

**Lived experience of avoidant personality disorder:  
How people diagnosed with avoidant personality disorder make sense of  
their everyday lives and challenges**

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PAPER I-III

APPENDIX I: Interview guide

## Summary

The aim of this thesis is to inquire into the subjective experience of avoidant personality disorder. How do people who are diagnosed with this disorder experience and make sense of their everyday lives and strategies? How do they make sense of the origin and development of their psychological struggles? In addition, how do they experience their treatments? The methodological approach is a qualitative and interpretative phenomenological one, with an ongoing focus on researcher reflexivity. Furthermore, a co-researcher and two members of a resource group contributed to all stages of the research process with their first-hand knowledge of the phenomenon in question. Fifteen participants who had received a primary diagnosis of avoidant personality disorder were interviewed twice. Interpretative phenomenological analysis was utilized to analyze the transcribed interviews.

The findings are presented in three separate articles that present different parts of the rich data material (i.e., various aspects of the participants' subjective experiences). The first article explores how the participants experienced and made sense of their everyday challenges and strategies. The second article explores their sense making and subjective experiences of the origin and development of their current everyday struggles. The third article enquires about how the participants made sense of their experiences with treatments. Findings are presented in the articles as themes that summarize and convey important aspects of the participants' descriptions.

Together, the findings consist of three overarching themes: (1) struggling to be a person; (2) a story of becoming forlorn; and (3) searching for the courage to be. The overarching themes encompass corresponding main themes to capture both the similarities and variances of the participants' descriptions. The overarching themes conveyed how the participants struggled to be relational persons within a lifeworld of isolation, creating a longing for and fear of connection, along with an ongoing sense of doubt and insecurity. This struggle emerged in early childhood as a sense of growing disconnection and detachment from significant others and/or peers, which evolved and worsened through transitional periods that demanded ever more complex social and interpersonal skills. Their treatment experiences came across as being colored by a sense of being managed, not being understood, or not being able to make themselves understood, at the same time as they searched for the courage to begin resolving their fears and insecurities. However, experiences of vitality and movement in treatment were also present in the participants' descriptions. These seemed to be related to a relationship to a therapist who was interested and genuine and had time and space for them, as

well as making them feel understood. Each article includes a discussion of findings in relation to theories, research, and practice. The overall discussion of the thesis concerns an emphasis on an interpersonal developmental understanding of personality and of self-organizing experiences. Strengths and limitations of the research are explored. Implications for therapy and future research are reflected upon: in particular, the importance of further inquiry into avoidant personality disorder as understood through the development of self-in-relation-to-others.



## List of papers

### Paper 1

Sørensen, K. D., Råbu, T., Wilberg, T. & Berthelsen, E. (2019). Struggling to be a person: Lived experience of avoidant personality disorder. *Journal of clinical psychology*, 75(4), 664-680.

### Paper 2

Sørensen, K. D., Wilberg, T., Berthelsen, E. & Råbu, M. (submitted). Subjective experiences of the origin and development of avoidant personality disorder.

### Paper 3

Sørensen, K. D., Wilberg, T., Berthelsen, E. & Råbu, M. (2019). Lived experience of treatment for avoidant personality disorder: Searching for courage to be. *Frontiers in Psychology* 10, 2879.

## **Introduction: a person diagnosed with avoidant personality disorder (AVPD)**

When working as a clinical psychologist and psychotherapist you generally find yourself in a position of applying knowledge based on general patterns of a population to the psychological challenges faced by particular persons. Most of the time, we build and adapt our clinical experience and knowledge to develop and try out personalized explanations and strategies for change that come to prove themselves useful. However, after I had worked in a specialized outpatient group therapy clinic offering treatment to people diagnosed with personality disorders, one group of clients came to the foreground as being particularly hard to reach and understand: those diagnosed with avoidant personality disorder (AVPD). Our usual clinical strategies frequently fell short, resulting in therapies that became stuck at the same time as the clients' suffering continued. My own therapeutic experience when working with people diagnosed with AVPD became increasingly colored by dissatisfaction. When trying to make use of diagnostics and theories, as well as the rather scarce empirical findings related to AVPD, I could not seem to find answers to crucial questions such as the following. What are the particular experiences of this person and in what way are they connected to their being described by AVPD? How does this person make sense their own experiences, and what are they trying to achieve through avoidance? What does "avoidance" or even "improvement" mean in this context for this person? Moreover, how can I be of help with my expertise? When I tried to explore these questions with my clients diagnosed with AVPD, they seemed to find it hard to articulate their experiences and sense making. Both them and I somehow came to impasses in which there was no development, just increasing mutual frustration. It became clear to me that I was missing a knowledge of the subjective experiences of AVPD that I could draw upon in clinical work. Thus, the research project and the current thesis originated from a need to understand persons diagnosed with AVPD better so as to give voice to the subjective experiences of their concerns.

## **Epistemological grounding and overview of thesis**

Using the words "a person diagnosed with AVPD" may involve two complementary but different perspectives of knowledge acquisition: that of "the diagnosis" and that of "a person." A diagnosis represents a taxonomic, nomothetic category grounded in knowledge about the general group or population. Understanding a person may relate to the interpretative perspectives of the contextualized particular, or the unique elements of individual phenomena

(Scott & Marshall, 2009). Both epistemologies, and corresponding ontologies, are needed for expanding our knowledge of AVPD. The two approaches to knowledge acquisition can be seen as mutually inclusive and as necessary facets of a knowledge creation process (Valsiner, 2012). As bits and pieces of description, understanding, and explanation of AVPD come together dialectically to inform each other, new research questions arise that require suitable methodologies to be answered.

The taxonomic and nomothetic perspective on AVPD concerns the diagnostic category itself, as well as the hypothesized etiological and sustaining aspects of it that are considered targets for therapeutic interventions. Within this approach, which stems from the natural sciences, we find research on general or statistical patterns and laws with the goals of explanations, prediction, and control, as well as an emphasis on cause–effect relations (Ponterotto, 2005). Within the social sciences, the methodologies and logic of nomothetic research are assumed to capture aspects of the real world, “which exists and acts independently of our knowledge and beliefs about it” (Benton & Craib, 2010, p. 121). Current nomothetic or realist perspectives look beyond mere observations for stratified layers of underlying structures and mechanisms, to create metaphors and hypotheses of unobservable phenomena to experiment and examine these assumed mechanisms and their relations (Benton & Craib, 2010). Efforts are made to study people as objectively as possible, as natural kinds, that is, as if they were unaware of and uninfluenced by their classification and observation (Hacking, 1995).

On the other hand, interpretative perspectives argue that there are fundamental aspect of human life that cannot be captured through searching for general laws and an emphasis on observation (Benton & Craib, 2010). Reality in the interpretative traditions is considered to be constructed and multiple, to be viewed within the social-historical context that influences the mind of the individual (Ponterotto, 2005). Thus, people create understandings and meanings within their own historical, social, and cultural contexts. According to this view, what we come to know of the world will not be objective reality per se, as our perception and consciousness is in itself interpretative (Benton & Craib, 2010). People are seen as human kinds in that they are self-referring, self-knowing, and influenced by their classification and observations in their experience of themselves (Hacking, 1995; Martin & Sugarman, 2001). To study meaning making or subjective reality, one traditionally applies qualitative research methods, which are mainly aimed at exploring and describing phenomena through interpretation (Smith, 2015). As the ideas for the current research project took form, it found

its place within the qualitative research paradigm of interpretative methodologies of inquiry into subjective experience.

To reflect the view that a back and forth continuous movement (hermeneutic circle) between knowledge of AVPD as a diagnosis or natural kind and persons as human kinds is important, this thesis will begin with a short presentation of the current empirical and theoretical status of AVPD (i.e., aspects of the diagnosis and treatment). This approach reflects the knowledge sources I turned to, but found wanting, when looking for a way to understand my clients diagnosed with AVPD. Moreover, it provides the context for the departure into the knowledge gap concerning the subjective experiences and sense making of persons diagnosed with AVPD, leading us into the presentation of the research project. The discussion of the main findings will bring us back to how the present study may contribute to expanding our knowledge of AVPD in regard to some empirical findings and theories that provide further contextual understanding of AVPD. The thesis will conclude through a critical view on implications and limitations of the research project and the findings.

### **The diagnosis of AVPD**

The diagnostic definition of AVPD, as well as all the other personality disorders, has undergone major nosological changes, as the diagnostic manuals are transitioning from a categorical towards a dimensional organization. Today, the International Classification of Disease (ICD) 11 (World Health Organization, 2018), and the alternative model in section III (Emerging Measures and Models) of the fifth edition of the diagnostic and statistical manual of mental disorders (DSM-5; American Psychiatric Association, 2013), have left personality disorder categories behind to include dimensional classification of severity of self- and other personality functioning and specification of personality trait domains.

However, this current thesis will use the definition of AVPD described in the main section (II) of DSM-5 (American Psychiatric Association, 2013) as its point of departure. AVPD is described as “a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation” (p. 672). This pattern must be traceable back to early adulthood and present in a variety of contexts. Furthermore, to be diagnosed with AVPD, the DSM-5 requires at least four of the following seven criteria to be present (p. 672-673):

1. Avoids occupational activities that involve significant interpersonal contact, because of fears of criticism, disapproval, or rejection
2. Is unwilling to get involved with people unless certain of being liked
3. Shows restraint within intimate relationships because of the fear of being shamed or ridiculed
4. Is preoccupied with being criticized or rejected in social situations
5. Is inhibited in new interpersonal situations because of feelings of inadequacy
6. Views self as socially inept, personally unappealing, or inferior to others
7. Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

It is important to note that the DSM-5 presents general criteria for personality disorders that have to be met before any specific diagnosis of the personality can be made. These involve the presence of an enduring pattern of inner experience and behavior that deviates markedly from the individual's culture. This pattern must involve at least two of the following areas: cognitions, affects, interpersonal functioning, and impulse control. The pattern must be considered stable and of long duration in the sense that it must be traceable back to adolescence or early adulthood. Furthermore, it must be inflexible and pervasive across various personal and social situations, creating clinically significant social, occupational and other personal distress as well as functional impairment. If another mental illness, physiological effect of a substance, or general medical condition could better account for the presented pattern, the diagnosis of a personality disorder should not be made.

The diagnosis of AVPD is among the most prevalent personality disorders, with an estimated lifetime prevalence of approximately 2% (Torgersen, 2009). The prevalence within clinical populations ranges from 11 to 57% (Karterud, Wilberg, & Urnes, 2017). Despite formerly having been perceived as a less severe personality disorder, people diagnosed with AVPD report severe levels of psychosocial impairment, subjective distress, and reduced quality of life (Cramer, Kringlen, & Torgersen, 2007; Eikenaes, Hummelen, Abrahamsen, Andrea, & Wilberg, 2013; Olsson & Dahl, 2012; Skodol et al., 2002; Skodol et al., 2005; Ullrich, Coid, & Farrington, 2007; Wilberg, Karterud, Pedersen, & Urnes, 2009). Correspondingly, high social costs are associated with AVPD: both direct ones related to assessment and treatment and indirect ones arising from loss of productivity (Soeteman, Hakkaart-van Roijen, Verheul, & Busschbach, 2008).

## **A brief history of the AVPD diagnosis**

AVPD was first introduced in the third edition of the DSM (American Psychiatric Association, 1980). Its inclusion was mainly due to the work of Theodore Millon (1928-2014), who continued to be engaged in the development of the construct and in the later DSM revisions (Millon, 2011). Millon presented historical, modern, and contemporary parallels and contributors to the conceptualization of AVPD that he argued built a clinical and theoretical ground for its being a distinct category of personality disorder (Millon, 1981, 1991, 2011). Within his grand theory of biopsychosocial personology (see Millon, 1981, 2011), he described a shy, reticent, and avoidant type of personality pathology with a reduced ability to experience pleasure at the same time as being hypersensitive to psychic pain, leading to few rewards and much suffering, which they thus actively seek to avoid (Millon, 2011). Corresponding qualities were an impoverished sense of self, shyness, detachment, and active social avoidance. Their oversensitivity and hypervigilance to rejection or humiliation by others results in a growing degree of isolation and increasing distress through intrusive experiences of psychological pain (Millon, 2011). Millon distinguished active from passive detachment. The latter was considered to describe the form of detachment that make up a schizoid personality type, while active detachment was descriptive of AVPD.

After the inclusion of AVPD in DSM-III, several challenges to the diagnosis as a category became apparent. A major concern was comorbidity or co-occurrence, as AVPD frequently co-occurs with other personality disorders (e.g., the schizoid, paranoid, and dependent; Hummelen, Wilberg, Pedersen, & Karterud, 2006). The reason could be related to the similarity of the categorical criteria; however, these criteria are considered to represent different assumptions about underlying dynamics or motivations. For example, in a comparison of AVPD with schizoid personality disorder, high levels of social anhedonia were found to be uniquely predicative for schizoid personality disorder, whereas high levels of need to belong and internalized shame were unique for AVPD, supporting the notion that the lack of desire for social relationships distinguished schizoid dynamics from those of AVPD (Winarick & Bornstein, 2015). Another example is how unassertiveness in avoidant personality disorder has been related to fears of rejection or humiliation, whereas dependent unassertiveness seemed to be related to fears of abandonment and of being left alone to fend for oneself (Lampe & Malhi, 2018). Furthermore, AVPD was characterized by difficulties in initiating and approaching social relationships but dependent personality disorder was not,

and AVPD was associated with clinging to people whom they feel certain will meet their standards for safety (Alden, Laposa, Taylor, & Ryder, 2002).

Changes to the DSM III–R criteria for AVPD created greater overlap between the criteria for social phobia and AVPD, in particular the introduction of a generalized type of social phobia. Millon (1991) understood these changes to the criteria as emphasizing the phobic nature of AVPD, which underscored fears of becoming embarrassed or of feeling inadequate as well as minimizing aspects related to low self-esteem and hypersensitivity to rejection. Hence, quite a bit of research was generated aimed at clarifying this overlap. Discussions on this issue are ongoing as to whether there should be two distinct qualitative diagnostic categories of social anxiety and avoidant personality disorder, or whether the two should be viewed as representing differences of severity on a spectrum (Frandsen, Simonsen, Poulsen, Sørensen, & Lau, 2019). The latter view, often referred to as the severity continuum hypothesis, highlights how AVPD is considered to differ from social phobia only in regard to severity of dysfunction and symptomatic distress (e.g. Eikenaes, Egeland, Hummelen, Wilberg, & Eapen, 2015; Hummelen, Wilberg, Pedersen, & Karterud, 2007; Lampe & Sunderland, 2015; Reich, 2000). In the DSM-IV, the AVPD criteria were again changed to fit better with Millon's descriptions through emphasizing fears of rejection and feelings of inadequacy to explain avoidance, and thus bring aspects of the underlying personality dynamics to the foreground (Lampe & Malhi, 2018). However, the criteria for social phobia in the DSM-5 were changed to include fear of rejection: thus, the overlap may increase yet again (Lampe & Malhi, 2018). Questions regarding what diagnostic model of social anxiety disorder and AVPD that best represents observations, etiology, and mechanisms remain controversial within the field of diagnostic nosology and the nomothetic tradition of AVPD (e.g., Frandsen et al., 2019).

### **Empirical findings on aspects of AVPD and its etiology**

Alongside nosological questions, nomothetic research on AVPD has focused on the biological, situational, and environmental aspects of its etiology and their role in the evolution of the mental difficulties of the disorder. The aim could be said to throw light on specific aspects of the condition that brought about and/or sustained the psychopathology, which thus could be important targets for treatment interventions.

Normative personality traits such as the Five Factor Model, which includes the dimensions neuroticism, extraversion, agreeableness, conscientiousness, and openness to experience (McCrae & Costa, 1995, 1997, 1999); maladaptive personality traits based on the same Five Factor model; and personality disorder criteria from DSM-5 have all been found to be heritable (Czajkowski et al., 2018; Kendler et al., 2019; T. Reichborn-Kjennerud, 2010; South et al., 2017; Vukasović & Bratko, 2015). For AVPD, one twin study reported heritability estimates of 28% (Torgersen et al., 2000), and a population-based study reported estimates of 35% (Reichborn-Kjennerud et al., 2007). There are some indications of a genetic risk factor of neuroticism, reflecting a general vulnerability to personality disorders (Kendler et al., 2008; Kendler et al., 2019). A genetic factor represented by low scores on extraversion (or, inversely, high scores on introversion) is specifically related to schizoid personality disorder and AVPD (Kendler et al., 2019).

While genes contribute to the development of personality disorders, they seem to do so in a complex interplay with the environment (Reichborn-Kjennerud, 2010; Torgersen, 2009). Meyer and Carver (2000) found some evidence for a relationship between AVPD features and a sensitive temperamental disposition. A shy, anxious temperament, childhood and adolescent anxiety disorders, and deficient parental care emerged as risk factors for AVPD in a study by Joyce et al. (2003). Although associations between self-reported adverse childhood experiences and AVPD symptomology have been found, they do not appear to be specific to AVPD (Hageman, Francis, Fields, & Carr, 2015; Rettew et al., 2003). There are however some indications of a relationship between AVPD and social behavioral teasing and reduced childhood social involvement and engagement (Hageman et al., 2015; Rettew et al., 2003). Perhaps the most promising approach for understanding the etiology and development of AVPD is to look at developmental pathways models that view temperamental or trait dispositions as interacting with the psychosocial environment, influencing both the risks and resilience involved in a person's characteristic patterns of thinking, feeling, and behaving (Cicchetti & Toth, 2009; Tackett, Herzhoff, Balsis, & Cooper, 2016).

Although limited, some research on AVPD has been particularly interested in aspects of various interpersonal and intrapersonal dynamics, such as self-esteem, attachment styles, and metacognitive abilities, often comparing AVPD with other diagnoses, such as social phobia or borderline personality disorder. Lynam, Wilberg, and Karterud (2008) found that lower levels of self-esteem were associated with AVPD compared to borderline personality disorder, although both were within a range that indicated clinical problems. AVPD has been



associated with being less competent at solving conflicts (Cummings et al., 2013), as well as with difficulties with social problem solving and assertiveness (McMurrin, Duggan, Christopher, & Huband, 2007). Spinhoven, Bamelis, Molendijk, Haringsma, and Arntz (2009) found AVPD to be related to reduced specificity in autobiographical memories (hence, they were over-general), perhaps influenced by repetitive negative thoughts. Carr and Francis (2010) found significant associations between AVPD symptoms and the early maladaptive cognitive schemas “abandonment,” “subjugation,” and “emotional inhibition.” These cognitive schemas represent the beliefs that others will not be available for support, that one must suppress one’s desires, needs, and emotions in order to avoid aversive consequences, and that one must inhibit expressions of emotions to avoid being disapproved of by others (Young, Weishaar, & Klosko, 2003). When compared with “pure” social phobia, Eikenaes et al. (2013) found indications of AVPD being associated with difficulties with self-esteem, identity, and relational functioning, as well as with having problems experiencing enjoyment.

Attachment anxiety, in particular abandonment, was found to be an important aspect characterizing AVPD (Eikenæs, Pedersen, & Wilberg, 2015). Beeney et al. (2015) found that self–other boundaries (such as having difficulties with emotion contagion and feeling separate from others) mediated the relationship between attachment anxiety and AVPD. Normann-Eide, Johansen, Normann-Eide, Egeland, and Wilberg (2015) found AVPD to be characterized by lower levels of affect consciousness (the capacity to perceive, reflect on, tolerate, and express emotional experiences) when compared to persons diagnosed with borderline personality disorder. AVPD has also been seen to be related to the concept of alexithymia, the impaired ability to recognize and make sense of emotions (Nicolò et al., 2011). Mentalization, the capacity to perceive and interpret behavior as expressions of intentional mental states (Bateman & Fonagy, 2016), was operationalized as reflective functioning on narratives of childhood attachment experiences in a study by Antonsen, Johansen, Rø, Kvarstein, and Wilberg (2016). The authors found an association between AVPD and difficulties with reflective functioning. Another study compared metacognitive abilities (the ability to understand mental states) of patients with AVPD with and without comorbid social phobia and patients with social phobia alone (Pellecchia et al., 2018). They found that patients with AVPD presented the lowest scores. Moreover, Moroni et al. (2016) found deficits in two specific operationalized subcomponents of metacognitive or “mindreading” abilities; namely, monitoring one’s own internal states and “decentration,”

which signifies monitoring the internal states of others. These abilities were more impaired for persons with AVPD than those with other personality disorders.

### **Psychological treatments for AVPD**

Research on various treatments for AVPD has mainly followed nosological disputes and corresponding psychotherapeutic developments. The first studies of treatment mainly originated from the diagnostic dispute over similarities and differences between AVPD and social anxiety disorders in the 1980s, giving rise to the question of whether treatment developed for social anxiety could be beneficial for AVPD if the two disorders were caused by similar difficulties. These treatments consisted mainly of cognitive behavior therapy with exposure exercises, systematic desensitization, role-plays for behavioral rehearsal, self-image work, and social skills training — all of which presented promising research findings (Alden, 1989; Renneberg, Goldstein, Phillips, & Chambless, 1990). Later on, the emphasis shifted towards more cognitive strategies that focused on core beliefs and adaptive cognitions, together with behavioral change (Weinbrecht, Schulze, Boettcher, & Renneberg, 2016). Again, positive results were reported from various trials (Boettcher, Weinbrecht, Heinrich, & Renneberg, 2019; Emmelkamp et al., 2006; Rees, Pritchard, & Hilsenroth, 2015; Strauss et al., 2006). Psychodynamic treatment for cluster C personality disorders, including AVPD, also came forward as an option. In particular Svartberg, Stiles, and Seltzer (2004) found short-term dynamic psychotherapy to be as effective as CBT for this diagnostic group.

Later studies have given their specific attention to AVPD, and they have focused their treatments on the mechanisms considered important in the theories of personality disorders to which they belong. This presentation will be limited to two examples of these approaches, schema therapy and metacognitive interpersonal therapy. Both are commonly regarded as third-wave cognitive therapies, but also as being integrative, as they draw on ideas and techniques from various theoretical orientations. Schema therapy builds on attachment theory, as well as on psychodynamic and experiential therapies (Fassbinder & Arntz, 2019; Young et al., 2003). Metacognitive interpersonal therapy is influenced by narrative and relational approaches to personality disorders, as well as psychodynamic ones (Dimaggio, Montano, Popolo, & Salvatore, 2015). Both are examples of how focusing on core difficulties may inspire the development of more specifically tailored approaches to therapy. Regarding this limited presentation, it is emphasized that other psychotherapeutic schools are also

undertaking efforts to develop specialized treatments for AVPD, such as emotion-focused therapy (Pos, 2014), acceptance and commitment therapy combined with dialectical behavior therapy (Chan, Bach, & Bedwell, 2015), radically open-dialectical behavior therapy (Lynch, Hempel, & Dunkley, 2015), interpersonal psychotherapy (Gilbert & Gordon, 2013), and mentalization based therapy (Simonsen & Euler, 2019).

In schema therapy (e.g., Bamelis, Renner, Heidkamp, & Arntz, 2011; Young et al., 2003), schemas are viewed as stable trait constructs of mental representations that underlie one's personality. A schema mode represents a currently active state of emotions, cognitions, and behaviors that are triggered simultaneously in response to various sensitive situations. The modes are organized according to child modes that represent core emotional needs, punitive and critical modes internalized from childhood experiences, and various maladaptive coping modes. In schema therapy, AVPD is associated primarily with avoidant coping modes: The avoidant protector mode is characterized by situational avoidance and the detached protector mode with disengaging from inner emotions, experiences, thoughts, feelings, and people. These avoidant modes are used to cope with the critical and punitive ones. Most importantly, their aim is to protect the vulnerable child mode whose feelings of loneliness and inferiority are considered the core of the AVPD mode conceptualization (Fassbinder & Arntz, 2019; Jacob & Arntz, 2013; Lobbestael, Van Vreeswijk, & Arntz, 2008). In addition, a suspicious, overcontroller coping mode has been found to be associated with AVPD, perhaps related to fears of others' evaluations, which creates a suspicious attitude (Bamelis et al., 2011). Treatment for AVPD consists of various experiential, cognitive-behavioral, and interpersonal techniques aimed at reducing maladaptive coping, as well as the critical and punitive modes. At the same time, the aim is to learn to meet the core needs associated with child modes through building an adaptive and functioning healthy adult. Therapeutic techniques are aimed at processing negative childhood experiences, evoking emotions and facilitating emotional change, as well as introducing and practicing new adaptive behaviors aimed at fulfilling core emotional needs. Rather personalized and directive, the therapeutic relationship provides corrective interpersonal experiences. Some support for schema therapy for cluster C, thus including AVPD, has been reported by Bamelis, Evers, Spinhoven, and Arntz (2014). The authors reported lower dropout rates and more recovery for schema therapy as compared to treatment as usual and clarification-oriented therapy. A pilot study conducted by Skewes, Samson, Simpson, and van Vreeswijk (2014) investigated group schema therapy

for mixed personality disorders with a predominant diagnosis of AVPD. They found clinical improvement on AVPD symptom severity, as well as on depression and anxiety levels.

Metacognitive interpersonal therapy is based on theories of maladaptive interpersonal schemas — developed around a basic wish or motive, representations of self and others, a relationship and the involved affect — as constituting the core pathology of personality disorders (Dimaggio et al., 2017). Maladaptive coping and dysfunctional reasoning are seen as important aspects of personality disorders (Dimaggio et al., 2015). Also playing a crucial role in understanding the difficulties of personality disorders within this model are metacognitive abilities, mental operations aimed at decoding and understanding mental states of self and others, and related dysfunctions (such as alexithymia) (Dimaggio, Nicolò, Semerari, & Carcione, 2013; Gordon-King, Schweitzer, & Dimaggio, 2018). AVPD is conceptualized as being characterized by overregulation of emotion, together with inhibition of affect and avoidance of social interaction, as well as relational avoidance schema. Treatment is focused on interpersonal episodes to create awareness and to develop formulations to help change interpersonal schemas. Various cognitive, behavioral, and experiential techniques are used to improve metacognitive functioning, narrative integrative capabilities, sense of agency, self and interpersonal functioning, and affect regulation — and, hence, to reduce general distress (Dimaggio et al., 2015; Gordon-King et al., 2018). Case studies have supported metacognitive interpersonal therapy as being potentially effective for AVPD (Dimaggio et al., 2017; Fiore et al., 2008; Gordon-King et al., 2018; K. Gordon-King, Schweitzer, & Dimaggio, 2018; Popolo et al., 2019).

### **Challenges of nosology and nomothetic approaches**

When the diagnosis “AVPD” becomes the focus of study, we should keep our attention on the influence of an underlying assumption of it being a natural kind. When we bring to mind that AVPD is a construct, however, we also have to stay aware that categories are the basis of our thoughts, perceptions, actions, and speech. Every time we see something as a kind of thing, we categorize (Lakoff, 1987). Perhaps because of the automatic and unconscious way we go about categorizing, we often assume that we categorize things as they are. And perhaps even more often than we categorize physical things, we also categorize abstract entities (Lakoff, 1987). Some examples of abstract entities are personality traits, mental illness, and diagnoses such as AVPD. These abstractions do not correspond to tangible

objects that we can directly observe or test. Colored by the nature of the people embodying the abstractions, they contain properties that result from human imaginative processes, such as the formulation of metaphors and mental imagery (Lakoff, 1987). Constructs are mental abstractions that are open, abstract, and hypothetical, and they often assume their meaning from a theory of which they are part (Millon, 2010).

As we investigate a diagnosis as a natural kind, we assume that mental disorders are natural formations — objective entities that exist “out there,” independent of the clinical practices that study them (Pérez Alvarez, Sass, & García-Montes, 2008). We accept reduction of the phenomenon into component parts, which is necessary for statistical analysis. In other words, we translate from the abstract construct to measurable characteristics and make instruments based on this translation. The diagnostic manuals and the variously derived structured interviews for diagnostics are in danger of being viewed as self-sustaining representations of concrete things in the natural world, and thus of becoming reinforced and reified (Ekeland, 2014). Boag (2011), for example, warns about the dangers of verbal magic, such as “when a description of a behavior becomes mistakenly treated as a property of persons (reified) and then used to explain that same behavior” (p. 429). In other words, one needs to distinguish between description and explanation. Description can constitute efforts at classification and explanation in trying to understand how things come about (Boag, 2018).

Furthermore, empirical findings on AVPD are examples of measurable variables in a paradigm that views individual objects as carriers of general characteristics (Nerheim, 1996). When you generalize from a sample average in empirical research, you generalize to a population or a kind. The methodological and statistical procedures control for differences, treating heterogeneous groups as if they were homogenous (Valsiner, 2014). Empirical sciences assume stability, in that what one observes under given conditions at one point in time will occur again if the conditions are the same. In other words, the observations are supposed to be replicable. However, Smedslund (2016) has pointed out the irreversibility of psychological processes, due to persons continuously changing and learning from experience. This point brings forward the issue of temporality. Movement in time, from one similar phenomenon to the next, is a characteristic of human development (Valsiner, 2015). In addition, development takes place in interaction with the surrounding environment. Contexts vary limitlessly as to how they influence each person and how the person relates back to them. The inner world of the person and the outer surroundings may be distinguished, but they can

also be conceived as being co-created (Beebe & Lachmann, 1998). In this sense, the context becomes an inherent part of the phenomenon itself.

When we shift our understanding of a diagnosis as a natural thing to understanding it as a human kind, a new perspective emerges. As we are categorized as human kinds, like when we are diagnosed, the introduction of the category changes the way we think and feel about ourselves and thus how we act (Ekeland, 2014; Hacking, 1995; Pérez Alvarez et al., 2008). A diagnosis is laden with value, as it relates to deviances from social and/or statistical norms. Something not-normal is usually deemed to be bad in some way (Hacking, 1995; Wakefield, 1992). Thus, the diagnosis is evaluated as something we desire to have or not. Being diagnosed may become part of us changing, through a feedback process (Hacking, 1995). Mental disorders, such as AVPD, belong in the context of human sociocultural constructs, as they are created through views and beliefs of human behaviors and mental states that have been shaped and defined by society and history as abnormal (Marková & Berrios, 2012). However, it might also be necessary to consider the individual's mediating understanding of his or her natural and human realities, as people can react differently to being diagnosed (Madsen, 2014).

### **Transitioning to the person (diagnosed with AVPD)**

Interpretative traditions convey the view that human life is one of meaning and that meaning is “something that exists within human subjectivity rather than on the plane of material nature” (Atwood & Stolorow, 2014, pp. 3-4). Psychology as a social science is thus about interpreting the meanings that people give to their actions (Benton & Craib, 2010). The person acts in a meaningful, intentional, and contextual way (Schwandt, 2000). Time and development can be viewed as being an inherent part of this context of human action that together with our language mediates our experience and becomes co-constructed knowledge (Willig, 2001). Within this context, it is relevant to inquire into the experiences of the persons who have received a diagnosis of AVPD. This approach takes into account that a person who is diagnosed with AVPD will try to make sense of their personal lived experiences. The focus stays on the subjective versions of one's life as it is told, remembered, and talked about, not from an observers' point of view (Habermas, Bluck, & Eisenberg, 2000). Personality traits and characteristics play out and take on specific meanings within the context of our personality (Alden et al., 2002), our interpersonal relations (Beebe & Lachmann, 2003), and

our culture (Hofstede & McCrae, 2004). Furthermore, an autobiographical reasoning process or self-reflective thinking weave together the reconstructed past, the perceived present, and anticipated future, ideally giving a sense of unity across time and situations, as well as a sense of purpose and meaning (Adler, 2012). Through looking at personal identity as something more than a collection of traits that an individual possesses, but as the process by which an individual reflexively understand his or her self in light of their biography (Giddens, 1991), we return to the current research project.

### **Overarching aims of the study**

The overarching aim of this thesis is to further our understanding of AVPD from the perspective of persons diagnosed with this disorder. How do they experience their current and past psychological challenges and their efforts at improving their condition? To this end, a qualitative study based on repeated in-depth interviews with people diagnosed with AVPD was conducted. The analysis was grounded within a hermeneutic phenomenological framework through conducting an interpretative phenomenological analysis (IPA) of the data. Reflexivity was emphasized throughout the research process, among the researchers as well as in the context of a resource group, and with a co-researcher who ensured the inclusion of first-hand experience with the diagnosis.

### **Method: an interpretative phenomenological approach**

The approach of IPA is founded on the view that human beings are not passive perceivers of an objective reality: “rather they come to interpret and understand their world by formulating their own biographical stories into a form that makes sense to them” (Brocki & Wearden, 2006, p. 88). The approach is considered ideographic, as it most often concerns the study of specific individuals as they deal with specific situations or events in their lives (Larkin, Watts, & Clifton, 2006). Interpretative phenomenological analysis is phenomenological in its concern with a person’s lived experience of objects or events, and it emphasizes how the analyst strives to describe the essentials of a given experience, while suspending any assumptions (Smith, 2004; Smith, Larkin, & Flowers, 2009; Van Manen, 2014). Smith et al. (2009) refer to the Husserlian tradition of reflecting attentively on everyday lived experience, which also involves focusing on engaging with the experiences of other people (Shinebourne, 2011). Thus, the researcher tries to understand and describe the way individuals experience their everyday lived world (Larkin et al., 2006). In line with current phenomenological philosophy, one considers that observations are always interpretative and influenced by our historical, social, linguistic, and embodied context (Finlay, 2014; Heidegger, 2008; Larkin & Thomson, 2011; Shinebourne, 2011; Van Manen, 2014). Hence, IPA is also hermeneutic, through its recognition of the central role of the researcher in making sense of participants’ accounts of personal experience (Smith, Flowers, & Osborn, 1997; Smith et al., 2009). In approaching the accounts to be analyzed, researchers are influenced by worldly embeddedness and their own pre-conceptions, which are built from previous experiences (Gadamer, 2004; Smith et al., 2009). The researcher aims at staying continuously aware of their pre-conceptions. As the researcher’s reflections change and evolve throughout the process of interpretation, they become an inevitable part of the dynamic movement between the subjective accounts and the interpretation (Gadamer, 2004; Larkin et al., 2006; Smith et al., 2009). Furthermore, in IPA, an inductive stance stays in the foreground in that one starts off with broad research questions that allow for the collection of expansive data and the emergence of unexpected topics during the analysis (Smith, 2004).

### **The researchers**

I will use the term “professional researcher” to refer to members of the research team who were formally employed as researchers. Other researchers are referred to as co-



researchers and members of the resource group, both those having first-hand experience with AVPD, as well as those with extensive clinical experience of it.

The professional researchers involved in this study consisted of the main supervisor, Marit Råbu; the co-supervisor, Theresa Wilberg; and the study advisor and coauthor, Eivind Stie (formerly Berthelsen); as well the author of the current thesis, Kristine Dahl Sørensen.

I, Sørensen, am a PhD student at the Department of Psychology, University of Oslo and clinical psychologist at the Group Therapy Unit, DPS Aust-Agder, SSHF. Råbu is an associate professor and clinical psychologist, at the Department of Psychology at the University of Oslo, as well as being in private practice. Wilberg is a psychiatrist at the Department for Research and Development at the Clinic for Mental Health and Addiction at Oslo University Hospital and professor at the Institute of Clinical Medicine at the University of Oslo. Stie is a theologian with a PhD in qualitative research, a hospital priest at Sorlandet Hospital (SSHF), and an advisor at DPS Aust-Agder, SSHF. Together, we have experience with schema therapy, mentalization based therapy, and dynamic and integrative approaches to therapy, as well as an interest in subjective experiences related to psychotherapy and mental health, including personality disorders.

It was considered necessary to ensure an ongoing attention to ideographic first-hand knowledge of AVPD and a personal-recovery-informed view on development and change, together with an awareness of preconceptions of the diagnosis and its treatment. Thus, people with lived experience were also included in the research team. The aim was to reflect on the phenomenon of AVPD from various angles — that of the clinical expertise perspective and that of the lived experience perspective — to increase our critical look at the research process, as well as the relevance of the research (Veseth, Binder, Borg, & Davidson, 2017).

A co-researcher who had first-hand experience with AVPD participated in close collaboration throughout all stages of the research process. A resource group was established as a meeting point for further inclusion of the lived experience and service-user perspective. The group consisted of two persons with first-hand experience with AVPD, two clinical psychologists with longstanding experience of therapy with clients with personality disorders, the co-researcher, and I. Together we strived to emphasize various stances toward understanding mental challenges. Thus, we wished not merely to focus on psychological challenges, but also to address resources and possibilities for growth through building purpose and meaning in one's life (Veseth, Binder, Borg, & Davidson, 2016; Veseth et al., 2017).

## **Recruitment**

In seeking experiences from people who had been diagnosed with AVPD, we purposively recruited participants who had received a primary diagnosis of it from their respective therapists through the use of the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997). To provide variable subjective experiences and reflect common clinical reality, we strove to recruit men and women of various ages and with various treatment experiences regarding length, modality, and type (specialized for personality disorder or regular outpatient treatment offered at site).

Nine participants from the research project — “An Examination of the DSM-5 Level of Personality Functioning Scale in a Representative Clinical Sample” (Buer Christensen & Eikenaes, 2019; Buer Christensen & Hummelen, 2019; Buer Christensen et al., 2018) — who had agreed to be contacted at a later stage for additional research purposes were approached with a request to participate in the current research. They received written information about our research project through their therapists. Five persons agreed to participate and were interviewed.

Ten participants were recruited through contacting therapists at various psychiatric outpatient hospital units. Therapists were provided with verbal and written information about the research project and brochures to distribute to the patients who, in their view, had a primary diagnosis of AVPD. After those who expressed interest in participating were contacted by the first author by phone or text message, they were provided with oral and written information about the research project and were interviewed.

## **The participants**

The participants were nine women and six men; their age ranged from 20 to 51 years ( $M = 33$  years,  $SD = 9$ ). All participants had been diagnosed with AVPD and took part in various forms of treatments.

Four participants had finished their education at a primary level; nine had done so at a secondary level, and two had completed higher education. Seven participants lived alone. Six participants lived with a partner/husband or wife, of which three lived with children and three without. Two participants lived with their children only. All of the participants were on

welfare at the time of the interviews. However, many had work experience and were on time-limited welfare with the goal of returning to full or part-time work.

The treatment settings varied from individual sessions at an acute outpatient team along with general therapy at outpatient clinics to specialized treatment for personality disorders, with group therapy and individual sessions combined. The participants had experiences with treatment provided by psychologists, psychiatrists, psychiatric nurses, and specialized physical therapists. Two participants were taking part in their first course of treatment, two had undergone 2–3 courses of treatment, and 11 had taken part in three or more courses of treatment. Information shared by the participants during the interviews, showed that, in addition to their current primary diagnosis of AVPD, eleven participants had also received diagnoses of various forms of anxiety and/or depression while in therapy. Two participants had no recollection of former or co-occurring diagnoses, whilst two others said they had been informed of their AVPD only. None of the participants mentioned having received any other form of personality disorder diagnosis. Thirteen participants reported that they talked about their diagnosis of AVPD during their current course of therapy, and two discussed it during their previous course of therapy.

### **Qualitative interviews**

One form of phenomenological exploration can be said to take place within the context of an interview situation in which the subject and interviewer engage in an intersubjective relationship and recall and relieve experiences (Binder, Holgersen, & Moltu, 2012). One way of understanding interviewing is to have a dual focus on the interviewer and interviewed as two persons exchanging their viewpoints in a conversation on a specific topic as well as the knowledge that is being constructed between the two persons' viewpoints in this interchange (Kvale, Brinkmann, Anderssen, & Rygge, 2015). Thus, the focus is both on what is known/becoming known and on the relational context of the interview (Kvale et al., 2015).

This project used semi-structured, in-depth interviews as its main methodology, and all participants were interviewed twice. A lightly structured interview guide was developed to focus the phenomenon in question and to remain open to topics presented by the participants. A pilot interview was conducted to obtain feedback on the suitability of both the interview questions and the setting. The interview guide was also discussed with the resource group to

further ensure its suitability. The interview guide (see Appendix I) was slightly modified according to this feedback.

Repeated interviews can provide the opportunity to return to issues that might be explored further, as well as to probe and clarify issues that remained unclear following the first interview (Kirkevold & Bergland, 2007; Smith et al., 2009). Booth and Booth (1994) emphasize the importance of listening to and reading the transcript from the first interview before conducting the second to pick up on what was missed, what could be clarified, what probes one could try out, and any cues that might imply discomfort or ease. In this project, the co-researcher and I cooperated in reading transcripts of the first interview so as to use her first-hand experience to aid the process of generating further questions that might initiate fuller responses in the second interview. This approach also limited the possibility of missing out on important aspects that could be hard for me as a researcher to pick up on. Thus, the second interview gave the opportunity to elaborate on topics from the first interview, as well as adding further questions to build on salient topics. After interviewing nine participants, the co-researcher and I concluded that we had reached saturation of new topics and questions for her to add to the interviews. However, we proceeded to meet regularly to discuss the interview transcripts from the six participants that followed to guide the interview process further.

Interviewing the participants in this project brought forward important considerations regarding how to aid those who found it challenging to express themselves and to verbalize their experiences. As empirical research has shown, persons diagnosed with AVPD may have trouble with reflective functioning (Dimaggio, Lysaker, Carcione, Nicolò, & Semerari, 2008; Eikenaes et al., 2013). At the same time, people having difficulties expressing their perspective are often those most in need of being heard, as this knowledge is necessary to inform the improvement of service and treatment practices (Lloyd, Gatherer, & Kalsy, 2006). As they may become invalidated and marginalized, they can be empowered through expressing their own perspectives (Kvigne, Gjengedal, & Kirkevold, 2002; Lloyd et al., 2006).

One way that made it easier for the participants to answer questions during the interviews, was to ask questions frequently that participants could agree or disagree on, and then guide them towards more elaborate descriptions. Attention was directed at being careful to notice when the participants' limits were being pushed so that the interview did not take the form of an interrogation. Another method of searching for responses was to change the self-

reflecting position or point of view through the phrasing of the questions. The question “what do you like to do?” gave few responses. However, the question “if you at some point in time do not have these problems anymore, what do you think you would like to do?” triggered longer and fuller answers. Perhaps a shift of focus from a mode of psychological problems to a possible future in which the person could freely choose gave access to an increased consideration of likes and dislikes on their part.

The interviews lasted 60–90 minutes and were conducted at their site of choice. Eleven participants were interviewed in an office at their hospital units and four in their homes. To make the participants as comfortable as possible during the interviews, they were served a drink or light snack. They also received ongoing assurance that there were no right or wrong answers, only an interest in their own experiences. The interviews were audio recorded and transcribed verbatim. All of the confidential information was changed to ensure anonymity. We verified all transcripts once. The verbatim material was imported into NVivo software (QSR, 2015) for principal analysis.

### **Analysis of the empirical data**

The analytic processes of IPA concerns moving from the particular to the shared, through moving from more descriptive to increasingly interpretative levels of analysis (Smith et al., 2009). The analysis is further guided by principles of committing to focusing on understanding the participant’s point of view, together with paying attention to what it may mean to participants to have these concerns in their particular context (Smith et al., 2009). Thus, IPA seeks first to understand participants’ experiences via examining the meanings they impress upon it, and secondly to contextualize their accounts of meaning-making in reflections and theory, and thereby to link findings to the psychological literature (Shinebourne, 2011).

We may say that a continuous preliminary analysis takes place when preparing, reading through, and reflecting on the transcripts for each interview. Each one stands on its own, while influencing the next. One suitable way to describe this process is as the embodied, reflexive listening and reading that goes on before the formal analysis, but still influences it. During reflective listening, the language of the body and the verbal expressions both communicate. Sometimes what the body communicates may reinforce spoken words; sometimes it might contradict or weaken what is said (Kvigne et al., 2002). Although being

aware that nonverbal information of this kind is part of the researcher's experience, possible meanings expressed by the body through spontaneous and intuitive experiences can augment our understanding of the spoken words (Finlay, 2014; Kvigne et al., 2002). Kvale et al. (2015) add to this argument by stating that our bodies might know that of which our reflecting capacities are unaware; thus, listening to our bodily experience may guide reflexivity. When reading the transcripts, the words of the participants are transformed into texts. The information moves from a social interaction to something taken out of this context, which could be described as a verbal reproduction or abstraction (Kvale et al., 2015). Rennie (2012) built on the work of Eugene Gendlin (1926–2017) in proposing that we use our embodied experience when we create meaning by interpreting text. He described a search for words to articulate inchoate meaning, perhaps in a more deliberate but still automatic way. Reflecting on embodied reactions when reading might be used to guide the analysis as a form of secondary data source giving an experiential context of making meaning (Goldstein, 2016). However, this way of listening and reading must be considered carefully as to what degree we project our own experience onto the other and perhaps speculate or determine rather than understand (Galbusera & Fellin, 2014).

With this in mind, I conducted the main parts of the formal analysis in collaboration with Råbu, all the time bringing with me the embodied impression from the interviews and reading of the transcripts. We started with repeated readings of the transcripts to familiarize ourselves with the data. The transcripts for each participant were read slowly for exploratory notes, descriptive comments, and initial codes, all related to the particular participant's experiences.

The next step included separating text segments related to each research question into corresponding broad content units for each participant. For each research question, these segments were coded for meaning content and suggestive abstractions of emerging themes for each case. Subsequently, a cross-case analysis was conducted to generate suggestive themes on a group level. Recurrences between cases, as well as similarities and variations, were considered. Together this process highlighted the complexity of the material. This back-and-forth movement between cases guided our understanding of text segments that formerly had appeared to consist of more superficial descriptions but altered in meaning when they were considered in light of segments from more articulate participants. Furthermore, this phase also incorporated the embodied reflexive experiences from interviews, listening through, and repeated readings, together with going back to the separate transcripts to ensure that the

emerging themes stayed close to the participants' descriptions. In the final phase, we considered the themes according to connections and interrelationships and then organized them into a superordinate theme, main themes, and subthemes. The developing themes from this formal analysis were reflected upon in meetings with the co-researcher and the resource group, as well as with Wilberg and Stie, until reaching a consensus over the presented versions.

### **Credibility checks of the analysis**

Various credibility checks were integrated into the analytical process. During the interviews, each participant was given the opportunity to add any information that might have been omitted through the question "is there anything important that I did not ask about?" The repeated reflections with the co-researcher, who read all transcripts, and the meetings with the resource group contributed to reducing researcher bias, as well as keeping the user perspective salient throughout the analysis. Råbu read all of the transcripts. We also collaborated throughout the formal analysis, with an ongoing focus on understanding the complex nature of the data from multiple perspectives (which were also ensured through discussions with Wilberg and Stie). At the same time, validity checks of the themes were done through returning repeatedly to the original transcripts to ensure a fit between the interpretations and the empirical data.

Finally, the participants were contacted and asked for feedback on drafts of each manuscript and on Norwegian summaries of the findings. Twelve participants gave their responses to the first, ten responded to the second, and seven responded to the third manuscript. Together, they conveyed that the superordinate and main themes reflected their experiences, while the variance in the findings also reflected variance in their experiences. Several participants also conveyed that they found the texts both interesting and emotionally challenging to read, and were touched to have their experiences reflected through the findings.

### **Ethical considerations**

The Regional Committees for Medical and Health Research Ethics (REK sør-øst, nr. 2015/980) approved the research project. All participants gave their informed consent to participate. The verbatim recordings and coding for identifiable details were stored safely

according to ethics regulations. All transcripts were de-identified. Pseudonyms were used in transcripts and in the presentations of findings, as well as in reflections by the researchers and the service users.

All participants were in treatment at the time of the interviews, and their respective therapists were informed of their participation in the research. To ensure that they had available support in case of any distress, all participants were encouraged to contact me if they had any questions or concerns about the interviews or about any shared experiences. None of them expressed any negative reactions to the interviews; rather, they found the research important and they hoped that their participation could contribute to understanding their concerns better. None of the participants decided to withdraw from the research project.

### **Reflexivities: the positions of the researcher and of the research**

As the aim of the project has been to stay close to the experiences of the participants, we sought to adhere to a continuous reflection upon our positions as researchers. Finlay (2002a; 2003) defines reflexivity as the process of continually reflecting on an object or event in hindsight and simultaneously being aware of how this reflecting plays out in your embodied consciousness. One takes into account that researchers (or people) cannot step out of their own horizon of pre-understanding, and thus it will always be part of the shared field of experience that characterizes a meeting between people (Binder et al., 2012). Reflexivity aids us in becoming transparent and trustworthy through the presentation of our efforts towards balancing phenomenological closeness to the participants' experience and hermeneutic reflection upon one's position as a researcher (Binder et al., 2012). Thus, reflexivity was brought to the foreground from the very beginning to the end of this research project. The reflexive processes that took place were of various kinds, all important to the analysis. As the articles allow only for brief and more general descriptions of reflexivity, due to their short format, this presentation will be more thorough to make the analysis more transparent.

Various types or positions of reflexivities may be outlined (e.g. Finlay, 2002b; Finlay, 2003; Finlay, 2017; Gough, 2003; Wilkinson, 1988). One position is that of a personal introspective reflexivity to give some awareness to the motivations, interests, and attitudes a researcher brings to the process (Finlay, 2003; Gough, 2003). Another position is disciplinary reflexivity, which involves a critical look at the research project's place and function within a



theoretical and methodological context (Gough, 2003; Wilkinson, 1988). Yet another position is functional reflexivity, which entails an awareness of one's role as a researcher in interaction with participants, including the distribution of power and inequalities (Gough, 2003; Wilkinson, 1988). Lastly, intersubjective reflection is a position that focuses on the effects of the dynamic encounter situated between the researcher and the participants, as well as how these intersubjective dynamics may contribute to the co-constituted meanings (Finlay, 2003). These various reflexive positions have been present to a greater or lesser degree throughout the research process, shifting in which position came to the foreground or lingered in the background. For this project, a look at functional and intersubjective reflexivities also includes the ongoing interaction with researchers with first-hand knowledge of AVPD.

### **Personal reflexivity**

As the introduction of this thesis outlined, my way into this research project was that of a personal, albeit professional, experience of dissatisfaction with my therapeutic work with people diagnosed with AVPD. This was the conscious point of departure. Later on, I reflected on why this particular group of clients came to be important to me, beyond the feeling of failing as a therapist. I looked into the personal experiences that resonated with my engagement for this group of people. Growing up, I was quite reserved and shy without perceiving this as being troublesome, except when I was pushed to socialize in ways that I found uncomfortable. In my youth, I decided to come to terms with being more outgoing, as I realized that I needed to expand my network. As a result, I today view myself as a "social introvert" through balancing taking care to replenish my energy on my own and enjoying spending energy with others. The questions that came from these personal reflections were how being reserved, shy, or introverted can develop into a pattern of avoidance with such devastating effects, and what actually enabled me to adapt to my personality traits without too much distress. Throughout the research process, I tried to keep these questions open and to refrain from answering them in a theoretical way until the very end of the project. To enable myself to do so, thereby staying open to the descriptions of the participants, I repeatedly returned to a more disciplinary reflexivity.

### **Disciplinary reflexivity**

Ongoing discussions with the other researchers, the co-researcher, and the resource group ensured my awareness of the experience-near descriptions before I moved on to more abstract interpretations. I also kept a research journal in which disciplinary reflexivity became an important focus. Several theories and phrases were brought to my attention and their

underlying assumptions made apparent. Terms such as “personality disorder,” “treatment,” “change,” “causes,” and “avoidance” were revisited several times. I realized that besides the apparent influence of my profession as a psychologist, years of working in a hospital setting had shaped my thinking more than I had realized. This concerned the values and culture of the corresponding patient and clinician roles, as well as organizational procedures for providing streamlined, efficient treatments based on proper diagnostics. The influence was significant, despite my ongoing skeptical attitudes towards this medical way of thinking about mental health. I could trace my conviction of the importance of a humanistic stance in clinical psychology back to a growing discomfort with current practice in my context of a public hospital setting.

Another area considered was the notion of good-willed intentions to help, which also risks belittling the receiver of help (the patient), who is expected to be grateful and compliant in the role of being treated as a target for interventions. How do these more or less conscious attitudes of therapists come to influence the way we relate to a client’s possible dissatisfaction with treatment or lack of expected progress? Furthermore, reflections on what we understood as our cultural expectations of being competent and comfortable in social settings were important, along with how various personality traits are more valued culturally than others. How could cultural norms influence our understanding of deviance and therapeutic goals for people diagnosed with AVPD? Intertwined in the above reflections, inequalities and questions of power imbalances made themselves apparent, both between researcher and participant and between professional researchers and co-researchers with first-hand knowledge.

### **Functional reflexivity**

An inherent inequality of power lies within this kind of qualitative inquiry, as the researcher sets the stage for the project in general and in the interview setting (Gough, 2003). The participants place their trust in the researcher and become vulnerable as they share their personal stories and reflections. Although protecting and regulating this power imbalance is the aim of the ethical regulations, there are still important aspects that may influence the form and findings of such a study.

An important issue concerned using the diagnostic term itself in the research. The stigmatizing and objectifying pitfalls of using a diagnosis were brought into the foreground through awareness of the language used. One example was adopting the phrase “persons diagnosed with AVPD” consciously instead of just saying or writing “AVPD,” to emphasize that “the person” was the main issue. Discussions with the co-researcher and the resource

group underscored the importance of maintaining this point of view. The research group reflected on how professional clinicians and researchers were in danger of viewing people as carriers of a diagnosis or as “objects of study.” A consequence of focusing on a diagnosis could be difficulties with staying open and attentive to the personal experiences of clients or participants as subjects. Personal experiences of being uncomfortable with being predefined through their diagnosis were shared in the resource group. Another important topic of reflection was the notion of “being treated” as opposed to being guided or assisted with finding a way through one’s personal recovery and the existential challenges considered as being of particular importance to AVPD. That is, a mere search for cause and effect could be perceived as degrading if this search did not take one’s personal views and history into account.

The issue of power balances were also important to the work of the resource group itself. A power imbalance came from my role as a professional researcher responsible for the methodology and the concluding analysis, as well as the writing of articles and the thesis. On the other hand, the co-researcher and the members of the research group with first-hand knowledge were also clear that they did not wish to identify themselves as “professional researchers.” Rather, they acknowledged that their first-hand knowledge was as valuable and important as expert knowledge and that our enthusiasm on the topic and willingness to find a way of working together over time created a better balance between us.

### **Intersubjective reflexivity**

Intersubjective reflexivity came to the foreground as I conducted and reflected on the in-depth interviews with the participants. What became apparent was that the ideal version of a qualitative in-depth interview was often far from the reality of what took place in this research. At the same time, giving voice to these experiences came across as more and more important. According to Kvale et al. (2015), a good in-depth interview presupposes a participant characterized by being cooperative, motivated, eloquent, and knowledgeable. Participants answer in a consistent fashion and give rich and vivid descriptions of their lifeworld. The interviewer should allow these richly verbalized accounts to be spoken without hindrance, just giving gentle direction to keep the focus on the phenomenon in question. Good interviews thus should give detailed, in-depth account of phenomena, and the better the quality of these textual data, the more sound become the findings and conclusions.

Our interviews deviated from these ideals in several ways. Our participants expressed their discomfort with open-ended questions, with knowing what and how to answer, and with

being the center of attention. One interview in particular gave rise to reflections that shed light on how my trying to ensure good interviews for some time actually hindered me from paying attention to what the participants conveyed. As I sat with one participant in the first interview, I ran out of questions and could not focus on any particular topics to investigate further. The participant was friendly, but not very communicative, and the form became one of “a question, an answer, a question, an answer.” I returned to transcribe the interview for the co-researcher to read before the second interview. As I did so, a feeling of shame emerged as the process revealed how I had just posed questions and clearly had not tuned into the participant. I heard myself push on when she had nothing more to say, and I had not noticed the subtle cues of her discomfort that became evident to me while listening and transcribing. She kept on telling me that she did not know what to say. I responded with slight irritation to what I felt was an unwillingness to talk. Dwelling on this sense of shame and sharing it with my fellow researchers enabled me to re-read the transcript and take in the message it actually conveyed: that the participant truly did not know what to tell me. With the new understanding of what she had told me, I could then meet the participant for the second interview and gently explore what it meant to her. The experience of this second interview was fundamentally different from the first, as she described what it was like for her not to know answers to questions, not knowing what to say or what others wanted from her, not understanding what the other person had said, and so on. This important topic came to expand my understanding of this and the other interviews, placing these descriptions in a new light.

A contrasting experience was also important: how I also enjoyed the company of pleasant and friendly participants, realizing afterwards that we had talked about very serious topics in the lightest of ways. Reflecting on this, I came to think of my former experiences in doing therapy with people diagnosed with AVPD, and to question whether similar interactions had played out in these settings. I came to consider how some participants might have tried to make me feel comfortable, despite being uncomfortable themselves. This awareness made me more attentive to expressing gratitude for their efforts, as well as verbalizing how it could be challenging for them to answer my questions or just to talk about their experiences.

The most important lesson learned was how mere listening and reading was insufficient for the analysis, as the words could only convey their inherent meaning within an embodied awareness of the interpersonal exchanges that took place in the interviews, and of my reactions while reading the transcripts. As I kept this in mind, the participants also came forward better as persons, and their diagnosis moved to the background. My formal roles as a

researcher and clinical psychologist were easier to place when attending to this awareness. Again, the co-researcher and resource group were kind reminders of the importance of this stance, insisting on staying close to the phenomena and letting formal roles and abstract interpretations wait until necessary for the analysis.

Intersubjective reflexivity was also important to the resource group, which reflected on various topics of participation. These included how it felt to engage with each other in this type of setting, which was removed from the usual therapeutic context of patient–therapist relations. In our resource group setting, we strove to ensure the openness to explore the research issues in question in an atmosphere of equality of experiences. Yet this process of open exploration was not without its challenges. The process of working together in this way created some frustrations and confusions when trying to communicate our various points of view. Important personal experiences and convictions had to find their place within the format of a research project. Furthermore, we had to find a way to make room for contributions when the act of stepping forward in a discussion itself created tensions and discomfort. At the same time, joy was expressed over participating in something that came across as being very important for us as group members. In a more personal way, the members of the group reflected on how they had learned from each other, how important it had been to share experiences, and that our meetings often had affected each of us in a deep and personal way.

### **Findings: Short presentations of the three papers**

The three papers concern various aspects of the subjective, lived experience of AVPD, analyzed from the data gathered through repeated in-depth interviews with the 15 participants diagnosed with AVPD. To present the rich material in sufficient detail, the findings related to three research questions were organized into three articles, each with a specific aim.

#### **Paper 1**

##### *Subjective experience of avoidant personality disorder: Struggling to be a person*

This paper presents findings related to the first research question of how the participants diagnosed with AVPD experienced and made sense of their challenges and strategies for managing everyday life.

The subjective experiences of mental challenges related to a diagnosis such as AVPD may be quite different for the person having received the diagnosis than for an outside observer. Inquiry into subjective experiences can inform the descriptive base of the disorder and provide important views on the phenomenon. The aim of the paper was thus to reach a more nuanced understanding of the subjective, lived experience of persons diagnosed with AVPD. Our findings were organized into a superordinate theme of “struggling to be a person.” This struggle entailed how the participants came forward as trying to constitute themselves as functional relational persons within a lifeworld of isolation. Their ongoing efforts were colored by a conflicting stance of both fearing and longing for connection, as well as for solitude. They longed to belong to the fellowship of others, to connect with others and to themselves, as well as for the freedom and restitution that being on their own provided. They feared others’ opinions, motives, and agendas, feeling more vulnerable the closer they got to others and the more the possibility of being exposed increased. Being alone also entailed the danger of being overwhelmed with painful inner states, thoughts, and feelings. All the time, a sense of a doubting oneself arose, filled with insecurities about their own performance, opinions, evaluations, and feelings. The participants told of trying to appear as normal, secure, and competent as they perceived others to be, and of making efforts to be accepted through conformity. They spoke of making themselves invisible when this “as-if normal” strategy became impossible, or of retreating to their homes for rejuvenation. Much time was spent on both scrutinizing and shunning their experiences. These activities seemed to create more distance from their sense of self, resulting in a sense of not knowing

themselves. They lost contact with their own will and their wishes. Some descriptions, however, were of positive absorption and a sense of development, free of worry and rumination. They told of engagement in arts, crafts, and music, as well as in physical activity. Furthermore, some described a sense of connection with small children and animals, whom they considered genuine and true in their displays of love and dependency. Lastly, being in nature was for many participants an experience of freedom, competence, and presence.

These findings were discussed in light of theories of self-reflexive awareness, sense of agency, and social sharing, which together contribute to our sense of personal identity. The findings indicated much time spent reflecting on their own performance, on efforts to be included, and on how they compared to their perceived ideal concept of normality. This self-reflection seemed to be influenced by feelings of insecurity and doubt that at times included their sense of agency, as well as their core or phenomenal self. We suggested that reduced social sharing experiences could give reduced knowledge of normative and cooperative social behaviors. Furthermore, that limited access to shared implicit meanings of social interaction and to parameters for perceiving our place in our everyday world could contribute to a sense of ontological insecurity.

This paper was published in *the Journal of Clinical Psychology*. It has received two reviews: one in the Research Digest Blog of the British Psychological Society by Jarrett (2019) and one in the Research Matter section of *Therapy Today* by McLeod (2019).

## **Paper 2**

### *Subjective experiences of the origin and development of avoidant personality disorder*

This paper presents findings related to the second research question: how our participants made sense of the origin and development of their current everyday struggles.

The empirical search for causes of a disorder such as AVPD may be quite different from the way a person tries to make sense of how and why their mental challenges developed. Inquiring into subjective causes of mental disorders is important, as this form of understanding is considered to influence the way people cope and function. Personal life story narratives of clients' experiences also influence the collaborative aspects of therapy, as explanatory models for a disorder are shared in the therapeutic relationship. Thus, the aim of this paper was to understand better how participants diagnosed with AVPD made sense of the

origin and development of their current everyday struggles. Our findings were organized into the superordinate theme of “a story of becoming forlorn.” This story told of a child, youth, and young adult who became increasingly alone, lost, unhappy, and bereft of comfort. Some participants considered how their personality traits or genetics could have contributed to their troubles, but all talked of various life events as being important to their development. Experiences of having had parents who had been occupied by their own troubles or who expressed these troubles relationally, and/or having been bullied and/or rejected by peers were both of great significance to the participants’ life stories. Either way, the participants described a sense of having to succumb to their fates, keep quiet, and endure their situations. Resonating through their stories was a sense of being emotionally and/or relationally distant from their core family of origin and peers. Even the stories that told of good familial relations still conveyed how the participants had not considered talking about their troubles while growing up. Furthermore, at the time they did not consider what seemed to be a family norm of not talking together about personal concerns as something problematic or amiss. In their developmental passages and contextual changes, the sense of being forlorn increased. As new contexts demanded more of them, they became ever more lost as to how to be, act, or manage in social and intimate settings, as well as in situations of performance such as school or work. At the same time, some participants told of some good relations to others, such as a best friend, a grandmother, or a sibling. Some also found that a change of setting, such as a new school, provided a new beginning. However, their troubles reemerged with additional changes or when having to face the experience of disconnection in other family, peer, or romantic relationships. Regardless of their developmental stories, or of the degree to which they provided answers to why they struggled today, it seemed as if they lacked a stable internal base from which to venture out into new contexts.

These findings were discussed in light of an autobiographical developmental perspective, in the sense that people tend to relate to painful life experiences through telling their stories, and thereby to give meaning to their experiences. Meaning making seemed to be contextualized through the developmental interplay between the person and their social worlds. Furthermore, a developmental focus, in interplay with temperamental aspects, included the emergence of attachment patterns, emotional and verbal modes of communication, participation in talk about mental states, and participation in normative peer socialization. All of these elements play important roles as to the form and degree of



vulnerability the participants came to experience. We underline the importance of narrative discourse for the lived experiences and sense making of developmental actions and events.

### **Paper 3**

*Lived experience of treatment for avoidant personality disorder: Searching for courage to be*

This paper presents findings related to the third research question, of how our participants made sense of their experiences with treatment.

The way a client experiences treatment is important for the therapeutic relationship (including the alliance), as well as for learning of new understandings and skills (and thus for the outcome of treatment). Little is known about how people diagnosed with AVPD experience and make sense of their treatment and their personal efforts at change. Thus, the aim of this paper was to inquire into how people diagnosed with AVPD made sense of their experiences of treatment. Our findings were organized within an overarching theme of “searching for courage to be.” The participants came across as seeking help that could give them the courage to begin resolving their fears and insecurities, to dare to relate to and understand themselves and others, and to manage their everyday lives. To be able to do this, they strived to trust and to feel strong and free. However, most had entered treatment hoping that someone could give them explanations and directions, which in a sense would provide a prescription for relief. A sense of being managed or handled by a therapist emerged, together with not being able to make oneself understood. Being diagnosed, receiving medication, and/or attending therapy all became colored by a sense of being defined as a passive receiver of treatment, which over time seemed to maintain or accentuate a sense of relational distance. In contrast to these findings, were descriptions that conveyed a sense of vitality, movement, and initiative. When the participants had experiences of becoming active and involved in their own treatments, the possibility of change and development emerged. This sense of active vitality seemed to pertain to a therapeutic relationship in which therapists were characterized as having time and space for them. Furthermore, the therapists were perceived as giving guidance to participants to express themselves verbally; hence, the participants felt understood. The care and interest conveyed gave a sense of beginning trust that made them consider trying out interpersonal skills and new knowledge, including the discovery of others’ inner mental lives. Still, within these tales of beginning hope and courage, fear and insecurity

were still present. As their initial feelings of connection and trust pushed for change, their habitual strategies of coping seemed to pull at them simultaneously.

These findings were discussed in light of theories of the therapeutic relationship, in particular the establishing of interpersonal connection, communication, and collaboration as opposed to compliance and pseudo-alliance. Instead of their becoming the receivers or objects of understanding and treatment, we underscored the importance of their becoming known as subjects. Rogerian qualities in the therapist, as well as intersubjective presence and openness, seemed to contribute to growing trust, agency, and collaboration, which again laid the groundwork for new learning. For clients with AVPD, attuned verbal and emotional interaction on the part of the therapist may aid in articulation and acceptance of subjective reality, its situated point of view, and its relation to actions, events, and personal development.

This paper was published in *Frontiers in Psychology*.

## **Discussion**

The central aim of this thesis has been to inquire into the subjective experience of people diagnosed with AVPD. Three aspects of this phenomenon guided the exploration of the research project. The first concerned how the participants experienced and made sense of their everyday lives and strategies. The second investigated how the participants made sense of the origin and development of their current struggles. Lastly, we inquired into the subjective experience and sense making of treatment for AVPD. The three papers of the study all comprise findings and discussion sections, which will not be repeated here. Instead, I will summarize the findings to bring together an overall understanding through recasting them together. I will place and discuss this overarching view of the findings within a theoretical and empirical framework. I thus intend to point towards some central aspects of subjective experiences that may be associated with the diagnosis AVPD. I will review the limitations of the research and conclude with a consideration of its implications.

### **Closing in on the lived experience of AVPD: estrangement from self and others**

From the beginning of this research project, my intention was to understand better the subjective experience and sense making of people struggling with challenges diagnosed as AVPD. Their difficulties in putting words to their experiences made me aware of how we needed descriptions that could be used as a starting point for interpersonal therapeutic connection. Furthermore, I envisioned a “trying out” of verbalizing aspects of their inner psychological world that they would be able to identify with (or perhaps not, but it would still be something to work on).

When pulling together the overarching themes, one encompassing story seems to come forward. It is a story of feeling ever more forlorn when growing up, which leads to an ongoing struggle of being a person. In her or his struggle, this individual keeps on searching for the courage to be themselves. Each of the participants had their own individual narrative of the events that drove their story forward, creating variations of what it meant to them and how and to what degree these meanings made sense. Among these individual variations, there were still elements that resonated together, forming impressions that created a sense of a lingering, ever-present, and daunting aloneness that came about over the years, whether named or unnamed. The aloneness became a frightening familiar, coupled with a yearning for inclusion in the social relational world. The outer world, however, often seemed more like a clandestine

society with secret initiation and communication rituals, never revealing how one gains membership. The fear within this aloneness becomes more apparent if one pictures a young child that has little to no experience of what it means to be fully welcomed and accepted by benign others.

In this recasting of the participants' stories, it is as if they conveyed a sense of being surrounded by a void of loneliness. Even if there were other people present, they were not fully there. Rather, it was as if others were like two-dimensional figures who all acted their parts in a projection of assumed normality, while the inner worlds of others became something hidden and frightening. There was a sense of undisclosed and unnamed inner states, which if shown could have created a gradual awareness of the reality of subjective life. What came to appear as hidden social rules and intentions seemed to be coupled with ever-increasing experiences of alienation from the spheres of social exchange and intimacy. The repertoire of social acts was limited, and the known ones were often repeated without realizing that different social settings demand different actions. The participants' own minds were constantly present, yet their inner lives were also fleeting, sometimes remaining just out of their reach, barely tangible, as if their grounding in themselves had become ever more elusive. Ongoing questioning of the reality of others' acts and their own experiences made them desperate to determine why they were lost, and how it might be possible to find their way back out of this void of detachment and into the reality of togetherness. This world of others had seemingly taught them that they had missed something crucial that left others to reject them as not likeable. However normal they tried to be, others seemed to ensure that they remained outcasts. Left on their own, the void imposed on them, reminding them of their failures as they desperately kept trying to fill it with something to ease their despair.

Their personhood seemed more like a persona or a mask, even to themselves. Insecure and doubting, they were always aware that had to be something more, something that is supposed to make life good — something to explain how others were content and protected in the face of the dangers and pains of life. All of this internal landscape lay there as if waiting to become recognized by another, and thus life could become bearable through not having to be so alone anymore. The other, such as a therapist, could lend their words and their knowledge to moving slowly about in this landscape together, to create and recreate through telling and giving voice, letting the view change and develop as they travel. Perhaps good experiences could lend a sense of vitality to the journey: from trusting and caring for others, from creativity and activity, from the feeling of freedom, ease, and belonging in nature. The aim

was not to take away the pain, fears, and insecurities, but to name, recognize, understand, and make sense of them as part of their natural responses within their life stories, which were continuously being created.

What comes to the foreground from these descriptions are theories of how the self develops in ongoing dynamic interactions with others; how a sense of our individual selves come to be through others, one way or another. Our sense of sameness creates the background for our individuality to stand out. I will apply an understanding of the self that enables us to give words to lived experience, and thus not enter debates concerning the actual existence of the self as an object. Such a debate seems foreign to our epistemological foundation within co-constructive, interpretative phenomenological perspectives. Thus, this discussion will base its understanding of the self to represent experiential reality through it being an integral part of conscious life. A certain experience becomes experienced as one's own through what may be called an experiential core self (Gallagher & Zahavi, 2012). Considered implicit and prelinguistic, this core sense of self is interwoven developmentally with explicit and conceptual self-references and the narrative autobiographical identity that organizes our experiences and actions (Gallagher & Zahavi, 2012).

### **Self-with-other: psychic aloneness**

Going back to the work of Daniel Stern (1934–2012), we find an understanding of the self as an organization of experience (Simms, 1993). Within Stern's observational empirical work and theory on interpersonal development, there is an emphasis on the dynamic aspects of experience that connect development and current interpersonal encounters, the interpersonal and personal, and the subjective and the intersubjective — all leading up to an understanding of the self as a self-with-other experience (Emde, 2013). This self-with-other experience was considered as being based in a distinct form of early implicit relational knowing that evolves in parallel, but also in interaction with, later language-based and explicit knowledge (Michels, 2017).

What colors the experience of the self that comes forward in the participants' descriptions seems primarily to be ongoing doubt. It is as if their inner core of self-experience is not trustworthy as a solid base for judgement and evaluation. Alongside the doubt, there is always the more or less direct experience of disconnected aloneness. The self comes across as longing for connection, with an intuitive knowing that they have missed some kind of

relational connection that should have been there. Together, the doubt and the aloneness seem to generate feelings of anxiety connected to the person's being and functioning in the mundane social world.

Stern (1985) considered the following senses of self as critical for normal social functioning: the emergent, core, subjective, and verbal senses of self. In his theory, these senses of self derive from invariant physical and mental experiences occurring in infancy and onwards. Thus, generalized representations of interactions are created that keep on organizing experiences at different levels, becoming building blocks of internal working models. What is crucial to all of the invariants that organize our experiential self is that they are all part of our sense of relatedness. They all take place in interaction with others, as each person's sense of self connects to a sense of relatedness. An emergent or initial experience of a process of self-organization, and then a core self of physical and sensory relatedness, distinguish the physical worlds of the other and me in implicit procedural memory. These experiences create senses of agency, coherence, affectivity, and self-history. The core self becomes the base for the subjective self that emerges in intersubjective relatedness. This subjective self represents a way of organizing the experience of one's own mind and that of others, which builds on social sharing to bridge overt actions with internal subjective states. What becomes shared are frameworks of meaning through means of communication like gestures, postures, and facial expressions. This process takes place before the development of language and depends on joint attention, intentions, and affective states. Affect attunement proves to be a basis of relatedness through expressing or recasting the quality of the affect by expanding on it, with a focus on the internal mental state and the shared qualities of the feeling state that lie behind overt behaviors. Attunement involves categorical affects, like joy and anger, as well as vitality affects or "the temporary contoured feelings that accompany all experience" (Stern, 2009, p. 13). A sense of connectedness and being with another emerges in attunement experiences (Stern, 1985). The feeling states that are never attuned to will only be experienced alone, thus these feeling states will be isolated from the "interpersonal context of shareable experiences" (Stern, 1985, p. 152). The significant others thus socialize the child's subjective experiences by influencing what and how much is shared, as well as the consequences of sharing. It is important to note that the temperament and the adaptations of the child also influence its mutual interaction with the significant others. However, what the child learns will influence their capacity for "psychic intimacy," which refers to their openness to disclosure and ability to take part in mutually revealing, interpersonal relations of coming to know and be known

(Stern, 1985, p. 126). If little becomes shared, a sense of “psychic isolation” may emerge (Stern, 1985, p. 126).

Stern’s concept of psychic isolation seems to capture an important aspect of our findings. The participants’ being-with-others in the intersubjective realm seems to be colored with a sense of psychic *aloneness*. Their private inner worlds remain unshared, and their sense of the inner world of others underdeveloped, as the bridge between overt behaviors and inner mental states seem insufficiently co-constructed. Perhaps experiences of attunement in intersubjective sharing were few or nil, creating a pervasive feeling of aloneness, or of more selective attunements (of which only some parts of subjective life could be shared to create any sense of union, reinforcing some aspects of psychic life and behaviors while leaving the unattuned aspects out of intersubjective existence). Unrecognized aspects that go undercover may be seen as the start of a “false self” (Winnicott, 1960); that is, those parts of experience that become shared at the expense of the unshared (Stern, 1985, p. 210). Lastly, some participant descriptions of their experiences of the self seem to relate to a sense of others defining them, perhaps attributable to early misattunements (as when you let someone into to your subjective world and it is questioned through misattunements, so that you cannot relate to it anymore). Their doubt also came forward as related to others. Misattunements and selective ones may be sensed as forms of unauthentic and untrustworthy responses of others, creating a sense of insecurity. Thus, self and other experiences are important for their contributions to attachment and sense of security, as well as for how one is guided towards or away from psychic intimacy (Beebe, Sorter, Rustin, & Knoblauch, 2003).

### **Attachment: detached insecurity**

When moving from theories of self-organizing experiential development of being-with-others towards theories of attachment patterns, possible relations emerge that may further expand our thinking about our findings. As the development of core and subjective senses of self may contribute to the sense of disconnection and doubt of our findings, attachment theory may shed further light on the ongoing insecurity that comes forward in the participants descriptions. Disconnection and insecurity may be seen as related and as part of the interrelationship between the child and the caregiver or significant others. However, attachment relates to our behavioral and regulatory patterns of dealing with perceived physical and psychological threats, and what we do when in need of protection and support

(Mikulincer & Shaver, 2016). Our findings imply that our participants felt alone with themselves, and were trying to manage on their own. The possibility to turn to others for protection and support when in distress was seemingly not often present as a viable option.

Attachment behaviors emerge from birth and develop throughout life (Bowlby, 1969; Mikulincer & Shaver, 2016; Mikulincer, Shaver, & Pereg, 2003). When the interpersonal interaction involves a caregiver who provides good enough availability, as well as attuned responses to the attachment needs of the child, a sense of attachment security develops and explorative activities follow (Ainsworth, Blehar, Waters, & Wall, 1978). The caregiver provides the child with a sense of a secure base to explore from, and a safe haven to return to when in distress (Mikulincer et al., 2003). If the attachment needs are not adequately met, a sense of insecure attachment follows, and explorative behavior becomes affected or distorted (Ainsworth, 1979). Proximity seeking is considered the primary strategy for support or protection that is set in motion in the face of danger (Bowlby, 1969; Mikulincer & Shaver, 2016). If proximity seeking fails to initiate adequate and matched attachment responses from the significant other, secondary strategies develop to aid affect regulation (Shaver & Mikulincer, 2002). The child may fight for attention through what is called hyperactivating or protest strategies to cope with frustration over unpredictable responses from their caretaker, which again may add to the development of an anxious attachment style (Ainsworth et al., 1978; Bowlby, 1969; Mikulincer & Shaver, 2016; Mikulincer et al., 2003). If the child experiences an ongoing, felt unavailability of the caretaker, or if attachment needs and signals are discouraged or punished, the child may suppress his or her attachment needs to avoid frustration and distress. Furthermore, the child may become compulsively self-reliant and resort to an avoidant attachment style (Ainsworth et al., 1978; Bowlby, 1969; Mikulincer & Shaver, 2016; Mikulincer et al., 2003). When these attachment strategies come across as oscillating or breaking down, they form a disorganized attachment style (Main & Solomon, 1986).

In adults, insecure attachment styles have come to be conceptualized as dimensions of attachment-related avoidance and anxiety (Mikulincer & Shaver, 2016). High levels of avoidance are related to discomfort with closeness or depending on others, as well as a preference for emotional distance, self-reliance, and deactivating strategies. A high degree of attachment anxiety is seen as being related to a strong desire for closeness and protection, as well as a preoccupation with and worry about availability and one's own value, together with hyperactive strategies (Hazan & Shaver, 1994; Mikulincer & Shaver, 2016). Furthermore,



adult attachment styles involve working models of how positively or negatively you view yourself, the degree to which you view yourself as worthy of love and support, and issues regarding the reliability of others and the possibility of them rejecting you (Bartholomew & Horowitz, 1991).

Our findings conveyed a diminished sense of a secure base or safe haven from the participants' proximity-seeking experiences in early attachment relationships, leaving them to fend for themselves through secondary attachment strategies. It seems as if they mainly resorted to withdrawal deactivation. Yet hyperactive longing, worry, and rumination remained present and created a pull towards others. However, constant efforts at deactivation reduced the possibility of various forms of rejection that seeking closeness and reliance on others might entail. Neither hyperactive nor deactivating strategies alleviated their distress enough to ensure security for explorative behavior. They came to view others negatively, as they did not consider it possible that they would be there to support or comfort them. If they reached out for help, others would reject them. They had to manage on their own. When relying on themselves, they reduced the risk of painful rejections, while still feeling lonely, different, insecure, and unworthy of love and inclusion. The pull towards others resumed through their attachment and connection needs when fear imposed on them, which again had to be suppressed, as no one was there to approach. So, not only do the participants convey a sense of no one being there to help them in their despair and feelings of danger, but as they resort to self-reliance, their core subjective sense of self seems even more brittle, as their needs for attachment and connection were suppressed to experiences that were unshared, unattuned, and most likely unnamed.

### **Verbal self: a story unspoken**

Self and others become objects for reflection and empathy when language enables shared meaning through words and the construction of a verbal self that coexists dynamically with the core and subjective selves, and in the same fashion becomes part of our self-with-other relatedness (Stern, 1985). Discourse among family members and peers about feelings, thoughts, and beliefs provides the ground and context for symbolic conceptual learning and reflective thinking about the minds of self and others (Carpendale & Lewis, 2004; Guajardo & Watson, 2002). Through talking together, we represent and organize our experiences and our memory of social interaction in the form of stories that link intentional states with actions,

informed by culture and norms that lend a basis for interpretation of why one does as one does (Bruner, 1990; Guajardo & Watson, 2002). Communication bridging internal mental states and actions aids in the understanding and evaluation of social events (Guajardo & Watson, 2002). In other words, the way we talk together about what happens to us influences the way we co-construct and remember our experiences, including those we do not talk about (Pasupathi & Eisenberg, 2001). Whether communications about psychological states and the discourse of remembering events are facilitated or constrained (which is related to the degree of exposure to and involvement in mental state language, as well as the parental scaffolding in storytelling) can influence the development of our mental state understanding and the telling of our stories (Carpendale & Lewis, 2004; Habermas et al., 2000).

Our participants conveyed that they were quite unfamiliar with talking about themselves or telling their stories. Some had longed for someone to talk to; others seemed unaware of the possibility to tell someone about their experiences. Yet some said that no one would listen to them if they were to tell how they fared; others decided not to bother others with what they had to share. Either way, much of their experience seemed unspoken. For some, what they spoke about seemed somewhat disconnected from their inner experiences of core subjective reality. Much of their inner personal experiences seemed unnamed and were not present in their talking about themselves-with-others. There seemed to be a gap between their verbal conceptual self and their global experience of the non-verbal senses of self: as if large parts of self-experience were left out from interpersonal verbal sharing, as they were not recognized, accepted, or given the words to express them. It could be that participants' family norms of how they talked together, in particular about inner mental states, could have influenced what experiences and events were communicated or facilitated. As mentioned earlier, subjective experiences that are unattuned, misattuned, or selectively attuned in being-with-other, may find their place outside of intersubjective existence. Naturally, these experiences will most likely be misnamed or not be named in conversation, creating a further split between the parts of the self that are spoken and interpersonally reinforced by others and the realm of the unspoken, hidden parts of self-experience (Stern, 1985).

### **A social self of shame**

Our core subjective and verbal being-with-others all takes place in the developmentally expanding social contexts of everyday life. Part-taking in social sharing

involves conducting and presenting ourselves in actual interaction with others, based on how we understand normative and cooperative behaviors (Colle et al., 2017). Goffman (1978) presented a perspective on the self through his focus on how we present ourselves to one another, proposing that the self is also a social phenomenon unfolding in normative interaction rituals. Our participants told of reduced social experiences throughout their childhood, adolescence, and adulthood, as well as of rejection and bullying from peers. Their sense of social estrangement increased as new developmental challenges and transitions demanded further elaboration of social knowledge and skills, making their deficits in these areas more apparent. Our findings also gave an impression of the intense and draining work the participants put into their everyday social performance, self-presentation, and concealment of inner states — all with the intention of fitting in through efforts at conformity. At the same time, they considered these self-presentations as failing and as resulting in perceived embarrassment and social rejection, all without understanding exactly why.

People are generally sensitive to small variations to expected social conduct, which again depends on how the perception of the interaction is perceived in context (Fine & Manning, 2003; Goffman, 1986). Embarrassment arises when we fail to meet normative expectations, when we do not manage to conceal our shortcomings or fail to keep our composure in social interactions (Goffman, 1967). Feeling comfortable is commonly viewed as a natural state in social interactions, thus leading those who are frequently uncomfortable or embarrassed to feel deviant and inferior. Most of them try to hide their discomfort by shortening their participation in social interactions or just avoiding them (Goffman, 1967). The dynamics of self-presentation and embarrassment resonate well with our findings of how our participants tried to conform to what they considered normal social functioning, thus presenting themselves “as-if-normal.” In particular, the findings reflect the despair that emerges from realizing that you have failed socially, upon seeing the failure confirmed in the eyes and demeanor of others. This despair may be viewed as shame, as the felt state of how our faults become publicly exposed makes us feel rejected, separated, and isolated from others and drives us to hide ourselves (Martens, 2005). Shame is also considered to be a self-conscious emotion related to self-rumination and distress (Candea & Szentagotai, 2013), as well as to a perception of the self as flawed and thus unworthy of acceptance and belonging (Brown, 2006). Efforts at self-presentation that include repeated experiences of embarrassment and shame may come together as part of being-with-others in everyday life, and most likely will remain as untold and unattuned experiences. Our findings point toward

self-regulation of shame, as the participants strived towards presenting themselves as flawlessly as possible, as well as withdrawing from possible shame inducing contexts, whether internal or external (Schalkwijk, Van Someren, & Wassing, 2019). Thus, the social selves of the participants come across as being marked by shaming experiences of various forms of rejection involving a flawed self with scarce knowledge of social normative rituals. They also seemed to lack experience in talking about shame and vulnerability though reaching out to find empathy, understanding, and connection in others. The latter experiences are considered to generate resilience to the possibly devastating effects of internalized, silent, and secret shame or embarrassment (Brown, 2006).

## **Contributions**

### **Implication for therapy: to become known**

What emerges through our findings as being of particular importance for adapting therapy for people diagnosed with AVPD seems to be intersubjectivity: to become known as a person and a subject by others and by themselves. Perhaps most important of all is getting to know the aspects of self-organizing experiences that have been left outside of interpersonal attunement and verbal sharing. Most likely, these unshared interpersonal experiences are deemed unacceptable, as they are dynamically associated with insecurity, fear, and shame. Rather than viewing these hidden experiences as something that should be treated, they most likely are in need of becoming part of subjective reality through intersubjective attunement and discourse. Our findings indicate that a sense of vitality emerges in an atmosphere of genuine warmth, together with attuned verbal therapeutic responses. This vitality does not seem to be associated with a reduction of “symptoms,” rather, it reflects being talked to as an intentional, mindful being by therapists who also make themselves experientially available.

Our findings thus indicate that without an ongoing focus on the importance of being-with-others for self-organizing experiences, the therapeutic context will likely not be secure enough for exploration and learning. Perhaps current efforts at developing specialized treatment (such as targeting specific aspects of AVPD for interventions) could benefit from a stronger focus on core subjective self-organizing experiences, in addition to focusing on verbal narratives and reflective/social selves. To emphasize these aspects of self-experience might contribute to a sense of improved connection in the emotional bond of the therapeutic relationship, as well as to an improved sense of the inner unity of one’s self-experience. When

recognized and accepted, core subjective self-experiences might find their rightful place within the client's life story. A more coherent sense of self might evolve in a developmental context as something that came from early patterns of self- and other regulation in core interpersonal relations. Experiences of social shame may be viewed as understandable when considered as resulting from deficiencies in learning social skills and normative rules when growing up, rather than reflecting personal flaws. Perhaps the gap between earlier unshared aspects of subjective self-experience relating to the verbal and social self might come to make sense, hence establishing a trusting, securely attached ground for change that may increase experiences of acceptance and even joy in social sharing.

### **Implications for nomothetic understandings of AVPD as a diagnosis**

Overall, our findings may all be viewed as belonging to an interpersonal understanding of personality as forming in a developmental process. When pulling together this discussion, what comes forward is an emphasis on what may have become unrecognized, unacceptable, and unknown aspects of self-experience. These include a missing sense of security, together with deficiencies of interpersonal learning in terms of normative cooperative social skills and behavior. If we place this discussion back into a model of personality developed by McAdams (2006), we may come to learn more of AVPD as a diagnosis without excluding the person diagnosed. McAdams' model includes three levels or domains. The first one addresses how one is placed on dimensions of general dispositional traits, like those of the Five-Factor Model (neuroticism, extraversion, openness to experience, agreeableness, and conscientiousness) by McCrae and Costa (1995, 1999). On the second level, we find the characteristic adaptations of the person contextualized in time and space, and in interpersonal and social settings (i.e., how a person typically act in everyday situations, how they deal with stress, and what they want or wish for, along with their roles, motives, attitudes, values, schemas, internal working models, attributions, and so on). On the third level, meaning is introduced through psychosocial constructions of the self in the development of a life story, co-authored through social interactions and within culture (McAdams, 2006; McAdams & McLean, 2013). It is the last level that includes the individual, subjective life of the person and that emphasizes the importance of making meaning through narrative. This is where our findings best find their place. Perhaps lending a voice to persons diagnosed with AVPD may aid their own storytelling. Furthermore, our findings of subjective experiences may be utilized to personalize empirical nomothetic

findings of characteristic adaptations, like social cognition components or attachment patterns, to guide a clinical transition from knowledge of the general AVPD population to an understanding of the particular person diagnosed with AVPD.

The diagnostic move from categorical models of personality disorders to dimensional conceptualizations of self and other functional impairment severity and pathological personality traits is of importance for an improved classification that aligns better with taxonomic findings of AVPD as a diagnosis (although the latter has been removed from ICD 11). In the alternative model of DSM-5, section III, and the related diagnostic measure of levels of personality functioning, self and other functioning have been construed as two components (Bender, Zimmermann, & Huprich, 2018; Buer Christensen et al., 2019; Buer Christensen et al., 2018). In a study by Buer, Christensen et al. (2019), the “self” component in particular identity (sense of self, self-esteem, and emotional regulation) was found to be the better predictor for psychosocial impairment. At the same time, the authors propose that self and other components may perhaps be viewed best as representations of self-in-relation-to-others— that is, as dynamically interwoven. This view aligns with how the discussion of this thesis places our findings within an interpersonal and intersubjective understanding of self-organizing experiences. The latter are understood as being of particular importance to a further understanding of AVPD, and to improving the quality of life for people who receive this diagnosis.

### **Discussion of methodological issues**

Quality and validity in IPA is assessed mainly according to criteria suggested by Yardley (2000): sensitivity to context, commitment and rigor, transparency and coherence, impact and importance (Smith et al., 2009). Other qualitative approaches use similar concepts of quality that relate to their specific traditions of conducting and communicating research (Hunt, 2011). Levitt, Motulsky, Wertz, Morrow, and Ponterotto (2017) have worked to establish criteria for evaluating qualitative research that may be applied within its various traditions and specific methods. They use the concept of “methodological integrity” to capture the degree to which research designs and procedures support the research goals, respect the researchers’ approaches to the inquiry, and are tailored for the fundamental characteristics of the subject matter and the investigators (Levitt et al., 2017, pp. 9-10). This concerns both fidelity (the researcher’s intimate connection to the phenomenon of study) and utility (the

effectiveness of the research design and methods in achieving the goals of the study). Together, fidelity and utility contributes to the trustworthiness of the research (Levitt et al., 2017); that is, the trustworthiness of its observations or data (reliability) and interpretations and conclusions (validity) (Stiles, 1993, p. 601).

### **Fidelity and utility of the research**

Levitt et al. (2017) suggest the following questions when considering research integrity (p. 11): Are the data adequate? Is the researcher's perspective managed for data collection and analysis? In addition, are the findings grounded within the data in such a way that they support the understanding? The following questions are recommended to evaluate the utility of qualitative research (Levitt et al., 2017, p. 11): Are the data contextualized and the limits made clear? Can the data lead to insights that are relevant to the goals and the method applied? Do the findings contribute to the research goals in a meaningful way? Moreover, are the findings meaningfully coherent?

In the current research, the phenomenon of study was the subjective experience of AVPD, and we grounded our analysis within an interpretative phenomenological epistemology that was considered suitable for inquiring into subjective meaning making. The use of IPA was considered an appropriate way to approach the research question, to guide the selection and size of the sample, and to undertake the analysis. Reflexivity was emphasized throughout the research project to ensure that researcher perspectives were managed, as we were inquiring into a rather unexplored phenomenon. As the interviews progressed, reflexivity was of particular importance, as the participants were unexperienced and sometimes uncomfortable talking about themselves, thus increasing the need to remain continuously aware of possible imposed interpretations. We selected our participants, people diagnosed with AVPD, purposely to gain access to the phenomenon in question. To stay close to the clinical reality or naturalistic setting of participants as patients in treatment contexts, we chose to stay open to co-occurrences of other diagnoses, although we sure that AVPD was considered the primary diagnosis for treatment by the respective therapists. We furthermore aimed to include participants of both genders, of various ages, and with various treatment experiences to capture the variance of the phenomenon. The inclusion of 15 participants was considered to fit the methodology of IPA and the scope of the project. Repeated interviews gave sufficient data to capture the variance of the phenomenon. The professional researchers ensured the grounding of interpretations in the data through a back-and-forth movement of analysis and rereading of transcripts. Inclusion of first-hand perspectives in the resource group

and by the co-researcher aimed at ensuring relevance and a groundedness in subjective experience. Feedback from the participants on the drafts of findings also ensured that interpretations were perceived as being grounded in the data from the perspective of the participants. As the research questions originated from both clinical and first-hand experience with the phenomenon in question, an ongoing focus on the utility of the design, procedures, and findings for clinical work as well as for service-users was maintained. Transparency was striven for in the communication of the procedures and the context of the findings to clarify the limits of the research, as well as to enable comparison of the sample with other clinical settings to guide reader evaluations of the transferability of the findings to other contexts.

Together, reliability and validity are considered to be enhanced through the above described procedures. Furthermore, the transferability of findings can be evaluated by readers through the emphasis on communicating them in a reflexive and transparent way, making it possible to judge their relevance according to various clinical settings and for the generation of hypotheses or further theoretical considerations.

### **Limitations**

The present research concerns subjective experiences of AVPD for a selected group of participants in their respective contexts. Our participants were all patients at outpatient clinics at a particular hospital, and the findings must be considered within this context. Other people with psychological issues related to AVPD who are not part of a similar hospital context may thus have other experiences of importance that could lead to a better understanding of AVPD. Neither can the findings be said to be strictly specific to AVPD, as our research did not concern comparison with the subjective experiences of other people diagnosed (or not) with other personality or symptom disorders. In addition, we did not use participant characteristics as analytical tools to compare subjective experiences within our sample. Thus, the findings do not tell of variance that could be related to factors such as age, gender, developmental events, treatment experiences, or other co-occurring diagnoses. However, all of these areas of potential comparisons are of interest for further qualitative and quantitative research. Further research could also benefit from particular attention to self-organizing experiences, related to the perspective of being-with-others, of people who have been diagnosed with AVPD.



## **Concluding comments**

The overall topic for this research project was the subjective experience of AVPD. As shown, a focus on a better understanding of the person diagnosed with AVPD has been kept through ongoing reflections with all involved researchers. Both formal and first-hand knowledge have contributed to this process of giving voice to these subjective experiences. In a way, the findings represent the participants' sharing of that which has not been shared before. The starting point of this research project was to search for a way to offer knowledge about the diagnosis of AVPD to particular persons seeking help and guidance. The journey of this inquiry has shed light on some areas of subjective experience and meaning-making to explore when working with people diagnosed with AVPD. For me, the experiences shared through this project have enhanced empathy and comprehension through the resonance of the human concerns of belonging and rejection, security and insecurity, vulnerability and acceptance, dependency and autonomy, and the deep need of becoming oneself through the heart and mind of another person.

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# Struggling to be a person: Lived experience of avoidant personality disorder

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## Abstract

**Objective:** To better understand the subjective lived experience of persons diagnosed with avoidant personality disorder (AVPD).

**Methods:** Persons with an AVPD ( $N = 15$ ) were interviewed twice with semistructured qualitative interviews and analyzed through interpretative–phenomenological analysis. Persons with first-hand experience of AVPD were included in the research process.

**Results:** The superordinate theme, “struggling to be a person,” encompassed two main themes. The first, “fear and longing,” incorporated the subthemes “longing for connection,” “dreading to get close” and “being alone, for better or for worse.” The second main theme, “a doubting self,” included the subthemes “feeling insecure” and “searching for a sense of self.”

**Conclusions:** The findings shed light on how the reflexive selves of people with AVPD might struggle with sense-making, sense of agency, and identity. This study underscores how impaired tacit knowledge of social behavior can hamper the process of being a person in relation to others.

## KEYWORDS

avoidant personality disorder, qualitative research, sense of self, service-user involvement, subjective lived experience

## 1 | INTRODUCTION

Avoidant personality disorder (AVPD) is characterized by “a pervasive pattern of social inhibition, feelings of inadequacy, and hypersensitivity to negative evaluation” (American Psychiatric Association, 2013, p. 672). The

diagnosis includes difficulties related to fear of criticism and rejection and feelings of inferiority and restraint in intimate relations due to fear of being ridiculed and shamed (Karterud, Wilberg, & Urnes, 2017).

When we seek to improve our classification of mental illness, mental problems become the object of study, not the person having mental problems. However, because people ascribe meaning and intentions to their actions (Schwandt, 2000), the separation of mental problems from the persons experiencing them becomes questionable. To expand our understanding of personality disorders such as AVPD, we might benefit from turning our attention to an ideographic inquiry of the subjective experience underlying the diagnostic criteria.

AVPD is among the most prevalent personality disorders (Torgersen, 2009). The estimated lifetime prevalence is approximately 2% (Torgersen, 2009); within clinical populations, the prevalence ranges from 11% to 57% (Karterud et al., 2017). Further, AVPD is associated with severe levels of psychosocial impairment, subjective distress, and reduced quality of life (Cramer, Torgersen, & Kringlen, 2007; Olsson & Dahl, 2012; Ullrich, Farrington, & Coid, 2007; Wilberg, Karterud, Pedersen, & Urnes, 2009). The social costs of AVPD are high, both in terms of direct costs related to assessment and treatment of the disorder and indirect costs stemming from lost productivity (Soeteman, Hakkaart-van Roijen, Verheul, & Busschbach, 2008).

Although some studies have found psychotherapy promising for treating AVPD (e.g., L. Alden, 1989; Bamelis, Evers, Spinhoven, & Arntz, 2014; Barber, Morse, Krakauer, Chittams, & Crits-Christoph, 1997; Emmelkamp et al., 2006; Rees & Pritchard, 2015; Renneberg, Goldstein, Phillips, & Chambless, 1990; Strauss et al., 2006; Stravynski, Lesage, Marcouiller, & Elie, 1989; Svartberg, Stiles, & Seltzer, 2004), the empirical literature on effective treatment has been scarce and inconclusive (Weinbrecht, Schulze, Boettcher, & Renneberg, 2016). There is some evidence that persons diagnosed with AVPD are difficult to retain in treatment (L. Alden, 1989; Barber et al., 1997) and might be at increased risk of relapse posttreatment (Gude & Vaglum, 2001; Karterud et al., 2003). As well, there might be difficulties associated with establishing and maintaining a therapeutic alliance with the patient (Strauss et al., 2006).

One challenge to empirical research into treatment outcomes for AVPD might be related to the diagnosis itself. There is a high rate of co-occurrence between AVPD and social phobia (e.g., Eikenaes, Egeland, Hummelen, & Wilberg, 2015), as well as with other personality disorders, particularly within cluster C (Lampe & Malhi, 2018; Weinbrecht et al., 2016). Research is emerging on an alternative hybrid dimensional/categorical model for the classification of personality disorders in *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5) as part of an effort to resolve co-occurrence among personality disorders (Morey, Benson, Busch, & Skodol, 2015). Current research (L. E. Alden, Lapsa, Taylor, & Ryder, 2002; Arntz, 1999; Eikenaes et al., 2015; Eikenaes, Hummelen, Abrahamsen, Andrea, & Wilberg, 2013; Torvik et al., 2016) supports approaching AVPD as a distinct personality disorder and not only a severe type of social phobia. Nevertheless, the in-group heterogeneity of both symptoms and severity of functional impairment within each personality disorder is substantial (Crawford, Koldobsky, Mulder, & Tyrer, 2011). Additionally, symptom stability seems to be less constant than previously assumed (Torvik et al., 2016); moreover, it remains unclear how the expression of various personality traits relates to or distinguishes between, pathology and normality (Livesley & Jang, 2000).

Research on personality traits has generally been based on statistical correlations at the group level. However, traits play out and take on specific meaning within the context of an integrated personality (L. E. Alden et al., 2002), one's interpersonal relations (Beebe & Lachmann, 2003), and one's own culture (Hofstede & McCrae, 2004). The person becomes more than a carrier of general characteristics (Nerheim, 1996), as he/she perceives himself or herself as "a person" (Barresi, 1999; Glas, 2006; Rogers, 1967). One way of approaching the phenomenon of personality function and dysfunction is using qualitative research to investigate how people make sense of their personal and social worlds. Empirical observations of subjective lived experience can add to a descriptive base for theory construction and provide additional views of the phenomenon, which in turn can facilitate both research and clinical work (Flanagan, Davidson, & Strauss, 2010; Livesley & Jang, 2000; Nehls, 1999; Smith, 2015). To our knowledge, no qualitative studies have been conducted on the subjective experience associated with the diagnosis of AVPD.

**TABLE 1** Demographic characteristics of study participants

Recruited participants	N = 15
Gender	
Women	9
Men	6
Age	
21–30	8
31–40	4
41–50	2
51–60	1
Living situation	
With husband/wife/partner without children	3
With husband/wife/partner and children	3
Alone with children	2
Alone	7
Educational level	
Primary education	4
Secondary education	9
Higher education	2
Employment (at the time of the interviews)	
Working	0
Welfare	15
Experience with therapy, including current	
First experience	2
2–3 courses of therapy	2
3 or more courses of therapy	11

The aim of the present study was to reach a more nuanced understanding of the subjective lived experience of persons diagnosed with AVPD within a qualitative research approach. The research question was: How does a person diagnosed with AVPD experience and make sense of his or her challenges and strategies for managing everyday life?

## 2 | METHODS

### 2.1 | Participants

#### 2.1.1 | Interviewees

The interviewees were 15 patients diagnosed with AVPD and receiving treatment in outpatient hospital clinics in Norway. Demographic information was collected about their age, gender, living arrangement, educational level, employment status, and previous therapy (Table 1). There were nine women and six men; their ages ranged from 20 to 51-year-old ( $M = 33$  years,  $SD = 9$ ). No participants were working at the time of the interviews; all were receiving welfare.

#### 2.1.2 | Researchers

The group of researchers consisted of (A) a clinical psychologist and Ph.D. candidate in clinical psychology; (B) a clinical psychologist and associate professor; (C) a psychiatrist and professor; and (D) one theologian with a Ph.D. in health sciences. A, B, and C all work part-time as psychotherapists, and D works as a hospital priest. Together, the

clinicians had backgrounds in schema therapy, mentalization-based therapy, relational, dynamic, emotion-focused therapy, and psychotherapy integration. All of the researchers share an interest in qualitative research on the subjective experience of various phenomena of everyday life, more specifically personality disorders, therapeutic processes, and outcomes. The first author (A) conducted the interviews. Analysis of the data was performed by two of the researchers (A and B). Reflection upon our epistemological stance and the analytical process was facilitated by B and D. Discussion and reflection upon the analytical process, as seen within the context of the knowledge status for AVPD, was accomplished with the guidance of C.

### 2.1.3 | Service-user involvement

To increase the quality, relevance, and ecological validity of the study, we included persons with first-hand experience of AVPD in the research process (Borg & Kristiansen, 2009; Veseth, Binder, Borg, & Davidson, 2013). A coresearcher collaborated with the first author throughout all of the stages of the investigation. In addition, a resource group (comprised of two persons with experience with AVPD as patients and two experienced clinical psychologists) held repeated meetings to reflect upon and offer suggestions concerning the research questions, the interview guide, and the themes that emerged.

## 2.2 | Procedures

### 2.2.1 | Recruitment

The participants were purposively recruited based on having received a primary diagnosis of AVPD by their respective therapists through the use of the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II; First, Gibbon, Spitzer, Williams, & Benjamin, 1997). Ten of the participants were recruited by contacting therapists at various outpatient hospital units. Therapists were provided with verbal and written information about the research project and brochures to distribute to the patients who, in their view, had a primary diagnosis of AVPD. Those who expressed interest in participating were contacted by the first author by phone or text message, were provided with oral and written information about the research project and were interviewed.

Additionally, nine participants from the research project "An Examination of the DSM-5 Level of Personality Functioning Scale in a Representative Clinical Sample" (Buer Christensen et al., 2018), who had agreed to be contacted at a later stage for additional research purposes, were approached. They received written information about our research project through their therapists. Five persons agreed to be contacted by the first author and were interviewed.

All of the participants provided their signed informed consent to participate. The project was approved by the Regional Committees for Medical and Health Research Ethics. Biographical details have been slightly changed to ensure anonymity. Pseudonyms are used in the presentation of the results.

### 2.2.2 | Interviews

An interview guide was developed by the researchers, the coresearcher, and the reference group for use in the first interview. This guide was only lightly structured to maintain an attitude of openness to the topics presented by the participants. A pilot interview was conducted to ensure suitability of the interview guide to the research question and, as well, to receive feedback from participants on how the interview situation itself was perceived. The interview guide was then slightly revised according to this feedback. Questions pertaining to the subjective experiences of challenges and strategies for managing the everyday lives of persons diagnosed with AVPD were: What is it like for you to have AVPD? How do you understand AVPD? What do you avoid? How would you describe yourself? What is it like to be you? What is everyday life like for you? What do you like to do (in your everyday life)? What do you not like to do (in your everyday life)?

Two semistructured, in-depth, face-to-face interviews, lasting 60–90 min each, were then conducted by the first author. The second interview occurred approximately 2–3 weeks after the first. The second interview was conducted to improve rapport and to provide both the participants and the interviewer with an opportunity to further elaborate on topics introduced in the first meeting. A preliminary analysis of the first interview formed the basis of follow-up questions for the second interview. For nine of the participants, the coresearcher read through the anonymized transcripts and provided feedback to the first author of her reflections and suggestions for further questions for the second interview. The coresearcher then read the interviews to include what she considered to be important areas of inquiry. Thus, the second interview focused on the elaboration of topics that arose in the first interview to provide fuller descriptions.

The participants came across as having limited experience talking about themselves; many expressed discomfort with the interpersonal nature of the interviews. Their answers tended to be brief, with frequent silences and superficial descriptions. Hence, adaptations were consecutively made to the interview technique to assist the participants in verbalizing their lived experience. The adaptations consisted of a more active interviewing stance prompting fuller descriptions. Several participants informed the interviewer that frequent questions made it easier for them to talk. Efforts were also undertaken to accommodate the participants' wishes for privacy and comfort; the interviews were conducted at the interviewee's site of choice. Eleven people preferred to meet in an office at their hospital unit. Four preferred to be interviewed at home. The interviews were audio-recorded and transcribed verbatim, with all of the confidential information changed to ensure anonymity. All of the transcripts were verified once. The verbatim material was imported into NVivo software (QSR International, 2015) for principal analysis.

## 2.3 | Qualitative methods

### 2.3.1 | Data analysis

Since the aim of this study was to better understand the lived experience of persons diagnosed with AVPD, we chose to base our analysis within a hermeneutic-phenomenological epistemology through the use of Interpretative Phenomenological Analysis (IPA; Smith, Larkin, & Flowers, 2009). The phenomenological aspects emphasize how one strives to describe the essentials of a given experience while at the same time, suspending one's assumptions (Van Manen, 2014). This philosophical study of "being," or of existence and experience, has its historical roots in the works of Edmund Husserl (1859–1938; Larkin & Thomson, 2011; Van Manen, 2014). However, in line with current phenomenological philosophy, one considers that observations are always interpretative and influenced by our historical, social, linguistic, and embodied context (Finlay, 2014; Larkin & Thomson, 2011; Van Manen, 2014). IPA thus acknowledges that observations are always "inextricably in the world, and in relationships with others" (Larkin & Thomson, 2011, p. 102), as we attempt to understand the world of the other and describe what it is similar to (Larkin, Watts, & Clifton, 2006).

The interviews were thus analyzed by applying IPA (Smith et al., 2009), combined with a focus on the reflexive, and exploratory aspects of hermeneutic phenomenology (Binder, Holgersen, & Moltu, 2012; Finlay, 2008). We assumed an inductive position by starting off with broad research questions, allowing for unexpected topics to emerge (as opposed to preconceived hypotheses developed from theories; Smith, 2004).

Each transcribed interview was read and reread to become familiar with the data. Then, each interview was analyzed with a focus on preliminary comments and initial codes related to participants' meanings and experiences. Further, text segments were separated into broad content units that represented various aspects of the participants' subjective everyday experiences of AVPD. The next step involved yet further coding of meaning content of segments related to the participants' everyday challenges and coping strategies. This step highlighted the similarities and variations that enhanced the complexity of the material. Suggestive abstractions of emerging themes were then developed for the relevant text segments related to each case. Subsequently, the cases were compared in a cross-case analysis to generate suggestive themes on a group level, based on recurrence across individual interviews. This step also gave way to a deeper understanding of the segments that appeared to consist

of more superficial descriptions yet became enriched when considered in light of segments drawn from the interviews of more articulate participants (Kirkevold & Bergland, 2007). In a final phase, the themes were considered according to connections and interrelationships and were organized by the developing superordinate theme, main themes, and subthemes, which resulted in consensus over the presented version.

### 2.3.2 | Credibility checks

Various credibility checks were integrated into the analytical process to assess the accuracy of the findings. First, each participant was afforded the opportunity to add information that might have been omitted. At the end of the second interview, the participants were asked, "Is there anything important that I did not ask about?" Second, repeated common reflections with the coresearcher and reference group aimed at reducing researcher bias and keeping the user perspective active and relevant throughout the analysis. Third, the research analysis was continuously reviewed by researchers A and B to ensure that multiple perspectives were included in the understanding of the complex nature of the data, whereas still reaching a consensus regarding the interpretation and resulting themes. Fourth, researcher A conducted validity checks of the themes by returning to the original transcripts repeatedly during the analytical process, ensuring a fit between the interpretations and empirical data. Finally, researcher A contacted the participants and asked for feedback on a draft of this study and a summary of the findings. Twelve participants responded to our request. The participants conveyed that they felt understood and, although reading through the material was emotionally challenging, they also felt moved that their own experiences were reflected in the written text. They described being both surprised and touched in reading how other people struggled with the same issues that they encountered in their own lives.

### 2.3.3 | Reflexivity

Within hermeneutic phenomenology, phenomenological exploration and theoretical and reflexive interpretation are understood as creating a dialectic tension that should be rendered transparent if the findings are to be considered trustworthy (Binder et al., 2012). Both acknowledging one's presumptions and remaining aware of the context of interviews are important to the analytical process. The theoretical stances of the involved researchers were reflected upon openly in meetings and made salient to enhance both theoretical distancing and closeness to the participants' making of meaning. The first author kept a diary for immediate impressions and reflections directly after the interviews and for reviewing the audio recordings. The purpose of this diary was to record reflections on the interpersonal context and possible meaning content, as well as to note areas to be further explored in the interviews. In addition to enhancing researcher reflexivity, the diary aided in the sharing of background information with the other researchers.

The first author, furthermore, aimed to transform these reflective notes into an embodied experience integrated into the ongoing analytical process. The intent was to aid what Rennie (2012) understood as efforts to articulate inchoate meanings of the interpreted text while striving to remain faithful to the participants' experience of the phenomena in question.

## 3 | RESULTS

Immersion in the accounts of the participants' experiences supported a general overarching superordinate theme of "struggling to be a person." This dynamic captured two main themes: "fear and longing" and "a doubting self" and their corresponding subthemes (see Figure 1).

The representativeness of our findings and recurrence of themes across individual cases is indicated by the frequency labels *general*, *typical*, and *variant*, as suggested by Hill et al. (2005). Accordingly, the main themes were all





**FIGURE 1** Dynamic interrelationship between themes

*general* in the sense that they applied to all or all but one case and are referred to in the text as *all participants*. The themes were considered *typical* in that they applied to more than half the cases, referred to in the text as *most participants*. *Variance* within themes was found to be represented by less than half but more than two cases; this label is reported as *some participants* in the text.

Themes are illustrated below using quotes from individual participants. These quotes were considered to bring forward the meaning conveyed in the material.

### 3.1 | Struggling to be a person

The superordinate theme of “struggling to be a person” reflects the participants’ ongoing efforts to constitute themselves as functioning persons among others. This struggle seemed to be related to trying to emerge as relational individuals within an experienced life world of isolation. Such efforts and their associated states were conveyed as lonesome struggles in which their everyday experiences were simultaneously scrutinized and shunned. Within their search for a sense of self and intervening doubt, their mainly solitary sense-making seemed impeded by conflicting inner stances of fear and longing. This conveyed experience of longing to be a unique person among others while fearing what relations might tell them of who they resulted in a sense of unresolvable intentions. The themes thus seemed to be in dynamic interplay, with an oscillation between strategies that somewhat overlapped: as one strategy came more into the foreground, others lingered in the background, and shifts would occur depending on the situation. This oscillating movement, however, did not come across as providing any forward direction that could offer the participants an experience of progress or of becoming.

#### 3.1.1 | Fear and longing

All of the participants conveyed a sense of being locked in a conflicting stance of fear and longing in their relations to both themselves and others. They felt a desire to connect with others but, at the same time, feared becoming close. They both longed for solitude and feared aloneness.

### Longing for connection

What came across in the descriptions of all of the participants was a longing to connect and thus belong to the fellowship of others. Some expressed that they were fond of people and wished to be liked. Most felt upset by how they could not manage to socialize. At the same time, their understanding of expectations or demands for inclusion in social life appeared to be deduced from observations of others' apparent behaviors—what they thought people might expect and demand from each other in social settings. The participants seemed to have built up an impression of ideals for social behavior that they perceived as impossible to live up to: "I guess that is the main issue for me: that I wish to be normal, and then I do not manage the way I wish" (Evan).

As the participants did not feel "normal" as they observed others to be, it became crucial that they acted "as if—normal" whereas simultaneously hiding their perceived shortcomings. Participants used words such as "putting on a mask" and "following the templates of behaving," as opposed to "the real me" or "the sick me." The participants described attempting to act as if they were happy, content, strong, or competent. This pretense was described as difficult and draining work: "I notice that you spend incredible amounts of energy. You just spend your entire consciousness in just not ... trying not to make a fool out of yourself and appear normal" (Steve).

All of the participants described hours of preparing for social engagements. The preparations were of various sorts: Imagining what would likely take place, planning how to converse and behave, and so on. A few situations were viewed as easier than others. For some participants, settings with only a few familiar and well-known persons, such as spending time with childhood friends or close family, were more comfortable: Here it was more possible to observe interactions and predict what might occur. Others found situations in which nobody really knew each other, such as the first days at school, more manageable since they made it more "normal" to be a bit insecure and confused. Relating to others was also described by some participants as easier if the interaction was focused on a common activity with organized guidelines for behavior, such as playing sports. However, after some time, the social interaction would naturally evolve into greater degrees of intimacy. This made it more difficult to play the "normal" part because their sense of differentness and the perceived risk of their true self-being revealed increased

*It was easier when we were a big group of students, but after like half a year, everyone had sort of made their small groups of friends already, and then, it seemed a bit strange that I did not have that, so then it was better for me to pretend and lie (Eva).*

Some participants described their longing for connection as something related to a sense of being known by other people. As their strategy for inclusion was based on pretense, they had few if any experiences with feelings of being truly seen by, and thus feeling close to, another person. As one participant said, "Nobody knows me, and I have never felt seen. Not even my mother knew me like that. I know I have missed it. I never felt loved" (Lily).

Some of the participants had attempted to communicate their difficulties with a friend or someone in their family. Most often, they concluded that the other person did not understand them, failed to take them seriously, or reacted by expressing his or her concern. Expressed concern caused these participants to feel worse, as they did not want others to feel bad because of them. They often resorted to keeping their troubles to themselves, not knowing how to better make themselves understood: "I wish I could open up and show (what is inside), but I do not know exactly how to do it" (Christian).

However, for some of the participants, a few relationships contained a sense of close connection void of pretense. Those who had small children or animals described these connections as important, genuine, and true. These relationships evoked tender feelings in the participants and gave meaning to life. Their own sense of vulnerability seemed to become somewhat forgotten in the moment of providing care and protection: "I feel like it is real when I show my feelings for my daughter... In a way, I feel like she is one of the few real people that kind of mean it" (Tom).

Participants whose children were older, however, described a growing distance in their relationships with them. As their children matured, their demands seemed to become more unmanageable: "I can feel really close to my

daughter. However, it has been difficult because she is getting older. She has started to tell me off. Thus, my insecurity has begun to show up with her too" (Elisabeth). Furthermore, however, close the participants felt to their animals, a longing for human contact still seemed to linger in their efforts to participate in social contexts.

### **Dreading to get close**

All of the participants described how their efforts toward (and inferred longing for) connection was accompanied by a simultaneous fear of others' possible opinions, motives, or agendas. They described what can be characterized as an ambivalence of efforts: reaching out for relationships yet, at the same time, withdrawing from them. Within this inhibiting state, the participants seemed to feel increasingly vulnerable as they grew closer to another person, fearing what might happen to them if they were to be exposed.

"The other" was viewed with great suspicion by all of the participants. Their observations of overt behavior did not seem associated with inferred trustworthy information regarding others' possible inner lives. They suspected that people would view them as unlikeable. Furthermore, they feared that others could be dishonest, fool them, be angry with them, talk behind their backs, betray them, or reject them: "I am very, very suspicious of people. Not that they would harm me physically, but what are their intentions? Or they seem nice, but really, they are not. That they are acting falsely. In addition, you do not know" (Eva).

Some participants expressed a feeling of being treated unfairly by others who seemed to always have their way. As they fearfully acquiesced to the assumed wills of others, frustration and anger would build up within them: "I have a temper now, even if I do not show it. It is a bit creepy, and it hurts. It has to do with how I always bend my neck for others, and I cannot be bothered anymore" (Ronny).

All of the participants described escalating physical reactions of the fear building as the moment of some interaction or social event drew near. As they approached and finally entered a social setting, their fear most often became intense and overwhelming. Several participants stated that they could reason that the situation was not dangerous—that they knew the people present fairly well. However, their bodies gave the opposite message of imminent threat. Thus, the willed attempts at connection often became drowned in a bodily call for safety through disconnecting

*Every time I leave a conversation or something, I go out to breathe and tell myself, "It is not dangerous; it is not dangerous." Then, I calm myself, and it gets just as bad again. I get very tense and I sweat, like it is dangerous (Ronny).*

Most of the participants described how they stayed vigilant when with others; they were always on guard against possible signs of danger in their social surroundings. They described how they needed to protect themselves from exposure. Despite their efforts to appear "normal," they also simultaneously attempted to blend in to prevent being noticed: "I get quiet. I do not dare say much. I just sit and attend to whatever goes on" (Jenny).

Some participants said that they avoided eye contact. They wore sunglasses, kept their heads down or hid behind others whom they perceived to be somewhat safe, more confident and better able to master most social situations. Some chose routes for walking that were less populated, or they interacted with others mainly through their computers or text messages. Some strove for perfect behavior, as doing so could conceal their perceived flaws or possible defects. Others attempted to become almost invisible; if they managed to do so, they reasoned, the likelihood of others including them in a social interaction was reduced. Hence, the risk of being exposed as vulnerable and a failing person could also be lessened.

### **Being alone, for better or for worse**

All of the participants described spending long periods of time at home on their own. They expressed that these solitary periods felt like their best option for gaining both freedom and restitution from the perceived impossible demands of others—and a corresponding fear of rejection. Some participants said that they did not mind spending

time alone and would grow angry if someone attempted to pressure them to relinquish their solitude and join others. The anger seemed fueled by their need to regain control of the ongoing perceived social pressure. At the same time, some participants described feeling sad, almost grieving, when they were alone. They felt deprived of the social life that they knew surrounded them. Some of the participants communicated a sense of not only feeling isolated but also as though their aloneness was a given state of being. This felt state of aloneness almost seemed a preconceived condition of life: it is just the way it is and always has been. Further, their aloneness appeared colored by a lack of hope, even despair, at ever managing to change their condition: "There comes heaviness, like 'now you are alone again little man, and you will never manage this; you will die alone'" (Peter).

All of the participants described how, when on their own, painful thoughts and feelings of solitude, longing and fear lingered on the borders of their consciousness, threatening to overwhelm them. If they were to open up to themselves and recognize how they truly felt, it seemed that fear could envelope them, making it almost impossible to endure and keep it all together. Awareness could mean taking in the full scope of their experience, thus threatening the brittle security their solitude rendered. All of the participants talked of various means to keep at bay these fleeting and painful thoughts and feelings. The most common strategy was to stay occupied in various ways. Most described filling their time by playing computer games, watching TV, drawing, cleaning, walking, working out, meditating, or listening to music intently and intensely to allow it to occupy their full attention. These strategies of being active on their own were described by some as often boring and only partially successful: "I feel like there is not much going on. I do not do much. I watch TV. Then, I relax. I do not have to think; there are no expectations" (Eva). However, some felt calm and comforted by their routine activities as if the routine itself provided order to their otherwise confusing conditions: "I collect photos of my favorite royal celebrities. I calm down, sit and sort them. I love to sort stuff. It is my escape" (Elisabeth).

All of the participants also reported using mental strategies to distance themselves from unwanted thoughts and feelings. They described focusing on something else as a distraction. It could be a pleasant memory, building a fantasy version of their lives in which they fared well or simply saying to themselves they did not want to feel or think: "I would rather think that nothing is wrong. I do not want to hear about it. It just stirs thoughts and feelings. It hurts. I lock up most stuff inside of me. But it is in here somewhere" (Anita). These strategies were described as energy consuming, often leaving them exhausted without ultimately relieving the pressure from within.

Some solitary activities provided a quite different quality of positive absorption and sense of development. Arts and crafts, music, and singing could put the participants in a state of movement and flow. Some participants described similar experiences when improving their physical talents in sports or their intellectual abilities in studies. The sense of accomplishment by reaching small milestones was described as great fun. They experienced their minds as temporarily free from worry and the sense of time as somewhat dissolving: "I like to listen to music and make music. It is very rewarding. It is more like a sense of flow, and there is a feeling of progress too" (Steve). This sense of flow, however, was described as disappearing at the moment any thought of evaluation by others entered their minds. Thus, the moments of movement and development seemed rather fragile and fragmented.

### 3.1.2 | A doubting self

All of the participants conveyed a sense of ongoing doubt originating from insecurity about their own performance and reasoning. They also reported what came to be understood as a fleeting sense of self that could leave them questioning their own identity and agency.

#### Feeling insecure

All of the participants talked of feeling insecure, often accompanied by descriptions of inhibiting doubt. They often contrasted this feeling with their ongoing observations of how others seemed content, secure, and competent in their everyday lives. The participants' insecurity gave the impression of being accentuated by this comparison:

“Others are being themselves in a way. They seem to easily interact with others, they initiate contact, and they seem to do things easily” (Evan).

Some participants focused mainly on their insecurity about performing common activities, such as driving a car or going to the gym. They lacked confidence and trust in themselves at managing such simple things and felt ashamed and disappointed in themselves: “It is about fearing that you have misunderstood something that the rest of the world, everybody else, gets” (Elsa). If others were to criticize them, it would only confirm what they already knew: they could not be trusted to perform any task. Although some participants were aware of actually managing some feared activities, they did not view this act as a success; rather, they saw it as further evidence of toiling to master what others accomplish with ease.

Some participants did feel a sense of mastery and capability when left on their own to perform at work or enjoy some hobby. Following known routines and performing concrete tasks seemed to add to their sense of knowing what to do. Their insecurity, however, returned at the moment when routines were challenged or when they were joined by another person and felt attention directed toward them.

Most of the participants were mainly concerned with how they doubted their own ability to make judgments, evaluate situations, or arrive at decisions. They questioned whether their reasoning was valid or even real. Hence, they did not trust themselves to make choices or accept responsibilities. If expected to make a choice or state an opinion, they found themselves unable to decide on one alternative or a single point of view: “That doubt is very present all the time. I seldom feel sure about something being right compared to something else” (Steve).

Some participants did express that they had quite clear opinions when they were on their own. However, they reported that they usually kept such opinions to themselves to avoid uncomfortable discussions or having to defend their views. The participants often felt that they lost their sense of knowing their own experiences when anticipating others’ judgments: “When I enter a situation, if I feel something positive or negative, I do not trust it. Is it right to feel like that?” (Eva).

All of the participants attempted to understand why they felt so insecure to resolve or improve their conditions. The search for answers came across as mainly being directed within or through impersonal sources. Some had read about issues related to mental health. Others wondered whether there was something wrong with the way in which they think, act, or look that could explain why they cannot manage. One participant referred to how he perhaps lacked “a social gene” (Steve). In particular, all of the participants expressed how their own performance or reasoning became the subject of meticulous and uncompromising analysis in their search for answers: “There is always something grinding in my head, so there is no rest. I do not know how to answer myself to kind of make it better” (Anita). Most often, such ruminations resulted in feelings that they were failures. They often considered their perceptions of reality untrustworthy, as they found no certain answers to confirm or disconfirm their interpretations. Even if some information was considered to fit their experience and provide some relief, the respite seemed temporary; it was quickly followed by more questions that they mulled over.

### **Searching for a sense of self**

The participants’ strategies for managing their insecurity and their solitary, fearful longing, it would seem, made it difficult for them to connect with how they experienced themselves as persons. Some participants described a feeling of losing contact with their sense of self, both while alone and in the company of others. Their pretending and hiding with others added to the experience of being present without being themselves, or even “like one is not even there” (Amanda). It was as if they were not viewed as a real person by others or simply were not seen at all. Further, a disturbing sense of emptiness in place of their feelings seemed an unwanted consequence of the participants’ intention of avoiding thinking or feeling. In particular, positive feelings, such as enjoyment and love, were described as somehow distant, or even lost, within themselves: “I think that it is real fun or should be, but I do not feel anything” (Eva). Some participants searched within to regain connection with their emotions, questioning whether they felt anything at all.

Because they often did not manage to connect fully with their feelings or sense of self, some participants also seemed to lack direction to guide their motivations. Some described a sense of hopelessness—how they did not know what they wanted or wished for, and perhaps never had. Some spoke of a desperate need to know what might give them joy or a sense of purpose; this need would enable them to keep going. As Peter expressed, “Adrenaline pumps through my body, and my mouth dries out. I’m desperate for answers. It burns and stings, and I want it to stop; I want to know what I want!”

Some participants described a sense that their agency had become blurred, as though they had lost touch with their own will after years of adapting to that of others. Some said they sometimes felt they had lost control over their bodies or that they did not know themselves. They expressed feeling confused when thinking about who they are. Some questioned the entire concept of identity, asking whether other people usually had a clear sense of themselves: “I feel like me as a person is not present. I feel like I do not know myself anymore ... I do not feel like I know who I am. That is kind of what I would like to know” (Amanda).

This sense of losing connection with oneself became even clearer through some participants’ descriptions of when they felt free, competent, and present. They emphasized that, when spending time in nature, the forest or in the mountains, they were free from painful thoughts and feelings. When accompanied by some safe others, such as their partner or a friend, there were no perceived demands to behave in certain ways, no possible critical attention, and thus no brooding about how others viewed them. Their actions and goals were defined, shared, and understandable: where are we to rest, what are we to eat, what path shall we follow? There was no questioning of the agency; they walked, climbed, or fished. The mind focused on the moment, and direction was given by their surroundings and tasks. Their bodies came alive through physical use and effort: “There it is only me. I do not have to perform something for others to see. I find enormous pleasure from reaching the mountaintop. Then, you are kind of free” (Elsa).

## 4 | DISCUSSION

This study concerned the everyday subjective lived experience of persons diagnosed with AVPD. Our findings came to convey an enduring struggle to be a person that encompassed interrelated themes of fear, longing, and aloneness, together with doubt, insecurity, and search for a sense of self. The participants longed to connect with others yet feared to get close. They felt safe when alone yet lost in their aloneness. They perceived themselves as failing in social settings yet did not fully understand why. They conveyed that they desired inclusion and intimacy but somehow did not believe these feelings could come to pass. The participants wished to understand themselves better yet feared what this understanding might lead to. Overall, the findings revealed how the participants’ efforts at sense-making of their own experiences sometimes resulted in the questioning of their identity and sense of agency—leaving them bereft of options for resolving their relational challenges. In this section, we further examine our findings to deepen our understanding within a theoretical framework. We explore the question of how one can come to know oneself and others sufficiently to feel secure in one’s identity and agency and how this process can relate to our findings. We then consider how these concerns can inform therapists working with persons diagnosed with AVPD.

Part of making sense of one’s experiences and building a sense of self-involves efforts toward knowing oneself through self-reflexive awareness (Giddens, 1991). Within phenomenology, one distinguishes between pre- or nonreflective and reflective self-consciousness. Gallagher (2012) suggested that, when we think about something without being more than marginally aware of our own thinking, we are in the prereflective state. Our focus is on the object of our thoughts, and we merely sense that we are, in fact, thinking. However, when actively thinking and attempting to understand, we can reflect on what we have done already in *retrospect evaluation*, what we are to do in *prospective deliberation*, and on our current action in *situated reflection*. The reflexive selves of the participants in the present study appeared to be attempting to make sense of their experiences, as well as actively trying to

understand themselves. They spent great amounts of time on retrospect evaluation, prospective deliberation, and situated reflection. Their awareness seemed to be pointed toward ongoing evaluations of their own performance according to the underlying intention of inclusion and belonging. Further, their perceived ideal concept of normality seemed to be used for comparative purposes: it was held as a remote standard that, in actuality, bore little similarity to the challenges of relational insecurity and fear that, while perhaps recognizable to most people, was in their case overwhelming.

Reflective states can, in this sense, be understood as implying a core experiential self, or a phenomenal self, through which feelings, thoughts, sensations, and behaviors are perceived as “mine” (Glas, 2006). When we experience that we generate or cause our actions, as well as our thoughts, we gain a sense of agency normally not reflected upon. However, we can become concerned about what we are doing and come to think about and describe our actions. We then make sense of them by explaining them through their links to our intentions, predicated on our beliefs and desires (Gallagher, 2012). The intentions of the participants, in contrast, often came across as conflicting, unresolvable, or vague. It appeared almost impossible for them to perceive themselves as acting coherently according to their intentions; their sense-making thus became challenged. Their actions seemed inhibited by the ambivalence of choices between opposing motives; at times, their actions seemed unrelated to their intention, as they ended up doing the opposite of what they had initially prepared for. In this sense, we can see how their core experience of “being a person” could be hampered by feelings of mounting insecurity and doubt, as well as a questioning of their very own sense of agency. Our findings also suggest that our participants spent so much time reflecting on themselves that it seemingly disrupted their everyday life functioning. Giddens (1991) described how a practical, implicit consciousness of what conditions and modulates our actions generally develops from the continuity and routines of our everyday lives. Accumulation of shared knowledge and experiences derived from interactions with others builds common ground for co-operative and normative behaviors. We form attachment patterns in our early close relationships with significant others (Ainsworth, Blehar, Waters, & Wall, 1978; Bowlby, 1969), and we develop our relational repertoire over the years in various forms of social contexts (Jarvis, 2009). When interacting, we practice sharing of our attention and intentions, goals, beliefs, and emotions, which come to define the meaning of the interaction (Colle et al., 2017). This implicit consciousness and common ground also anchor social agents through shared parameters of what can be viewed as existential concerns, such as how we understand time, space, continuity, and identity (Giddens, 1991). In this sense, potential overwhelming anxiety from threats to our sense of being in the world is kept at bay through what Giddens (1991) called “ontological trust.” This sense of confidence in our perception of our everyday world and our place within it, at times, seemed missing in the participant interviews. The participants described having few actual experiences of social sharing. Thus, they had little sense of belonging to a social group or feelings of bonding or intimacy; they also displayed reduced knowledge of co-operative and normative behaviors. When the participants did experience clear and salient frames of reference, such as when performing concrete tasks with another or spending time with an old friend, there did, in fact, seem to be some sense of trust in how their interaction would turn out. However, as social events ensued, expectations of reciprocal knowledge of the various agents included in the interaction emerged, such as attributing mental states to others and communicating emotions that implied personal and intimate sharing (Colle et al., 2017). Suspicion and fear caused the participants to retreat from and thus miss social experiences that might have provided more trustworthy and comforting answers to questions related to the inner mental lives of themselves or others.

The above issues are related to building one’s sense of personal identity, that is, how one is unique and how one belongs to a particular type, kind, or class of individuals (Glas, 2006). However, they also pertain to psychological concepts such as “theory of mind,” “metacognition,” or “mentalization,” which refer to the understanding of human behavior as expressions of mental states—an understanding that helps us to perceive what we ourselves and others think and feel (Karterud et al., 2017). Such capacities have been found to be hampered in some subjects with AVPD (e.g., Bateman & Fonagy, 2004; Colle et al., 2017; Dimaggio, Lysaker, Carcione, Nicolò, & Semerari, 2008; Moroni et al., 2016; Semerari, Carcione, Dimaggio, Nicolò, & Procacci, 2007). Our findings shed light on how failure to

resolve these questions of identity, agency, and relations might lead to an experience of inertia. The phenomenal self cannot, in and of itself, develop before sense making becomes directed toward a movement that consoles inhibiting—and sometimes perhaps existential—fear. In creativity, in the engagement of talents, and in nature, a sense of movement did become salient in the accounts of the participants; such times were experienced as providing a sense of presence and freedom from rumination. However, the level of dysfunction and suffering that has been reported by people diagnosed with AVPD (Cramer et al., 2007; Olsson & Dahl, 2012; Ullrich et al., 2007; Wilberg et al., 2009) underscores the despair and impasse of the process of becoming a person, as might characterize these people's struggles.

This study could be interpreted as lending support to the dimensional model of personality disorders in the DSM-5. The findings can seemingly be viewed as representing the more common human challenge of becoming a person, but the degree of impairment in core self and interpersonal capacities that were conveyed is representative of dysfunction corresponding to the level of a personality disorder diagnosis. This fact aligns with the emphasis on severity levels of personality functioning inherent in the alternative model of personality disorders (Bender, Morey, & Skodol, 2011). In addition, the findings might be viewed as shedding light on how the areas of self- and interpersonal functioning of persons diagnosed with AVPD could be characterized by challenges with self-agency, identity, intimacy, and theories of mind.

The therapeutic relationship provides an opportunity for persons diagnosed with AVPD to experience being met with acceptance and understanding. In a clinical context, persons with the disorder are likely to display the same ambivalence of longing, fear, insecurity, and doubt; indeed, the same strategies of presenting their mask of "as if—normality," hiding and withdrawal are likely to play out. The process of establishing a therapeutic alliance, as well as repair of relational ruptures, will likely be challenged. The findings of this study could lend an articulate voice to persons with AVPD and thus aid therapists' nonverbal attunement (Havas, Svartberg, & Ulvenes, 2015) and verbalized empathy regarding both connections and ruptures.

To further counteract patients' insecurity and doubt, therapists can emphasize making explicit how a person develops co-operative and normative practical knowledge of social behavior. Through a reflective process, patients might begin to make sense of why they do not manage what seems easy for most people. With this realization, their motivation to encounter new social learning might increase, together with a beginning of acceptance of life's inherent uncertainties. Research on treatment of AVPD has been scarce and inconclusive, but the suggestions above do align with promising recommendations emphasizing the importance of social skills training and drawing on findings from social cognition research on mentalization, self-other differentiation, interpersonal grounding for building a self-concept, and affect consciousness (Colle et al., 2017; Lampe & Malhi, 2018; Weinbrecht et al., 2016).

#### 4.1 | Limitations

All of the participants were recruited from a hospital setting, implying that they had an incentive to change. The findings of this study, in this sense, might be influenced by their efforts toward improving their condition through therapy. Further, the sampling process naturally suggests that the people who agreed to participate were those who were willing to communicate their experiences. Other people with similar concerns might not seek out treatment or wish to discuss their struggles, perhaps representing an even greater presence of suffering than conveyed in this study.

The scope of the findings was limited by the aim of this study, that is, to inquire into the everyday subjective experiences of the participants utilizing an inductive stance grounded in a phenomenological hermeneutical epistemology. The findings thus did not distinguish between various diagnostic categories of personality disorders and symptom disorders or between normality and pathology. We furthermore did not include theories of etiology or the origin of their current concerns, nor did we evaluate how therapeutic approaches could have influenced their everyday sense-making. However, such topics could be the subject of future qualitative or quantitative research studies.



## 5 | CONCLUSION

The findings of this study of the subjective experience of AVPD bring nuance to the diagnostic criteria of the disorder (American Psychiatric Association, 2013), and they could inform understanding of the phenomenology of the various concerns that such persons might face. The research highlights the challenges encountered by the participants in the areas of companionship, sense-making, personhood and agency—experiences that left them doubting themselves and others, while conflicting motives and intentions of fear and longing impeded their sense of development. A therapeutic relationship, embracing such concerns, could provide a setting for sense-making of their struggles and the beginning of trust in themselves and others. This ability could serve as a starting point for sensitive and gradual exposure to the social sharing of experiencing minds.

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## CONFLICTS OF INTEREST

The authors declare that there are no conflicts of interest.

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# Lived Experience of Treatment for Avoidant Personality Disorder: Searching for Courage to Be

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**Objective:** To inquire into the subjective experience of treatment by persons diagnosed with avoidant personality disorder.

**Methods:** Persons with avoidant personality disorder ( $n = 15$ ) were interviewed twice, using semi-structured in-depth interviews, and the responses subject to interpretative-phenomenological analysis. Persons with first-hand experience of avoidant personality disorder were included in the research process.

**Results:** The super ordinate theme emerging from the interviews, “searching for courage to be” encompassed three main themes: “seeking trust, strength, and freedom,” “being managed,” and “discovering the possibility for change and development.” The main theme, “being managed,” included the subthemes: “getting a diagnosis,” “receiving medication,” and “attending therapy.”

**Conclusion:** Although this may not be specific to avoidant personality disorder, the findings highlight the importance of being met inter-subjectively as a person with intentionality and agency, even when one does not feel like one. The importance of establishing an emotional bond and emergent trust for open therapeutic collaboration, learning, and becoming able to build courage to begin to approach that which one fears is emphasized.

**Keywords:** avoidant personality disorder, treatment, psychotherapy, subjective experience, qualitative research

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## INTRODUCTION

Avoidant personality disorder (AVPD) is characterized by fear of rejection and feelings of personal inadequacy, leading to extensive avoidance of social interaction, and is associated with significant distress, impairment, and disability (American Psychiatric Association, 2013; Lampe and Malhi, 2018). Despite AVPD being one of the most prevalent personality disorders encountered in clinical settings (Karterud et al., 2017), there is little research on specific treatment for this condition (Lampe and Malhi, 2018).

Various treatment and case studies of psychotherapy for AVPD indicate that psychological treatments may be helpful (Bartak et al., 2010; Weinbrecht et al., 2016; Lampe and Malhi, 2018; Simonsen et al., 2019). Examples of promising specialized therapy approaches for AVPD are cognitive behavioral therapy (Alden and Kazdin, 1989; Svartberg et al., 2004; Emmelkamp et al., 2006);



metacognitive interpersonal therapy (Dimaggio et al., 2015, 2017; Gordon-King et al., 2018); emotion-focused therapy (Pos, 2014); acceptance and commitment therapy, combined with dialectical behavior therapy (Chan et al., 2015); interpersonal psychotherapy (Gilbert and Gordon, 2013); and short-term dynamic psychotherapy (Svartberg et al., 2004); as well as schema therapy (Bamelis et al., 2014). These specialized approaches spring from various theories of the core difficulties of AVPD and corresponding therapeutic strategies for adaptive change; however, it remains unclear if any particular forms of psychotherapy are more beneficial than others (Weinbrecht et al., 2016; Lampe and Malhi, 2018; Simonsen et al., 2019).

Although outcome studies have shown promising results regarding symptom reduction or other self-reported measures, it is unknown how these findings coincide with the clients' personal views on their progress or on whether they felt supported in making positive changes (Katsakou and Pistrang, 2018). The concept of "symptom reduction" can in itself be seen as representing a medical view on personality disorders that has traditionally focused on finding "cures" for mental illness (Gillard et al., 2015). This medical view may lead us into a problem focused, and hence problem solving, view of psychotherapy, in which the therapist gathers information, forms ideas about solutions, and plans interventions to change, remediate, and heal the patient (Atwood, 1996). Furthermore, experiments, such as randomized controlled trials, can tell us something about whether treatment causes change but do not tell us why the variable or intervention led to change, as they do not address the question of which of the mechanisms and mediators the change occurred through (Kazdin, 2007).

The ongoing focus on how psychotherapy orientations, specific interventions, or therapist and client contributions influence treatment effectiveness has generated important knowledge but may direct our attention away from how clients experience therapeutic relationships and change processes (Levitt et al., 2016). Often the focus of psychotherapeutic research is on the delivery of techniques. Yet, techniques are necessarily used within the context of the relationship between the therapist and the client, which is influenced by the unique characteristics they both bring into the dynamic interaction, and which, over time, can facilitate new experiences and meanings (Clarkin, 2012; Shean, 2013). One way of approaching these questions is through qualitative research into the richness of the client experience of the process of therapy and treatment (e.g., Kazdin, 2007).

Persons diagnosed with AVPD, and personality disorders in general, have difficulties relating to others, as well as with their sense of self or identity. For example, individuals with AVPD have difficulties in identifying their own and other inner mental states, together with difficulty understanding that the states of others are not related to their own thinking (Moroni et al., 2016), a vulnerable sense of self and less self-reflexiveness, to help them regulate affect in relational contexts (Eikenaes et al., 2013). The use of avoidant dysfunctional defense responses may be related to efforts at preserving self-coherence (Bijttebier and Vertommen, 1999; Eikenaes et al., 2013) or to cope with fears of rejection (Lampe and Malhi, 2018).

One could question whether such difficulties warrant particular attention being given to the clients' experiences of the relational context of therapy. To our knowledge, no qualitative study has been conducted specifically on the subjective experience of treatment for AVPD; however, there has been a substantial amount of research into the experiences of therapy by clients in general. In an extensive review of qualitative research studies into the clients' experiences in therapy, Levitt et al. (2016), found that, at the core of all the themes investigated, regardless of therapy orientation, were clients' experience of adopting an agential role toward holistic change within a therapeutic relationship of care and being known. Their experience of holistic change was related to curiosity about, and gradual self-attunement to, their own experience, and recognition of obstructive experiential patterns and unmet needs, as well as forming more adaptive alternatives. The therapeutic relationship would facilitate this exploration if it was flexibly structured and if clients experienced permission to be vulnerable and to discuss potentially threatening information, as well as to acknowledge difficulties and challenges to the relationship.

Qualitative studies of treatment and recovery, mainly for borderline personality disorder, reflect what these clients deemed most important for their development (Shepherd et al., 2016; Katsakou and Pistrang, 2018; Kverme et al., 2019); safety and containment, being cared for and respected, being an equal partner in treatment, and focusing on agency in practical and autonomous change, were all valued and important aspects of treatment. The authors understood these treatment characteristics as linked to the development of self-acceptance and self-confidence, through constructing new narratives related to their sense of self, as well as new ways of relating and feeling connected to others. Furthermore, these processes were seen as taking place within various social spaces, including professional relationships. These findings align with the recommendation by Levitt et al. (2016) to consider what the clients bring into therapy and to focus on how their experiences and potentials contribute to an interactive healing process.

Previously, we reported from our qualitative research project on the subjective lived experiences of AVPD as it relates to everyday life challenges and strategies (Sørensen et al., 2019). Their everyday lives came across as characterized by an ongoing struggle with sense making, sense of agency, and identity, as the participants both feared and longed for connection with others and described searching for a sense of self. Furthermore, this struggle seemed related to efforts at emerging as a relational person in a lifeworld of isolation that resulted in a sense of unresolvable intentions and left them bereft of options for resolving their relational challenges (Sørensen et al., 2019). Another research question within this project inquired into how persons diagnosed with AVPD made sense of their experiences with treatment and corresponding efforts at improving their condition. We understand "treatment" as all forms of formal therapy and treatment, ranging from specialized psychotherapy to more supportive therapy, medical treatment, physiotherapy, mindfulness and yoga approaches, skills training, and psychoeducational approaches, in all modalities that participants have taken part in.

As with other qualitative studies (Levitt and Piazza-Bonin, 2016, 2017; Levitt et al., 2017; Råbu and McLeod, 2018), it was necessary to publish separate papers on findings related to different research questions to present the rich qualitative data in sufficient detail.

The aim of the present study was to inquire into how persons diagnosed with AVPD made sense of their experiences of treatment.

## MATERIALS AND METHODS

### Participants

#### Interviewees

The 15 interviewees consisted of nine women and six men who had received primary diagnoses of AVPD and were in treatment in outpatient hospital clinics in Norway. Their ages ranged from 20 to 51 years (mean = 33 years, SD = 9 years). Three participants lived with their children and a partner, three with a partner, two with their children, and seven participants lived alone. Four participants had completed their education at a primary level, nine at a secondary level, and two had finished a higher education. None of the participants worked at the time of the interviews and all received welfare. Two participants were taking part in their first course of treatment, two had undergone 2–3 courses of treatment, and 11 participants had taken part in three or more courses of treatment. Their treatments varied from individual therapy to specialized group therapies and psychomotor physiotherapy in outpatient settings and individual therapy in private practices. Therapists were psychiatrists, clinical psychologists, or psychiatric nurses. In addition, several participants had sought help *via* religious guidance, yoga, or meditation practices.

#### Researchers

KS is a clinical psychologist and PhD student. TW is a psychiatrist and professor. EB is a theologian with a PhD in Health Sciences, who mainly works as a hospital priest. MR is a clinical psychologist and associate professor. Together, the clinicians had backgrounds in schema therapy, mentalization-based therapy, relational and dynamic therapy, and psychotherapy integration. All researchers share an interest in qualitative research into the subjective experience of various phenomena of everyday life and more specifically of personality disorders and therapeutic processes.

#### Service-User Involvement

We included persons with first-hand experience of AVPD throughout the research process, to increase the quality, relevance, and ecological validity of the study (Borg and Kristiansen, 2009; Veseth et al., 2013). A coresearcher collaborated with the first author through all stages of the research process. We also established a reference group consisting of two service users, two experienced clinical psychologists, the first author, and the coresearcher who met regularly to discuss and reflect

upon the research questions, the interview guide, and the emerging themes.

## Procedures

### Recruitment

We purposively recruited participants who had received a primary diagnosis of AVPD by their respective therapists, using the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II; First et al., 1997). Second, we purposively strived to recruit men and women of various ages and with various treatment experiences, regarding length, modality, and type (specialized for personality disorder or regular outpatient treatment offered at site), provide variable subjective experiences, and reflect common clinical reality. All participants were recruited from the same hospital but at various outpatient sites within the same region.

Nine participants from the research project, “An Examination of the DSM-5 Level of Personality Functioning Scale in a Representative Clinical Sample” (Buer Christensen et al., 2018, 2019) who had agreed to be contacted at a later stage for additional research purposes were approached by the first author (KS). They received written information about our research project through their therapists. Five persons agreed to participate and were interviewed.

Ten participants were recruited and interviewed through reaching out to therapists at various outpatient clinics. The therapists were given written and oral information about the research project as well as brochures to give to patients with a primary diagnosis of AVPD. Those who expressed interest in participating were contacted by the first author by phone or text message and received written and oral information about the project.

### Interviews

The first author, the coresearcher, and the reference group developed a lightly structured and open-ended interview guide to ensure that the subjective experience of the participants could be represented faithfully. We conducted a pilot interview to receive feedback from a participant on how the interview situation was perceived and then slightly revised the interview guide according to the feedback. The first author conducted two in-depth, face-to-face interviews, lasting 60–90 min each. The interview guide was primarily used in the first of the two in-depth interviews. We included a second interview to improve rapport and give the opportunity to elaborate on topics introduced in the first meeting. The second interview took place approximately 2–3 weeks after the first.

Questions that related to experiences with treatment and efforts to improve their condition were What have you done to get better? Can you tell me about the treatments you have taken part in so far? What has been useful/less useful in your treatments so far? What do you think you need to get better?

A preliminary analysis of the first interview by the first author and the coresearcher formed the basis of the follow-up questions for the second interview. For nine of the participants, the coresearcher read the anonymized transcripts and gave

feedback to the first author on her reflections and suggestions for further questions regarding important areas in the second interview.

Although most participants conveyed their inexperience in articulating and reflecting in an interpersonal setting, such as in-depth interviews, the questions related to treatment experiences seemed of importance and accessible to them, and they appeared to be open to sharing their views on their treatments; however, the question “What do you think you need to get better?” elicited few responses. A rephrasing of the question to “If you got better, how would you be and what would you do?” resulted in fuller descriptions. Perhaps a shift in focus from a mode of psychological problems to a possible future in which the participants imagined feeling content gave access to increased attention to their wishes, likes, and dislikes. When participants referred to theoretical concepts, the interviewer would prompt them to try to explain their views in their own words what they understood those concepts to mean.

We made efforts to ensure the wishes of participants for privacy and comfort, and the interviews took place at their site of choice. Thus, 11 participants were interviewed in an office at their hospital unit, and four were interviewed in their homes.

The interviews were audio recorded and transcribed verbatim for analysis. All transcripts were verified once and imported into NVivo software (QSR International, 2015) for principal analysis.

## Qualitative Methods

### Data Analysis

As we position ourselves within a research tradition that views meaning as “something that exists within human subjectivity, rather than on the plane of material nature” (Atwood and Stolorow, 2014, pp. 3–4), our analysis found its base in phenomenological hermeneutical epistemology, through being based in Interpretative Phenomenological Analysis (IPA; Smith et al., 2009). Within this approach, we understand subjects as embodied beings embedded in a social and cultural world (Zahavi and Martiny, 2019). IPA is phenomenological through its concern with the perception of objects or events by individuals and hermeneutic through its recognition of how observations are always interpretative (Smith et al., 2009; Larkin and Thomson, 2011).

The analytical steps of IPA recognize this dynamic movement of descriptively giving voice to the concerns of the participants represented in the transcripts and the interpretation involved in contextualizing and making sense of these concerns from a psychological perspective (Larkin et al., 2006). Hence, the first analytical phase involves trying to understand the participant worlds through focusing on the subjective experiences conveyed in the transcripts. This phase is commonly characterized by efforts at capturing the essential elements of the transcripts (Smith, 2015). Subsequent analytic phases are increasingly interpretative and often informed by existing theoretical constructs, trying to offer interpretative accounts of what it *means* for participants to have their concerns,

within their particular contexts (Larkin et al., 2006, p. 113). In doing so, the researcher may move from descriptive to increasingly higher levels of abstraction, which allowing production of a theoretical framework. The analytic account is thus based on, but may transcend, the participants’ own terminology and conceptualizations, providing it can be traced back to a core account and related to a particular research question (Smith, 2004; Larkin et al., 2006). To remain aware of the movement between descriptions and interpretations, we emphasized explorative and reflexive aspects of hermeneutic phenomenology throughout the research process (Finlay, 2008; Binder et al., 2012).

We read and reread each transcribed interview to become familiar with the data. Next, text-segments related to the research question of the subjective experience of treatment for AVPD were separated into corresponding broad content units for each participant. These content units were coded on content meaning. Next, we suggested abstractions of emerging themes for each case before making comparisons in a cross-case analysis, generating suggestive themes at a group level. This stage involved highlighting similarities and variance while considering recurrence across individual interviews. Thus, we deepened our understanding of segments that appeared to consist of more superficial descriptions yet became enriched when considered in light of segments drawn from the interviews of more articulate participants (Kirkevold and Bergland, 2007). Finally, the emergent themes were organized into a superordinate theme that captured the inferred overarching meaning, which organized the final main themes and subthemes, resulting in consensus regarding the presented version.

### Credibility Checks

We integrated several credibility checks during the analysis to assess the accuracy of the findings. We asked each participant to add any information that might have been omitted or if there was any information that we should have asked about. We ensured reduction of researcher bias and maintained an active user perspective through meetings and reflections of the coresearcher and the resource group. Research analysis was continuously reviewed by the researchers, KS and MR, to ensure that multiple perspectives were included in the understanding of the complex nature of the data while still reaching a consensus regarding the interpretation and resulting themes. KS conducted validity checks of the themes by returning to the original transcripts repeatedly during the analytical process, ensuring that the interpretations and empirical data were consistent. Finally, KS contacted the participants and asked for feedback on a draft of this article and a summary of the findings. Seven participants responded to our request. The participants expressed how the themes resonated well with, and captured, their experiences. Some said that it was good to see that they were not alone in their experiences and that to be understood in treatment was of particular importance. In addition to remarking that the findings reflected similarities among them, they also noted that different persons had varying experiences of treatment; for example, not everyone had attended group therapy.

## Reflexivity

As we base ourselves within a phenomenological-interpretative understanding of human experience, we also see the researcher as “unavoidably present and influential in the inquiry” (Gemignani, 2017, p. 185). The role of the researcher as an active participant in the construction of knowledge warrants reflexive attention to the researchers’ positions and perspectives, as well as to personal responses and biases throughout the research process (Finlay, 2002).

When analyzing text segments related to subjective experience of treatment and efforts to change, the emerging themes seemed in particular to draw our attention to the concepts, “therapeutic change” and “treatment.” How have we come to understand therapeutic change and treatment? We often use the words treatment and measure outcome in ways that do not consider clients’ subjective meaning of change. Rather we predefine and operationalize change into outcome measures that assume alignment between the experiences of the observer and the observed’s experience of being helped. This view may represent the influence of the ongoing discourse and performances of current psychotherapy practices (Gemignani, 2017). The researchers hence strived to stay aware of the assumption that the participants wanted to change themselves in theoretically predefined ways and thus to remain open to the participants’ experiences.

## Ethical Considerations

Due to the potential vulnerability of the participants when talking about sensitive topics in the interviews, we took efforts to secure comfort and support for the participants. The interviews took place at site of their choice and were conducted by the researcher, KS, who is an experienced clinical psychologist and psychotherapist. In addition, participants were all in therapy at the time of the interviews to ensure the availability of prolonged support in case of need. All participants gave their signed informed consent to participate. The project was approved by the Regional Committees for Medical and Health Research Ethics (REK Sør-Øst 2015/980).

Biographical details were changed slightly to ensure anonymity.

## FINDINGS

All participants described having sought help in life phases of overwhelming frustration over their anxieties, worries, and on-going ambivalence of longing for and fearing connection to others and themselves, as their coping strategies had not brought sufficient relief to allow them to continue enduring their situations.

Our analysis supported an overarching superordinate theme, “searching for courage to be.” This superordinate theme represents the most abstract level of analysis and incorporates the main themes, “seeking trust, strength, and freedom,” “being handled,” and “discovering the possibility for change.” These main themes pertain to all participants but also include important variance and nuances of the participants’ experiences of treatment.

The representativeness of our findings and the recurrence of themes across individual cases are indicated by the frequency labels *general*, *typical*, and *variant*, as suggested by Hill et al. (2005). The main themes were all *general*, in the sense that they applied to all cases, or all but one case, and are referred to in the text as *all participants*. The themes considered *typical* applied to more than half of the cases are referred to as *most participants*. Variance within themes was represented by less than half, but more than two, cases. This is reported as *some participants* in the text.

Themes are illustrated below by quotes from individual participants.

## Searching for Courage to Be

Our analysis led to the superordinate theme, “searching for courage to be,” which encompassed the various experiences of treatment described by the participants. The title of the superordinate theme was inspired by the book title, “The courage to be,” by Paul Tillich (1886–1965), but without further reference to his philosophy or theology. That is, beyond the beautiful quote: “The courage to be is the courage to accept oneself as accepted in spite of being unacceptable” (Tillich, 1952, p. 164), and a resonating sense of how daunting a search for such an acceptance can be, which seemed to permeate the themes on all levels.

The participants had sought help that they hoped would support their search for courage to start resolving their insecurities and fears, wanting to become able to understand and relate to themselves and others, as well as to better manage their everyday lives. Most participants still searched for the help they needed, telling stories of how they did not yet feel fully understood, or found a way to make sense of, or begin to resolve, their struggles; however, all participants also told of stories or incidents of trust and understanding that seemed connected to their own sense of possible resolution and development. Those who had more experience with trust and understanding in their therapeutic relationships told of toil and movement toward emerging integrity in their way of being (Table 1).

## Seeking Trust, Strength, and Freedom

All participants described that their goals were to find greater self-confidence and inner strength and to become able to stand their ground and cope with adversities, without feeling as if they would fall apart.

**TABLE 1** | Overview of the main themes and subthemes.

- Searching for the courage to be
  - Seeking trust, strength, and freedom
  - Being managed: getting a diagnosis, receiving medication, and attending therapy
  - Discovering the possibility for change and development

*The main themes are general and pertain to all participants.*

“I need inner strength and to become able to trust and believe in myself. I have to trust that I am as valuable as everyone else, kind of equal. I just wish to be well.”

They also described wishing to know their likes and dislikes and live more by them, feeling free to do what they wanted without being afraid of others' possible evaluations and reactions. At the same time, they wished to feel included in the world, to feel joy and happiness, or just be ok.

The participants did not long to get many friends but wished to have some good ones to talk to and to do things with. They wished to be able to support themselves and work, to travel, or to just go shopping, or to places, they had heard of. To become able to reach their goals, they wanted to get to know themselves and know what to do to improve their condition; however, to approach such goals and wishes implied facing several fears: the risk of potential rejection, the risk of not being taken seriously, and the risk of someone not believing you. They would also need to take in the full scope of their condition, of the possibility of failing or being exposed, and of all the insecurity that follows from entering the unknown. Subsequently, some participants said that asking for help implied that you had to acknowledge that you had mental problems, something that seemed associated with both shame and defeat.

“I would rather manage on my own so I say that I am fine. I may have difficult days at home, but then when I get to the clinic, I say that I am ok. I do not want to be that kind of person that does not dare to do things.”

This was described as a barrier for them. They thus hoped to improve by themselves, stalled the initiation of therapy, or downplayed the seriousness of their condition when being assessed by health professionals. When impelled to overcome these barriers, there were various paths into treatment. Some participants had initiated contact with their general practitioners themselves who then referred them to further treatment. Others had been advised or pressured to seek help by family or friends who had become aware of their struggles and worried about them. Most had received various forms of help and treatment on their path to relieve their struggles, ranging from religious support, to prescription drugs, physiotherapy, meditation, and to more or less specialized psychotherapy. Despite the barriers and various ways into and through treatment, all participants described seeking help to resolve questions of how to be and what to do, which could alleviate their struggles.

### Being Managed

The experience of treatment that came across as most salient for all participants was a conveyed sense of being managed or handled within the treatment contexts in which they participated. This sense of being managed was not expressed as something that they necessarily considered negative or felt opposed to. Rather, they seemed to have entered treatment with a hope of receiving explanations and directions given by a professional that could understand and somehow prescribe relief; however, a sense of discontentment evolved, becoming

more noticeable when participants progressed into what seemed to be a more established relational pattern of staying detached within their treatment setting. Their disconnection seemed related to descriptions of interplay between not feeling able to make themselves understood and not feeling understood, in a way that maintained an experience of simultaneously being inactive and being told what to do. Therefore, although being managed often was initially what they wished for, they described becoming discontent and left wanting, as the treatment progressed. This pattern seemed to emerge within the context of getting a diagnosis, receiving medication, and attending therapy.

### Getting a Diagnosis

All participants said that they had received several diagnoses; most were first diagnosed with various anxieties and depression, and subsequently with AVPD. The experience of being diagnosed was, for most, described as one of finally being understood, and as giving hope in that their challenges were recognized as something that could be explained and treated. Although the diagnosis of AVPD brought relief, most participants expressed concerns about how to make sense of this diagnosis, in terms of what to do or how to be. Unresolved issues of how to deal with a diagnosis of one's personality seemed to span from not wanting to be the kind of person that the diagnosis described and fears of having to conform to all characteristics of the diagnosis, to bewilderment over what they should do when diagnosed.

“This diagnosis, there is a lot that falls into place about how I have related to things. But I think it is pretty normal to have those traits and it is this ambivalence towards this being a problem and me being sick needing treatment or this just being the way that I am, it's my personality and I just have to accept it.”

Most considered the diagnosis of AVPD more like an explanation of why they had felt so depressed and anxious, rather than an acceptance of *being* disordered. Some described that they felt that they were not able to develop or express the person they truly were or could be, due to their fears and insecurities and that the diagnosis did not reflect their true self.

### Receiving Medication

All participants described how they had considered medication, and most had tried prescription drugs, mainly antidepressants. Most participants conveyed how they did not ascribe improvement through medication as something initiated from within or assigned to their own sense of mastery. Rather they considered medication to be an effective way to create distance from their painful thoughts and feelings, making them easier to suppress and thus leaving them able to work or move through their everyday lives.

Some participants described how their medication had actually made them fare worse than before, leading to states of apathy, loss of vitality, desire, and creativity. Others described

their medication as necessary, as they pictured themselves not managing their everyday life or just falling apart without it.

After some time, the participants who had decided to use medication described how they became uncomfortable with this disconnection from what they knew their inner states to truly be, feeling like they moved away from who they were, losing themselves even more than before.

“Medication (antidepressants) makes it somewhat artificial. It is just like putting your problems inside a locker and throwing away the key without doing anything about them. It kind of works and makes you function. Then, it did not work, and I just quit because I thought it could not get any worse.”

They thus conveyed that, even if their functioning improved, they did not feel like they actually fared any better and still felt unhappy about their condition.

### *Attending Therapy*

All participants described aspects of their former therapies that conveyed a sense of becoming passive receivers of others' evaluation and being taken care of at others' will. This managing left them inactive, discontent, and detached, like a victim of their circumstances. They did not state that their therapists had bad intentions or were there to mistreat them. Rather, there was reduced connection, or an absence of common sense making, that could have resonated with their own experiences.

“My general practitioner sent me here and I did not know why. I thought this was a place for crazy people. The therapist I got did not understand me or what I said. It was kind of tiresome. I sat there, nodded and smiled and she talked and then I talked a bit and that was it. I had no idea what she talked about most of the time. I just kept my thoughts inside.”

Some participants described how the therapist had regularly asked questions like, “How would you describe your problems?” or “What are your goals?” which they did not know how to answer. Mere questions about their thoughts, feelings, or opinions about something could leave them quiet. Either they did not know the answer, felt unsure about the right thing to say, or they found it frightening or uncomfortable to talk about themselves.

“My problem is that I always am like: OK, if I am to sit and talk to someone, then what should I say? What should I talk about and why?”

Some therapists were described as being too “professional,” meaning that the therapist was conceived as unwilling to engage in conversation that was more personal or to express their own thoughts and opinions. The therapists were experienced as parrying the participants' efforts at being polite or gaining advice, by asking for the participants' own thoughts or opinions, or by presenting interpretations of the participants' conversational efforts that seemed out of place.

Some participants described their former therapies as mostly consisting of talking about what had taken place since their last session. Some said that they had found it so uncomfortable to talk about themselves that this talking did help them to get a bit more used to it. They described talking together as giving some immediate relief; however, the relief did not last.

The participants also described therapists as sometimes conducting therapy with approaches that the participants found confusing, in the sense that they did not understand the presented theory, or why they were supposed to do the things the therapist prescribed. Some did not consider the therapeutic approach appropriate or helpful but seemed not to have considered the possibility of telling the therapist this. Some participants said that they thought the therapist knew best, despite their own growing sense of the futility of the approach. Some did not wish to offend, hurt, or disappoint their therapist, and even acted as if the therapy worked to please them. Yet, some just waited and hoped that it all would come to make sense to them or that the situation would resolve itself some way.

“We did an exercise today. Suddenly we were to go out of the room and just walk through the corridors and observe if anyone looked at us. I got annoyed at once because it was obviously going to fail with the two of us wandering about like baboons without any goal or purpose. I felt like that was completely unnecessary.”

All participants gave descriptions of their therapists in ways that often gave the impression of some distant person that had remained unknown to them and that had mostly not made them feel known, beyond being a patient. Somehow, the descriptions were either of the therapists or their own inner thoughts and feelings, rather than of the relationship itself, leaving a sense of two persons not having established an emotional bond.

### **Discovering the Possibility for Change and Development**

In contrast to the above experiences, most participants also described, to a greater or lesser extent, experiences arising from treatment that exuded a sense of vitality, initiative, and movement. This sense of becoming an active participant in the treatment seemed connected to a sense of building trust and becoming understandable to themselves, through active efforts by the therapist to understand them. This activity and agency seemed to open up the possibility of development and change. Simultaneously, those participants who described this emerging development also expressed having to work hard to face their fears and insecurities, feeling that fear constituted the greatest barrier to change.

Participants who talked about vitality and movement in treatment described their therapists as having time and space for them. They considered that their therapists helped them to express themselves and as being interested and active. One participant said:

“She asked the right questions that I was able to answer.”

Furthermore, the therapists were described as willing to express their own thoughts and opinions, to give advice and guidance, show care and concern, as well as investment in the development of the participant. The participants' descriptions thus reflected a sense of starting a process of sense making that seemed to move them toward both growing awareness and acceptance. This process seemed to imply a beginning of discovery of self and others.

"Sometimes my therapist says things that I have already thought about. Then I think that I am perhaps able to think a bit on my own? Sometimes she says; oh, I never thought about it like that, that is a nice way to think. If you have another person that can confirm or disconfirm that she has thought like that too, then I may trust my thoughts a bit more."

Those participants who had taken part in various forms of group therapy described how they had been surprised to find that others would struggle with similar concerns, that others, who apparently fared well, could also suffer, and that there could be some common ground for all members. Even those participants who found it very challenging to take part and become visible in the group described this emergent discovery of others.

"It is horrible to be in the group. I just want to cry, my heart beats, I get a lump in my throat like I am going to throw up. It is like everybody is looking at me and thinking ... but it is interesting to listen because they are there for a reason too. It is like a wake-up call that others might be like me."

Just the observation of the dialogues between other group members seemingly made an impact. Some had to revise their initial skepticism, some had to adjust to surprisingly vulnerable reactions from others, and some found themselves missing the group, even if they had never managed to feel included.

"It helps to do something together. You build something together through sharing."

The concrete content of the various therapeutic approaches of both individual and group modalities often seemed to take a less salient place in their experiences; however, most referred to the importance of learning new ways of thinking and perceiving themselves and others. Those who had taken part in more specialized psychotherapy would use the therapeutic nomenclature in a way that seemed to guide their sense making. These participants described how they had come to understand the connections between their developmental stories and their current functioning better and thus became more aware of their difficulties.

"In relation to maladaptive schemas... I have started to write up on all my high score schemas and started to think about what created them. Then I discuss with

myself whether these schemata should hold any power over me today. Whether it was something that happened then and whether I can do something about it now so that they will not take control over me today."

They explained how this awareness gave a sense of being able to manage themselves better, but that it also gave way to the need to find new practical solutions and strategies.

Together, these experiences of activity and movement were described as positive and associated with hope. Simultaneously, these participants conveyed a sense of standing on the edge of changing, trying to muster enough courage to try new ways of being. It was as if these engaged therapists would suggest possibilities at the same time as fear would pull the participants back. Being pulled back by this fear seemed connected to an experience of having to overcome on one's own, like the awareness of connection with the therapist could become lost as their fear of novelty or change increased.

Discovery or new active learning hence came across as becoming possible within the context of interpersonal connection and a sense of trust, either in individual therapy or in a group setting. Simultaneously, connection and trust seemed to become more distant for the participants as their fear of change grew stronger, leaving them vulnerable to feeling lost and resorting to their familiar strategies of dealing with difficult thoughts and feelings, through disconnection and withdrawal. This oscillation between beginning trust and mistrust, as well as between connection and disconnection, seemed reflected in the tendency to both wish for prescribed solutions and being handled, as well as for the vitality that came with a beginning discovery of self, others, and agency. The participants thus searched for courage to do what frightened them the most, and the courage seemed within reach if they felt made understandable, accepted, and active.

## DISCUSSION

The aim of this study was to inquire into how participants make sense of their experiences of treatment for AVPD. We present findings that convey an overarching theme of searching for courage to be. The participants expressed how their experience of being managed in treatment settings created, over time, a sense of discontentment and disconnection; however, they also told of experiencing the discovery of the possibility for change and development. Their goals were described as finding strength and trust within themselves, as well as freedom from the evaluations of others, thereby becoming able to choose what to feel, think, and do for themselves. To become able to do this, they perceived it necessary to overcome their fears and insecurities. Thus, their search for courage could be understood to involve finding a way to trust themselves to manage everyday life, through finding the strength not to let the judgment of others define their own state of mind, and to distinguish trustworthy, from not-so-trustworthy, others. This path could imply a courageous leap of faith in connecting to others, through believing that the other could accept and

invite them into a sense of companionship while daring the risk of rejection. This courageous leap of faith emerged as essential for treatment, specifically for the therapeutic relationship in relation to opening up to acquiring new knowledge and attempting new behaviors. In the following section, we explore how these findings relate to theory, to further our understanding of the subjective experiences of treatment for AVPD.

Persons diagnosed with AVPD experience considerable ongoing fear and insecurity, and work hard to endure these, while longing for connection, both to themselves and others (Sørensen et al., 2019). The participants in this study expressed how they search for answers regarding how they can become able to overcome their fears and insecurities and accomplish their goals. The relational context of therapy did come across as being of utmost importance for the participants in this study and seemed related to their experience of their treatments. This aligns with the well-established moderate but reliable association between the quality of the relationship and outcomes in therapy (e.g., Ardito and Rabellino, 2011; Horvath, 2018; Noyce and Simpson, 2018). The interpersonal relation between the client and the therapist and the instrumental aspects of the therapy are considered to occur in a dynamic and complex interplay, evolving and changing over time (Norcross and Lambert, 2018).

Our findings do point toward challenges our participants faced in establishing a reciprocal therapeutic relationship in treatment. The main challenge seems related to entering a mutual complementary relationship in the first place. At the same time, as the quality of therapeutic relationship seemed crucial to the experiences of therapy, the participants came across as being rather unaware of how to approach this therapeutic challenge, which again could be seen as mirroring relational challenges in their everyday lives (withheld for anonymous review).

To take part in a reciprocal therapeutic relationship includes forming an alliance of agreement of tasks and goals, as well as an emotional bond (Bordin, 1979, 1994). This involves establishing interpersonal connection, communication, and collaboration that fosters both agreement and negotiation of rupture repairs that arise with empathic breaches and alliance fluctuations (Safran and Kraus, 2014; Horvath, 2018). Research on client experiences of treatment and the therapeutic relationship supports the importance of the therapist providing safety, containment, care, respect, equality, and insight, as well as promoting agency within a relationship that allows for both connection and communication of relational challenges (Levitt et al., 2016; Shepherd et al., 2016; Katsakou and Pistrang, 2018; Kverme et al., 2019).

Our participants rather described a sense of growing disconnection and detachment, as they seemed pending understanding from the therapist at the same time as struggling with making themselves understood. Rather than entering a collaborative exploration of their goals and the best way to approach these goals, they seemed to wait for the therapist to give answers and prescribe solutions and directions. As they received these solutions from the therapist, the sense of interpersonal disconnection seemingly grew. Their initial hope

for help to achieve their goals of trust, strength, and freedom dwindled as prescription, rather than collaboration, about solutions characterized the relationship. Telling their therapists about these experiences came across as a non-option, as the participants seemingly complied. This experience of being managed could be understood within the context of becoming the receiver, or perhaps the object, of knowledge and understanding. You may experience being looked upon with a clinical gaze, which conveys a sense of being a case or an object of interest, perhaps something like a disorder, or as showing deviations from the norm, that may be cured or moved closer to the norm by another (Gardner, 2016). Perhaps related to a focus on “cure” or “symptom reduction,” the relationship becomes in danger of being that of observer and observed, thus being characterized by detachment and objectivity (Buber, 1937; Jaaskelainen, 2000). Thus, the findings may convey a therapeutic interpersonal pattern that initially reinforces an emphasis on symptom reduction without either being aware of how connection, understanding, and collaboration are lacking.

By contrast, when feeling understood and known as a person, the participants’ descriptions came across with a sense of emerging vitality, initiative, and movement. Thus, viewing the themes together points toward the importance of building emotional connection to foster a sense of trust and safety in the therapeutic relationship that allows for collaboration and risk taking when approaching the client’s goals (e.g., Spencer et al., 2019; Tsai et al., 2019). The participants that described positive qualities of the therapeutic relationship did experience their therapists as being warm and caring while giving time and space for them. These therapists were furthermore perceived as being active and genuine through giving guidance and conveying faith in the participant’s developmental potential. Intertwined in these descriptions were tales of possible new learning, related to ways of thinking and perceiving themselves and others; however, a lingering fear over possible consequences of rejection and failure remained.

Fear of rejection and feelings of inadequacy in interpersonal encounters are viewed as central to AVPD. It has been suggested that pseudo-alliance and compliance are phenomena that must be carefully considered by therapists forming alliances with clients who are interpersonally sensitive, avoidant, and shame prone but who are simultaneously longing for connection (Bender, 2005; Doran, 2016; Simonsen et al., 2019). In addition, when collaboration is overly emphasized there is the danger of fostering compliance, which can be mistaken for alliance, in particular in cases where the therapist and client set aside their own needs to attend to the other’s or strive to maintain harmony and avoid commenting on strains in the relationship (Doran, 2016). The findings of Strauss et al. (2006) in their study on early alliance, alliance ruptures, and symptom change for AVPD and obsessive-compulsive disorders exemplify this aspect. The authors emphasize the importance of alliance rupture repairs for better alliances and outcomes and vice versa when strains are unattended. They furthermore view their findings in light of the importance of establishing trust and collaboration early on in therapy. Our findings also support the importance of monitoring alliance ruptures and compliance during therapy



with people diagnosed with AVPD, as our participants would not tell of their dissatisfaction with treatment. However, to enable clients diagnosed with AVPD to share implies a beginning sense of trust. Our findings appear to indicate that a sense of being understood and feeling known was associated with trust and what could be understood as an increased sense of acceptance, which opened up potential for collaboration.

Trust can be viewed as essential for new learning, change, and development in treatment (Langley and Klopper, 2005). Our participants mainly described an experience of being managed that was not initially considered negative, as they searched for help from someone believed to be competent and professional. They initially seemed willing to place their trust in the competence of the therapist. They may also have been aware of the rationality of information about new adaptive ways of thinking conveyed in therapy, while remaining unable to apply them, most likely reflecting that trust is a feeling state that includes affective, cognitive, and conative elements, influenced by past experiences, as well as our surrounding context (Baier, 1986). Past experiences of the participants may have influenced their expectations of being accepted, rejected, or harmed when revealing their vulnerability thus decreasing their willingness to give discretionary power to another (Baier, 2010).

When treated as an intentional being with agency, an attitude of possible trust came across in their descriptions, together with an openness to there being something relevant for them to learn. To develop and change in a way that leads to an experience of intentionality and agency can be described as becoming a subject in the eyes of another subject (Fonagy and Allison, 2014; Fonagy et al., 2015; Bateman et al., 2018). Inter-subjectivity can be understood as the space in which we become; the interdependency that makes room for the emerging self (Stolorow and Atwood, 1992; Atwood and Stolorow, 2014). It can be seen as a relationship of co-operation between subjects with personal engagement through recognition, interest, confirmation, and a sense of responsibility for the other (Buber, 1937; Jaaskelainen, 2000). Within this relationship, there is an idea that interactions can become something more than the sum of two individual perspectives; the interaction itself may become something autonomous; for example, in the co-creation of new meanings that might both influence and transform the participants (De Jaegher et al., 2017).

For this to occur, some therapists described by our participants seemingly made themselves experientially available to their clients. The same came across in the participants' descriptions of their experiences of attending group therapy, where listening to others putting their experience into words opened up new ways of perceiving fellow group members. Perhaps the group setting provided a first opportunity for these participants to discover how sharing of experiences may lay the ground for a sense of belonging. Thus, not only does the therapist have to convey their experience of the client as a subject, but they must also convey themselves as subjects, to build a therapeutic relationship of possible trust; however, this does not necessarily mean self-disclosure, perhaps more an emphasis on the embodied subjective presence in the interpersonal engagement and attuning

to the others' goal-directed, intentional being (Gallagher and Zahavi, 2012). If therapists use observational language, that is, give voice to what they observe about their clients' experiences, dreams, beliefs, motivations, and desires, as well as of their mutual relationship, they may add to a sense of discovering oneself as an intentional agent through this guidance in reflexive thinking about oneself and others (Banham and Schweitzer, 2017). The attuned observational language combined with non-verbal attunement matching with the client's affective state and arousal could make the interaction less threatening (Havas et al., 2015). As we practice articulating our situated points of view and relate them to our actions and events of which we are part, we express both our agency and our sense of self (Angus, 2012). We talk together about our narratives of our experiences in a concrete and particular shared world of interactions and how we understand and respond to them (Gallagher and Zahavi, 2012). This implies that a therapist must emphasize and validate the experience of the other while conveying their own efforts to understand the meaning of that subjective reality (Stolorow and Atwood, 1992). A sense of courage to approach that which scares us the most (Rachman, 2004) may thus come about when your subjective reality is confirmed and articulated in a reciprocal therapeutic relationship.

## Limitations

The aim of this study was to further understand the subjective experiences of treatment of persons diagnosed with AVPD; hence, it did not investigate how therapy for AVPD works or the quality of outcomes. The findings are based on the participants' descriptions of their subjective experiences and not on the feasibility of their actual treatments or of the qualities of their therapists. In addition, all participants were taking part in treatment at the time of the interviews. This could imply that our findings were influenced by these therapeutic contexts. Furthermore, the participants were recruited from an out-patient hospital setting and could hence be representative of a specific level of severity of personality functioning, descriptive of this specific treatment setting. Lastly, due to the inductive and ideographic nature of the study, the findings do not distinguish between the possible influence of participant characteristics, diagnostics, or traits, between various treatments, or between normality and pathology; however, these important topics could be the subject of future research studies.

## CONCLUSION

Although we cannot say that our findings are specific to AVPD, we may understand the participants' subjective experience of treatment for AVPD as articulating: "Make me an agent in my own life, so that I can discover my intentions and myself; however, I meet you with great vulnerability, as this form of trust has, from earlier experiences, not generated trustworthy knowledge about me or the ways of the world." Through creating the circumstances for trust to emerge in an attuned inter-subjective space, new experiences and new knowledge may be passed on from the therapist to the client. Perhaps giving

way to the courage to open up to how fears and anxiety are always part of life but can be faced when met within a fellowship of acceptance and faith in our abilities to develop and learn. Further, through new experiences, new learning through successes and failures may bring a sense of growing strength, trust in oneself to manage, and the freedom that comes from knowing that, even if you do not manage everything, you are still acceptable.

## DATA AVAILABILITY STATEMENT

The datasets generated for this study will not be made publicly available. The dataset is textual and consists of transcribed in-depth interviews that have been de-identified. The content is still personal, cannot be made anonymous without changing the content and if made publicly available participants would be able to recognize themselves. Furthermore, the transcripts are in Norwegian and only the quotes have been translated to English.

## ETHICS STATEMENT

The studies involving human participants were reviewed and approved by the Regional Ethics Committee, REK, Sør-Øst

ref.nr. 2015/980. The patients/participants provided their written informed consent to participate in this study.

## AUTHOR CONTRIBUTIONS

KS collected the data and took a leading role in data analysis and writing the manuscript. TW, EB, and MR contributed to developing the study design and the reflective and analytic phases of the project and to writing the article.

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**Conflict of Interest:** The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

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## **APPENDIX I**

Interview guide

## **APPENDIX I: Interview guide**

### About the avoidance, the diagnosis, and the person:

What is it like for you to have avoidant personality disorder?

How do you understand this disorder? (or; why do you think you have received this diagnosis?)

What do you avoid? (or; what is it that you try to avoid?)

How would you describe yourself?

What is like it to be you?

How do you think you came to be the way you are today? If needed:

- What do you think is the cause or origin of your concerns?

(If uses theoretical explanations: how would you explain this using your own words?)

How did you understand this explanation, this concept?)

### About everyday life

What does a normal day look like for you?

- What do you do during a typical day?

- Who do you meet/spend time with during a typical day?

- If necessary: when do you get up in the morning, what do you do after that, activities, meals...

What do you like to do?

- What would you like to do more?

- When do you feel comfortable?

- When do you feel good?

(Note: Check if it is what the person her/himself likes, and not what others like them to do.)

What do you not like to do?

- What would you like to do less?

- When do you feel uncomfortable?

- When do you not feel good?

- What is it about that that you do not like?

### Change outside of treatment

What have you done to get better besides treatment?

### Psychological challenges as related to treatment

What symptoms/challenges made you seek treatment?

Could you tell me about the treatment/s you have been in so far? How has it been?

What was useful/less useful in your treatment so far?

What do you wish would get better now?

What you would need/what would it take to fare differently?

(Note: Therapy-language versus own words)

### Final checks

Is there something important that I did not ask about?

What do you think that I should ask others who have this diagnosis?