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GENERAL PRINCIPLES FOR TREATING PERSONALITY DISORDER WITH A PROMINENT INHIBITEDNESS TRAIT: TOWARDS AN OPERATIONALIZING INTEGRATED TECHNIQUE

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Psychotherapists need to perform tasks such as being empathetic, performing an ongoing assessment of cases, self-disclosing, making explicit treatment contracts, validating patients' experiences and promoting awareness of psychological experience, if they are to be effective in treating personality disorder (PD). Successful therapy also requires a systematic accurate PD model. We suggest here that it is still unclear how, when, and according to what session markers therapists need to perform specific operations to maximize therapeutic gains. This article describes and operationalizes a step-by-step procedure for organizing and delivering the interventions necessary for effective outcomes, such as maintaining a good therapeutic relationship, increasing understanding of mental states, reducing symptoms and improving social adaptation. The procedure is illustrated by reference to the treatment of cases of emotionally overly-constricted PDs. We include a theoretical proposal to facilitate the development of measures for evaluating the efficacy of therapist actions.

Growing evidence that psychotherapy works (Castonguay & Beutler, 2006a; Lambert & Olges, 2004) points to the importance of identifying effective ingredients and therapist actions that improve patients' lives. Many techniques (Castonguay & Beutler, 2006b; Critchfield & Benjamin, 2006a; Livesley, 2003, 2007, 2008a; Norcross, 2002) cut across different therapeutic models and experienced clinicians do not rely exclusively on treatment methods based on their preferred theoretical orientation. The task forces set up by Divisions 29 and 12 of the American Psychological Association, and the North American Chapter of the Society for Psychotherapy Research have made important contributions along these lines (Castonguay & Beutler, 2006a; Norcross, 2002).

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Until now, the Task Forces highlighted what a clinician can do to be successful. Effectiveness factors include a strong alliance, therapist self-disclosure, empathy, goal consensus, positive regard, congruence and genuineness, cooperation, repair of alliance ruptures, management of countertransference, accuracy of interpretations of the relationship, and encouragement. However, it is rather unclear what a therapist needs to do to achieve these (Critchfield & Benjamin, 2006b) and what clinicians using therapy manuals actually do during sessions, what actions actually generate adaptive change (Clarkin, 2008) or increase distress.

The aim of this article is to describe the actions a clinician might take at each point in a therapy based on an understanding of the underlying personality pathology. We propose a step-by-step procedure for using interventions progressively, moving from simpler to more complex ones based on changes in patients' level of functioning and their responses to previous interventions. We illustrate the process by reference to patients over-constricted in their emotions, self-narratives and range of behaviors, that is with an inhibitedness trait (Livesley, 2007; Tyrer et al., 2007), and characterized by low affiliation, avoidance of attachment or intimacy and restrained expression of emotion. These persons are over-controlled, both in emotion and behavior perfectionist, cognitively rigid and not willing to engage in new experiences or take risks (Lynch & Cheavens, 2008). They are usually diagnosed with avoidant, obsessive-compulsive, paranoid, narcissistic, passive-aggressive, dependent, depressive, or schizoid PDs.

The core idea of the procedure is that therapists and patients need to progressively build shared representations of patients' mental states as inferred from patients' self-narratives. Therapists elicit specific autobiographical episodes instead of accepting generalized and abstract statements, and then focus on the details of these relational episodes to discover how a patient felt, thought, and acted. The next step is to identify cause-effect psychological links, e.g., how a thought elicited an emotion or vice-versa, or how an emotion triggered a behavior. As mentalistic knowledge becomes richer, and patients pass from poor awareness of emotions and motives for actions to awareness of how they think, feel, and act in specific relational contexts, therapeutic goals evolve (Stiles, 2006). The next step is to elicit new related episodes until therapist and patient have enough evidence to form hypotheses about the schemas underlying interpersonal exchanges. If psychological information remains inaccessible, the therapeutic goals need to remain in the stage-setting part, until better mental state understanding is achieved. For example, it is pointless to try and change a problematic relational pattern when a patient is not even able to relate episodes in which it is clear how this pattern unfolds and what affects were elicited by the interactions in it.

A successful stage-setting provides the mentalistic information necessary for the second treatment part, in which patients are helped to take a critical distance from their schematic representations, find different ways to think about problems, imagine creative solutions to conflicts, reach a

larger integrated repertoire of representations of the self-with-other, with nuanced social and problem-solving skills and creative ways for living an adaptive social life, and finally understanding the others.

A MULTI-DIMENSIONAL CONCEPTION OF PD

The elements constituting PD pathology appear to be multidimensional, a range of interventions is therefore required to tackle the different problems (Critchfield & Benjamin, 2006a; Dimaggio, Semerari, Carcione, Nicolò, & Procacci, 2007; Kernberg, 1975; Livesley, 2008b; Meyer & Pilkonis, 2005; Westen, Shedler & Bradley, 2006). For example, a patient might both feature poor emotional awareness and be driven by a negative schema of the self with others and both elements need to be treated, each with its specific techniques. This argues for an integrated approach combining aspects from the various models (Critchfield & Benjamin, 2006a; Livesley, 2003, 2008a), as it is necessary to treat each patient at a particular stage in his or her treatment according to the aspects of the disorder surfacing at that point in therapy.

As regard persons with constricted or inhibited personality traits, their pathology involves: (1) poor metacognition (Bateman & Fonagy, 2004; Dimaggio, Semerari, et al., 2007; Fonagy, Gergely, Jurist, & Target, 2002; Semerari et al., 2003; Semerari, Dimaggio, Nicolò, Procacci, & Carcione, 2007; Vanheule, 2008); (2) stereotyped, constricted, and dysfunctional construction of the relationship between self and others (Benjamin, 1996; Ryle & Kerr, 2002); and (3) over-regulation of emotions and impulses (Ebner-Priemer et al., 2007; Millon & Davis, 1996).

POOR METACOGNITION

A critical impairment associated with PD is limited comprehension of states of mind—termed metacognition (Dimaggio et al., 2007; Livesley, 2008b) or mentalization (Bateman & Fonagy, 2004). Metacognitive impairments displayed by individuals with PD include difficulty recognizing, describing, and identifying inner experiences and the psychological causes of their behavior, actions, and emotions. Consequently it is difficult for such individuals to put themselves in others' shoes and abandon their own viewpoint to achieve a sophisticated understanding of what drives others to act, feel, or think (Dimaggio, Lysaker, Carcione, Nicolò, & Semerari, 2008; Fonagy, 1991). Similarly, prominent narcissistic, schizoid, or avoidant traits or disorders are related to poor awareness of one's own emotions and their causes (Bach, de Zwaan, Ackard, Nutzinger, & Mitchell, 1994; De Rick & Vanheule, 2007; Dimaggio, Procacci et al., 2007; Lawson, Waller, Sines, & Meyer, 2008; Taylor, Bagby, & Parker, 1997).

Metacognitive dysfunction also involves difficulties forming coherent self-other representations and assuming a bird's-eye view of the multiple aspects of one's involvement in the social world. Metacognitive impair-

ment has substantial implications for treatment: for example, poor emotional awareness predicts poor outcome (Ogrodniczuk, Piper, & Joyce, 2005; Vanheule, 2008). Metacognitive or mentalizing skills appear to increase in good-outcome cases at least in some forms of treatment (Dimaggio, Procacci, et al., 2007; Levy et al., 2006). Treatment should aim at helping patients: to understand their own minds and the causes that lead them to think, act, and feel as they do, to distinguish their fantasies from the real world, to understand the actions of the others might be driven by motives different than their own. Finally, one key goal of therapy could be to promote the ability to use psychological information to cope with symptoms—e.g., "I know now that when I work 14 hours a day I become tired and prone to dissociation, so I have learned to take a break"—and solve social problems.

STEREOTYPED, COARCTATED, AND DYSFUNCTIONAL INTERPERSONAL SCHEMAS

Dysfunctional constructions of self-with-other relationships hamper adaptation. Among the predominant self-representations are not loveable, unworthy, guilty, omnipotent, and betrayed. Those applied to others include rejecting, abusing, mistrustful, deserving punishment, etc. These representations are often paired to form dyads, such as unloveable self/rejecting other, which influence both decision-making and others' reactions negatively (Andersen, Thorpe, & Kooij, 2007; Ryle & Kerr, 2002).

Successful treatment appears to transform, modulate, and enrich patients' relationship representations (Critchfield & Benjamin, 2006b). As we describe later, patients need to become progressively aware that they are driven by relational patterns forcing them to think, act, and feel in similar ways over time and in different situations. The therapist should then strive to help patients take a critical distance from these expectations, by, for example, recognizing that the others show signs of acceptance instead of the expected criticism. A later but crucial step is everyday practice by patients in order to expand their range of behaviors and schemas with the purpose of living a more flexible and adapted social life.[1]

IMPULSE AND EMOTION OVER-REGULATION

Inhibited PD patients over-regulate their wishes and affects and do not let their emotions flow. For example, obsessive-compulsive persons have difficulty accessing feelings and do not let feelings guide their actions. In-

1. For space reasons, we do not deal in this paper with how a therapist should tackle dysfunctional patterns as they colonize the therapeutic relationship. We merely note that working on the therapy relationship is a core part of an integrated PD therapy (see Clarkin, this issue; Critchfield, this issue) and the procedure we propose is constantly accompanied by in-session relational work.

stead they suppress emotions and may consider their urges to be signs they deserve to be blamed (Millon & Davis, 1996). Emotional distancing is also important in avoidant, narcissistic (Dimaggio, Procacci, et al., 2007) and paranoid (Lynch & Cheavens, 2008) styles. Flat affects may be the result of affect-avoidance, patients find arousal discomforting so they swiftly distract themselves from any emerging affects or inhibit the emotional responses (Helmes, McNeill, Holden, & Jackson, 2008; Tayor, Laposa, & Alden, 2004).

Coarctation and flat affects have a major impact on treatment. Therapists find it difficult to understand the causes for symptoms and social dysfunctions and are, as a consequence, unable to achieve joint treatment planning. For example, it is hard to help a patient cope with difficulties in forming romantic relationships when the latter is unable to describe the associated emotions or quickly shifts topics when it emerges in conversation. Flat affects also result in poor involvement in the therapeutic process: for example, patients talk about self-harming fantasies without the associated emotional pain which would push them to seek help. Moreover, while arousal is low, patients are unable to remember what their therapist said during a session, thus rendering it almost useless (Stiglmayr et al., 2008). To promote emotional awareness therapists should pay attention to the slightest changes in a patient's face, prosody, and posture and make this the focus of the discourse. This helps patients to gradually realize that different moments in their social lives are accompanied by a range of emotions and to start integrating knowledge of affects in their self-representations. They might thus discover that they are in fact motivated towards courting a partner, whereas previously they thought they preferred spending time alone, but they were worried about being rejected or ashamed at thinking of themselves as failures.

THERAPEUTIC MARKERS

Before passing to the step-by-step treatment procedure, we describe here the key markers signaling that basic steps have been accomplished and that it is possible to achieve more complex and difficult goals. A series of markers signal that the patient is ready to accomplish new goals, for example start exploring new forms of relationship once awareness of underlying dysfunctional schemas is achieved. Therapeutic markers are changes—both positive and negative—in metacognition, quality of affects or quality of the therapeutic relationship: for example, a reduction in confrontational or withdrawing attitudes (Safran & Muran, 2000), access to autobiographical memories (Weiss, 1993) and symptom reduction. Only if interventions lead to improvement—or at least nondeterioration—in some of these factors, can they be considered successful, allowing a switch to interventions requiring greater reflective abilities or capable of provoking increased negative affectivity without activating defensive reactions. We would point out that in the sequence described one should not necessarily

start from the first step but from the status reached by the patient in therapy. If, for example, narratives are clear, there is no need to strive to collect them, if emotions are described accurately one can pass directly to finding their causes, and so on. In short: therapist actions should start where the patient is and change if the patient improves or worsens.

STEP-BY-STEP PROCEDURE

We propose here that interventions need to be delivered according to a sequence of steps, according to patients' ability to describe fully-fledged narrative accounts of their lives and use them as a text in which to dig to find psychological knowledge. We divide the procedure in two parts: (1) stage-setting; and (2) change promoting, with the requirement that the first be successfully completed before passing to the second.

Stage-setting is the whole set of operations aimed at reconstructing patients' inner world, inferring it from elicited or spontaneously related episodes from their autobiographies. Therapists could pass from initially promoting lower levels of self-reflection such as emotional awareness or a feeling of self-efficacy, to higher-order ones such as forming plausible hypotheses about psychological cause-effect relationships among elements of subjective experience, e.g., recognizing one felt hurt by a boss refusing a raise and then angrily withdrawing from all social contacts.

Change-promoting includes a wide array of strategies and techniques, which we describe only partially for space reasons. Basically we concentrate on: fostering patients' ability to question their ideas and distinguish between fantasy and reality; focusing on adaptive self-aspects formerly overshadowed by dominant problematic experiences, until they are integrated in self-narratives; promoting new behaviors in a tentative and exploratory manner; forming an integrated view of the self capable of making sense of contradictions and lapses; decenter, that is from a nuanced understanding of the others' minds as different from one's own (see Figure 1). We also pinpoint the importance of making patients aware of therapeutic change: for example, how new behaviors lead to positive feelings and consequences and how these are in contrast with previous, malfunctioning patterns.

Note that we are not promoting a phase-model of treatment. Instead we suggest one needs to continuously move back and forth between the two overarching parts and work through the same problems over and over again until they are solved. Furthermore, ours is not a sequence with fixed starting and ending points. Each session starts from the level a patient achieved previously and, as new aspects of the self arise, one can turn back and begin stage-setting again until a new narrative scenario has been scanned. During the same session a therapist may promote stage-setting operations regarding a new emerging area, while later involving the patient in strategies for solving problems already carefully understood in mentalistic terms.

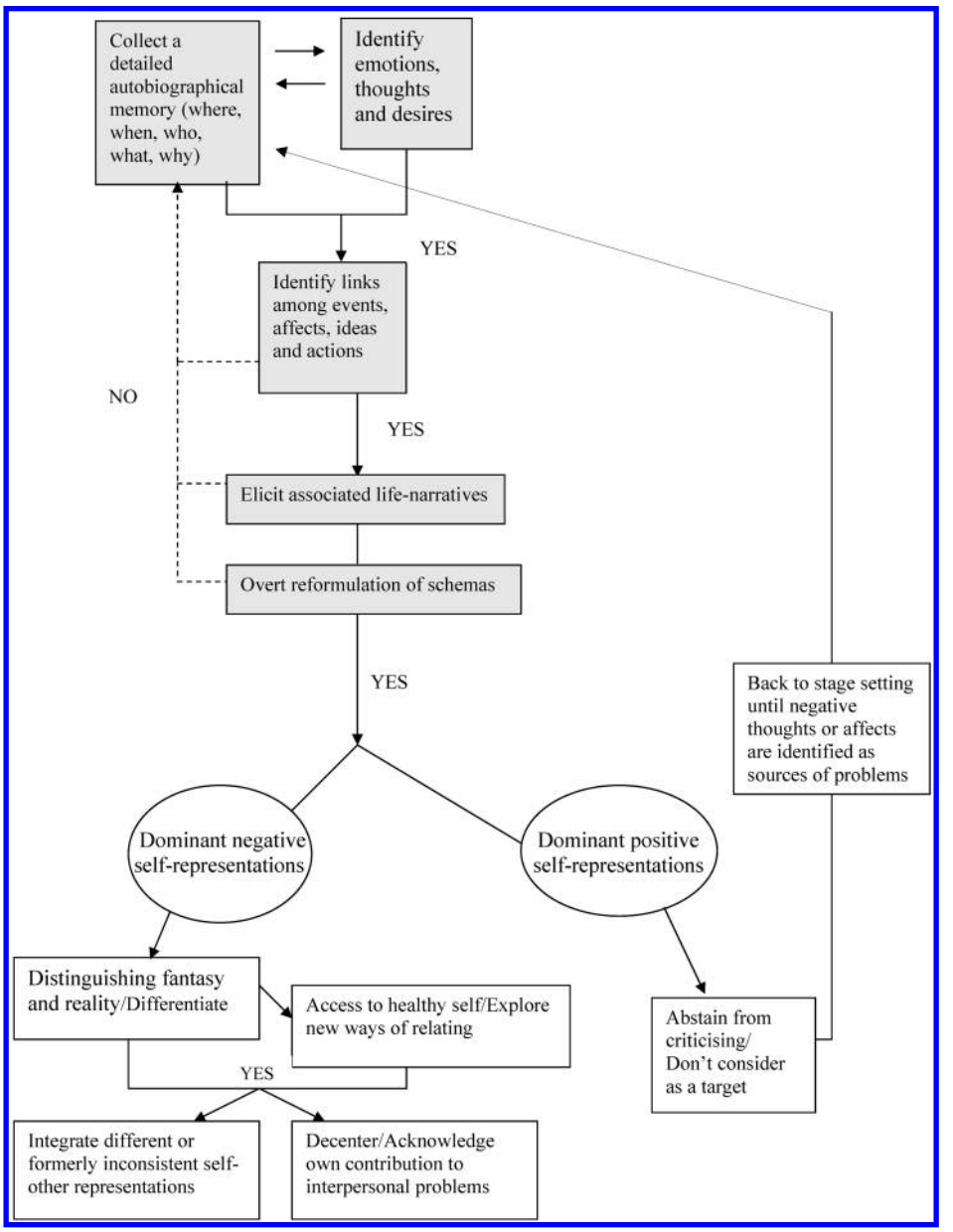

FIGURE 1. Step-by step session procedures. *Note.* Each box includes aspects of knowledge shared by patient and clinician during their discourse. The rule for moving from one step to the next one, in the top-down direction, is that the patient has given signs—such as relaxing, sharing ideas, feeling better, or providing new information—of accepting hypotheses or observations of the therapist. Only part of the arrows are displayed for the sake of clarity. The rule is that when one step fails (NO) the therapist turn back to upper levels. Normal arrows indicate that it is possible to move to the next level, dashed arrows indicate the need to return to previous steps. Stage-setting steps are in gray, change-promoting in white. To simplify the figure the NOs in the lower part have been deleted.

We also underscore that the suggested procedure is aimed at treating the PD and not the many other symptoms troubling patients' lives, such as depression, anxiety, dissociation, hypochondria, or obsessions. Needless to say, symptom reduction is a fundamental part of treatment but it would need a whole manual to cover it with but partial accuracy; it will, therefore, not be a focus of our paper. We simply note how our procedure might guide in selecting strategies and techniques according to the metacognitive skills the patient has acquired in a specific moment. For example, if a person is barely aware of his or her emotions, behavioral techniques, such as exposure and response prevention for co-occurrent obsessive compulsive disorder, are likely to produce positive effects. When persons are instead aware of being driven by negative interpretations of events, with well-developed self-reflexive skills, a more mentalistic approach to symptoms can be used, such as helping patients question catastrophic beliefs by assuming they do not mirror reality but are simply stereotyped ideas originating possibly from their personal history.

STAGE SETTING

COLLECT DETAILED AUTOBIOGRAPHICAL NARRATIVES

The first step is to construct a reliable text, rich in information, which patient and therapist can easily consult. The more the autobiographical episodes collected are rich in narrative and psychological details, the easier will it be to agree later when forming hypotheses about existing schemas or negotiating strategies to change ineffective behaviors. In other words detailed self-memories form a shared raw material accessible to both patients and therapists (Lysaker & Hermans, 2007), thanks to which the needed inference level for understanding why patients reacted in a particular way or symptoms arose is minimal and the risk of disagreements, misunderstandings, and conflicts low. The most reliable text is autobiographical memory or self-narratives describing how patients perceive themselves, others, and their relationships and the motivations that drive them (Angus & McLeod, 2004) (Figure 1).

This is more than simply asking patients to tell the stories of their lives, and nor do we suggest inquiring systematically about the whole story. It also differs from a typical CBT inquiry because it is not primarily focused on beliefs or the cognitive interpretations of events. Therapists would not search for generalized memories or theories, which are often nothing but semantic explanations of facts the therapist does not know. Generalized statements or theories are not, we suggest here, a fruitful basis for investigating mental states. When a patient says he or she was belittled by others at work or in the family, we find it unuseful to question such accounts or trust them at face value. We instead seek specific examples, located in well-defined moments (when) and specific places (where), clearly portraying the actors on stage (who), and the dialogue among them, and with a

defined plot, including a theme weaved around the protagonist's wishes and his or her vicissitudes during interpersonal relationships (what), and last, the reason (why) the story gets told, i.e., the question the person wants to be solved in the message that the story conveys to the addressee—the therapist (Angus & McLeod, 2004; Hermans & Dimaggio, 2004; Luborsky & Crits-Christoph, 1998; Neimeyer, 2000). One can prompt such narratives with questions like: "Could you describe an episode from your life relevant to the topic you are talking to me about?," "Where were you? Who was with you?," "What did you answer then and what did you do?"

When a patient has provided satisfactory answers to these questions, it is easier to investigate elements of subjective experience and very often we find that the episodes elicited feature many details the patient did not include in the first generalized account. Further investigations of psychological states can thus be done with much specific information that would not have been available if details had not been elicited.

ACCESS TO DOMINANT THOUGHTS AND EMOTIONS

At the same time as eliciting self-narratives, early treatment steps include understanding the emotions and ideas nesting within patients' discourse. With some, telling a story comes first and this is the avenue to detecting affects. With others, emotional signs, e.g., prosody and face, are easier to access than a detailed episode and serve as cornerstones for collecting associations and forming a story (Figure 1).

Therapists aim to understand what a patient felt and thought at a precise moment in a narrative or while telling it to the therapist. Questions such as "What did you feel while the episode was occurring?," "What was your reaction when your boss yelled at you?" could be asked in order to clearly understand inner experience. If descriptions are vague (e.g., I felt tense), the therapist should prompt further details. Nonverbal signals are fundamental and one could watch for any nuances revealed by voice and posture: "Did I see you grimace while you were telling that part of the story? Did you feel something?" Once the emotion has been defined, the therapist can look to forming a story: "So we know you were ashamed. Does that remind you of some moment in which someone made you feel this way?"

Attempts at clarification can fail if patients become defensive. It is therefore necessary to avoid pressurizing and concentrate less on inner states and more on topics on which dialogue is smoother, even if without apparent psychological importance, until signs indicate that emotions can be explored again. At this stage, a patient's affectivity may be so lifeless or flat that the problem is not emotional contact, but too low a level of emotional arousal. A therapist can at this point work on re-enlivening the therapeutic relationship, by, for example, using humor or encouraging patients to talk about matters that vitalize them and increase arousal (Dimaggio, Semerari, et al., 2007).

ELICITING THE PSYCHOLOGICAL LINKS BETWEEN EVENTS, THOUGHTS, EMOTIONS, AND ACTIONS

When a narrative is detailed and patients are aware of their emotions and beliefs, the next step is to understand the logical and psychological causal links among elements in experience. PD patients often act with no awareness of their underlying motivations. Therapeutic improvement occurs when they begin to link what they feel and experience to their social environment (Beutler, Castonguay, & Follette, 2006). Therapists ask what generated an emotion or triggered a reaction, explore the links between the details in the story—what someone said or did—and the patient's actions, and by understanding specific thoughts associated with actions or affects.

In over-constricted PD, the lack of psychological links is often a fundamental part of the metacognitive dysfunction (Dimaggio, Semerari, et al., 2007; Semerari et al., 2007). Hence the natural process of exploration begins to address this dysfunction. A clinician often helps the process along by offering simple hypotheses: "You've told me that your work situation has been dicey for the last two months. Your anxiety and insomnia have appeared more or less during this period. Could you be anxious because you're worried about losing your job?"

Patients may describe emotions they are unable to place in a context. In this case, the clinician invites the patient to record significant episodes over the next few days and consider whether any of these events might cause the emotion. For example, a woman might feel depressed. Repeated requests from her therapist to explore recent episodes can help her to recognize how an argument with her partner the previous evening caused her depressed mood next morning.

In these early moments of treatment, it is important to monitor one's responses, because therapists often reactive negatively when patients have difficulty describing their emotions and the causes behind them (Ogrodniczuk et al., 2005).

VALIDATING AND SHARING EMOTIONS, THOUGHTS, AND PSYCHOLOGICAL PROCESSES

We are not adding anything new here to the idea that validation of patient's experience, positive regard, and empathy are useful therapeutic stances. What we underscore here is that, in line with our proposed sequence, we assume patients will progressively gain access to parts of experience, parts that will often show up in a surprising, puzzling, and uncanny manner. Consequently, throughout the stage-setting part therapists should, between one step and the next, interpose a moment in which to focus on any sign of patients' discomfort and work in order to convince them that the new experiences arising will be met by a supportive, caring, and understanding person. Only if the validation and empathy provided

towards the patient in distress are sufficient or the patient gives signals that the discoveries are not distressing, can a therapist move to the next steps. There are many ways of achieving this. One can point out that the emotions or thoughts experienced by the patient are human and acceptable (Linehan, 1993). One can also highlight the reasons for which particular experiences and behavior, in spite of being painful and dysfunctional, are in a certain sense well-motivated. Self-disclosure is precious: therapists can point out that they have experienced something similar and also narrate episodes from their own life. Empathy is not without risks, of course. A woman with narcissistic PD and paranoid traits told her therapist that she decided to discontinue treatment with a former therapist after one session. She felt too much attuned and feared he could control her or guess too much about her family, (Nicolò, Carcione, Semerari, & Dimaggio, 2007)!

Therapists can also engage in imaginary perspective-taking, by, for example, saying after an impulsive acting-out: "I realize that I too in similar circumstances would perhaps not have been more lucid than you. It's not important whether what you felt or thought was right or wrong; when you're frightened, it's easy to act without considering the consequences."

To make the patient feel understood and supported requires constant attention to the therapeutic relationship, something which should go side-by-side with every step of our procedure (see Dimaggio, Carcione, Salvatore, Semerari, & Nicolò, 2010; Semerari, 2010); we do not deal with it for the reason of space.

STIMULATING ASSOCIATED AUTOBIOGRAPHICAL MEMORIES

To change, people need to understand that problems lies inside their minds and are not caused by other people, at least to a significant degree. PD patients are instead unable to acknowledge that problems are mostly caused by their representations of the self with others, and not by the actions of the real others. Naturally, the current social context is often fundamental for the perpetuation of a PD; a patient should not therefore have to bear all the blame for a problem, especially when the environment is invalidating or violent, or social reintegration is beyond a patient's ability. In such cases one could consider whether to involve relatives or hospitalize the patient, but such procedures are beyond the scope of this article.

With this caveat in mind, therapists need to help patients understand suffering comes from an inner source and not an external one, and in order to do so must provide evidence for this being the case. Having but one example of a kind, that is one episode of a specific theme, is not enough proof for the existence of inner schemas driving behaviors; in other words, one swallow does not make a summer. Therefore, before engaging with the patient in the reconstruction of inner schemas it is necessary to elicit the recollection of episodes that are similar or psychologically associated with a progenitor.

One might object that schemas could also be inferred by asking a patient to thoroughly tell his or her life story during early sessions and then note how similar patterns of feeling, thinking, and acting recur. Thus, for example, a therapist might link one recent episode with one occurring in the past and narrated previously. We do not argue against this strategy, but patients often disagree with such observations or accept them without emotional involvement. Our procedure instead provides for starting from a proximal episode and asking patients to retrieve memories that are felt to be similar, so that they themselves make the link. This way the therapist's work is easier, because there is only the need to agree on details of a similarity which has been established from the outset, and not to force patients into accepting that something happening in the present is but a mirror of past events.

At this stage, the therapist may ask the patient: "Can you recall similar episodes to this occurring at any time in your life and in other contexts—work, friends or family?" More specific cues can be used to start associative chains: "You said you felt angry (or frightened, or sad), when your partner did not help you. Has this happened with other people in other moments of your life?"

We stress that these interventions are also a way to achieve goals such as being empathetic and building the alliance (Castonguay & Beutler, 2006a). Patients feel understood if therapists pay attention to the details of their stories and reformulate them using a similar language to their own.

OVERT REFORMULATION OF SCHEMAS

Once patients have told enough stories focusing on an apparently common theme, and are aware at an emotional or pre-verbal level, that is they feel narratives are related with each other but cannot say why, therapists can try to form hypotheses about the inner schemas underlying regularities in feelings, thoughts, and reactions. Therapists first need to covertly reconstruct the schemas. This can been done either intuitively in the heat of the sessions, or retrospectively with structured analysis of session transcripts—i.e., assessing the Core-Conflictual Relational Theme (Luborsky & Crits-Christoph, 1998). Usually the therapist, with a focus on the more significant psychological aspects, summarizes a number of episodes, and then pinpoints how the structure of the story is stable over time and space, and feelings or reactions are triggered by similar events: "You told me you were ashamed when the professor gave you a grim look during the exam and then you reacted by staying home for a week because you thought you were a failure. You also talked about being ashamed when you told me about your father criticizing you in front of your friends when you were a teenager. Are these episodes similar for you?"

The therapeutic relationship provides precious information for overtly reconstructing schemas. Therapists can ask patients if they have ever had

disturbing feelings during a session. If a patient has difficulty replying, whereas the therapist can clearly recall episodes in which the former acted in a similar way to the latter's self-narratives, the therapist can note the link: "You told me that you feel ashamed because your friends consider you clumsy. Last time I thought you almost blushed as if you were afraid of being judged by me. Was your emotion in the two situations similar?" If both agree that these analogies are plausible, it is possible to point out that at the core of the patient's narratives there is a uniform way of ascribing meaning to events and this can be a target for treatment.

Patients may start acknowledging they need to change something in themselves rather than the people around them. Another option is that the new story that emerges is different but gives hints about how to explain why the first one was told. For example, the first narrative might be about being sad and depressed and feeling clumsy among peers, with a focus on social isolation. Then the new episode might be one in which the patient was criticized or insulted when behaving contrary to a parent's expectations. In this case the sadness, depression, and constricted social behavior might be understood as safety strategies for protection against harsh criticism.

Overall the aim of this step, one that paves the way for passing to the change-promoting part of the procedure, is to make patients aware that inner representations of events drive interpretations of social relations. They can therefore now question the face value of such interpretations.

CHANGE-PROMOTING

DISTINGUISHING FANTASY AND REALITY/DIFFERENTIATING WHEN DISTRESSING EMOTIONS ARE CAUSED BY NEGATIVE SELF-REPRESENTATIONS

When patients are aware of recurrent themes or schemas in their stories they are ready to understand they are suffering because they are driven by recurrent schemas generating interpretations of events bringing pain and symptoms. In other words they have an imaginal world they treated as if it were true (Fonagy et al., 2002), e.g., being left alone forever because their partner does not telephone one day or being fired because their boss has an angry face. Interventions to encourage a distinction between reality and fictional, negative representations taken as true usually lead to symptomatic relief.

Interventions involving the therapeutic relationship are particularly effective in highlighting the unrealistic nature of these expectations: "You were convinced that I'd have criticized you for arriving late to this appointment. It's what you always think when you do something you consider to be against the rules. Do you feel criticized by me now?"

We have concentrated on encouraging a distinction between fantasy and

reality only as regards negative or egodystonic self-representations. In fact prematurely challenging representations that are either positively biased—"My partner shouldn't ask for help from me because my work is much more important than her needs," or negative but still egosyntonic—"Everyone's ill-intentioned and tries to trick me, and for this reason I'm entitled to overtly express my anger" risks eliciting negative reactions that would be counterproductive and alliance-threatening. When, for example, a patient with narcissistic features asserts that everyone admires him for his exceptional qualities and that his partner loves him and is ready to forgive his unfaithfulness, there is little sense in stressing this assumption is quite unrealistic. Very often patients react by feeling their therapist does not believe them or takes the other's side. Patients feel unvalidated as a result and react by withdrawing or attacking the therapist. It is also almost useless, in early therapy steps, to try to convince a paranoid patient that threatening others or retaliating is not the right way to soothe her anxiety or restore justice; nor is it useful to force her to consider it is her arrogant, overbearing, and vindictive attitude causing others' negative reactions. We therefore contend such convictions should not be challenged until therapy is advanced and alternative views of others should not be proffered at this stage. We suggest that preliminary operations with patients featuring these positively biased or egosyntonic representations should be to turn back to stage-setting and focus on other details of their self-narratives until pain or suffering emerges (see Figure 1, right side). At that point one could help patients concentrate not on how others caused the pain but on the pain itself and its enduring quality in spite of others' presence: "I sense that you felt very frustrated when your partner asked you for help. Probably you are struggling to do your best to accomplish goals at work and don't feel enough trust and support from others, so that any force distracting you from such important objctives can look like an obstacle to you." If the patient agrees, the next step could be to displace the focus from current interactions by eliciting related episodes in which the patient had the same feeling of being not supported or trusted, until the patient is able to realize that these are basic enduring feelings the others might only elicit but not really cause.

We suggest these interventions are useful with both grandiose narcissistic fantasies and paranoid ideation, and might be applied to other egosyntonic but unrealistic representations, such as the idealization of the other often present in persons with dependent features. The main aim of therapy should be to understand patients feel thwarted, for example, in goals such as autonomy or safety, and thus explain that fantasizing about retaliating or resorting to grandiose self-images are not problems in themselves but protective reactions. After this the goal could be to soothe the underlying suffering and help the patients understand how they have internalized representations of others as hostile or nonsupporting and lack coping strategies when facing these situations. For example, if a narcissist gets disheartened because others cannot bear him, the clinician can

stress that even if others are incapable or unable to provide assistance, the problem lies in the patient's need for support and inability to self-validate.

ADVANCED STAGES OF TREATMENT

The steps described hitherto include promoting awareness of inner states and schemas in interpersonal relationships and understanding suffering is triggered mainly by inner representations of events and not by simple facts. When patients have achieved this knowledge it is possible to involve them in advanced therapeutic operations, i.e., ones requiring higher metacognition, where they form complex representations of the self and the others and use them in order to think differently about problems and find new solutions. When this more nuanced mental state understanding is reached, it is also easier to use new ideas about self and others to explore new ways of relating in everyday life. For space reasons we shall describe them concisely.

We contend that operations described here such as: promoting access to the healthy self (Flückiger, Caspar, Holtforth, & Willutzki, 2009), adopting behaviors guided by these aspects, practicing them during everyday life until they become parts of the self system, integrating previously dissociated aspects of the self into self-representations and, finally, getting patients to acknowledge their own contribution to problems and dysfunctional relations and challenging their biased beliefs—e.g., grandiosity—are only possible once simpler ones have been successful.

An example of this rationale is our suggestion to proscribe social exposure in persons with avoidant features and they are able to distinguish between fantasy and reality. If such patients are prematurely pulled into the social arena, with an ideal aim of challenging their maladaptive beliefs about expecting rejection and learning new social skills, they risk deteriorating. To face social exposure, we contend, such patients first need to recognize their feelings, understand what the eliciting factors are and know that they are not threatened by real others but by their biased representations of them and that these representations are rooted in their imaginal world and do not mirror reality. When they face feedback from another, they should consequently be able to question their previously held beliefs about rejection and use facial and verbal cues to find alternative explanations such as "I think he's angry at me, but probably he's sad," or "He's angry but I understand I'm not the cause but his partner's unfaithfulness."

Also having a nuanced representation of who they are is necessary when therapists try to help patients combine positive and negative aspects of themselves. If done prematurely, this operation is likely to make patients feel criticized by therapists or accept the latter's point of view to please them, without a true understanding of themselves. When, instead, this is done later in a therapy, after healthy aspects of the self have been recog-

nized, validated by the therapist, and become part of their conscious self-image, patients are likely to gain benefits from integrating negative aspects into self-representations.

To establish links between positive and negative parts of the self, the therapist could point out how specific contexts cause shifts between mental states. For example, one of us was treating a dependent woman and noted that she tended to dissociate and see herself as useless and hopeless each time she had contact with an ex-partner, who was twenty years older than herself and whom she saw as dominating and invalidating, whereas a few days later, and no contact with him, the dissociation improved and she believed again she had true qualities. This helped the patient to break off the relationship and the dissociation disappeared shortly afterwards.

Turning back to the general topic of advanced stages of treatment, individuals require an ample repertoire of procedures for interpersonal exchanges in order to achieve effective relationships; they also need to feel a sense of identity that remains stable while the different aspects of the self emerge and guide them, so that there is consistency in their passing, for example, from the role of a loving father to one of a strict but fair teacher. Finally an articulated view of others is essential, in order to avoid conflicts and negotiate one's desires.

For these reasons the aims of the advanced stages are: (1) enriching the patient's personality repertoire, by, for example, accessing new and healthy schemas previously overshadowed by dominant themes; combining new features emerging in a richer self-narrative, e.g., understanding one might behave clumsily but has a sense of humor others appreciate. Therapists could encourage attempts to exercise parts of the self emerging recently during therapy and likely to be more adaptive forms of construction of meaning and behavior. Patients may discover that the surfacing of, for example, the desire to play music again after many years brings positive emotions and that playing will not make others react angrily like their parents once did; (2) understanding others /constructing alternative readings of others' minds, and recognizing that one's actions impact on others and contribute to causing the problems from which one suffers; and (3) acknowledging self-serving biases that lead to exaggerated or selectively positive self-images, like narcissistic self-enhancement.

One effective intervention is to discuss with the patient where treatment has arrived so far and then explain that to achieve further gains new paths need to be tried and patients need to persistently strive toward reaching their goals, whatever outside obstacles, fluctuations in mood tone, and reductions in motivation there may be. This intervention is also, therefore, a renegotiation of therapy goals. We mean that as new aspects of the self emerge, therapy goals change.

Patients might spend years talking about fears of social rejection and then discover they have unmet ambitions they could achieve except that they lack the social skills for this. Therapy thus passes from a goal of in-

creasing self-awareness to one of social exposure and new learning. In a very similar way to typical CBT exposure to feared situations, patients and therapists can agree on the forms of relationship and contexts which the former are more willing to experience. Precisely because patients are experiencing something new, unusual, and often frightening, such experiments are to be conducted with care; for example, a patient who has stayed at home without any social contact for years might find applying for a new job too demanding, threatening, and complex. Instead simpler experiences, e.g., going regularly to a gymnasium could be simpler. Goal is not success in performance: if patient and therapist agree on going to a gymnasium, success does not consist of being regularly there but of the attempt to go there and the registering of thoughts and feelings while engaged in this action. Experience surfacing during this exposure is material for the following sessions. Patients are thus able to understand that they are not outcasts but that they like the new social environment and simply have to learn first how to cope with intense arousal when meeting new acquaintances. Conversation should concentrate on the results of the experiment and ensure that the patient is aware that the new situation is having—when it does—positive effects and that these depend on the patient's new ways of thinking and acting.

Continuing with the example of socially isolated patients, it is also important to carefully monitor their reactions and pay particular attention to new problems that were concealed by social avoidance, for example, a tendency to get angry at the slightest sign of disagreement on the part of another, or to lose motivation when another does not display the enthusiasm the patient expects. These experiments therefore often bring to light problems resulting in therapy returning to the stage-setting part.

As stressed previously, most PD patients have difficulty adopting others' points of view and consider them to have intentions reflecting their own anticipatory schemas, with such attributions being negative –she is criticizing, abusing, or rejecting me—or tainted by self-serving biases—he adores me or she should respect me. At this advanced stage in therapy it is possible to exercise theory of mind and promote a more accurate reading of others' minds (Dimaggio et al., 2008). For example, when individuals with narcissistic traits realize they feel hurt by others and despise them in moments in which they themselves are lacking in an internal authorization to pursue their own goals, it is a likely consequence that they not continue constructing others according to their stereotyped schemas.

What is perhaps the last step in PD therapy and to be, in our opinion, avoided until the majority of the previous steps have been accomplished, is the correction of self-serving biases: idealized expectations that the self has the right to receive constant attention from others, who have to be always available, the right to retaliate, even violently, for wrongs suffered or the idea that one is a just and moral person and that this is the only correct way for everyone to behave.

A clinician can use irony and humor to confront grandiose convictions,

idealized expectations, moralizing and so on, so that patients do not take these self-aspects too seriously and learn to put them in the background when appropriate. Therapist's self-disclosure helps greatly; being aware of and ironic about one's own grandiose, defensive or moralistic characteristics, which patients have often easily deduced on their own after years of mutual acquaintance, stimulates cooperative reflection.

DISCUSSION AND CONCLUSIONS

In this work we have constructed a proposal as to how and when to tackle core elements of PD with prominent inhibited traits such as poor metacognition, stereotyped schemas of self-with-other and over-regulation of affects, moving from collecting detailed autobiographical memories, to promoting self-awareness and then using psychological information to promote change.

The arguments we have expounded here have some advantages and we believe that they are, at least in part, innovative. The first advantage is that we supply criteria with which to adjust the timing of interventions and a sequence in which they can be applied. Among signs that one can pass from simpler to more complex steps are: improved metacognition, symptom relief or absence of deterioration, fostered in-session positive atmosphere and therapeutic alliance or repaired alliance ruptures, and increased retrieval of self-memories.

Note that we are not advocating a stage-model of therapy. The starting point comes from current patient status; if he or she spontaneously tells detailed stories with good emotional awareness and a skilled description of psychological cause-effect relationship, e.g., understanding why he or she felt an emotion in response to another's behavior, the therapist can start directly from the next level, i.e., eliciting associated episodes. One can also move back and forth along the step-by-step procedure as new patterns of thinking and feeling emerge or in line with in-session fluctuations in metacognition. For example, a patient displaying good emotional awareness might talk about being rejected and later in the session describe his or her poor self-efficacy at work only with abstract statements. In this case the exploration of the second theme needs to start from eliciting autobiographical episodes, an unnecessary step as regards the rejection theme.

The method of working proposed here is a heuristic that therapists from different schools could apply in different ways according to the model they adopt. Thus a psychodynamic or interpersonal therapist might provide further detail about how to achieve empathy while a CBT therapist might emphasize technical methods for reducing symptoms or changing dysfunctional beliefs. Our proposals could be readily transformed into measurement tools. For example, task-analytic transcript analysis (Greenberg, 2007) could be used to evaluate therapist compliance with the sequence proposed and this in turn could be related to outcome measures.

One might also test the idea that the sequence we propose is effective with some populations, while early interventions aimed at symptom relief—there is, in fact, evidence that symptom relief improves the quality of the alliance (Westen, Novotny, & Thompson-Brenner, 2004)—work better with other patients. Finally, though tailored for patients with inhibited traits, many aspects of this procedure could be adapted to patients with dysregulated traits once containment (Livesley, 2003) has been achieved. In any case, we believe that following the perspective we provide here could open promising avenues for research and offer a guide for treating an understudied PD population.

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