interventions (Alden and Capreol 1993). In this study, 76 people with APD were selected as participants. Then they were randomly assigned to the graduated exposure, skills training, and control groups. Cognitive therapy elements were included in both treatment conditions. It is stated that all participants had problems with social avoidance and non-assertiveness. Graduated exposure was effective for people who additionally have difficulties related to distrustful and angry behaviors, but skills training wasn't effective for them. For the people who have problems about others' coercion and control toward them, both methods were beneficial, but they particularly benefitted from skill training focused on establishing close relationships. Alden and Capreol suggested that while planning a cognitive-behavioral intervention, a comprehensive assessment of different types of problematic interpersonal behaviors should be made. As is also understood from this study, it should not be forgotten that there are many factors that affect the treatment process.

Another study on the subject is conducted by Emmelkamp et al. in 2006. In this study, CBT and short-term dynamic psychotherapy (STDP) were selected to be compared for their effectiveness in APD. Participants with APD were divided into 3 groups. CBT was applied to one group for 20-week session, and STDP to another group for 20-week session. The third group was determined as the waiting list control group. As a result of the study, CBT was found to be more effective than both STDP and the waiting list. It is seen that these results maintained also in the follow-up studies. After the diagnostic evaluations, it is reported that only 9% of the CBT group and 36% of the STDP group still maintained the diagnosis of APD. The researchers emphasized that the importance of these results would be understood better, considering that the diagnostic persistence of APD is quite high (Shea et al. 2002).

In the study conducted by Strauss et al. (2006), CBT for personality disorders (Beck et al. 1990, as cited in Strauss et al. 2006) was applied to 30 adults with OCPD or APD for 52 weeks. After the therapy, only 7% of the participants were found to meet the diagnosis of OCPD or APD according to the SCID-II (Spitzer et al. 1990) assessment. The clinical significance of the symptom change for APD was calculated according to the method of Jacobson and Truax (1991) and it is reported as 67%. Cumming (2012) also conducted a study with participants who have OCPD or APD. In this study, CBT for personality disorders (Beck et al.

1990, as cited in Cumming 2012) was applied for 52 weeks. After therapy, it has been reported that only 6% of the participants met the diagnostic criteria of APD or OCPD.

Two studies done in those years were conducted with individuals who have comorbid social anxiety disorder (SAD). In a case study by Hyman and Schneider (2004), CBT for personality disorders (Beck et al. 1990, as cited in Hyman and Schneider 2004) and behavioral skills training are applied for 21 sessions to a person who has SAD comorbidity. Techniques such as cognitive restructuring, relaxation exercise, modeling, role-play, feedback, testing hypotheses during therapy, finding contradictory evidence, and psychodrama were used in the study. As a result of the study, a clinically significant decrease in symptoms has been reported. In the case study conducted by Hofmann in 2007, the participant also has comorbid SAD. In the study, 27 sessions were applied to change the person's distorted self-perception as a social object. Exposure, role-play and behavioral experiment cognitive behavioral techniques were used in the sessions. A drastic improvement was achieved in this intervention, which also remained in the follow-up study one year later.

Dependent Personality Disorder

DPD is characterized by an excessive and persistent need for care, which often begins in early adulthood and is seen in many contexts, leading to submissive behavior, inability to detach from people, and fear of separation (APA 2013). It is stated by Beck et al. (2004) that individuals with dependent personality disorder have self-perceptions based on helplessness. For this reason, these individuals need to be attached to a figure stronger than themselves to compensate for their helplessness, and they think that only these people will bring them salvation and happiness (Beck et al. 2004). According to DSM-5 criteria (APA 2013), it is seen that at least five of the eight criteria must be present to make the diagnosis.

These criteria are: "(i) has difficulty making everyday decisions without an excessive amount of advice and reassurance from others, (ii) needs others to assume responsibility for major areas of his or her life, (iii) has difficulty expressing disagreement with others because of fear of loss of support or approval, (iv) has difficulty initiating projects or doing things on his or her own, (v) goes to excessive lengths to obtain nurturance and support from others, to the point of volunteering to do things that are unpleasant, (vi) feels uncomfortable or helpless when alone because of exaggerated fears of being unable to care for himself or herself, (vii) urgently seeks another relationship as a source of care and support when a close relationship ends, (viii) is unrealistically preoccupied with fears of being left to take care of himself or herself (p. 675, APA 2013)." It is known that individuals with DPD rely on their spouses or parents to make decisions in their lifes, even on simple things (APA 2013).

Beck et al. 2004 stated that a person with DPD is sensitive about losing affection and support. DPD is also associated with both dysfunctional attitudes and high scores in all subscales of sociotropy (Nordahl and Stiles 2000). Four components that will be useful in understanding DPD is explained by researchers (Pincus and Wilson 2001, Bornstein 2005, 2007). The first of these is the cognitive component. It is explained as having perception of weakness and ineffectiveness about oneself and of competence about other people. The second component is the motivational component, expressed as the individual's excessive effort to establish and maintain relationships that provide interest and support. In the third component, (namely emotional component) fear of abandonment and rejection, anxiety about negative evaluation by authority figures play a role. In the behavioral component, a behavior pattern including the effort to minimize these feared possibilities and to maintain the relationship is observed.

People with DPD engage in some behaviors called as "relationship-facilitating behaviors", that are also mentioned in the behavioral component; these behaviors are supplication, ingratiation, exemplification, self-promotion and intimidation (Bornstein 2007). The goals aimed to be achieved by these strategies are stated by Bornstein (2007) as follows respectively: "appear helpless and vulnerable, create indebtedness, exploit others' guilt, emphasize personal worth, frighten and control others (p. 39)".

Cognitive theorists stated that one of the factors causing DPD is self-defeating thought patterns (Overholser and Fine 1994, Bornstein 2007). These patterns are explained as automatic thoughts that bring helplessness and a person's negative internal statements that is self-deprecating (Overholser and Fine 1994, Bornstein 2007). The three cognitive impairments that stand out in the etiology and dynamics of DPD are automatic thoughts, negative self-statements, and negative attribution bias (Bornstein 2005). In addition, according to behavioral and cognitive models, it is stated that dependency in DPD is learned as a result of interactions experienced with caregivers in the early years of life and it is generalized to later relationships in order to obtain care and emotional rewards (Simonelli and Parolin 2017).

Overholser and Fine (1994) stated that the treatment of interpersonal dependency, which is also seen in DPD, is a difficult and slow process. These researchers, who stated that short-term approaches would be ineffective due to the chronic nature of the problems, mentioned the necessity of a treatment process with regular sessions for at least 12 months. They stated that the structure of the therapy changes in the process so that the client takes a more autonomous position. Overholser and Fine developed a four-stage CBT psychotherapy model, which they thought was promising for DPD. The first stage in the model involves the therapist helping the client with active guidance to make small but rapid behavioral changes. The second stage aims to increase the self-esteem of the client by using cognitive techniques. In the third stage, the focus is on strengthening the self-image with the aim of encouraging the client to autonomy. At this stage, problem solving training, Socratic method and self-control strategies are used. The fourth and final stage is for relapse prevention. At this stage, efforts are made to reduce the likelihood of the client acting dependently again in the future. At

each stage, the outputs that should be achieved before proceeding to the next stage are defined. Although the treatment process was described as difficult and slow by Overholser and Fine, Faith (2009) stated that the prognosis for people with DPD is good. She suggested that the easiness of establishing a rapport, as a result of clients already have a tendency to rely on others for support, may have an effect on this good prognosis. Faith emphasized that this tendency can be turned into an advantage as long as the therapists ensure that the boundaries are clear, and the client becomes more independent over time. Also, it is stated that the probability of premature termination of the treatment is less in DPD than in personality disorders from other clusters (Disney 2013). Seligman and Reichenberg (2007) suggested that the main purpose while working with people with DPD is to develop the client's self-sufficiency, self-expression and autonomy in a safe therapy environment, and then to carry these characteristics outside the session. It is mentioned that cognitive therapy can be particularly useful in DPD, because cognitively oriented therapies focus on people's beliefs about themselves as well as their fear of being judged (Borge et al. 2010).

When the studies on CBT in DPD are reviewed, it is seen that the number is quite insufficient and should be increased. For example, in Web of Science, only 2 studies were found as a result of the search made by writing the keywords in English ("cognitive behavioral therapy" and "dependent personality disorder") and selecting "all fields" in the English results. In one of these two studies, it has been found that personality disorders in individuals with health anxiety, especially those who also have anxious and dependent features, reinforce the benefit of CBT, especially in the long term (Tyrer et al. 2021). As can be seen, the effectiveness of CBT in dependent personality disorder was not examined in the study; however, the fact that dependent features positively affect the treatment with CBT is considered important in terms of the present study. The other study is conducted by McClintock et al. (2015). A randomized, controlled study was conducted by these researchers to examine the effect of Mindfulness Therapy in maladaptive interpersonal dependency. As a result of the research, it was found that the people in the Mindfulness Therapy for Maladaptive Interpersonal Dependency (MT-MID) group, which was developed within the scope of the study, showed more improvement than the control group in all assessments in terms of interpersonal dependency.

Having looked at other studies on DPD and CBT effectiveness, in the case study by Masroor and Gul (2012), it is stated that schema-focused CBT is an effective intervention method for people with DPD. Another study (Borge et al. 2010) was conducted with individuals who have social anxiety disorder with APD or DPD comorbidity. In the study, cognitive therapy was applied to one group and interpersonal therapy (IPT) to another group. It was found that both treatments provided decrease in APD and DPD dimensions, but more decrease was observed in DPD dimensions with cognitive therapy. Also, in the same study, the researchers examined the factors that predict the change in individuals and concluded that the change in cognitive factors also predicted the change in both personality disorders (Borge et al. 2010).

There are also researchers who argue that an integrated approach should be preferred rather than using CBT alone. For example, it is stated by Bornstein (2004) that integrating cognitive therapy and existential therapy would be a useful strategy in order to change the thoughts, behaviors and emotional reactions of individuals with DPD. Borstein (2004) noted that both the cognitive model and the existential model emphasize the role of distorted self-perception in the dynamics of dependency. According to the researcher, although cognitive therapists explain this distortion with the maladaptive self-schemas and existential therapists with the inauthentic self, both approaches base the dependent behavior on the individual's perception of himself/herself as weak and helpless, and see the emotional reactions related to dependency as a result of this distorted self-perception. Again, by the same researcher, it is stated that conceptualizing with more than one perspective provided by the integrated approaches may be more useful in understanding DPD. Bornstein (2004) also suggested that focusing on dependency-related thoughts and emotional reactions, and intervening in these areas may provide more permanent benefits than traditional treatment methods.

Obsessive Compulsive Personality Disorder

OCPD is described in the DSM-5 as an excessive preoccupation with orderliness, perfectionism, mental and interpersonal control, at the expense of flexibility, openness, and effectiveness (APA 2013). Eight criteria, of which at least four must be met for diagnosis are: (i) is preoccupied with details, rules, lists, order, organization, or schedules to the extent that the major point of the activity is lost, (ii) shows perfectionism that interferes with task completion, (iii) is excessively devoted to work and productivity to the exclusion of leisure activities and friendships, (iv) is overconscientious, scrupulous, and inflexible about matters of morality, ethics, or values, (v) is unable to discard worn-out or worthless objects even when they have no sentimental value, (vi) is reluctant to delegate tasks or to work with others unless they submit to exactly his or her way of doing things, (vii) adopts a miserly spending style toward both self and others; money is viewed as something to be hoarded for future catastrophes, (viii) shows rigidity and stubbornness (p. 678,679, APA 2013)." The expressions of "control" and "must" that indicate imperativeness are very important for people with OCPD (Beck et al. 2004).

While people with OCPD are worried about disapproval (Nordahl and Stiles 2000), in the meantime, it is seen that they apply the rules, which they apply to themselves, also to other people who are important to them (Villemarette-Pittman et al. 2004). As can be expected, this is a factor that can increase interpersonal problems. According to Horney (1950, as cited in Villemarette-Pittman et al. 2004), another factor that increases interpersonal conflicts is the difficulty experienced by people with OCPD in expressing emotions and understanding other people's perspectives. Bailey (1998, as cited in Villemarette-Pittman et al. 2004) stated that while people with OCPD have difficulty in expressing their feelings of warmth and affection, they easily express their emotions such as anger, frustration or irritability. In a study by Solomonov et al. (2020), it is stated that OCPD is not a

homogeneous group in terms of interpersonal relationships, and two separate groups of OCPD were mentioned. The first group, called as the "aggressive" subtype, is the group with a vindictive, egocentric or hostile dominant character, tending to show anger and irritability, and which interpersonal conflicts are common. The second group called as "pleasing", is a group that is submissive and open to exploitation, overly friendly, overly concerned with the approval of others, characterized by high self-doubt and low self-confidence. We think that anger expression can be seen in the aggressive subtype of OCPD. But the anger behavior that can be seen isn't in the type of intimidation (that is used for making oneself accepted, Bornstein 2007), which is also included in the preferred behavioral strategies in DPD; instead, we think that it is caused by excessive self-confidence, such as the anger behavior common in narcissistic personality disorder (McCann and Biaggio 1989). However, there is no clarity in the literature also about the relationship between OCPD and self-confidence. For example, very different findings have been obtained regarding the concepts of self-confidence and self-esteem, which go parallel to each other. While Raja and Azzoni (2007) considered low self-confidence as an obsessive-compulsive trait in their study, Weertman et al. (2008) stated that OCPD is not characterized by low self-esteem. It is thought that the difference here may be due to the two subtypes of OCPD mentioned by Solomonov et al. (2020).

Pretzel and Hampl (1994) stated that the first thing to do for CBT application in OCPD is to teach the cognitive structure of emotions to the client and to set therapeutic goals related to the current problem; however, it is stated that, while working with people with OCPD, it is very difficult to set goals which both the client and the therapist accept. Pretzel and Hampl emphasized that the client may not see as a problem what the therapist sees as a problem, and efforts should be made to set goals that both parties will adopt at the first stage. After these goals, which are listed according to the criteria of importance and easiness, schemas and automatic thoughts about the problem should be determined, and it should be explained to the client that emotions and behaviors are shaped according to thoughts and perceptions about these events and the meaning given to the experienced events (Pretzel and Hampl 1994).

When the relationship between OCPD and CBT is examined, it is seen that the literature is quite weak also for this relationship, but Beck et al. (2004) stated that cognitive therapy is effective for the treatment of OCPD. In addition, they mentioned that people with OCPD, due to the nature of this disorder, would prefer structured and problem-focused approaches to approaches that focus on the therapeutic process or transference relationship as a means of change (Beck et al. 2004).

Pretzel and Hampl (1994) stated that although it is known that OCPD can be resistant to change, a consistent and collaborative approach would provide significant improvement and they made a CBT conceptualization about OCPD. In some studies, conducted without a control group, it was found that CBT provide improvement OCPD criteria in 80-90% of the participants (Ng 2005, Strauss et al. 2006, Cummings et al. 2012).

In the study conducted by Ng (2005), CBT was applied to 10 outpatients with OCPD and depression that is resistant to the drugs. With the measurements made, it was determined that each of the participants had moderate anxiety and depression, as well as a high degree of hopelessness. Cognitive therapy for personality disorders that is suggested by Beck et al. (2004) was used in the sessions. As a result of CBT applied 18-35 sessions, it was found that there was a significant decrease in both depression and anxiety levels of the participants, and that 9 of the participants no longer met the diagnosis of OCPD according to the DSM-IV (APA 1994). Also, as discussed in avoidant personality disorder, a study was conducted by Strauss et al. (2006) in which CBT was applied to participants with OCPD or APD. In this study, the clinical significance of symptom change (Jacobson and Truax 1991) for OCPD has been reported as 83%. In the study of Cummings et al. (2012), which was also discussed previously, it is found that CBT is beneficial for people with APD and OCPD.

Discussion

In this article, it is aimed to examine the characteristics and criteria of cluster C personality disorders, including avoidant, dependent and obsessive-compulsive personality disorder, and to review the studies on the effectiveness of CBT in these disorders. When the studies are examined, it is seen that there are promising results related to CBT (Ng 2005, Emmelkamp et al. 2006, Strauss et al. 2006, Borge et al. 2010, Cumming, 2012, Masroor and Gul 2012), and it is understood that practitioners can also benefit from integrated approaches in the intervention of personality disorders. (Bornstein 2004). In this group, which is categorized as timid and anxious (APA 2013), there are serious problems related to social life as in other personality disorders. For all three disorders, it is stated that the people have distorted thoughts and dysfunctional beliefs about themselves and those around them (Nordahl and Stiles 2000, Beck et al. 2004, APA 2013). It is thought that there will be many points that CBT will provide benefits for cluster C personality disorders. However, although it is considered as the most treatable cluster (Bender 2005), we see that studies in this topic are quite insufficient. We think that the hopelessness created by the term "enduring pattern (p.645, APA 2013)" in the diagnosis, leaves Cluster C personality disorders deserted, as in other personality disorders, in terms of what can be done for improvement or treatment. However, as is known, these disorders lead to many functional impairments. People with APD, in which people cannot socialize even if they desire and experience withdrawal; DPD, which makes people vulnerable to exploitation; OCPD, which cause interpersonal problems due to the rules people feel obliged to live by (APA 2013) are thought to deserve as much effort as any other disorder. We think that seeing less effect, establishing therapeutic relationship laboriously, and accepting the permanence of the patterns immediately for each diagnosed person will deprive individuals of the benefits they may see, even if minor benefits. Also, we think that this situation that causes the exclusion of a group of people is not in line with our professional principles. For this reason, we think that it is

very important to increase controlled studies on both CBT and other alternative therapies.

When the literature is reviewed, it is seen that there are studies that have proven the effectiveness of CBT for all three of the cluster C disorders, even if they are few in number (Ng 2005, Emmelkamp et al. 2006, Strauss et al. 2006, Borge et al. 2010, Cumming, 2012, Masroor et al. Rose 2012). As mentioned, the knowledge on the subject is insufficient since there are very few controlled studies and personality disorders are generally studied as an "additional" disorder alongside other disorders. In this article, it is aimed to generally focus on the studies which Cluster C personality disorders are studied singly. Although it is known that personality disorders have a high comorbidity rate with many disorders such as anxiety disorders (35%, Sanderson et al. 1994), eating disorders (27%, Herzog et al. 1992), major depressive disorder (the rate reported in the review study is 20% to 85%, Corruble et al. 1996), bipolar disorder (45%, Barbato and Hafner 1998), it is thought that studies that focus on personality disorders will provide more accurate opinions about the course and results of treatments.

A point to be mentioned is the studies that mention the factors that will affect the course or outcome of the treatments. Enero et al. (2013) stated that people with OCPD who responded positively to CBT had a lower level of distress before treatment than others. According to this finding, researchers stated that shaping the treatment planning in people with high levels of distress accordingly bring effective results. We think that there may be many factors that affect the course and the outcome of treatment in Cluster C personality disorders, and it is necessary to conduct studies on them, then to make decisions based on these factors in treatment planning. In a study by Cummings et al. (2012), it was found that variable self-esteem in the context of therapy predicts change and improvement in personality disorders. In another example, it is stated that, like the two subtypes in OCPD, the dependency seen in DPD is also divided into three subtypes as love dependency, exploitable dependency, and submissive dependency (Pincus and Gurtman 1995). Considering that problems in interpersonal relationships are one of the key points in personality disorders (McLemore and Brokaw 1987), it is necessary to be aware of such subtypes that will affect the nature of the relationship patterns of people who have these disorders with those around them. Because, in cases where the diagnosis of personality disorder is handled as a homogeneous group and treatment goals are determined accordingly, we think that the point to be reached may not be the point where the person actually has the difficulty or at least may not be the point where he/she experiences the most difficulty. For this reason, it is thought that more studies on the subtypes of personality disorders should be done for more effective therapies and these subtypes should be addressed in the DSM.

An interesting point about cluster C disorders is that some studies bring to the mind that being anxious and fearful, which is the common feature of these disorders, can be considered as a protective factor. For example, a study by Chioqueta and Stiles (2004) evaluated the risk of suicide in people with personality disorders. In this study, only DPD was found to be associated with suicide attempts like Cluster A (paranoid, schizoid, schizotypal) and Cluster B (antisocial, borderline, histrionic, narcissistic) disorders, but there wasn't such association for the other two disorders, APD and OCPD. The finding can be seen as surprising, especially considering that the impairment in functionality for APD is more than both OCPD in some areas and major depressive disorder (Skodol et al. 2002). In addition, with the statistical evaluations made by Chioqueta and Stiles (2004), it is found that the situation for DPD is not the same as in other personality disorder clusters. In the study, while cluster A and B disorders can be associated with suicide attempts independently of comorbid depressive disorder, for people with DPD, the relationship between DPD and suicide attempts is found insignificant when the lifetime comorbid depressive disorder is controlled. Chioqueta and Stiles stated that the characteristic features of the cluster C can give explanation for this situation. They explained that avoidance of taking personal risks in APD, submissive and passive tendencies that reduce the possibility of self-harming behaviors in DPD, and excessive attention to rules and procedures in OCPD make these individuals less susceptible to suicide attempts. From these findings, researchers suggested that the assessment of suicide risk is very important for cluster A and B personality disorders, but this assessment for cluster C is not as obligatory as the other two clusters if the assessment of comorbid depressive disorder is made appropriately (Chioqueta and Stiles 2004).

Conclusion

Although studies for understanding cluster C personality disorders can be found relatively easily in the literature, it is seen that studies on treatment, especially on CBT, are very few. We think that even a small improvement in any part of the difficulties experienced by these individuals who have serious problems with social life, who have distorted thoughts about themselves and others, who try to continue their lifes with dysfunctional coping strategies (Beck et al. 2004, APA 2013) is very important. For this reason, it is thought that studies about the factors affecting both the process and the outcome of the treatment, and about which therapy technique or orientation is more effective, should be increased. As mentioned in the article, there are promising results regarding CBT. Therefore, we think that it is very necessary to increase the studies about especially cluster C personality disorders and CBT in the literature.

Authors Contributions: *The authors attest that she has made an important scientific contribution to the study and has assisted with the drafting or revising of the manuscript.*

Peer-review: *Externally peer-reviewed.*

Conflict of Interest: *No conflict of interest was declared by the authors.*

Financial Disclosure: *The authors declared that this study has received no financial support.*

References

Alden L (1989) Short-term structured treatment for avoidant personality disorder. J Consult Clin Psychol, 57:756-764.

Alden LE, Capreol MJ (1993) Avoidant personality disorder: Interpersonal problems as predictors of treatment response. Behav Ther, 24:357-376.

APA (1952) Diagnostic and Statistical Manual of Mental Disorders, First edition (DSM-I). Washington DC, American Psychiatric Association.

APA (1994) Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV). Washington DC, American Psychiatric Association.

APA (2013) Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5). Washington DC, American Psychiatric Association.

Baljé A, Greeven A, van Giezen A, Korrelboom K, Arntz A, Spinhoven P (2016) Group schema therapy versus group cognitive behavioral therapy for social anxiety disorder with comorbid avoidant personality disorder: Study protocol for a randomized controlled trial. Trials, 17:487.

Barbato N, Hafner RJ (1998) Comorbidity of bipolar and personality disorder. Aust N Z J Psychiatry, 32:276-280.

Beck AT, Davis DD, Freeman A (2004) Cognitive Therapy of Personality Disorders, 2nd ed. New York, NY, Guilford Press.

Beck JS (2011) Cognitive Behavior Therapy: Basics and Beyond, 2nd ed. New York, NY, Guilford Press.

Bender DS (2005) The therapeutic alliance in the treatment of personality disorders. J Psychiatr Pract, 11:73-87.

Bieling PJ, Beck AT, Brown GK (2000) The sociotropy–autonomy scale: Structure and implications. Cognit Ther Res, 24:763-780.

Borge FM, Hoffart A, Sexton H, Martinsen E, Gude T, Hedley LM et al. (2010) Pre-treatment predictors and in-treatment factors associated with change in avoidant and dependent personality disorder traits among patients with social phobia. Clin Psychol Psychother, 17:87-99.

Bornstein RF (2004) Integrating cognitive and existential treatment strategies in psychotherapy with dependent patients. J Contemp Psychother, 34:293-309.

Bornstein RF (2006) A Freudian construct lost and reclaimed: The psychodynamics of personality pathology. Psychoanal Psychol, 23:339-353.

Bornstein RF (2007) Dependent personality disorder: Effective time-limited therapy. Curr Psychiatr, 6:37-45.

Bornstein, RF (2005) The Dependent Patient: A Practitioner's Guide. Washington, DC, American Psychological Association.

Chioqueta AP, Stiles TC (2004) Assessing suicide risk in cluster C personality disorders. Crisis, 25:128-133.

Corruble E, Ginestet D, Guelfi JD (1996) Comorbidity of personality disorders and unipolar major depression: A review. J Affect Disord, 37:157-170.

Cummings JA, Hayes AM, Cardaciotto L, Newman CF (2012) The dynamics of self-esteem in cognitive therapy for avoidant and obsessive–compulsive personality disorders: An adaptive role of self-esteem variability? Cognit Ther Res, 36:272-281.

Deltito JA, Stam M (1989) Psychopharmacological treatment of avoidant personality disorder. Compr Psychiatry, 30:498-504.

Disney KL (2013) Dependent personality disorder: A critical review. Clin Psychol Rev, 33:1184-1196.

Emmelkamp PM, Benner A, Kuipers A, Feiertag GA, Koster HC, van Apeldoorn FJ (2006) Comparison of brief dynamic and cognitive–behavioural therapies in avoidant personality disorder. Br J Psychiatry, 189:60-64.

Enero C, Soler A, Ramos I, Cardona S, Guillamat R, Valles V (2013) Distress level and treatment outcome in obsessive-compulsive personality disorder (OCPD). Eur Psychiatry, 28:1.

Faith C (2009) Dependent personality disorder: A review of etiology and treatment. The Graduate Journal of Counseling Psychology, 1:66-75.

Farabaugh A, Fava M, Mischoulon D, Sklarsky K, Petersen T, Alpert J (2005) Relationships between major depressive disorder and comorbid anxiety and personality disorders. Compr Psychiatry, 46:266-271.

Garno JL, Goldberg JF, Ramirez PM, Ritzler BA (2005) Bipolar disorder with comorbid cluster B personality disorder features: impact on suicidality. J Clin Psychiatry, 66:339-345.

Grant BF, Hasin DS, Stinson FS, Dawson DA, Chou SP, Ruan WJ et al. (2004) Prevalence, correlates, and disability of personality disorders in the United States: Results from the national epidemiologic survey on alcohol and related conditions. J Clin Psychiatry, 65:948-958.

Hardy GE, Barkham M, Shapiro DA, Stiles WB, Rees A, Reynolds S (1995) Impact of Cluster C personality disorders on outcomes of contrasting brief psychotherapies for depression. J Consult Clin Psychol, 63:997-1004.

Herzog DB, Keller MB, Lavori PW, Kenny GM, Sacks NR (1992) The prevalence of personality disorders in 210 women with eating disorders. J Clin Psychiatry, 53:147–152.

Hofmann SG (2007) Treating avoidant personality disorder: The case of Paul. J Cogn Psychother, 21:346-352.

Hofmann SG, Asnaani A, Vonk IJ, Sawyer AT, Fang A (2012) The efficacy of cognitive behavioral therapy: A review of meta-analyses. Cognit Ther Res, 36:427-440.

Hyman SM, Schneider BA (2004) The short-term treatment of a long-term interpersonal avoidance. Clin Case Stud, 3:313-332.

Jacobson NS, Truax P (1991) Clinical significance: a statistical approach to defining meaningful change in psychotherapy research. J Consult Clin Psychol, 59:12–19.

Jungquist CR, O'Brien C, Matteson-Rusby S, Smith MT, Pigeon WR, Xia et al. (2010) The efficacy of cognitive-behavioral therapy for insomnia in patients with chronic pain. Sleep Med, 11:302-309.

Kernberg OF (1985) Borderline Conditions and Pathological Narcissism. Oxford, Rowman & Littlefield.

Lazare A (1971) The hysterical character in psychoanalytic theory. Arch Gen Psychiatry, 25:131-137.

Lucas R (1992) The psychotic personality: A psychoanalytic theory and its application in clinical practice. Psychoanal Psychother, 6:73-79.

Masroor U, Gul S (2012) Schema focused CBT intervention of dependent personality disorder: A case study. Pakistan Journal of Clinical Psychology, 11:43-57.

McCann J, Biaggio MK (1989) Narcissistic personality features and self-reported anger. Psychol Rep, 64:55-58.

McClintock AS, Anderson T, Cranston S (2015) Mindfulness therapy for maladaptive interpersonal dependency: a preliminary randomized controlled trial. Behav Ther, 46:856-868.

McLemore CW, Brokaw DW (1987) Personality disorders as dysfunctional interpersonal behavior. J Pers Disord, 1:270–285.

Millon T, Grossman SD, Millon CM, Meagher SE, Ramnath R (2004) Personality Disorders in Modern Life, 2n ed. New Jersey, Wiley.

Millon T, Grossman SD, Millon CM, Meagher SE, Ramnath R (2019) Modern Yaşamda Kişilik Bozuklukları (Çevirmen EO Gezmiş). İstanbul, Türkiye İş Bankası Kültür Yayınları.

Ng RM (2005) Cognitive therapy for obsessive-compulsive personality disorder--a pilot study in Hong Kong Chinese patients. Hong Kong Journal of Psychiatry, 15:50-54.

NICE (National Collaborating Centre For Mental Health) (2004) Eating Disorders: Core Interventions In The Treatment And Management Of Anorexia Nervosa, Bulimia Nervosa, And Related Eating Disorders. Leicester (UK), British Psychological Society, 2004..

Nordahl HM, Stiles TC (2000) The specificity of cognitive personality dimensions in cluster C personality disorders. Behav Cogn Psychother, 28:235-246.

Nordahl HM, Vogel PA, Morken G, Stiles TC, Sandvik P, Wells A (2016) Paroxetine, cognitive therapy or their combination in the treatment of social anxiety disorder with and without avoidant personality disorder: A randomized clinical trial. Psychother Psychosom, 85:346-356.

Overholser JC, Fine MA (1994) Cognitive-behavioral treatment of excessive interpersonal dependency: A four-stage psychotherapy model. J Cogn Psychother, 8:55-70.

Pincus AL, Gurtman MB (1995) The three faces of interpersonal dependency: Structural analyses of self-report dependency measures. J Pers Soc Psychol, 69:744-758.

Pincus AL, Wilson KR (2001) Interpersonal variability in dependent personality. J Pers, 69:223-251.

Raja M, Azzoni A (2007) The impact of obsessive-compulsive personality disorder on the suicidal risk of patients with mood disorders. Psychopathology, 40:184-190.

Sanderson WC., Wetzler S, Beck AT, Betz F (1994) Prevalence of personality disorders among patients with anxiety disorders. Psychiatry Res, 51:167-174.

Sato T, McCann D (2007) Sociotropy–autonomy and interpersonal problems. Depress Anxiety, 24:153-162.

Sato T, Sakado K, Sato S, Morikawa T (1994) Cluster a personality disorder: a marker of worse treatment outcome of major depression? Psychiatry Res, 53:153-159.

Seligman L, Reichenberg LW (2007) Selecting Effective Treatments: A Comprehensive, Systematic Guide To Treating Mental Disorders, 3rd ed. San Fransisco, CA, Wiley.

Shea MT, Stout R, Gunderson J, Morey LC, Grilo CM, McGlashan T et al. (2002) Short-term diagnostic stability of schizotypal, borderline, avoidant, and obsessive-compulsive personality disorders. Am J Psychiatry, 159:2036-2041.

Simonelli A, Parolin M (2017) Dependent personality disorder. In Encyclopedia of Personality and Individual Differences (Ed. V Zeigler-Hill, TK Shackelford). Cham, Springer.

Skodol AE, Gunderson JG, McGlashan TH, Dyck IR, Stout RL, Bender DS et al. (2002) Functional impairment in patients with schizotypal, borderline, avoidant, or obsessive-compulsive personality disorder. Am J Psychiatry, 159:276-283.

Solomonov N, Kuprian N, Zilcha-Mano S, Muran JC, Barber JP (2020) Comparing the interpersonal profiles of obsessive-compulsive personality disorder and avoidant personality disorder: are there homogeneous profiles or interpersonal subtypes? Personal Disord, 11:348-356..

Spitzer RL, Williams JBW, Gibbons M, First MB (1990) Structured Clinical Interview for DSM–III–R—Personality Disorders (SCID-II). Washington, DC, American Psychiatric Press.

Strauss JL, Hayes AM, Johnson SL, Newman CF, Brown GK, Barber JP et al. (2006) Early alliance, alliance ruptures, and symptom change in a nonrandomized trial of cognitive therapy for avoidant and obsessive-compulsive personality disorders. J Consult Clin Psychol, 74:337-345.

Svartberg M, Stiles TC, Seltzer MH (2005) Randomized, controlled trial of the effectiveness of short-term dynamic psychotherapy and cognitive therapy for cluster C personality disorders. Focus, 161:407-416.

Torgersen S, Kringlen E, Cramer V (2001) The prevalence of personality disorders in a community sample. Arch Gen Psychiatry, 58:590-596.

Türk Dil Kurumu (2021) Kişilik. https://sozluk.gov.tr/ (Accessed 4.09.2021).

Tyrer P, Wang D, Tyrer H, Crawford M, Loebenberg G, Cooper S et al. (2021) Influence of apparently negative personality characteristics on the longβterm outcome of health anxiety: secondary analysis of a randomized controlled trial. Personal Ment Health, 15:72-86.

Villemarette-Pittman NR, Stanford MS, Greve KW, Houston RJ, Mathias CW (2004) Obsessive—compulsive personality disorder and behavioral disinhibition. J Psychol, 138:5-22.

Weertman A, Arntz A, de Jong PJ, Rinck M (2008) Implicit self- and other-associations in obsessive-compulsive personality disorder traits. Cogn Emot, 22:1253-1275.

WHO (2010) International Statistical Classification of Diseases and Related Health Problems 10th Revision (ICD-10). Geneva, World Health Organization.

WHO (2021) International Statistical Classification of Diseases and Related Health Problems 11th Revision (ICD-11). Geneva, World Health Organization.