Psychological interventions for avoidant personality disorder
(Protocol)

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Psychological interventions for avoidant personality disorder

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ABSTRACT

This is the protocol for a review and there is no abstract. The objectives are as follows:

This review aims to evaluate the potential beneficial and adverse effects of psychological interventions for people with avoidant personality disorder.

BACKGROUND

Description of the condition

A personality disorder is “an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the person’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time and leads to distress or impairment”, according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (APA 2000). Avoidant personality disorder is characterised by DSM-IV-TR (APA 2000) as “a pervasive pattern of social inhibition, feelings of inadequacy, and hypsersensitivity to negative evaluation, beginning in early adulthood and present in a variety of contexts, as indicated by four (or more) of the following:

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 criticised 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."

DSM-IV-TR also comments on the overlap between avoidant personality disorder and social phobia (generalised type) and suggest that they may be alternative conceptualisations of the same or similar condition. Interestingly, Mendelowicz 2006 noted an increase in papers published on social phobia from 1973 to 2001, with a decrease in publications on avoidant personality disorder over the same period. However, it is also worth noting that the current draft of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), which will be published in 2013, recommends retaining social phobia as a diagnosis and reformulating avoidant personality disorder as avoidant type (APA 2010).

The International Classification of Mental and Behavioural Disorders (ICD-10) (World Health Organization 1992) refers to this disorder as "anxious (avoidant) personality disorder" and describes much the same characteristics as DSM-IV-TR but requires only three of the behaviours to be present in order to qualify for a diagnosis.

Avoidant personality traits are common but a diagnosis of avoidant personality disorder is only made when these are inflexible, maladaptive and persist to an extent that causes significant impairment or distress to the individual (APA 2000).

Tøgersen 2001 found avoidant personality disorder to be the most common personality disorder in a large community-based sample, with prevalence rates of 5%. In clinical samples, the disorder is thought to be present in about 10% of outpatients (APA 2000). Coid 2003 summarised the findings of various community surveys and reported prevalence ranges from 0.8% to 5% with high comorbidity. However, subsequently, Coid 2006 found a much lower prevalence rate of 0.8% in a household survey of 626 participants.

The aetiology of avoidant personality disorder is unknown, but research suggests there are a number of biological and psychological factors (Dalrymple 2007). Biological factors include neurochemical abnormalities such as serotoninergic system deficits (Cloninger 1986), familial and genetic transmission (Cloninger 1986) and inborn temperament, for example, a tendency to retreat from unfamiliar situations (Kagan 1989). Psychological factors have also been found to play their part in the development and maintenance of avoidant personality disorder. Examples of this would include childhood experiences (for example, pathological parenting such as parental rejection (Beck 1990)); cognitive biases similar to those seen in social anxiety disorder (for example, memory and interpretation biases) (Hirsch 2004), and social skills deficits (for example, avoidance of a range of social situations).

Kaplan 2005 found avoidant personality disorder to be associated with severe occupational and social impairment. In clinical samples, avoidant personality disorder is often comorbid with dependent personality disorder, anxiety disorders (especially social phobia, generalised type) and depressive episodes (Herbert 1992; Holt 1992; Turner 1992). Zanni 2007 found personality disorder symptoms may change with age; some symptoms can become less prominent while others become worse.

The prognosis for avoidant personality disorder is quite poor as individual habits and attitudes are often pervasive and ingrained, with many lacking the support and encouragement they need to improve their lifestyle (Millon 1996). Skodol 2005 and Newton-Howes 2006 found a personality disorder that co-occurs with an Axis-I disorder may have a negative impact on the outcome of the latter. Percudani 2002 found a higher probability of these patients withdrawing from treatment. Other studies suggest individuals with personality disorders are less likely to make contact with psychiatric services compared with those with other conditions such as schizophrenia or depression (Andrews 2001). They are often not recognised by professionals and they do not seek help (Herbert 2004).

Description of the intervention

Psychological therapies encompass a wide range of interventions (Bateman 2004) including psychoanalytic psychotherapy, cognitive therapy, therapeutic communities and nidotherapy. The general goal of treatment in avoidant personality disorder is improvement of self-esteem and confidence. As the individuals’ self-confidence and social skills improve, they will become more resilient to potential or real criticism by others.

It is important to consider all relevant studies without restriction on the type of psychological therapy and to consider psychological interventions where drugs are also given as an adjunctive intervention. Individual and group therapeutic interventions may be used, although the nature of avoidant personality disorder itself may make group therapy less common.

How the intervention might work

Psychoanalytic therapies (which include dynamic psychotherapy, transference-focused psychotherapy, mentalisation and group psychotherapy) aim to help the patient understand and reflect on his inner mental processes and make links between his past and his current difficulties.

Cognitive analytic therapy (CAT) is a brief psychological therapy utilising ideas from psychodynamic psychotherapy, cognitive therapy and cognitive psychology (Denman 2001). Current coping strategies are looked at in detail and are adapted to bring about change through the client’s strengths, resources and tools. Treatments based on cognitive behavioural therapy (CBT) place emphasis on encouraging the patient to challenge their core beliefs. A review of the evidence for this form of intervention concluded that "the overall evidence in favour of cognitive behavioural therapy in the treatment of personality disorder is therefore relatively slim, with much of the evidence coming from one research group.
but it has involved more patients than any other form of treatment” (Bateman 2004).

Dialectical behavioural therapy (DBT) is a complex psychological intervention that was developed using some of the principles of CBT (Linehan 1993) and may help change behaviour by improving skills and the ability to contain difficult feelings. It is currently popular, but the evidence for its efficacy is less clear with some reviewers considering that its only proven benefit appears to be in the reduction of self-harm episodes (Bateman 2004).

Therapeutic community treatments involve participants (also known as residents) not only having therapy together but also working and living together in a shared, therapeutic environment. This provides them with an opportunity to “explore intrapsychic and interpersonal problems and find more constructive ways of dealing with distress” (Campling 2001). Therapeutic community treatment is the only single treatment modality for severe personality disorder that has been subject to a meta-analysis of randomised controlled trials. This demonstrated the effectiveness of therapeutic community treatment (Lees 1999), but specific personality disorders were not identified.

Nidotherapy is a formalised, planned method for achieving environmental change to minimise the effect of the disorder both upon those with the diagnosis and those around them. The effectiveness of this treatment has not yet been established. Unlike most other therapies, it aims to fit the immediate environment to the individual rather than change the individual to cope in the existing environment (Tyrer 2007). Whilst the eventual outcome of nidotherapy is environmental manipulation, it may be regarded as a psychological intervention in that it relies upon first developing a psychological understanding of the person’s strengths and difficulties. The psychological formulation leads to goal setting, from which flows the necessary changes in the physical and social environment (Tyrer 2005).

**Why it is important to do this review**

Despite avoidant personality disorder being one of the most common personality disorders and having considerable impact on individuals and their families, it is interesting that relatively few studies have examined the treatment of individuals specifically selected for avoidant personality disorder (Alden 2002). Evidence for the efficacy of psychodynamic psychotherapy for personality disorders comes from Piper 1993, Winston 1994 and Bateman 2001. One study by Emmelkamp 2006 found CBT to be more effective than Brief Dynamic Therapy (BDT) for treating avoidant personality disorder, although methodological shortcomings with this study have been found (Leichsenring 2007). There has been an increased interest in developing and evaluating psychological treatments for personality disorders in recent years, suggesting that a systematic review is now timely to assess the quality of available evidence.

**Objectives**

This review aims to evaluate the potential beneficial and adverse effects of psychological interventions for people with avoidant personality disorder.

**Methods**

**Criteria for considering studies for this review**

**Types of studies**

Controlled trials in which participants have been randomly allocated to an experimental group and a control group, where the control condition is either treatment as usual, waiting list or no treatment. We will include all relevant randomised controlled trials with or without blinding of the assessors.

**Types of participants**

Men or women 18 years or over with a diagnosis of avoidant personality disorder defined by any operational criteria such as DSM-IV. We will include studies of people diagnosed with comorbid personality disorders or other mental health problems other than the major functional mental illnesses (that is schizophrenia, schizoaffective disorder or bipolar disorder). The decision to exclude persons with comorbid major functional illness is based on the rationale that the presence of such disorders (and the possible confounding effects of any associated management or treatment) might obscure whatever other psychopathology (including personality disorder) might be present.

**Types of interventions**

We will include studies of individual and group psychological interventions. Psychological interventions will be subclassified into single modality and complex psychological interventions. Single modality psychological interventions are those that only involve one specific type of intervention. Complex psychological interventions are those that involve more than one modality of treatment, for example, group therapy plus individual therapy (Campbell 2000). We will include studies of psychological interventions where medication is given as an adjunctive intervention, but will report any studies where the comparison is between a psychological and a pharmacological intervention separately. We will not include studies comparing two or more different therapeutic modality groups but without a control group.
Types of outcome measures

Primary and secondary outcomes are listed below in terms of single constructs. We anticipate that a range of outcome measures will have been used in the studies included in the review, for example, avoidance may be measured by self-report scales or by an external observer. Whilst we acknowledge that the nature of avoidant personality disorder can lead to difficulty in long-term follow-up, we will report relevant outcomes without restriction on the period of follow-up.

Primary outcomes

- Avoidance symptoms: improvement in avoidant behaviour as measured on validated clinical scales such as the Structured Clinical Interview for DSM-IV Axis II Personality Disorders (SCID-II) (First 1997) or the Structured Interview for DSM-IV Personality (SIDP-IV) (Pfohl 1997), or self report measures such as the NEO Personality Inventory (NEO-PI-R)/NEO Five-Factor Inventory (NEO-FFI) (Costa 1992) or Millon Clinical Multiaxial Inventory-III (MCMI-III) (Millon 1994).
- Global state/functioning: as measured through improvement on the Global Assessment of Functioning numeric scale (GAF) (APA 2000), Clinical Global Impression of Severity scale (CGI-S) (Guy 1976), Symptom Checklist-90 (SCL-90R) (Derogatis 1994) or similar validated scales.
- Social functioning: as measured through improvement on the Social Adjustment Scale (SAS-SR) (Weissman 1976), the Social Functioning Questionnaire (SFQ) (Tyner 2005) or similar validated scales.
- Adverse events: incidence of overall adverse events and of the three most common adverse events; dichotomous outcome, measured as numbers reporting.

Secondary outcomes

- Quality of life: self-reported improvement in overall quality of life measured through improvement in scores on the European Quality of Life instrument (EuroQol) (EuroQoL 1990), SF36 (Ware 1993) or similar validated scales.
- Engagement with services: health-seeking engagement with services measured though improvement on the Service Engagement Scale (SES) (Tait 2002) or similar validated scales.
- Anxiety symptoms: improvement in anxiety symptoms measured on the State-Trait Anxiety Inventory (STAI) (Spielberg 1983) or similar validated scales.
- Depressive symptoms: improvement in depressive symptoms measured on the Hamilton Depression Rating Scale (HAMD) (Hamilton 1969), the Beck Depression Inventory (BDI) (Beck 1961) or similar validated scales.
- Satisfaction with treatment: measured through improvement in scores on the Client Satisfaction Questionnaire (CSQ-8) (Artkisson 1982) or similar validated scales.
- Leaving the study early: measured as a proportion of participants discontinuing treatment from the point of randomisation.
- Employment status: measured as number of days in employment over the assessment period.

Search methods for identification of studies

Electronic searches

We will search the electronic databases listed below.

- Cochrane Central Register of Controlled Trials (CENTRAL), part of the Cochrane Library
- MEDLINE
- EMBASE
- CINAHL
- PsycINFO
- ASSIA
- BIOSIS
- Dissertation Abstracts
- National Criminal Justice Reference Service Abstracts
- Science Citation Index (SCI)
- Social Sciences Citation Index (SSCI)
- Sociological Abstracts
- ZETOC (Conference search)
- metaRegister of Controlled Trials

We will base the searches on the following MEDLINE search strategy, which includes the Cochrane highly sensitive search strategy for identifying randomised trials (Lefebvre 2008). The strategy includes search terms for all types of personality disorder as this is one of a series of PD reviews. We will modify the search terms and syntax as necessary for other databases.

1 exp Personality Disorders/
2 (moral adj2 insanity).tw.
3 (DSM and (axis and II)).tw.
4 (ICD and (F60 or F61 or F62)).tw.
5 ((odd$ or eccentric$ or dramatic$ or emotional$ or anxious$ or fearful$) adj5 cluster$).tw.
6 ("Cluster A" or "Cluster B" or "Cluster C").tw.
7 ((aggressiv$ or anxious$ or borderline$ or dependent$ or emotional$ or passiv$ or unstable) adj5 personalit$).tw.
8 (anankastic$ or asocial$ or avoidant$ or antisocial$ or anti-social$ or compulsiv$ or dissocial$ or histrionic$ or narciss$ or obsessiv$ or paranoid$ or psychopath$ or sadist$ or schizoid$ or schizotyp$ or sociopath$).tw.
9 (personalit$ adj5 disorder$).tw.
10 character disorder$.tw.
11 (anal$ adj (personalit$ or character$ or retentiv$)).tw.
12 or/1-11
Selection of studies

This review is one of a series of reviews about personality disorders. We will carry out the selection of studies out in two stages. Four members of the review team (JS, NH, JD, MF) will read the titles and abstracts independently to identify all studies carried out with participants with personality disorder, regardless of any specific personality disorder(s) diagnosed. They will then independently assess full copies of studies identified against the inclusion criteria for this review. We will identify not only trials with participants diagnosed with avoidant personality disorder but also trials with participants having a mix of personality disorders for which data on a subgroup with avoidant personality disorder may be available. We will resolve uncertainties concerning the appropriateness of studies for inclusion in the review through consultation with a third author (CD). Authors will not be blinded to the name(s) of the study author(s), their institution(s) or publication sources at any stage of the review.

Data extraction and management

UA, HJ and MF will independently extract data using a data extraction form. We will enter data into Review Manager 5.1 software (RevMan) (Review Manager 2011). Where data are not available in the published trial reports, we will contact the authors and ask them to supply the missing information.

Assessment of risk of bias in included studies

For each included study UA, HJ and MF will independently complete the Cochrane Collaboration’s tool for assessing risk of bias (Higgins 2008, section 8.5.1). Any disagreement will be resolved through consultation with UA. We will assess the degree to which:

- the allocation sequence was adequately generated (‘sequence generation’);
- the allocation was adequately concealed (‘allocation concealment’);
- knowledge of the allocated interventions was adequately prevented during the study (‘blinding’);
- incomplete outcome data were adequately addressed;
- reports of the study were free of suggestion of selective outcome reporting; and
- the study was apparently free of other problems that could put it at high risk of bias.

We will allocate each domain one of three possible categories for each of the included studies: low risk of bias, high risk of bias and unclear risk of bias where the risk of bias is uncertain or unknown.

Measures of treatment effect

Where different outcome measures of the same construct are reported, we will use the standardised mean difference (SMD) to provide an overall estimate of effect size for that construct. For dichotomous (binary) data, we will use the odds ratio (OR) with a 95% confidence interval (CI) to summarise results within each study. The odds ratio is chosen because it has statistical advantages relating to its sampling distribution and its suitability for modelling, and is a relative measure so can be used to combine studies. For continuous data, such as the measurement of impulsiveness and aggression on a scale, we will compare the mean score for each outcome, as determined by a standardised tool, between the two groups in each study. We will report continuous data that are skewed in a separate table and we will not calculate treatment effect sizes to minimise the risk of applying parametric statistics to data that depart significantly from a normal distribution. We will define skewedness as occurring when, for a scale or measure with positive values and a minimum value of zero, the mean is less than twice the standard deviation (Altman 1996). We will use the mean difference (MD) where the same outcome measures are reported in more than one study. We will use the standardised mean difference (SMD) where different outcome measures of the same construct are reported. If studies are considered to have more than one eligible outcome for a forest
plot, we would select a single outcome based on expert advice, principally the most commonly used with the highest validity.

### Unit of analysis issues

#### Cluster-randomised trials

Where trials have used clustered randomisation, we anticipate that study investigators would have presented their results after appropriately controlling for clustering effects (robust standard errors or hierarchical linear models). If it is unclear whether a cluster-randomised trial has used appropriate controls for clustering, we will contact the study investigators for further information. Where appropriate controls were not used, we will request individual participant data and re-analyse data using multilevel models that control for clustering. Following this, we will meta-analyse effect sizes and standard errors in RevMan (Review Manager 2011) using the generic inverse method (Higgins 2008). If appropriate controls were not used and individual participant data are not available, we will seek statistical guidance from the Cochrane Statistical Methods Group and external experts as to which method to apply to the published results in attempt to control for clustering. If there is insufficient information to control for clustering, we will enter outcome data into RevMan using individuals as the units of analysis, and then we will use sensitivity analysis to assess the potential biasing effects of inadequately controlled clustered trials (Donner 2001).

#### Cross-over trials

It is unlikely for cross-over trials to be used for a psychological intervention due to issues concerning a 'washout' period. However, if any cross-over trials are found and we conduct a meta-analysis combining the results of cross-over trials, we will use the inverse variance methods recommended by Elbourne 2002. Where data presented from a cross-over trial are restricted (and more information is not available from the original investigators), we will use the presented data within the first phase only, up to the point of cross-over.

#### Multi-arm trials

We will include all eligible outcome measures for all trial arms in this review. Where there are more than two arms of the trial that meet the inclusion criteria, two or more intervention arms and/or two or more control group arms, there are a number approaches that can be used. These include combining arms to create one single pair-wise comparison; selecting one pair for comparison only; splitting the 'shared' group into two or more groups to provide two or more comparisons; including two or more correlated comparisons, or undertaking a multiple treatment meta-analysis. In the event of a multi-arm trial meeting our inclusion criteria, we will seek statistical advice on which of these options is the most appropriate for the study.

### Dealing with missing data

We will contact the original investigators to request any missing data and information on whether or not it can be assumed to be 'missing at random'. For dichotomous data, we will report missing data and dropouts for each included study and will report the number of participants who are included in the final analysis as a proportion of all participants in each study. We will provide reasons for missing data in the narrative summary and will assess the extent to which the results of the review could be altered by the missing data by, for example, a sensitivity analysis based on consideration of 'best-case' and 'worst-case' scenarios (Gamble 2005). Here, the best-case scenario is that where all participants with missing outcomes in the experimental condition had good outcomes and all those with missing outcomes in the control condition had poor outcomes, and the worst-case scenario is the converse (Higgins 2008, section 16.2.2). For missing continuous data, we will provide a qualitative summary. The standard deviations of the outcome measures should be reported for each group in each trial. If these are not given, we will impute standard deviations using relevant data (for example, standard deviations or correlation coefficients) from other, similar studies (Follmann 1992) but only if, after seeking statistical advice, to do so is deemed practical and appropriate. Where missing data might be assumed to be missing at random then it may be appropriate to analyse only the available data. Where it may not be possible to assume this, i.e. the data are 'not missing at random', it might be possible to impute missing data with replacement values, for example, last observation carried forward. We would only use other methods of imputing missing values with uncertainty or using statistical models on the advice and with the assistance of a statistician.

### Assessment of heterogeneity

We will assess the extent of between-trial differences and the consistency of results of any meta-analysis in three ways: by visual inspection of the forest plots; by performing the Chi$^2$ test of heterogeneity (where a significance level less than 0.10 will be interpreted as evidence of heterogeneity) and by examining the I$^2$ statistic (Higgins 2008; section 9.5.2). The I$^2$ statistic describes approximately the proportion of variation in point estimates due to heterogeneity rather than sampling error. We will consider I$^2$ values of less than 40% as where heterogeneity may not be important; values in the range 30% to 60% may represent moderate heterogeneity; values in the range 50% to 90% may represent substantial heterogeneity, and 75% to 100% represents considerable heterogeneity.

We will attempt to identify any significant determinants of heterogeneity categorised as moderate or high. We cannot state in
advance what our preferred method of dealing with heterogeneity, if present, will be as this will be contingent on the data. However, we will first check that the data were correctly entered. There are a number of methods that can be used for handling heterogeneity and these include the following. The studies can be examined to explore the reason for heterogeneity but this is not recommended where there are few studies. A random-effects model could be used. Where a study paper is an outlier, sensitivity analysis can be carried out with and without the study. Other strategies include ignoring the heterogeneity, not performing a meta-analysis and changing the effect measure. We will seek statistical advice before using any of these methods.

Assessment of reporting biases
We will draw funnel plots (effect size versus standard error) to assess publication bias if sufficient studies are found. Asymmetry of the plots may indicate publication bias, although they may also represent a true relationship between trial size and effect size. If such a relationship is identified, we will further examine the clinical diversity of the studies as a possible explanation (Egger 1997).

Data synthesis
We will undertake a quantitative synthesis of the data using both fixed-effect and random-effects models. Meta-analyses may be conducted to combine comparable outcome measures across studies. In carrying out a meta-analysis, the weight given to each study will be the inverse of the variance so that the more precise estimates (from larger studies with more events) are given more weight. We will use random-effects models because studies may include somewhat different treatments or populations. We will group outcome measures by length of follow-up. Where appropriate, and if a sufficient number of studies are found, we will use regression techniques to investigate the effects of differences in the study characteristics on the estimate of the treatment effects. We will seek statistical advice before attempting meta-regression. If meta-regression is performed, we will execute this using a random-effects model.

Subgroup analysis and investigation of heterogeneity
If sufficient studies are found, we will undertake subgroup analysis to examine the effect on primary outcomes of:
1. principal diagnosis;
2. setting (inpatient, custodial, outpatient/community); and
3. psychotherapeutic method.

Sensitivity analysis
If there are sufficient data, we will undertake sensitivity analyses to investigate the robustness of the overall findings in relation to certain study characteristics. A priori sensitivity analyses are planned for:
1. concealment of allocation;
2. blinding of outcome assessors; and
3. extent of dropouts.

ACKNOWLEDGEMENTS
We would like to thank the authors of other reviews in the series for their hard work establishing the methodology on which this protocol is principally based.

REFERENCES

Additional references

Alden 2002

Altman 1996

Andrews 2001

APA 2000

APA 2010

Attkisson 1982

Bateman 2001

Bateman 2004
Bateman AW, Tyrer P. Psychological treatment for

**Beck 1961**

**Beck 1990**

**Campbell 2000**

**Campling 2001**

**Cloninger 1986**

**Coid 2003**

**Coid 2006**

**Costa 1992**
Costa PT, McCrae RR. *Revised NEO Personality Inventory (NEO-PI-R) and NEO Five Factor Inventory.* Odessa, FL: Psychological Assessment Resources, 1992.

**Dalrymple 2007**

**Denman 2001**

**Derogatis 1994**

**Donner 2001**

**Egger 1997**

**Elbourne 2002**

**Emmelkamp 2006**

**EuroQol 1990**

**First 1997**

**Follmann 1992**

**Gamble 2005**

**Guy 1969**

**Hamilton 1969**

**Herbert 1992**

**Herbert 2004**

**Higgins 2008**

**Hirsch 2004**
Psychological interventions for avoidant personality disorder (Protocol)

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Winston 1994

World Health Organization 1992

Zanni 2007

* Indicates the major publication for the study

**HISTORY**
Protocol first published: Issue 1, 2012

**CONTRIBUTIONS OF AUTHORS**
UA and HJ prepared the protocol. JD, MF, NH and JS will examine and select the citations and CD will provide adjudication. JD, MF, SG and BV will examine and select the papers and CD will adjudicate. UA, HJ and MF will extract the data, complete risk of bias tables and enter the data. UA, SG, HJ, CD, KL and MF will write the discussion.

**DECLARATIONS OF INTEREST**

- Uzair Ahmed - none known.
- Simon Gibbon - none known.
- Hannah Jones - none known.
- Nick Huband - investigator in a completed randomised controlled trial of social problem-solving therapy plus psychoeducation for people with personality disorder (*Huband 2007*).
- Michael Ferriter - none known.
- Birgit A Vollm - none known.
- Jutta Stoffers - none known.
- Klaus Lieb - Chair, Department of Psychiatry and Psychotherapy, University Medical Center Mainz; advisor to a planned randomised controlled trial of Inpatient Schema therapy in patients with personality disorders.
- Jane Dennis - none known.
- Conor Duggan - Chair, UK National Institute of Clinical Excellence Committee on antisocial personality disorder; advisor to a current randomised controlled trial of schema-focused therapy at Ashworth Special Hospital, UK; investigator in a completed randomised controlled trial of social problem-solving therapy plus psychoeducation for people with personality disorder (*Huband 2007*).
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