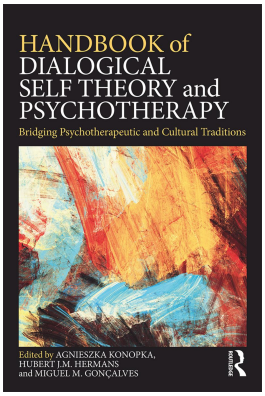

Handbook of Dialogical Self Theory and Psychotherapy Bridging Psychotherapeutic and Cultural Traditions

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Metacognitive interpersonal therapy as a dialogical practice

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Introduction: metacognitive interpersonal therapy as a dialogical psychotherapy

Psychological health and adaptation depend on the capacity to be open and flexible, and see the world from multiple perspectives. Humans need a series of self-narratives to deal with social challenges and scripts that guide them in adaptive decisions in the relational world. These scripts need to include how to deal with a conflict, how to court a potential romantic partner, how to respond to a colleague who is pressing with requests we would prefer to avoid, and so forth. According to proponents of Dialogical Self Theory (DST; Hermans & Dimaggio, 2004; Hermans & Hermans-Konopka, 2010; Hermans & Gieser, 2011; Hermans et al., 1992; Lysaker & Lysaker, 2002), the self is made up of a series of *I*-positions, as a society of mind (Mead, 1934), which interact and continuously negotiate the course of action to be undertaken and the meaning to ascribe to events.

Every *I*-position has its own goals, motives, and preferences and can take control of action. The person is guided at one moment by the devoted father position, then shifts to the committed worker and then, when playing tennis, to the pleasure seeker. In order to grant unity and coherence humans need higher-order stances, termed meta-positions (Hermans & Hermans-Konopka, 2010). A person might have a meta-position whose macro-narrative sounds like:

> I want to raise my kids in a well-knit family and in order to do so I have to be successful at work. Enjoying my leisure time helps me soothe my distress and remember I can still live without the responsibilities the father role involves and remain playful.

Positions can be recognized as self, "I as a victim," "I as weak" "I as independent," or be external: "My controlling mother," "My angry boss," "My cheerful son." Both in the mental landscape – see Konopka, Hermans, and Gonçalves (Chapter 2 this volume) for its description – and in real-world positions interact with each other. One's inner dialogue can sound like:

> I want to spend a night by the sea with my colleagues but my jealous wife would overreact. I have to give up because I could not stand her anger. I have her voice and face in my mind: jumpy, smoking, asking me endless questions and just going on and on. I say to myself to not surrender as it makes me feel depressed and frustrated, but I'm unable to stand up for myself.

The outcome of this same dialogue can have a wider impact and be included in a life script: "I'm unable to do things my own way. I'm weak and doomed to slavery."

Personality disorders (PD) patients tend to ascribe meaning according to stereotyped dialogical relationship patterns (Dimaggio et al., 2003), which we will frame according to metacognitive interpersonal therapy (MIT) (Dimaggio, Montano et al., 2015a).

Interpersonal motives

In order to assess the dominant theme, a clinician has to try to understand what the patient's wish or motive is. MIT assumes that the most important motives are shaped evolutionarily and suffering comes from forecasts that these motives remain unmet (Fassone et al., 2016; Gilbert, 1989; Lichtenberg, 1989; Liotti & Gilbert, 2011; Panksepp, 1998). Motives include the following:

a) *Attachment* (Bowlby, 1969): the need for love, protection, safety, and attention.
b) *Caregiving*: the tendency to lend help when we perceive someone as scared, vulnerable, or suffering. It can be activated by children, relatives, or persons in distress.
c) *Autonomy/independence and exploration*: activated in order to explore the environment and find resources, associated with curiosity and playfulness (Panksepp, 1998).
d) *Social rank*: triggered when resources are limited, warranting access to them after a hierarchy has been established. Driven by social rank, persons can experience anger when they perceive someone is defying them or threatening their status, pride, or contempt when they feel superior, shame when humiliated, or sadness when they lose.
e) *Group inclusion/affiliation*: refers to the basic need to belong (Baumeister & Leary, 1995; Lichtenberg, 1989). Humans cannot live without a sense of being part of a larger community, of which they share the values, interests, and rites.
f) *Sexuality*: more than its more basic counterpart, that is to say mating behavior. Sexuality regulates behaviors relating to attracting a partner with the goal of forming long-term bonds where primary sexual drives can be met and yield erotic pleasure.
g) *Cooperation*: fundamental for the formation of stable bonds and the maintenance of cohesive groups (Tomasello et al., 2005). It aims at forming alliances and combining resources to meet shared goals.

Persons enter into dialogues with others, in their mental landscape and in the society, driven by these motives. If they predict or perceived that others are not responding so their motive is fulfilled, they are prone to maladaptation and suffering. Once PD sufferers imagine the others will react negatively to a wish, for example to be appreciated (social rank) or to be supported in exploration, they have difficulties forming open-ended dialogues as they have limited access to alternative and healthier *I*-positions, which will imagine the wish can possibly be met.

Schemas

MIT understands schemas consistently with the core conflictual relationship theme (CCRT; Luborsky & Crits-Christoph, 1998; see also Batista et al., 2017). Once a clinician has detected the dominant(s) motive(s) in patients' autobiographical memories, the elements of the schemas are: (a) the core *I*-position underlying the wish, for example "I as not deserving love," "I as unworthy," "I as alone"; (b) the "if … then …" procedure (Baldwin, 1992) to fulfill the basic wish; for example: "I want to be appreciated so if I show what I did then the other …"; (c) the expected or appraised *response of the other*, which corresponds to other-positions in the landscape of the mind. The other's response triggers (d) the *self's response*, including cognitions, affects, bodily sensations, which trigger maladaptive coping procedures. Underlying the basic wish, there are usually at least two nonintegrated *I*-positions. When one is driven by attachment, she can see things from a dominant *I*-position: "I as not deserving love." At the same time, a suppressed and less easy to contact *I*-position can be "I as lovable." The first *I*-position triggers fear of rejection, the second ignites hope. When in her imaginal dialogue the person anticipates or appraises a real response by the other as impending rejection, the negative *I*-position is reinforced and takes control. Thus, if the other is positioned as neglecting, the self experiences sadness, demoralization, and impotence. Different *I*-positions shift between taking control; for example, after a moment of sadness, the *lovable I*-position can take center stage and experience anger in face of the other perceived as unjust and mean.

PD patients' inner dialogue and their exchanges with real others tend to be repetitive and they have a paucity of *innovative moments* (Gonçalves et al., 2017). Their dialogues lack a capacity for flexibility and schemas tend to dictate how the dialogues unfold. Such schema-driven attributions narrow tendencies to openness and innovation, which are typical features of a dialogical self (Hermans et al., 1992). A clinician's task is to enliven this capacity.

PD patients' dialogues also lack meta-positions that would allow them to see themselves with a bird's-eye view and realize that things can appear different when seen from a different angle. For example, a patient with avoidant PD endorses an "I as unworthy" position, and positions the other as harsh, critical, or tyrannical. He lacks the capacity to recognize the presence of different *I*- and other-positions in other moments of the relationships. Said otherwise, they lack a meta-position speaking as: "Sometimes I feel unworthy and imagine the others

will despise me, but there are situations in which I have a sense of worth and capacity, I am proud of myself and think I deserve praise from others."

We take the case of a young woman driven by the autonomy motive: she wants to move to another town to begin university. She imagines her parents will undermine her independence. Her father will think she is arrogant and disrespectful because she is betraying family traditions, her mother will feel abandoned. We consider both parents' reactions as other-positions, which correspond to the *other's response* in the CCRT. In the face of these reactions, the *I*-position underlying the wish for independence becomes "I as paralyzed," "I as hurting," and "I as disappointing the other." Autonomy is now switched off and caregiving is turned on, at the cost of renouncing to pursue one's deep-seated goal. The self's response includes guilt, shame, and sadness (for not having been supported), with a likely reduction in feelings of agency, enthusiasm, and fulfillment.

Impaired metacognition

Metacognition is the capacity to identify, reflect upon, and regulate mental states, both of the self and of the others (Dimaggio & Lysaker, 2015; Semerari et al., 2003, 2014). It includes *metacognitive mastery*, the ability to use information on mental states to find solutions to everyday life social challenges and soothe suffering (Carcione et al., 2011). Humans engage in *metacognitive activity* by identifying and understanding how they feel and what drives them to act, and by forming an integrated view of themselves in face of *I*-positions continuously alternating in their mental landscape. They identify contents based on different cues. They realize they are experiencing a specific emotion because they link a bodily sensation to a particular situation and a thought that is passing through their mind: a stomach ache and the idea of failing mean they are worried about the outcome of an exam.

Humans use metacognitive capacities when trying to understand how others feel and what intentions drive their behavior. One guesses others' emotions by observing facial expressions, posture, and prosody. Lastly, metacognition includes the ability to use an understanding of mental states to regulate them. Mastery is at stake when we try to calm down, concentrate, relax, or enjoy ourselves. A knowledge of mental states is beneficial for the maintenance of relationships, because it helps us foresee what will probably occur through a rich and deep understanding of our own and the other's mind, while trying to solve any relational conflicts, and achieve mutual goals. At its highest level, metacognition includes the capacity to adopting meta-positions from which to observe the different *I*- and other-positions and integrate them in a coherent self. Evidence is that PD patients have poor metacognitive capacity, which is more impaired when the PD is more severe (Semerari et al., 2014). There is preliminary evidence that metacognition increases in good outcome therapies (Popolo et al., 2018) and predicts therapy outcome (Maillard et al., 2017).

MIT aims at increasing awareness of mental states when recalling specific autobiographical memories or in the heat of important social exchanges. Persons

can be helped to name the affects they are experiencing, instead of speaking of "tension" or "uneasiness," so that they realize they experience shame, guilt, sorrow, or anger. MIT focuses on understanding the complex interplay between cognition, affects, and behaviors in specific narrative episodes. A woman might describe herself as a caring mother, but when invited to report episodes, her therapist can help her realize that, when she has to take care of children, she feels frustrated and belittled. She then experiences a mixture of shame, constriction, and anger, which points to the existence of another *I*-position, "I as an independent worker," which was previously unacknowledged and not validated because it met a *judgmental* other-position.

Maladaptive coping

PD sufferers tend to deal with suffering and problems caused by others' expected or actual responses by adopting maladaptive coping procedures. When PD sufferers position the others as malevolent, rejecting, abusing, humiliating, neglecting, needy, and so forth, they first experience feelings such as sadness, guilt, and shame. Then they try to regulate these feelings but they fail and enact maladaptive behaviors, including avoidance, aggression, and submission. These behavioral reactions to emotions elicited in interpersonal contexts further deteriorate relations and consolidate maladaptive schemas. Another form of coping is cognitive and includes worry, rumination, and various forms of repetitive thinking (Wells, 2009). Repetitive thinking is a set of mental strategies, used purposefully or automatically without awareness, aimed at regulating emotions (Borkovec et al., 2004). We describe here the case of interpersonal rumination: when a person thinks she has disappointed the other, she experiences shame. She focuses on the episode where she acted inadequately and thinks: "Why did she behave like that?" "What did she expect from me?" "Was the fault mine or hers?" A frequent variant is counterfactual rumination, where patients try to modify certain aspects of a distressing memory in order to achieve a different outcome: "If only I'd done . . ." or "If I'd told him . . ." (Ottavi et al., 2016). The contents of rumination change according to the type of PD. For the sake of clarity we focus on what happens in obsessive-compulsive PD (OCPD) consistently with the case we discuss later in the chapter. An OCPD sufferer may ruminate about having made mistakes at work that will threaten his position of "I as honest, trustworthy, and reliable." At the same time he ruminates about others having failed to do their job because they were unreliable or selfish. Interpersonal rumination takes the form of a stereotyped and repetitive dialogue where the different positions repeat the same sentences without any solution to pointless conversations. As a result, negative affectivity increases.

Metacognitive interpersonal therapy (MIT) structure and procedures

MIT is mostly about making persons aware of typical positions they ascribe to both the self and others and how this positioning drives social behavior, thus

improving metacognition. Dialogically speaking, this means first understanding what oneself and the others think and feel, and why. MIT then helps clients to build meta-positions allowing for a cohesive self that makes them see themselves and society from a broader perspective. Thanks to these meta-positions patients become capable of openness and innovation. MIT also tries to form new *I*-positions and other-positions, with the goal of re-opening a dialogue, both among internal positions and with real others. With such new dialogical relationships patterns, the influence of old maladaptive ones is reduced, and clients are more able to experience agency and hope to fulfill their innermost wishes.

MIT (Dimaggio, Montano et al., 2015a; Dimaggio et al., 2012) is made up of *shared formulating of functioning* and *change promoting*. Shared formulating includes (a) eliciting specific autobiographical episodes with clear space and time boundaries where positions are well described and interact; (b) searching for affects and their links with thoughts and actions; (c) collecting other autobiographical memories that patients feel to be associated with the first, so that they realize that recurrent meaning-making patterns exist and this helps them see they are driven by stereotyped and crystallized dialogical relationship patterns, instead of thinking that suffering comes from reality; and the final step is (d) to devise together with patients a formulation of the schema and use awareness of this to plan change. During formulation, clinicians try to foster early access to healthy self-aspects, and point them out to patients. The purpose is to make patients aware as early as possible that their narratives include innovative moments (Gonçalves et al., 2017), in which they hope they will meet their goal. In order to elicit healthy *I*-positions and let innovative moments emerge, clinicians very early set up behavioral experiments, which are not aimed at behavioral change, but just at attempting to counteract behavioral routines and then increase awareness of mental states when reflecting on these experiments (Dimaggio, Salvatore et al., 2015b; Dimaggio & Shahar, 2017; Gordon-King et al., 2017).

Change promoting includes (e) fostering differentiation between fantasy and reality. Clinicians try to make clients realize their ideas are subjective and do not necessarily reflect reality; (f) increasing access to healthy *I*-positions. These *I*-positions can be of different kinds, ranging from the positive side of the same construct, for example "I as lovable" vs. "I as unlovable," or "I as powerful" vs. "I as powerless"; they include the capacity to be driven by personal preferences and desires instead of letting oneself be guided by the need to please others; (g) encouraging new behaviors in line with patients' innermost wishes; (h) understanding that others' inner worlds are complex and nuanced; and (i) forming meta-positions that lead to coherence and dialogical connections among various *I*-positions and other-positions. Change promoting happens eliciting what in DST has been named the *promoter position*, which is able to trigger curiosity and exploration and, thanks to repeated enactment of new behaviors, to generate new *I*-positions and foster innovative outcomes in personal narratives.

MIT is undergoing an experiential turn, which is the main novelty introduced in this chapter. Clinicians invite patients to remember significant narrative episodes from their lives and enact them during exercises such as guided imagery

and rescripting (Hackmann et al., 2011), two-chair work (Greenberg, 2002), and role-play. This means re-opening the dialogue with the way patients imagine the others will react or with parts of the self that were previously suppressed or ignored, and guiding them to construct a new dialogical relationship.

MIT focuses on the regulation of the therapy relationship (Dimaggio, Montano et al., 2015a; Safran & Muran, 2000). Therapy is about promoting new forms of internal dialogue and interacting in different ways with real others. Patients and therapists often start their journey positioning the other in ways that are consistent with their own patterns, but therapists need to see patients as unique human beings, rather than reflections of their own tendencies to position the other. Therapists try and detect any problem in the relationship, disengage from repetitive patterns, and promote the capacity to recognize the otherness in the other (Buber, 1970).

Rewriting the dialogical self in the imaginal world: the experiential work

The self undergoes continuous rewriting and this mostly happens through inner dialogues. MIT therapists invite clients to recall specific problematic autobiographical memories in which interaction with others was difficult. These memories include a reactivation of the conversation with the internalized others, that is with other-positions. The problem is, as we noted earlier, that these conversations tend to have predetermined outcomes, with a paucity of innovative moments (Gonçalves et al., 2017). To promote change, MIT therapists invite clients to re-experience episodes during guided imagery, role-play or two-chair exercises. The purpose is to open an imaginal space, detached from everyday life experience, where clients can see the plot that unfolds as belonging to their mental landscape, rather than a mere reflection of past events. During imaginal re-enactment, clients likely experience intense emotions and clinicians have more room to work suffering through.

Guided imagery is used with different purposes. A typical example is therapy for post-traumatic stress disorder, where clients relive their memories and then either discover they can tolerate exposure to painful emotions they previously avoided or dissociated (Foa et al., 2007) or, thanks to imagery rescripting (Arntz et al., 2007; Hackmann et al., 2011), inhabit different *I*-positions and therefore cope differently with distressful interpersonal situations. Many negative memories of interpersonal events can be processed, for example when trying to rewrite the relationships with one's parents or close relatives. In this case, the imagery work is not just aimed at overcoming trauma, but at changing dialogical relationship patterns.

Imagery work may focus on future scenarios. Therapists can suggest to clients to relate to others in previously unexplored situations: meeting a group of friends and imagining how the conversation might be, or dating a person they like. Clients can safely experience new forms of relating that are likely to elicit positive emotions. For example, one client with fear of social exposure can

discover the pleasure of joking with another or experience a position of "I as nice" vis-à-vis another positioned as "accepting and welcoming."

MIT follows a series of steps when using guided imagery and rescripting, in order to foster a secure atmosphere. The sequence begins with the therapist proposing re-experiencing a specific episode: "This episode appears significant to me, do you agree? I'd like to imagine being in it; do you feel like trying?" The therapist should seek client's feedback and give any information requested if using this technique for the first time. The client should be aware that he or she can interrupt the experience at any moment, or decline the invitation. Once the client accepts, the experience begins with some relaxation or mindfulness technique. The goal is to create a hiatus between external world and the flow of the therapy conversation on the one hand, and immersion in the imaginal landscape on the other. When the client is ready, the therapist asks if she can reenter the memory, not just by recalling, but by being there as if it was happening now. The client needs to speak in the present tense and not reason about what unfolds. She is instead invited to describe what she sees and feels and what every character does. Typical questions are: "Can you describe what you see to me?" "In which room of your family house are you now?" "Can you hear your mother's voice? How her tone sounds? What do you see in her face?" Other questions are focused on internal reactions: "Your friend is saying she won't be there for you, how are you feeling?" Associations with other memories or reflections about the story are noted, but the client is gently discouraged to explore them further, as therapists avoid as this stage promoting any kind of cognitive reflection. They do not ask, "Are you sure that your mother wants to blame you?" but rather, "So you notice she is blaming you. Where do you see this judgment in her face or hear it in her voice? What do you think and feel in front of her attitude?"

The goal of imagery work in this phase is to increase awareness of inner states, and potentially make emotional arousal mounts, although remaining tolerable. Once therapists have gathered enough information, they stop the exercise and start reflecting with the client about the experience. They can invite the client to notice aspects of her inner world that were previously unnoticed, for example emotions that were not there before the experience, or reactions she did not expect. The last stage is rescripting, which can either lead on immediately from the original imagery experience or occur after the break we have just described. The therapist proposes the client to go back into the scene with the goal of doing something different. When there is no break, the therapist says to the client something like: "Ok, we know what happened and how you felt. Now breathe deeply and then try to say that . . ."

Imagery rescripting moment is the core of the dialogical exercise. Clients are invited to repeat the dialogue with the others in the narrative, while responding differently and exploring and regulating their emotions and cognitions. Therapists keep a stable focus on what clients experience when they attempt to engage them in a new form of dialogue with significant others: "How do you feel when speaking with this tone of voice?" "How does saying to your mother 'I want to

be listened to' sound to you?" "Where is fear placed in your body while you reply to bullies?" "You say you feel more powerful now, after telling your father to not beat you again. Can you tell me more? Do you feel it in your muscles, guts, face?"

At the end of guided imagery and rescripting, client and therapist jointly reflect about the episode and try to integrate the new dialogical experience into the client's self. This helps in understanding that new *I*-positions – e.g. "I as strong," "I as worthy," "I as free" – and other-positions – e.g. "the supporter," "the protector," "the caring girlfriend" – exist in the imaginal landscape. Therapists should invite clients to remember these new positions in-between sessions and to realize they belong to their inner world. Clients learn that embodying these new positions allows for more flexible responses and grants safety, relief, and relaxation and constitutes solid ground for exploratory behaviors. We now illustrate the basic steps in MIT with one clinical vignette, highlighting the dialogical component of the imagery experience.

Dario's case

Dario, a 24-year-old university student, met DSM V (APA, 2013) criteria for obsessive compulsive disorder (OCD) and OCPD. He underwent two years of weekly MIT, attending more than 90% of the scheduled weekly appointments. He sought psychotherapy because of severe OCD: when he walked through the streets, he was worried that his looking at men meant he was gay and became very anxious at the idea. In the second session he told the therapist that the day before he had gone to the university to get some documents. In a corridor he met some students and thought: "You are looking at them all; you're a dirty fag." He became anxious and imagined that all the others were convinced "Dario is a fag." He then considered that his anxiety was a sign that he really was homosexual, thus creating a vicious cycle. He usually thought that he needed to inhibit the thought he was homosexual because if he was unable to control his thoughts he would become mad. This controlling strategy also increased his anxiety.

With regard to metacognition, Dario had problems in many domains. He was aware he was anxious, but could not perceive that his anxiety was connected to the emergence of a specific *I*-position, that is "I as inadequate." He was poor at understanding what the others were thinking and feeling and at the same time differentiating, that is adopting a meta-position from which to reflect on his own assumptions and question them or consider them just interpretations and not facts. For example, he was sure that his university colleagues criticised or scorned him because they thought he was gay. For this reason he adopted avoidance as a form of behavioral coping and did not attend his courses. He spent much time home alone, studying and doing a lot of physical workouts. Dario had poor metacognitive mastery and was unable to use mental strategies to soothe suffering, calm down, concentrate, relax, or enjoy himself. The only strategy he used to regulate anxiety, at the beginning of his therapy, was calling the therapist when in despair.

He entered therapy with little hope that his obsessions could be cured. The therapist dealt with this by telling him that the therapy could offer tools to diminish the problem, once there was an understanding of the mechanisms underlying his suffering so that solutions could be found. The therapist readily explained that the primary goal of the therapy was symptom-centered, that is by reducing his intrusive thoughts and anxiety, and that they would then try to understand the interpersonal mechanisms underlying his suffering in order to change them. This second goal was more about overall personality change in order to prevent a symptom relapse and live a more fulfilling life. Dario accepted the therapy contract and was relieved by this formulation.

With regard to his symptoms, the therapist gave him both antidepressive and low-dosage antipsychotic medication (Sertraline, 100 mg/day and Olanzapine, 5 mg/day). Dario had some fears about becoming dependent on medication and was worried about the stigma "It means I'm crazy," but was readily reassured by the therapist and took the drugs regularly, with some benefit. A next step was to find strategies to cope with his symptoms by explaining the mechanisms underlying the three perseverative thinking strategies accountable for their maintenance, that is, worry, threat monitoring and suppression, and how to stop them. Importantly, repetitive thinking includes endorsing problematic *I*-positions that adopt positive and negative cognitions about own cognitive processes. These cognitions about own cognitions are named metacognitive beliefs. One example of this was "worrying saves me from being taken off guard." The therapist provided psychoeducation about the existence of these metacognitive beliefs and how they tend to maintain suffering instead of solving problems. Then he helped the patient realize how the more he worried, the more the idea of being gay got stronger and the associated shame more intense. The therapist then produced written diagrams where the process of worrying was portrayed. The first step was having intrusive thoughts, such as "If I pay attention to men's muscles this means I'm gay," triggering self-critical statements, such as "If I'm gay I'm immoral and deserve rejection." This thought generated anxiety and was accompanied by a constant monitoring of his thoughts – "Am I thinking about men now?" – and by attempts to suppress his thoughts about men. The only result of this monitoring and suppression was again a symptom rebound and feeling fragile. Feeling vulnerable increased his anxiety, which Dario tried to solve by further attempting to control his thoughts. The end result was a feeling of anxiety, impotence, and being overwhelmed by thoughts. Dario could recognize himself in such a formulation and started to realize that the real problem was not so much being gay or not, but the very process of worrying.

With this formulation the therapist offered Dario a series of strategies to interrupt worry, threat monitoring, and suppression, and gain control over his mind: (1) read reminders written during sessions in order to remember that having an intrusive thought is not a sign of homosexuality, but moments in which Dario needs to stop worrying; (2) phone the therapist, or write a message or an email, should he not be able to calm down his anxiety and need to hear the therapist's voice repeating the formulation; (3) divert attention from the worry

coming from the vicious cycle: "If I'm anxious about being gay this means I'm gay, which makes me anxious." In order to break this cycle, the therapist used techniques imported from detached mindfulness (Wells, 2009) and attention training (Moritz et al., 2011). First, the therapist engaged Dario in some simple mindfulness exercises, for example increased awareness of bodily signals and of external sounds during short meditations. Then he asked Dario to purposefully think about being gay, and then learn how not pay attention to this, by increasing his attention to other stimuli, such as bodily signals and external sounds. This was repeated until his anxiety disappeared during the experiment, so that Dario could think of terms like "gay," "homosexual," and "faggot" as just words without the associated meaning and his painful reactions. Once his anxiety was well regulated, the therapist passed to cognitive restructuring. Dario thus came to understand that thoughts are just thoughts that can simply pass through one's mind without meaning anything special about oneself. He also learnt that anxiety is just a reaction to a feared outcome but not a sign that an event is real. Dario also took a critical distance from the idea that we should be able to control our thoughts or suppress them, because otherwise we risk going crazy, and accepted that thoughts just pass through our mind. The therapist reinforced these ideas with self-disclosures, such as: "At this moment I am thinking about many things, for example that I'd love a pizza. Do you think this means I'm crazy or not a good therapist because I cannot keep my thoughts under full control?" Dario soon realized he considered the therapist's functioning normal, and therefore accepted his mind could function that way too.

During the first three months, the symptom improved significantly, which permitted passing to the next step of identifying and revising maladaptive dialogical relationship patterns. Initially, Dario had difficulties reporting episodes with clear space and time boundaries in which he interacted with others, and all the dialogue unfolded in his imaginal landscape and involved worry. Given his difficulties in reporting narrative episodes, the therapist first worked through the therapy relationship. During one session, the therapist asked Dario how his workouts were going. Dario described his weightlifting, and the therapist in an interested, non-judgemental way asked him what weight he was lifting. All of a sudden, Dario blushed as if he was embarrassed. The therapist noticed the change and asked what was passing through his mind and if the change depended on his question. Dario said that he had passed from a sense of feeling appreciated by the therapist to the idea that: "Now he'll think I'm a weakling and a wimp." This is a typical alliance rupture, unwillingly provoked by the therapist's question, which elicited the maladaptive dialogical pattern in the patient. In line with procedures to solve ruptures (Safran & Muran, 2000), the therapist first took responsibility for the rupture: "I realize my question may have induce a sense of being judged/criticised." Then he provided cues about how he actually thought of the patient:

> Dario, I really didn't think you are weak, not even for a moment. It's just that I do a lot of training too and was curious about it. I realize that

> something may have happened inside you: it's like you hoped to be appreciated by me (*wish*). You first had an idea that I did appreciate you (*response of the other 1: other-position as benevolent judge*). Then you imagined, after my question, that I broke this illusion and you turned to the usual thing you think about the others, that is that they despise you (*response of the other 2: other-position as harsh and spiteful*). This made you feel inadequate, unworthy, and ashamed (*core maladaptive position: "I as worthless"*). Then, you shied away and withdrew in order to protect yourself from further negative judgment (*maladaptive coping: withdrawal*). What do you think about my reconstruction?

Dario nodded sadly and recognized himself in this pattern. At this point, the therapist could use this narrative episode, that is the therapy relationship exchange, as the cue for eliciting associated memories. This time Dario was able to retrieve autobiographical episodes he felt had the same problematic dialogical relationship structure. Dario reported a memory of a few months before. He was at the university bar and he met a girl he liked, a colleague, who he had never dared to approach before. She was with some friends and she smiled at him when their eyes crossed. Encouraged by her smile, Dario said "hi," but almost whispering. She did not reply and turned her face towards her friends, who giggled. Dario was convinced they were laughing at him: "They were convinced I'm not a real man and cannot approach a woman the way a man would."

In keeping with MIT procedures, the therapist did not consider this an irrational belief. Instead, he first validated Dario for the shame he felt, and then started a joint reconstruction of the episode, noting it had the same structure as the therapeutic incident. Again, Dario could see himself clearly in the reconstruction of the pattern and started to realize that he had this tendency to either discard perception of the other as benevolent – lack of a stable, internalized, benevolent other-position – or ascribe criticism to others.

Connecting the therapy incident with this recent one, there was enough material for the final step of the *shared formulation of functioning* part. The full formulation sounded like:

> It looks like you are continuously striving to be appreciated, which is completely human. But then you focus more easily on, or expect to receive, reactions in which others say: "You're no real man, you're a fag." Then you experience worthlessness and shame, because of your core idea of being wrong. At the same time, there are some rare moments in which you experience being appreciated by others and feel ok, but this does not last and your mind is quickly flooded with the negative aspect of the pattern. Once you are in this state, you think you cannot enter a dialogue with despising others, and prefer to withdraw, isolate yourself, or try to become perfect by continued training in order to increase your muscle mass. You think: "If I'm perfectly fit, people will not despise me." But this does not

> work and when you focus on other men's bodies, your obsessions appear and you think you deserve criticism again.

One of the steps in MIT is to note and highlight healthy *I*-positions early and this is a crucial driver of therapy success. In this case, the therapist asked Dario to perform a short, guided imagery exercise. He asked him to return to the scene and to focus on the moment in which he noticed the girl smiling at him. When Dario retrieved the memory, the therapist asked him to scan the girl's face. Dario did it and noticed she seemed to like him. The therapist asked how he felt and he said: "Fine, I'm ok." At the end of the exercise, the therapist helped Dario notice that he endorsed a different pattern, where he still longed for approval (wish), which is supported by an "I-as-valid" position facing an accepting other. Both act as promoter positions, one is internal, the second external. Dario could then experience a sense of self-confidence and happiness at the idea that the other considered him worthy.

Dario now understood even better the roots of his obsessions, and they decreased further. Subsequent steps at this point were to increase differentiation, which in DST terms can be described as leaving aside negative and crystallized constructions of self and others, and let a richer repertoire of *I*- and other-positions come to the fore. The desired outcome is to use this broader repertoire to achieve flexible dialogicality, including the capacity to see the world from multiple perspectives instead of continuing to endorse one's own negative view of self and others and firmly believing these attributions to be true and accurately describe reality. With this new functioning, patients can see themselves in more benevolent, compassionate ways, access feelings of strength and competence and be driven by *I*-positions where fulfilling higher-order wishes – such as social rank and attachment – and specific goals, such as dating or doing a job that one likes, are perceived within their reach.

Together with differentiation, the first goal of *change promoting* is the consolidation of the emerging healthy self, which means allowing for new *I*-positions filled with positive feelings and capable of cooperative interactions to emerge. This happens in the context of the promotion of exploratory behavior, involving becoming curious and finding avenues for self-actualization and for fulfilling one's innermost desires.

One important moment in this respect happened when Dario retrieved a remote memory, which made him further understand how the pattern got formed and where. Dario remembered when he was 6 and playing football, with his father in the audience. He was afraid of his father's criticism, so he played badly and made a lot of mistakes, though he also remembered playing sometimes very well. The match was a draw, and he was satisfied, but his father came into the dressing room and said that a real defender has to be much ruder and meaner and that Dario had behaved like a "faggot." Dario felt humiliated when remembering this episode, which quickly turned into self-protective anger.

The therapist asked Dario to re-experience the episode in a guided-imagery and rescripting exercise. The therapist said:

> This episode appears significant to me, do you agree? I'd like to enter that scene in your imaginal landscape, do you feel like trying? If it is too distressing, just tell me and we either don't do it or we stop whenever you want.

Dario accepted with curiosity and some anxiety. After some minute of diaphragmatic breathing, eyes shut, the therapist invited Dario to describe what was unfolding.

D: I'm in the locker room with my teammates. We joke and laugh. My father steps in. He is laughing with the other relatives. I'm not hearing what he says.
T: What do you see in his face?
D: The face of one who mocks everyone. He turns to me and says: You behaved like a faggot! A real defender is like a rock and needs the guts you'll never have!
T: (*notes anger and further explores feelings*): You look upset. Is there anything else you are feeling?
D: Sadness. I feel humiliated.

The re-experiencing part was now complete and the therapist tried to engage Dario in rescripting work:

T: Now breathe again deeply, until you feel in control . . . well . . . now try and reply to your father. Tell him whatever you want.
D (*HESITATES, VOICE TREMBLES*): It's difficult
T: No worry, keep trying
D: (*looks angrier though voice is still low*): Dad, I did my best and I want you to acknowledge it. You are humiliating me in front of my friends instead. That's unfair.
T: Breathe again, lift your shoulders and raise your chin. Ok?
D: Ok
T: Try again, put more energy into your voice.
D (*LOUDER, ALMOST YELLING*): You shouldn't treat me this way. You humiliated me!
T: How do you feel now?
D: Stronger.
T: Where do you feel the strength?
D: In my legs and my arms, kind of when I lift weights. I'm stronger and my father seems smaller.

Thanks to this experience, the quality of the inner dialogue changed, letting a stronger *I*-position to emerge, not subjugated by a spiteful and domineering other.

MIT does not consider in-session dialogical change to be the only driver of improvement. Behaviors sustain change, in line with a model cycle involving planning change, performing new behaviors, and reflecting about them in the next sessions (Hermans & Hermans-Jansen, 1995; Kolb, 1984). New behaviors are about enacting in everyday life new forms of dialogical relationship, in order to fulfill innermost wishes.

Dario realized that physical training was not enough for him as he longed for more contact with peers. As an exploratory exercise they planned on participating in a *powerlifting* class and going there once a week. The task was just to try to go and report either his inner experience or actual conversations. This time the therapist used guided imagery to promote adaptive anticipatory dialogues. Dario imagined asking someone for advice about how to best execute one exercise. Dario positioned this imaginal other as welcoming, accepting, and driven by the same enthusiasm. Real exposure went well and Dario started participating in social events with the class, experiencing a sense of belonging and sharing. After one and a half years the therapy terminated with good outcome. Dario was not anxious any more, and whenever his anxiety increased, he was able to regulate it without much effort. He did not have either OCPD or OCD.

Conclusions

Promoting change in patients with PD involves opening their minds to new forms of dialogical relationship. Therapy aims at making patients realize that they observed the world from the eyes of problematic *I*-positions but those were only ideas and other forms of positioning exist. MIT for PD attempts to let new and more adaptive *I*-positions emerge and meet different Other-positions, perceived as welcoming, accepting, nurturing, and supporting, act as promoter positions. Rewriting dialogues requires preliminary steps, which are increasing awareness of self-states and of the way others are constructed. Patients need to realize how crystallized and repetitive forms of dialogue have been guiding their lives. In order to achieve such a change, experiential work makes change possible or faster. In the clinical case we have described, the client re-experienced past episodes during guided imagery and rescripting, where he first re-experienced pain coming from previously noxious dialogical interactions. He then discovered how he was able to respond differently, adopting new *I*-positions and positioning the others in ways that made him feel he could fulfill his wishes. There are promising signs that this approach is effective when treating persons suffering with PD but research is needed in the field. To date there are preliminary outcomes showing that MIT is helpful in treating these disorders (Dimaggio et al., 2017; Gordon-King et al., 2017; Popolo et al., 2018). This strengthens the idea that a dialogical understanding of mind can be a useful guide for therapy with difficult-to treat individuals.

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