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Review Article

Comparison of C and Cognitive Behavioral Group Therapy in Individuals Diagnosed with Avoidant Personality Disorder: A Review

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ABSTRACT

Avoidant personality disorder is a psychiatric disorder characterized by avoidance of interpersonal communication, feeling of inadequacy, and reluctance to social activities. There are not many studies in the literature on the treatment of avoidant personality disorder. In the majority of studies, cognitive behavioral therapy method was found to be quite effective in the treatment of avoidant personality disorder with psychotherapy. From this point of view, one of the aims of this study is to compile studies that deal with cognitive behavioral therapy method in the treatment of avoidant personality disorder and present their data. The main problem in avoidant personality disorder arises from interpersonal communication, and cognitive behavior group therapies provide some advantages over individual therapy sessions in this sense. For this reason, another aim is to present suggestions with reasons why cognitive behavioral group therapies may be more effective on this disorder than cognitive behavioral individual therapies, and to compile studies in which cognitive behavioral group therapies are applied on avoidant personality disorder. In this study, studies in domestic and foreign sources, which were conducted with a sample group with avoidant personality disorder and social anxiety disorder, were examined and the study was prepared by reviewing the literature, which is one of the secondary data collection techniques. Since there are not many studies on avoidant personality disorder in the literature, considering the high similarity and comorbidity of avoidant personality disorder with social anxiety disorder, studies on cognitive behavioral group therapies related to social anxiety disorder were also compiled. As a result of the studies examined, it has been found that the symptoms of avoidant personality disorder are related to the distorted cognition of the people and cognitive behavioral therapies are a very effective approach because they increase the awareness of the automatic thoughts that go through the minds of the clients, question their correctness and provides alternative thoughts to replace them. The results of studies dealing with the treatment of social anxiety disorder with cognitive behavioral group therapy show that the effectiveness of cognitive behavioral group therapies is higher than individual applications of cognitive behavioral therapies.

Keywords: Avoidant personality disorder; Cognitive behavioral therapy; Cognitive behavioral group therapy

INTRODUCTION

Personality is a structure that emerges as a whole of the family structure, culture, environment, social experiences and physical characteristics of the individual acquired later, in addition to the innate characteristics that distinguish the individual from others, and continues to affect that person's adaptation to his/her environment and lifestyle. This structure gives predictability to all of the individual's feelings, beliefs, behaviors, and thoughts [1]. On the other hand, personality disorders are a condition characterized by internal experience and behavior patterns that are alienated from the characteristics of the culture in which the individual lives, resistant to change, and cause functional disorders and distress (American Psychiatric Association 2013).

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Personality disorders have been divided into three subsets by the American Psychiatric Association (APA) according to the similarity of their defining features. People with one of the cluster a disorders are usually peculiar and strange; those with cluster B disorders are often emotional, unstable, and dramatic; it is stated that those with cluster C disorders fearful and anxious features (APA 2013). Avoidant Personality Disorder (AVPD), which will be discussed in this review, is a psychiatric disorder characterized by feelings of inadequacy, a widespread state of social inhibition, and hypersensitivity to negative evaluation. Individuals with AVPD show an apparent avoidance of social interactions, thinking that they are not wanted by others and isolated from them. Accordingly, these symptoms cause significant problems in maintaining daily life [2]. The rates of disruption in daily functionality were found to be much higher in individuals with AVPD than in other personality disorders [3,4]. In population samples, the median lifetime prevalence of AVPD is thought to be 1.7%, and the probability of it being a comorbid disorder in psychiatric outpatients is approximately 14.7% [5,6].

AVPD has common features with Social Anxiety Disorder (SAD) and some other personality disorders. Considering the lack of knowledge about the treatment of AVPD in the literature and the high overlap rates between it and other disorders, the treatment approach of AVPD is generally determined from the treatment approach of other disorders with common features such as SAD [7]. According to the results of a meta-analysis study, AVPD was found to be diagnosed in 46% of individuals with a SAD [8]. Many studies support the hypothesis of persistence of symptom severity in the explanation of AVPD and SAD comorbidity. Having said that, patients with AVPD show more severe symptoms and various losses than patients with a SAD disorder [9,10].

Experimental studies on the psychotherapeutic treatment of AVPD began in the late 1980s. Cognitive-Behavioral Therapy (CBT), psychodynamic therapy, and schema therapy methods were generally used in psychotherapeutic treatment approaches determined in line with SAD, in which AVPD has many common features. Previous studies have found that patients with AVPD respond quite well to the treatment approach determined by behavioral techniques [11,12]. However, latterly researches began to focus on behavioral therapies, including cognitive techniques and found that CBT was more effective than behavioral therapies which applied alone. CBT is a short-term, maladaptive psychotherapy approach based on the principle of "here and now" [13]. With this therapy method, the aim is to make the distorted cognitions and maladaptive behaviors functional. Cognitive elements in the treatment of AVPD with CBT include the development of an individualized model of social fear, the identification of dysfunctional core beliefs, the development of more adaptive cognitions and beliefs, and behavioral experiments to challenge safety behaviors [14,15].

Early CBT programs were predominantly applied in a group format. Group therapy is defined as the form of individual therapy with a group. In group therapy, clients generally work for a common purpose with other clients who have similar problems to their own, moderated by a psychotherapist who has completed their training in the relevant field. Group therapy is the form of the approach used in a particular type of therapy that is applied simultaneously to a group of clients, not individually. In Individual Behavioral Group Therapy (CBGT), CBT techniques are applied to clients based on the principles of group therapy in line with the purpose of CBT. The group format CBT approach in the treatment of AVPD includes techniques such as gradual exposure exercises or systematic desensitization, behavioral rehearsals in role-playing experiments, self-image work with video feedback, social skills training, and the results show moderate to good and permanent improvements [16,17]. From this point of view, although people with AVPD avoid social environments excessively, have reservations about establishing intimate relationships, and are extremely sensitive to criticism, in a way, just like the exposure technique, CBGT has similar effectiveness to the exposure technique in individuals with AVPD can be expected.

Individually applied CBT poses various difficulties for individuals with AVPD because the maladaptive behaviors and thought processes that are characteristic of interpersonal relationships in AVPD also extend to the relationship with the therapist. Individuals with AVPD often fear rejection by the therapist, tend to doubt the reality of the therapist's concern, and refuse to seek therapy for all these reasons [18]. AVPD symptoms usually occur in social environments. Because the group environment in CBGT provides a natural confrontation environment for these people and the biggest problems of people with this disorder are related to their social lives, CBGT is more effective than CBT, which is applied individually and has various disadvantages for individuals with AVPD. People with this disorder have very few social relationships and feel lonely. In this sense, CBT applied in a group format can be effective on patients in terms of eliminating the feeling of loneliness and preventing them from having negative automatic thoughts, generated without questioning its accuracy, such as "I am the only person with this disorder". In addition, an increase in social skills can make positive contributions such as an increase in the sense of hope, acceptance by others and self-acceptance, an unprejudiced approach with tolerance towards others, and gaining insight. Group therapies seem more positive than individually applied therapies in terms of providing many opportunities for these individuals to heal, such as reinforcement, exposure to social situations, and social support and role modeling [19]. These individuals may not get the same results from individually applied psychotherapies because many of them are reluctant to therapy and may be prejudiced against the therapist. They tend to think that their thoughts will be judged by the therapist. It seems that it will be very difficult or take a very long time to gain efficiency from a therapy started with such prejudicial behavior. Fear of negative evaluation and shyness characteristics in AVPD may cause individuals to delay or refuse to apply to any therapy due to stigma anxiety. Thanks to the opportunity of group therapy to bring together individuals with similar problems, they are more likely to apply to group therapy than individual therapy. Increasing social skills and regulating emotional experiences in order to reduce social shyness help these patients to establish intimate relationships outside the therapy setting. The group therapy environment also

provides this kind of support to individuals. The aim of group therapy is for patients to recognize their own personality traits, to recognize problematic areas in their interpersonal relationships, to realize their inappropriate behaviors, to develop their coping skills, and to gain insight into the causes of their problematic areas. People with AVPD may be worried about group therapy as in other social settings, but previous studies show that this type of therapy is effective in helping patients with AVPD cope with the confrontation they are exposed to [7].

Considering that AVPD is the most distinct disorder that causes functional impairment among Cluster C personality disorders, it causes life-threatening behaviors such as suicide due to its high comorbidity rate with depressive disorders, and there are very few studies on its treatment, one of the aims of this study is to compare the CBT approach and its effectiveness, which has been an effective treatment for AVPD for a long time, with CBGT, and to bring an academic study to the literature in which comparisons have not been made on this subject before. Thus, by reaching more clients in a certain period of time, time and effort can be saved and effective treatment approaches can be used on AVPD. The main problem in AVPD arises from interpersonal relationships, and CBGT offers a very effective approach to issues involving interpersonal interaction. Therefore, it can be suggested that CBGT might be more effective than CBT. From this point of view, another aim is to compare CBT and CBGT and to present the suggestions and the findings in the literature that CBGT can provide a more effective approach to AVPD.

LITERATURE REVIEW

Avoidant personality disorder

AVPD was first defined by Millon in 1969 and the term, firstly, entered the DSM-III. DSM-III mentioned the main features of AVPD as an intense feeling of shyness, avoidance behavior, and inhibition and defined 5 diagnostic criteria [20]. According to the DSM-V diagnostic criteria currently in use, in the diagnosis of AVPD, avoidance of professional activities involving interpersonal interaction for fear of criticism or disapproval, reluctance to engage with people for fear of not being loved, restraint in intimate relationships for fear of embarrassment or ridicule, being criticized or mocked. There are factors such as avoiding activities that require establishing personal relationships due to fear of rejection, limiting new interpersonal situations because they feel inadequate, seeing oneself in a socially inadequate position, and being reluctant to try new activities because it may prove their embarrassment [21]. There are also sources reporting that the probability of AVPD being seen in the community is between 0.5% and 1%, while its prevalence is 10% [22]. Although individuals with AVPD are very eager to establish relationships, they are too afraid to approach others and have difficulty expressing their feelings towards other people. These people display tense behaviors, are generally worried that they will blush or cry, and fantasize about ideal social relationships [23]. Anxiety and restlessness can be observed in shy people not only in very crowded environments, but even in environments where there is only one person. Instead of confronting their anxieties, individuals constantly show avoidance behavior, and this avoidance creates a suitable environment for the maintenance of their shy personalities, as they create a feeling of relief and reduce anxiety. Their self-confidence is quite low as they constantly avoid environments where they can develop their self-confidence. According to Stone, childhood traumas such as molestation, incest, and physical abuse may underlie shyness and interpersonal shyness [24].

Cognitive behavioral therapy

CBT is a structured form of therapy that accentuates that how we feel and how we act are determined by our thoughts. It was originally developed by Aaron Beck in the 1960s to treat depression [25]. Later, it was also evaluated on other disorders and became a therapy method whose effectiveness was approved. CBT is a psychotherapeutic approach that tries to change short-termed, maladaptive thoughts and behaviors whose foundation lies on the principle called "here and now" [13]. With this therapy method, the aim is to make the problematic cognitions and accompanying maladaptive behaviors functional. According to the cognitive approach, dysfunctional beliefs cause dysfunctional emotions and behaviors. Therefore, the primary purpose of CBT is to provide awareness of the client's thought processes. For this purpose, the therapist tries to catch the automatic thoughts that go through the mind of the client. It uses behavioral interventions, aiming for the client to test the cognitive distortions in these thoughts and produce alternative thoughts instead [26]. The cognitive theory examines cognition under two main headings: Automatic thoughts, verbal and imaginary structures that provide the flow of cognition, and schemas. Automatic thoughts may occur in the mind of the individual as thoughts or images that appear involuntarily and suddenly. In CBT, the focus is on negative automatic thoughts that arise in a stressful moment. Usually, as soon as these thoughts arise, one becomes aware of the accompanying emotion without being aware of the thought. Therefore, in CBT, emotions are handled first and then the underlying thought is tried to be revealed. Schemas can also be divided into two groups' intermediate beliefs and core beliefs. Intermediate beliefs; are the rules, attitudes, and assumptions developed by the individual about the core belief to protect him or her from negative core beliefs. In CBT, raising awareness of these strict rules are dysfunctional tried to be made and later, replace them with alternative thoughts, or these strict rules are tried to be made flexible. Core beliefs are the deepest mental building blocks that contain the individual's assumptions about him or herself, others, and the world, and how the individual organizes the information he or she acquires. They are shaped by past experiences. If the cognitive structure is considered as a topographic layer; core beliefs are at the top, deepest, and hardest to reach; Intermediate beliefs are on a lower layer, and automatic thoughts that are the easiest to reach, which are usually short-termed, ephemeral, and implicit. According to the cognitive formulation, the dysfunctional schema that the individual has is activated as a result of some experienced situations. As a result, the individual focuses his/her attention on the subject related to the schema, evaluates the event

according to the schema, and then experiences an emotion. While determining a coping strategy about the emotion experienced, secondary evaluations about the emotion and thought formed are also under the influence of the schema [27]. In therapy, it is primarily focused on negative automatic thoughts to ensure that the underlying basic belief is not functional.

At the beginning of the therapy process in CBT, individuals are enabled to recognize the cognitive model by realizing that cognitive, somatic, emotional, and behavioral symptoms are related to each other and that a change in one will affect the others. CBT usually consists of three phases. In the initial phase, the problem brought by the patient to therapy is evaluated. Patients are informed through psychoeducation. A treatment plan is created by determining symptoms, factors related to symptoms, cognitive and emotional characteristics. After the evaluation process, a more active phase begins. At this stage, cognitive-behavioral techniques suitable for the patient's basic symptoms are decided and implementation commences. Phase two studies are complete when symptoms have significantly reduced, and in the final phase, patients are ready to prevent relapse by maintaining the gains of treatment. At this stage, the patient is given more responsibility by reducing the intensity of the treatment [28]. In order to preserve the changes for a long time, sometimes "strengthening sessions" can be applied [29].

CBT is usually applied once or twice a week on outpatients. An intensive CBT program in the form of daily sessions may be necessary for inpatients. For this reason, it is necessary to decide on the duration of the study, taking into account factors such as the reason for coming to therapy, the intensity of the symptoms and the way they occur, the accompanying stress factors, the diagnosis, and insight of the individual. The therapists determine the frequency of therapy together with their clients. The duration of the therapy session is 45-50 minutes on average, and the treatment takes about 3-6 months. CBT is used in the treatment of many mental disorders such as panic disorder, generalized anxiety disorder, personality disorders, obsessive-compulsive disorder, and eating disorders [30]. It is also a method used in adolescents and children. CBT sessions are structured, time-limited, and collaborative with the client, in which the therapist is active and directing.

Techniques used: The most commonly used techniques in CBT are Socratic questioning and directed exploration [30]. In the directed discovery technique, which is a form of Socratic questioning used in practice, it is aimed to make the client aware of a knowledge that is not in the awareness area due to the mood at the moment, with many questions coming one after the other. In addition to these, behavioral experiments that enable the individual to understand that dysfunctional beliefs can be changed or stretched by alternative behaviors; a role-playing technique in which the client plays the situations or behaviors that will be useful in his life outside the therapy setting; gradual exposure technique, in which the individual is gradually confronted with the feared situation or object to prevent the avoidant behavior; techniques such as modeling, which is used to learn a new behavior or to eliminate a learned behavior, and visualization, in which the client's negative automatic thoughts are tried to be determined by the therapist by imagining a situation that is difficult to cope with, are also frequently used.

Since AVPD has many common features with SAD and SAD is comorbid with AVPD. Studies on SAD can shed light on the treatment of AVPD, and it is crucial to evaluate this situation with the treatment of AVPD [31,16]. One of the approaches of CBT to explain SAD was used by Clark DM, et al. [32], and McManus F, et al. [33], to explain the cognitive cycle that sustains social anxiety. According to this explanation, people with social anxiety may have negative expectations before entering a social environment due to the attributions they make to their negative social life in the past and negative self-evaluation. These expectations lead to negative beliefs that the person cannot represent himself/herself well enough. These beliefs both increase one's attention to oneself and increase one's thoughts about how others perceive and observe him/her. While in this emerging process of self-care, objective information from outside cannot be processed. The person perceives social environments as a threat to oneself. One may show avoidant behavior and safety-aimed behaviors to reduce the threat. Individuals with AVPD also have a negative automatic thought that they can be negatively evaluated by others, and the mentioned cognitive cycle approach describes this situation. Accordingly, the cognitive elements involved in the treatment of AVPD with CBT include the development of an individualized model of social fear, the identification of dysfunctional core beliefs, the development of more adaptive cognitions and beliefs, and the application of behavioral experiments to challenge safety-aimed behaviors. Literature reviews show that when cognitive restructuring and confrontation techniques are applied together, better results are obtained in CBT applied for SAD and AVPD than the confrontation technique applied alone [34].

Cognitive behavioral group therapy

Group therapy is defined as the form of individual therapy with a group. In group therapy, clients generally work for a common purpose with other clients who have similar problems to their own, moderated by a psychotherapist who has completed their training in the relevant field. Group therapy is the form of an approach used in a particular type of therapy applied to a group of clients rather than individually. CBGT is a group approach that uses behavioral (e.g. modeling and reinforcement), cognitive (e.g. cognitive restructuring and problem-solving), relational, and group procedures to improve individuals' coping skills and solve their internal and relational problems. In CBGT, CBT techniques are applied to clients based on group therapy principles in line with the purpose of CBT. CBGT differs from individual CBT in two aspects. The first of these is that modeling and operant techniques are used more in group sessions than in individual sessions during therapy. The second is that the interaction rate among group members contributes too much to therapy [35]. According to Yalom ID, et al [36], group therapies have many advantages over individual therapies. The group therapist has the opportunity to observe these communications live, as opposed to second-hand interpersonal communications. The group provides the client with a source of

feedback on behaviors and distorted cognitions that are offensive or acceptable to others. Being able to help others is a factor that makes the therapy easier. Individuals have the opportunity to become both a patient and a co-therapist. Clients in a group setting discover that not only they have experienced the problem regardless of its severity, but that others have had similar experiences. Thus, individuals can normalize their problems. The group provides a rich source of ideas for brainstorming, suggestions for using alternative strategies, and models for role-playing, especially in CBGT [37]. In a group setting, mutual reinforcement of clients' behaviors is more effective than reinforcement provided by the therapist to the client. This is another advantage of the group environment in CBGT.

There are a series of activities that should progress gradually and be done by therapists in the CBGT process. It contains pre-group planning, orientation, evaluation, intervention, generalization, termination, and follow-up activities. When planning CBGT, the therapist has responsibilities such as setting the group's goals, assessing membership, involving members in the group, deciding on the social environment or structure of the group, and creating the physical environment of the group. While making this planning, factors such as the theme of the group, the size of the group, the number of therapists, the frequency and length of the sessions, and whether there are enough clients for the group should be considered. In terms of structure, groups can be homogeneous (clients have similar problems) or heterogeneous (clients have different problems). Most CBGT programs have a homogeneous structure. Two types of basic organizations can be identified for the CBGT. The first is open groups, with new group participants arriving at any time and leaving at any time. The second is closed groups with a fixed start and a fixed end date for all participants. CBGT groups in the literature are generally closed groups. Usually, sessions are held once a week, 1.5-2 hours long, accompanied by a therapist and 8-10 participants. In the first group sessions, group members are informed about the aims of the group, the methods to be used, the planned goals, and the importance of keeping the information shared in the group confidential. The purpose of the evaluation is to establish a specific treatment goal for each client within the framework of the general goals. In the intervention stage, within the course of established goals, various therapy techniques are selected and implemented to facilitate change. Techniques such as problem-solving, modeling, behavior rehearsals, cognitive restructuring, rational-emotional techniques, socio-entertainment, relaxation, and breathing exercises are applied to teach clients some necessary skills. In the generalization phase, homework is given for the patient to transfer what he/she has learned in the group environment to the outside world and to continue what he/she has learned after the therapy process is over. Finally, the termination phase consists of factors such as coping with the feeling of separation, reviewing the group experience, giving and receiving feedback from the clients and the therapist, and transferring what has been learned to the future [35].

As with AVPD, CBGT provides the opportunity to make observations in a group environment by understanding the nature of the problem in an interpersonal environment, especially in individuals with interpersonal problems. Since CBT is based on an educational approach, clients acquire some skills in a group environment, and the experiences gained in this group environment are easier and more reliable for people with APD than learning through experience in the outside world. In addition, the results of this learning can be relatable to the outside world. Another advantage of group therapy is that clients with similar problems in CBGT learn through modeling by sharing their experiences and the solutions they use for their problems. Being together with clients who have similar problems in group therapy helps them normalize their problems and receive social support from others. The distorted cognition of the client about his/her problem can also be changed in this way. The core beliefs of individuals with AVPD about being criticized and rejected by others can be changed by the exposure provided by the group environment. Clients have the opportunity to learn by experience that such beliefs are not unsupported. In the definition made by Yalom ID, et al. [36], for group therapy, features such as universality, group commitment and devotion are among the factors that enable progress in treatment in CBGT.

AVPD is known as the personality disorder that causes the most impairment in functionality among the C cluster personality disorders. These deteriorations in the functionality of individuals can cause them to be unable to do their jobs in their daily lives, to be socially withdrawn, to be deprived of social support, which is a very important factor for our psychological health, to have negative effects on their business life and even to lose their jobs. For these reasons, comorbidity with major depressive disorder is at very high levels and may result in life-threatening behaviors such as suicide. When all these are considered together, it is important to conduct new research and apply an effective treatment method to such an important disorder for which there is still no adequate research. CBT, which has been applied for a long time in individuals with AVPD, has been found to be more effective than one-person methods such as behavior therapy and psychodynamic therapy since it focuses on the cognition of the clients causing the problem and the behaviors caused by this cognition [29]. In the publications, there are many studies in which CBT was applied on APD and high efficacy rates were reported. For example, in a study by Emmelkamp PM, et al. [14], in which they compared individual cognitive therapy and brief psychodynamic therapy on 21 randomly assigned individuals with AVPD they reported a high effect and 91% recovery rate in SCID II on self-report measures. Strauss JL, et al. [15], conducted an uncontrolled individual cognitive therapy practice with 23 individuals diagnosed with AVPD, and compared interpersonal therapy and cognitive therapy for social anxiety it was found that two-thirds of patients with comorbid AVPD did not meet the diagnostic criteria for AVPD 1 year after treatment, without any change on treatment conditions.

Early CBT sessions were generally conducted in a group format. CBGT techniques applied to clients with AVPD include gradational exposure exercises, systematic desensitization, behavioral rehearsals in role-playing experiments, self-image work with video feedback, and social skills training. According to the results obtained from CBGT applied to clients with

AVPD, moderate to good and permanent improvements were obtained with CBGT [11,17].

Because CBGT includes individuals in a social group, the client gets the opportunity to meet with people who have similar problems and find the opportunity to see different perspectives on the problem they experience and discover different ways of dealing with their problems. In addition, getting support from other people, being able to support them, and being accepted by other people provide a sense of trust in the person. In addition, seeing that his or her group mates can solve similar problems gives hope to the person, and a belief is formed that he or she can solve these problems. This can be a useful way to regulate clients' negative core beliefs. For example, Alden L [38], and Stravynski A, et al. [12], similarly regardless of the type of structured skills training, the CBGT method used for personality disorder, which allows patients to give and receive feedback about their interpersonal behaviors in their relationships with other people in the group, diminish their anxiety, depression, and shyness severities. Individuals with AVPD have self-confidence problems such as difficulty in establishing interpersonal relationships, avoidance of social communication, embarrassment, inability to express their feelings and thoughts comfortably, fear of being negatively evaluated by others, and feeling worthless. For example, Renneberg B, et al. [11], reported that there was a 40% improvement rate in the results of the participants evaluated by the fear of negative evaluation questionnaire after an intense 4-day CBGT program. In addition, according to the reports created by them or their therapists as a result of the follow-up evaluations obtained from these participants, one patient among the participants was able to start looking for a job successfully, and another patient, who always saw himself as incompetent, saw himself as an interpersonally competent person for the first time by observing his video recording and the other patients with severe avoidance reported that they were able to attend classes comfortably and express their opinions freely. In another study, it was observed that individuals use more appropriate coping methods in CBGT, their levels of psychological distress are reduced, and they realize their false cognitions in their core beliefs. These findings also support that CBGT can make progress on the main problems of the treatment of AVPD. Contrary to the proposition of this study, it was found that the CBGT method applied to clients with AVPD and comorbid SAD significantly reduced symptoms in clients with SAD, but it did not have as much effect on reducing the symptoms of clients with AVPD as it did on SAD [39,40]. The possible reason for this difference is thought to be due to the differences in the techniques used to measure the avoidant personality. In fact, disagreements between measures of personality disorders have a bad reputation [16].

In the literature, there are only a few studies in which CBGT was applied in the treatment of AVPD and its effectiveness was reported, and there are relatively old studies in terms of the year in which the studies were conducted. However, there are more studies showing that CBT is applied in the treatment of SAD and is more effective than individual CBT. As stated in the introduction, the suggestion that CBGT application may be more effective on AVPD than CBT is worth investigating, since AVPD has many common features with SAD, and SAD is comorbid with AVPD.

According to the data obtained from the review study of the articles evaluating the effectiveness of CBTs in adults with SAD published by Yalçin M, et al. [41], between 2005 and 2015, the techniques applied in the CBT program generally consist of psychoeducation, cognitive restructuring, in-session exposure studies, social skills training, and awareness training. These effectiveness studies based on the pre-test, post-test, and follow-up interviews, which did not include control groups, showed that CBGT was effective and significantly reduced social anxiety symptoms [42,43]. When the results of the review were examined in general, it was seen that there were studies focusing on some symptoms of social anxiety such as intolerance to uncertainty, self-attention, dysfunctional thoughts and beliefs about social anxiety, and in these studies, symptoms related to social anxiety generally decreased and quality of life increased [44,45]. Follow-up evaluations in another study in which SAD was treated with CBGT showed that the gains obtained still exist after the end of the treatment, and some studies even showed that the gains of CBGT persist for a longer period of time compared to other therapy techniques [46]. According to these findings, the result that CBGT is quite effective in SAD is thought to be adaptable to AVPD due to the reasons mentioned above.

DISCUSSION

Cognitively oriented group therapies applied on AVPD are found to be quite effective in some studies. Group therapies have different features than individually applied therapies, and these features make the group environment more advantageous [47-50]. To give examples of these advantages, it can be said the fact that group therapies save money and time as they can intervene with more than one client at the same time, normalize the problems by bringing clients with similar problems together, learn different solutions to a problem through modeling, and provide social support to clients in the relationships established in the group environment.

Although individuals with AVPD are willing to establish relationships, they lead a socially isolated and distrustful life due to their reservations. CBGT allow individuals with AVPD to establish social bonds in a safe environment and offer clients the opportunity to establish social bonds with each other in a safe environment. In addition, individuals with AVPD have negative automatic thoughts such as rejection, disapproval, and dislike by others [51-59]. Distorted cognitions can be altered by the social exposure that the group environment provides to individuals and the experience that such beliefs are unsupported. It shows that this type of therapy is effective in that group therapies enable patients with AVPD to cope with the confrontation they are exposed to [7].

There are very few studies in the literature on which group therapy should be applied on AVPD. There are studies showing that group therapies with a cognitive-behavioral orientation are effective on AVPD. However, these studies are old and very few in terms of the year they were conducted [11,17]. Therefore, in

this study, CBGT studies on SAD were also compiled, since AVPD and SAD have many common features and comorbidity rates are very high. In order to make clearer inferences, studies comparing the effectiveness rates of CBGT and CBT are needed [60,61]. At the same time, the prejudice that individuals with AVPD have towards group therapy due to their reservations may also make therapists consider combining individual and group therapy sessions.

Although group therapy studies on AVPD have gained momentum in recent years, there is very little data on group work with a cognitive-behavioral orientation which offers a very effective approach. Therefore, there is a need for additional studies examining the effectiveness of CBT and CBGT on individuals with APD.

CONCLUSION

This review article aims to draw the attention of researchers to the importance and effectiveness of CBGTs applied on AVPD. Considering the lack of studies in the literature on AVPD, it is thought that even a small improvement on the symptoms of individuals who are coping with significant difficulties is very important. Among the effective therapies that can be applied to individuals with AVPD, the dissemination of CBGTs is recommended due to the advantages of CBGTs such as saving money and time, normalizing the problem, changing distorted cognition, learning through modeling, social support, providing a safe environment, insight, and confrontation. It is considered important that the lack of work in this area should be tackled by the researchers. It is thought that this review will guide practitioners in the preparation of group therapies to be applied on AVPD.

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