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A rational model for maximizing the effects of therapeutic relationship regulation in personality disorders with poor metacognition and over-regulation of affects

Giancarlo Dimaggio*, Antonino Carcione, Giampaolo Salvatore, Antonio Semerari and Giuseppe Nicolò

Third Center of Cognitive Psychotherapy – Training School Associazione di Psicologia Cognitiva (APC), Rome, Italy

Background. The therapeutic relationship plays a key role in personality disorder (PD) psychotherapy. Some aspects of therapeutic relationship regulation appear important for treatment of PD clients, including those with constricted relational schemas, poor metacognition, and over-regulation of affects described here.

Aim. To propose a rational model for *how* and *when* to work on the therapeutic relationship by treating the underlying personality pathology.

Method. Formalize a step-by-step procedure for performing operations such as validation of clients' experiences, creating a sense of sharedness, assessing the quality of the therapeutic relationship in order to prevent and repair ruptures in the alliance, self-disclosing by the therapist, and metacommunication on the basis of clients' responses to treatment.

Conclusion. We discuss the implications of this model for further research into the PD therapy process.

Promoting change in individuals who are self-reliant, unwilling to self-disclose, lacking in emotional description and expression, and often holding negative representations of their therapist – characteristics of personality disorder (PD) clients with prominent inhibited or constricted features – is a painstaking task. Treating PD is difficult when the quality of the therapeutic relationship is continuously being jeopardized (Bateman & Fonagy, 2004; Clarkin, Yeomans, & Kernerg, 1999; Critchfield & Benjamin, 2006; Gabbard, 1992). Clinicians therefore need a model of how to work through the relationship while treating such clients. We endorse here an all-encompassing definition of the therapeutic relationship as 'the totality of the interpersonal field between the

* *Correspondence should be addressed to Dr Giancarlo Dimaggio, Third Center of Cognitive Psychotherapy – Training School Associazione di Psicologia Cognitiva (APC), Via Ravenna 9/c, 00161 Rome, Italy (e-mail: gdimaje@libero.it).*

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therapist and client and include in this term the concepts of the real relationship, the working or therapeutic alliance, and transference and countertransference as the set of representations' (Hill & Knox, 2009, p. 14). This includes the associated affects that a client and therapist have *vis-à-vis* each other, and the communicational signals exchanged by them.

Working on the therapy relationship is among the factors with the most proven effectiveness in psychotherapy in general (Castonguay & Beutler, 2006; Norcross, 2002) and is indispensable in treating PDs. This is nowadays recognized by almost any clinician treating such clients, no matter what the preferred treatment approach (Critchfield & Benjamin, 2006). On the other hand, working solely on the therapeutic relationship is not sufficient for treating PD clients (Clarkin, in press; Livesley, in press). Some approaches, such as dialectical behaviour therapy (Linehan, 1993), which include a strong focus on symptoms (i.e., self-harm), are effective and quick at reducing these, while others more focused on the therapy relationship *per se*, such as mentalization-based therapy, may take longer to reach the same result, although they are more effective at coping with other aspects of the personality pathology, i.e., the mentalizing dysfunction (Bateman & Fonagy, 2004).

In general, recent evidence shows that working on symptoms and working on the relationship are mutually reinforcing. Psychodynamic treatments focused on relational problems, including therapy relationship ones, need to include more specific work on symptoms to become more effective at reducing, for example, worries (Leichsenring, Salzer, Jaeger, *et al.*, 2009). The other side of the coin is that therapies such as cognitive behavioural therapy (CBT) whose major component is technical interventions aimed at reducing symptoms such as anxiety (Castonguay *et al.*, 2004) or depression (Constantino *et al.*, 2008) become more effective when enhanced with work on repairing alliance ruptures. The studying of the interplay between techniques and the therapeutic relationship is in fact being recommended more and more (Castonguay, Constantino, & Holtforth, 2006).

Work on the relationship needs to be accompanied by specific techniques (Safran & Segal, 1990) in order to treat symptoms, overcome reasoning problems (Constantino *et al.*, 2008), increase awareness of affects and of the reasons for actions (Bateman & Fonagy, 2004), interrupt malfunctioning patterns (Clarkin *et al.*, 1999), promote adaptive behaviour, and reduce drop-outs (Livesley, 2007). Our goal is, therefore, to operationalize a *rational model* (Greenberg, 2007) for the guidance of therapists as to *when*, *how*, *for what reasons* and on the basis of *what signals* to work on maintaining a good therapeutic relationship whilst also making technical interventions, in particular with the PD subset featuring both poor metacognition and over-regulation of affects described here.

We aim to provide an integrated treatment rationale for clinicians from different schools to use as a map for treatment planning, for example, when deciding when to switch from work on symptoms to work on the relationship and vice-versa, and for studying change mechanisms. Building a *rational model* is the first step in a research project using transcript analysis to evaluate whether successful sessions contain the therapeutic sequences theorized and whether any improvements occurring depend on the proposed strategy. The revision of the model via an intensive analysis of psychotherapies using task analysis processes (Rice & Greenberg, 1984) will lead to a *rational–empirical model* (Greenberg, 2007), which can, in turn, be applied to other therapies and thus perfected further. In this article, we set out the results already obtained in therapies such as cognitive analytic therapy (Bennett, Parry, & Ryle, 2006) and CBT (Aspland, Llewelyn, Hardy, Barkham, & Stiles, 2008), which concentrate on

repairing ruptures in the alliance. It is to be noted that the model we propose here focuses on the therapeutic relationship as a whole – and thus not only on the alliance – which also includes preventing alliance ruptures, reflection on transference, and counter-transference and metacommunication principles (Safran & Muran, 2000).

To date, there is evidence that: (1) one aspect of the relationship, i.e., the therapeutic alliance, defined as cooperating in tasks and goals on the basis of a valid bond (Bordin, 1979), is a key outcome predictor and mediator (Martin, Garske, & Davis, 2000) and (2) repairing ruptures in the alliance appears to assist in making PD treatment effective (Smith, Barrett, Benjamin, & Barber, 2006), even if there are calls for further research (Bender, 2005; Safran & Muran, 2006). There are, however, many unanswered technique theory questions: How can our knowledge of the relationship with clients be used to increase that of their mental states? How can the relational atmosphere be modulated to render psychopathology work easier? Is it possible to use information deriving from the relationship to avert problematical situations arising, disengage immediately from patterns that would rupture the relationship and quickly and effectively repair any ruptures occurring? Are there situations in which it is better to concentrate the focus on the therapeutic relationship and others in which it is advisable to avoid discussing the question explicitly in sessions? We shall concentrate on and try to provide answers to these questions while focusing only on a limited target of clients, i.e., with a prominent inhibited or constricted personality trait.

Inhibited or constricted features in PDs

The majority of clients with a PD suffer from other PDs and dysfunctional aspects (Clarkin, 2008; Dimaggio & Norcross, 2008), and this leads scholars to advocate that:

> Traditional categorical diagnoses […] have limited value in treatment planning […] do not capture the complexity or range of psychopathology relevant to treatment planning. They are global constructs that only provide broad treatment guidelines with limited value in selecting interventions because most interventions target specific behaviors such as self-harm, emotional lability, and impulsivity. An additional problem encountered with complex cases is that clinicians usually make a single personality diagnosis and neglect the other PDs (Livesley, 2008, p. 210).

A promising strategy, therefore, is to concentrate on the dysfunctional mechanisms of the pathology underlying each individual client's various overt manifestations and tailor a model to him/her. Focusing on underlying vulnerabilities makes it possible to tackle the same behaviour occurring in different disorders, treated as separate by categorical diagnoses (Dimaggio & Norcross, 2008; Krueger & Markon, 2006).

Treatment manuals have concentrated on PDs with prominent dysregulated features, like borderline, but this bias is inappropriate, given the high prevalence of clients with inhibited or constricted features and the seriousness of their pathology, which remains under-investigated (Clarkin, 2008) – the reason for our focusing on them. Many PD sufferers, in particular the ones with covert narcissism or those diagnosed with avoidant, obsessive-compulsive, passive-aggressive, dependent, or schizoid PDs, either on their own or in various combinations of fully fledged disorders or traits, present a set of characteristics: (a) difficulty in reflecting on one's own mental states or poor self-awareness; (b) over-regulation of affects; and (c) limited schemas for self-other relationships. As regards overt manifestations and problematic behaviour, such persons are self-contained and reluctant to self-disclose, with a tendency to be

self-reliant and self-sufficient, inhibit emotional expression, have a limited display of feelings, avoid emotionally arousing situations, not reveal positive feelings and fear sexual expression. A lack of empathy is often associated with these characteristics (Livesley, 2007). Lynch and Cheavens (2008) talk of a *constricted* type, which is perfectionist and risk-averse, features consistent with a tendency to avoid social contact, new relationships, and intimacy.

Poor metacognition

It is increasingly recognized that an important aspect of personality pathology is limited access to inner states (Livesley, in press). The ability to think in terms of mental states is known as self-reflection (Ryle & Kerr, 2002), mentalization (Bateman & Fonagy, 2004), or metacognition (Dimaggio, Semerari, Carcione, Nicolò, & Procacci, 2007; Semerari *et al.*, 2003). With poor metacognition we refer to the set of skills needed to recognize one's own mental states and reason about them, identify behaviour in terms of intentions, desires, and affects and use psychological knowledge to cope with distress and regulate social interactions (Carcione, Dimaggio, Conti, Nicolò, & Semerari, 2009; Dimaggio & Lysaker, 2010). Many PD clients have difficulty reflecting about their own minds. As recently described (Dimaggio, Vanheule, Lysaker, Carcione, & Nicolò, 2009), these patients can display: a limited feeling of agency; difficulty in identifying the psychological causes of behaviour and emotions (Dimaggio, Procacci, *et al.*, 2007); and difficulty recognizing the underlying schemas driving their social behaviour and their construction of others, so that they take their own ideas as being true and act accordingly, without being able to take a critical stance towards their beliefs (Dimaggio, Salvatore, Fiore, *et al.*, in press; Dimaggio, Salvatore, Nicolò, Fiore, & Procacci, 2010). At the same time as poor self-awareness, these persons have difficulty in forming a nuanced picture of what drives others to think, feel, and behave and in contemplating a mutual meeting of minds in the heat of problematic interactions (Aron, 1996; Bateman & Fonagy, 2004).

Over-regulation of affects

Many patients suppress or avoid their affects, whether positive or negative, as, for example, those with avoidant PD (Taylor, Laposa, & Alden, 2004) or with narcissistic characteristics who can perceive anger or idealized love but are detached and unable to identify other emotions for most of the time (Modell, 1984). Such persons show heightened sensitivity to negative emotions and prompt reactance to punishment/threat stimuli. When clients, with for example obsessive-compulsive traits (Millon & Davis, 1996), see that another is about to remark on negative features of the self, they withdraw and suppress their emotional feelings and facial expression. They also become rigid and oppose any novelties or risks in order to protect themselves from social threats.

Limited repertoire of schemas for self and others

Use of a limited set of interpersonal schemas to make sense of the wide variety of attachment, marital, professional, and social relationships, forecast their evolution and guide actions, is a defining feature of PD (American Psychiatric Association, 2000; Benjamin, 1996; Clarkin *et al.*, 1999; Gabbard, 1992; Ryle & Kerr, 2002; Young, Klosko, & Weishaar, 2003). Without an adequate schema repertoire to guide actions, it is difficult to form plans and strategies for achieving goals and tackling problems in one's social life. The constructions, of which internal working models of attachments are a typical example (Bowlby, 196), are usually built early in life (Young *et al.*, 2003) and

relatively hard to change. Maladaptive schemas (Nordhal, Holthe, & Haugum, 2005) or attachment styles (Westen, Nakash, Thomas, & Bradley, 2006) underlie the different manifestations of PDs, differentiate people with PD from people without PD and are related to higher distress.

These constructions can be ego-syntonic, e.g., schemas such as *grandiose self/despised other* and *humiliating other/self deserving to retaliate* in persons with, respectively, narcissistic, paranoid or negative, and ego-dystonic features, i.e., *fragile self/dominant and abusing other*. PD sufferers rely mainly on these for making sense of social life, with other schemas, including healthier and adaptive ones, being often overshadowed by the dominant, dysfunctional ones (Dimaggio *et al.*, 2006). Narrative itself can offer only scanty descriptions of *where* and *when* a scene takes place (Dimaggio *et al.*, 2003; Neimeyer, 2000; Salvatore, Dimaggio, & Semerari, 2004).

Working on the therapeutic relationship

The impact of the client–therapist relationship on outcome is recognized (Norcross, 2002). The therapeutic alliance, defined as client and therapist agreeing on goals, tasks, and the quality of the interpersonal bond (Bordin, 1979), accounts for a significant percentage of outcomes – from .22 to .26 (Horvath & Bedi, 2002; Martin *et al.*, 2000). Empathy and positive regard, i.e., a therapist's ability to understand the world from a client's point of view and to keep a well-disposed and non-critical attitude, are also considered to be potentially effective (Castonguay & Beutler, 2006). When experiencing disturbing or inexplicable affects, clients draw benefit from validation, with their therapist pointing out the adaptive and universal value of affects (Linehan, 1993), agreeing that the reasons behind them are, at least partly, understandable and helping them to integrate them into their self-narratives (Greenberg, 2002).

The above elements play a role in the therapeutic relationship with PD clients with prominent inhibited/constricted aspects, who construct their therapist according to a limited and dysfunctional set of schemas – e.g., *critical or dominating* – and have difficulty trusting or co-operating, defensively withdraw or forestall attacks by attacking first. A therapist needs to work hard to build a good relationship, overcome ruptures in the alliance and create a co-operative atmosphere in which to reflect on mental states. Moreover, such clients have a negative view of themselves and, the more they get close to the features they find unacceptable, the more they are scared by them, so that any aspects surfacing require continuous validation. Their limited ability to describe inner states makes it difficult to obtain the information necessary for joint treatment planning (Clarkin *et al.*, 1999; Critchfield & Benjamin, 2006; Livesley, 2003) and achieving a positive and lively relationship.

In short, in this article, we formalize explicit and detailed procedures for how to work on the therapeutic relationship in clients suffering from a PD with inhibited features. We propose *why*, *when*, *how*, and *in what logical and chronological order* one needs to: validate any subjective experience appearing; use any information arising from the therapeutic relationship overtly or covertly to understand both problems in the relationship itself and the client's way of functioning in daily life, and to stimulate the client's knowledge about these (Bennett *et al.*, 2006); repair ruptures in the therapeutic relationship or concentrate discussion on the latter, i.e., metacommunicate (Safran & Muran, 2000).

We are therefore investigating not *how much* work there needs to be on the therapeutic relationship but rather *when*, *how* and on the basis of *which interactions*

with other aspects of the pathology to shift from technical interventions to ones concentrating on the relationship. For example, during a session a clinician may focus on helping a client reduce worries by using CBT techniques. If symptom work is effective and the client feels better and relieved, there is no need to pay specific attention to the therapy relationship. But, when symptom work is ineffective or the therapy relationship is problematic, the clinician should switch to working on it, both to solve strains in the alliance and to acquire knowledge about relational issues; otherwise a poorer outcome and higher drop-out risk are likely (Constantino *et al.*, 2008).

Relational interventions can be effective when administered at the right moment, for example, in the heat of the moment during a problematical session, even if the amount of time spent on them is minimal, i.e., a few minutes. On the other hand, talking about the therapy relationship can be useless even when the majority of a session is spent discussing it if it is done in an inappropriate manner, with, for example, the clinician misidentifying the underlying pattern. An intervention can also fail when a therapist, in trying to repair a rupture in the relationship, does not take account of how much a client is able to comprehend mental states. Asking a person scarcely able to describe his/her own affects to consider the complexities of a human relationship is probably useless or counterproductive.

The model we propose relies on the work by Safran and Muran (2000) on ruptures in the therapeutic alliance. However, it is different because we concentrate not on how to work on the therapeutic relationship *per se* but on how to do it whilst engaged in achieving an improvement of a personality pathology. Aware as we are of the warning that: 'there is always a risk that any form of therapeutic metacommunication will further aggravate the alliance rupture' (Safran & Muran, 2000, p. 120), we try to keep this risk to a minimum by administering, metaphorically, the smallest effective dose of metacommunication and using it not by default but at precise points in a treatment or when other forms of intervention have failed.

Therapy goals

The psychotherapies of PD clients with inhibited/constricted aspects need to aim at their: (1) expressing affects better and understanding their underlying causes; increasing contact with emotions and desires and letting themselves be guided by them instead of relying constantly on perfectionist standards or moral rules; (2) gaining awareness of their schemas and the representational nature of their ideas instead of sticking to matter-of-fact aspects of events; (3) limiting the use of stereotypical schemas for relationships, enriching their narrative landscape and widening the set of relational procedures used in order to move with greater agility in the social arena; (4) using their knowledge of mental states to soothe psychological suffering, solve social problems, negotiate conflicts, and seek new solutions for the achievement of objectives; (5) reducing symptoms.[1] All these goals have to pass over the narrow bridge of problems in the therapeutic relationship (Dimaggio, Salvatore, Fiore, *et al.*, in press; Dimaggio, Salvatore, Nicolò, *et al.*, 2010).

[1] *The reduction of symptoms such as anxiety, depression, or dissociation, is fundamental in PD therapy but we discuss it only briefly here for space reasons. To discuss this in detail would in fact require an article on its own, describing the intertwinement between the therapeutic relationship and use of techniques for improving mood, overcoming trauma-related dissociation, or reducing obsessive-compulsive behaviours.*

The place for the therapeutic relationship

Such clients often defensively withdraw or attack the therapist. Problems surface in various situations: when the therapist tries to stimulate awareness of affects and their causes, negotiates treatment goals or attempts to alleviate panic or dissociative symptoms. Problematical schemas from relationships take over the therapeutic relationship too – with a significant contribution from the therapists of course (Mitchell, 1988; Safran & Muran, 2000). When the latter, for example, insist on clients trying out new modes of action, they risk being construed like an imposing or dominating parent or one demanding an unachievable performance.

The general principle is that whatever technical action therapists may perform, they should do it with an increasing joint involvement in thinking about the therapeutic relationship. We contend that it could be beneficial to pass from basic interventions not focused on the relationship, through others progressively more concentrated on it and finally to more complex ones in which therapists self-disclose or recognize their contribution to problems.

Clinical vignette 1

We portray here an imaginary vignette encapsulating some of the steps in the procedure. Let us suppose that a client has just recognized a number of thoughts and emotions. The therapist might then hypothesize that there are cause/effect links among them and suggest: 'Might you have felt Y because X happened and you thought Z?'. An intervention like this may work but lead to problems: the client may see that the therapist's idea is correct but the content emerging threatens his/her self-esteem: 'If I react like this, I must really be stupid'.

At this point therapists should work on the relationship, by, for example, pointing out the universality of the process the client ascribes to him/herself, in order to lessen the sensation that they have been criticizing him/her: 'Now you realize that you depend on others' opinions to be able to gauge your worth. It's this that makes you feel stupid. Anyone discovering a weakness in themselves may accuse themselves of it, but we all depend to some extent on others to understand who we are and what we are worth'.

The therapist may now note signs, for example, the client's facial expressions or therapist counter-transference markers, showing how the client continues to hold negative attitudes regarding him/herself. At this point one can hypothesize that the negative beliefs about the self depend on how the client sees him or herself as being represented by the therapist. In other words, the intervention – correct in its content – has activated a relational schema of the *incapable self/critical therapist* type, accompanied by shame and poor self-esteem. Recognizing the therapist's role in causing the problem can become indispensable: 'Perhaps my intervention sounded to you like a criticism but that wasn't my intention. May I have said something that gave you the impression I was considering you stupid?'. Such an intervention would not have been necessary if the client had simply seen the therapist's observation as correct in its contents.

Former task-analytic works have led Aspland *et al.* (2008) to devise a rational–empirical model in which the progressive engagement of the therapist in therapy relationship work started with the therapist (a) internally reviewing and recognizing a problematic pattern; (b) changing approach in order to address any empathic failure and validate the patient's experience; (c) restoring a cooperative relationship by encouraging the client's active participation or seeking for feedback showing an agreement about tasks has been achieved; (d) working at revised shared tasks, while

re-formulating a broader pattern of interaction guiding the client's actions life and using it as further information to address future empathic failures in the therapy relationship.

At the same time Bennett *et al.* (2006) formed an empirical model in which firstly evidence for the existence of problematic patterns is collected and a case formulation is attempted while the therapist pays attention to counter-transference, and then there is a negotiation of therapy goals until consensus is reached. If the therapy relationship is good, exploration of warded off feelings is possible, which leads to new insight into the client's functioning, with these experiences being validated by the therapist; this helps in building a sense of mutual attunement, thus ensuring that efforts at changing problematic patterns happen in a supportive atmosphere.

Based on these pioneering works, we propose that the progressively increasing engagement in work on the relationship be divided into two steps. We would stress that this is neither a phase model of therapy relationship work nor an algorithm with fixed sequences. It aims instead at describing a formalized sequence of actions that are expected to be beneficial and amenable to process research. During therapy we advocate that patient and therapist pass through repeated cycles of relational work, swinging back and forth among the various steps, until a problem is solved.

Step 1: Asessment of relational patterns and internal modulation of problems/work on psychopathology use of techniques

(a) Early intuitive identification of dominant transference patterns via analysis of clients' stories and observation of their non-verbal behaviour and of the therapist's internal markers; (b) covert problem management – *inner readiness to disembed* – with the therapist planning interventions aimed at preventing problems in the relationship on the basis of the previous assessment; (c) creating a sense of sharing focused on everyday life topics of common interest; (d) technical work on the client's psychopathology without explicitly working on the therapeutic relationship; (e) validation of any experience appearing (positive regard, acceptance).

Step 2: Explicit work on the therapeutic relationship

(f) Investigating problems in the therapy relationship; identifying the problematical patterns invading the relationship; inner discipline and covert management of problems; (g) self-disclosing in order to highlight common aspects in the client's and therapist's experiences and foster cooperation between them as peers; (h) overt discussion of problems and linking therapeutic to everyday life patterns; (i) self-disclosing in order to metacommunicate about problems in the relationship, help clients use knowledge on the therapist's mental states to understand the reactions they provoke in their everyday life, and acknowledge the therapist's contribution to dysfunctional patterns.

The two stages are summarized in Figures 1 and 2.

Several bad response markers show a therapist when to shift from one type of intervention to another or pass from stages 1 to 2: lack of increase or deterioration in psychological awareness (Stiles, 2006); deterioration of affect quality; deterioration of the therapeutic relationship, with increased defensive reactions such as withdrawing or confronting the therapist (Safran & Muran, 2000); lack of access to new autobiographical memories (Weiss, 1993); and absence of symptom response, symptom relapse, or absence of affect shifts (Bennett *et al.*, 2006; Horowitz, 1987). Only if

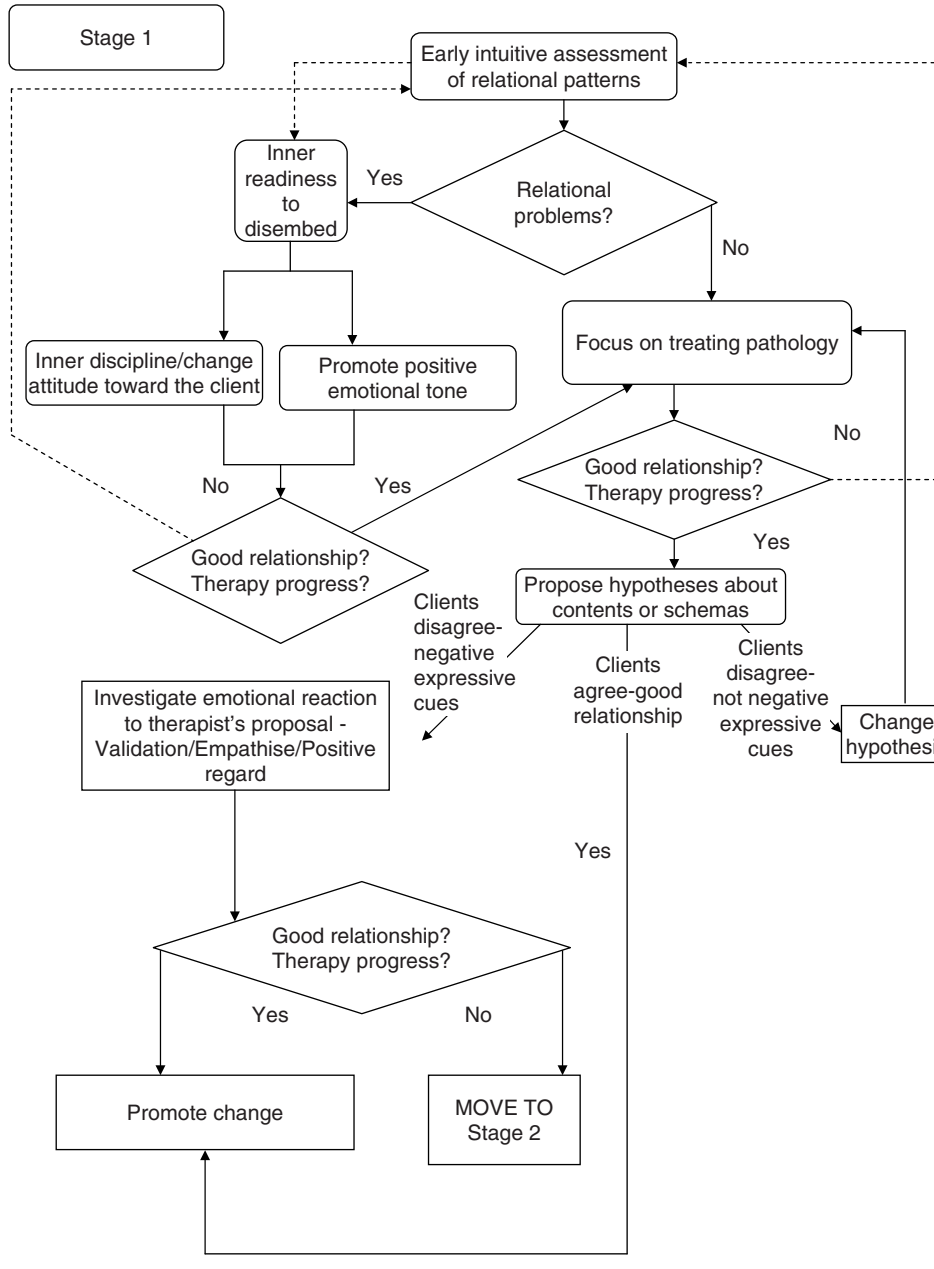

Figure 1. Assessment of relational patterns and internal modulation of problems/work on psychopathology use of techniques. *Note.* **NO** means that markers regarding symptoms, self-awareness, production of new self-narratives, and quality of the relationship are negative. Need for more focus on the therapy relationship. **YES** means that the same markers are positive and the therapist can continue work on treating the pathology instead of further focusing on the therapy relationship.

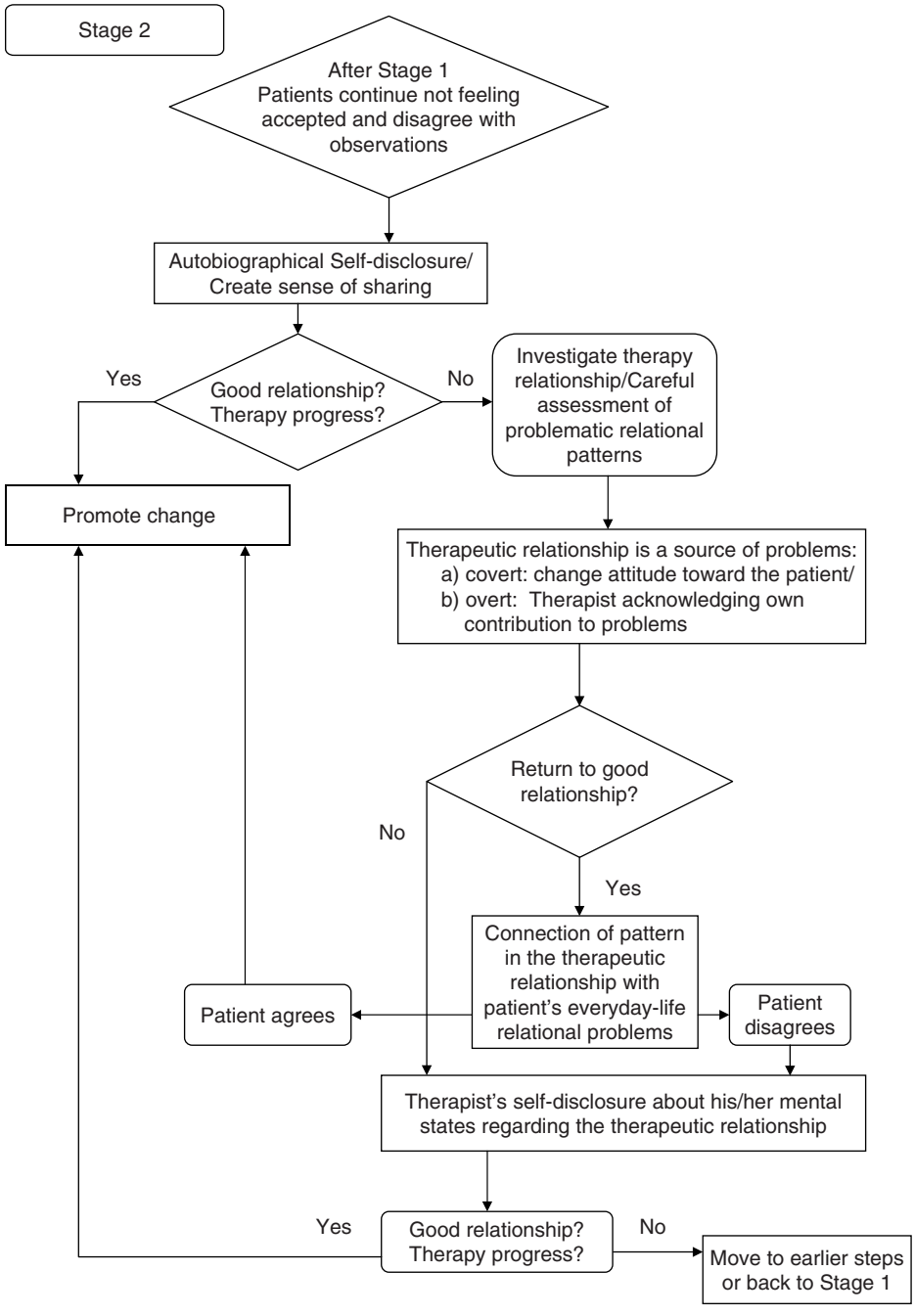

Figure 2. Explicit work on the therapeutic relationship. *Note.* **NO** means that markers regarding symptoms, self-awareness, production of new self-narratives, and quality of the relationship are negative. Need for more focus on the therapy relationship. **YES** means that the same markers are positive and the therapist can continue work on treating the pathology instead of further focusing on the therapy relationship.

interventions lead to a deterioration in some of these elements or steadily fail to foster improvement, can they be considered unsuccessful and thus require more detailed work on the therapeutic relationship – passing from Steps 1 to 2.

Step 1

Early covert assessment of relational patterns

While clients relate their stories, there are usually dysfunctional relationship patterns ready to enter into action. Clients' reactions to the slightest signals by a therapist can be to distrust the latter, feel criticized, feel ashamed, and so on. The latter is unlikely to be able to make a correct real-time assessment of the problem but needs to quickly arrive at an intuitive idea, based on verbal and non-verbal signals – facial expressions, language, etc. –, of why a client's immediate reaction is to attack or close up.

Internal modulation of problems: Inner readiness to disembed

Thanks to this intuitive assessment, the therapist is able to enter a state of *inner readiness to disembed* from the problematical pattern and correct his/her actions, thus avoiding contributing to the creation of a dysfunctional interpersonal cycle. For example, if there are signs that a client is closing up or feels shame, a therapist should immediately try to adopt a non-critical and non-pathologizing language, so that the client does not devalue him/herself by thinking: 'my therapist thinks I'm ill too'. This is particularly important and requires an understanding of personality pathology. Recognizing that typical patterns are often associated with specific pathologies (Clarkin *et al.*, 1999; Dimaggio, Semerari, *et al.*, 2007) is helpful in focusing on early signals of strains in the therapy relationship. If a therapist feels like he/she is walking on eggshells and swings from fear and anger during a first phone contact, these are likely signs that the client has prominent paranoid features, so that the therapist needs to be ready to avoid withdrawing or counterattacking. At the same time, therapists need appropriate training – such as, for example, supervision focused on helping them to identify their typical inner states *vis-à-vis* clients, role-play in which they learn to perceive their own inner worlds, or personal therapy – in recognizing their typical emotional markers, distinguishing their usual patterns of reacting from those due to the unique human being before them, and accepting their contribution to the relational matrix (Mitchell, 1988) which gets built during therapy. In particular, therapists need to develop a capacity to take a swift self-observing stance and a bird's-eye-view, when possible, of their inner world, until they are able to modulate their responses according to patients' needs.

Promote a positive emotional tone

PD clients with inhibited traits have difficulty feeling attuned with the other, so that the session atmosphere is often unpleasant, while it would be better for it to be positive. If clients go home angry, they will remember primarily the hostile features of a relationship – in line with affect-congruent information processing – and not the beneficial moments in an interview. A therapist should look repeatedly for topics of common interest and focus conversation on these, as a client will feel at ease talking about things he/she likes and knows well, a technique often used in metacognitive interpersonal therapy (Dimaggio, Semerari, *et al.*, 2007). In showing sincere interest, therapists are more likely to be constructed as fellows and not adversaries or strangers

(Semerari, 2010). This strategically 'low-key' atmosphere should be maintained until the flow of conversation gives rise to psychological elements on which one can dwell with limited risk. It is important that during conversation the therapist is authentic, displaying only any true involvement, while at the same time always maintaining a reflective stance in which he or she reflects on what is happening to both while they hold the dialogue (Bromberg, 1998).

Technical work on a client's psychopathology without an explicit intervention involving the therapeutic relationship

Where there are no dysfunctional signals in the relationship, the session can flow without an explicit intervention on the therapeutic relationship, while the therapist uses techniques to access affects and know and regulate them better, or focuses on disturbing thoughts. If questions, hypotheses, or suggestions about experimenting new behaviour between sessions give positive results – e.g., improved emotional expression – there is no *a priori* reason for working on the therapeutic relationship first. If, instead, an intervention does not work, it is logical, rather than investigating whether there is a relational problem, to re-evaluate the correctness of one's hypotheses and investigate alternative ideas. Only after the failure of repeated attempts or when the relational atmosphere is negative, is it worth considering the relational dimension.

Validating experience

Clients with PD with over constricted traits see affects and new experiences emerging through biased lenses. They criticize themselves, are scared by what they feel or reject it, have difficulty trusting the therapist, and keep themselves from probing further. It is therefore important to validate any experiences that surface and explain the role of emotions in adaptation (Linehan, 1993) and in meaning-making (Greenberg, 2002). A therapist can point out how much of the discourse contents that a client rejects – for example, realizing that he/she depends on a partner and considering him/herself immature as a result – are acceptable and partially adaptive (e.g., dependence ensures affective security). Sometimes it is enough to show positive regard towards any parts surfacing. In other cases, in spite of attempts to accept or understand them, clients may persist in a defensive or aggressive attitude. It is often *self to self* or *therapist towards self* relationship patterns that render validation ineffective, with clients believing that the therapist is pretending and accepting them out of duty, while concealing an underlying disapproval. If therapists repeatedly re-evaluate their hypotheses, try to covertly modulate their reactions and validate experiences, without obtaining an improvement in the psychopathology or relational atmosphere, they need to work explicitly on the therapeutic relationship.

Step 2

Investigate problems in the therapy relationship

This involves a more detailed assessment of relationship quality after the rapid one described in the first step of our procedure. At this point, a therapist should discuss aloud a client's non-verbal markers and the contents of the conversation, and analyse the latter's narratives in order to carefully assess the pattern dominating the therapeutic relationship. Relational problems can generate new information. For example, a client might verbally state that he/she feels at ease during therapy, whereas non-verbal signals

indicate closing up and dysfunctional interpersonal schemas like *criticized/spiteful* or *searching for care/neglecting caregiver*. The therapist may investigate the links between expressive behaviour and mental state. If the client considers that there are links, the therapist may ask him/her whether what he/she is feeling concerns something the therapist has said or done (Safran & Muran, 2000).

Simultaneously, in order to assess the schema, therapists should consider how their actions and sentiments contribute to the problem, i.e., pinpoint any counter-transference (Clarkin *et al.*, 1999). After they have identified any negative attitudes they have or seen that the client perceives them according to dysfunctional schemas, they should manage problems covertly. This process, which can be broadly described as working through counter-transference, includes awareness of the therapist's thoughts, emotional processes, and usual reaction tendencies, and an active engagement in preventing these reactions from negatively affecting the therapy relationship (Clarkin *et al.*, 1999; Greenson, 1974; Racker, 1968) or the therapist's interior discipline (Safran & Segal, 1990). This is, in fact, a version of the *inner readiness to disembed*, with therapists now having a precise awareness of the position they need to abandon, of the interpersonal process in which they are involved and of the negative consequences of remaining entangled in the problematical pattern. Even if the operation is covert, we include it in Step 2 because it follows the overt investigation of relational problems and is thus different from the *inner readiness to disembed*, in which both the diagnosis and the solution occur in the therapist's inner world. This operation is cognitively complex and is a way to reach the empathic stance advocated by Kohut (1971), i.e., therapists' ability to put themselves in patients' shoes.

We would recall that relational ruptures cause problems if they hinder other actions undertaken previously, such as negotiating objectives or reducing symptoms. A detailed assessment is, accordingly, only necessary if techniques have failed and the relational problem is likely to hinder treatment. We consider this to be the moment for a more detailed analysis of interferences by the relationship in the therapeutic process. This is the point in a diagnosis which, on the one hand, is the most important and, on the other, perhaps the one on which most has been written, so that we will restrict ourselves to recalling a few problem indicators: the client closing up – i.e., talking in a monotonous manner, not supplying new memories, stating that he/she is cooperating but not performing his/her part of the work – or attacking – i.e., criticizing the therapist, denying the usefulness of treatment even when there is an improvement and so on (Safran & Muran, 2000). In general, a therapist should, right from the start of a therapy, invite clients to freely express their feelings about the therapy and therapist, explaining that they are a precious source of knowledge and a resource for problem solving.

A satisfactory assessment of a relational problem makes it possible to identify processes such as: clients feeling they are considered inferior by a therapist embodying a position of superiority, clients reacting by competing and therapists feeling defied and imposing their ideas to safeguard their power. Alternatively, therapists may recognize that their angry and impotent insistence is a result of frustration due to considering a client's limited emotional expression to be reticence and trying to force the latter to open up. Therapists may recall unpleasant personal memories. By being aware of this therapists are able to interrupt any action tendencies under way by modulating their mental state or seeking help from a colleague or supervisor without the client knowing about this, except for the change in therapeutic style.

Such problems are frequent even at later stages in therapy, when, for example, a therapist suggests clients, by now aware of how they function affectively and

relationally, experiment new forms of relationship in everyday life. Clients – for example, those with dependent, avoidant, or negativistic traits – may fail to commit themselves to such new tasks and this makes therapists impotent or angry, their reaction being to blame the clients for the lack of progress. Before laying the responsibility on the client one needs to exit from the negative interpersonal cycle, by, for example, lowering one's excessive expectations about the client's readiness to change or one's own efficacy as a therapist.

We would recall that it is pointless engaging in a complex and risky process of metacommunication about the therapeutic relationship, if the same result can be obtained by changing strategy or covertly modulating one's inner state.

Self-disclosing in order to highlight aspects common to the client's and therapist's experiences

This self-disclosure is the continuation of the validation interventions in Step 1 and should be performed if the client continues to not feel understood and accepted. Self-disclosure is seen as problematic by many, especially by some authors from the psychoanalytic field (see Abend, 1995), while other psychoanalysts, especially those of a relational orientation (Aron, 1996; Gediman, 2006; Renik, 1996), maintain that it is a useful and unavoidable part of the therapy process. There is more consensus nowadays about a certain level of self-disclosure being a basic part of the therapy process, for example, when therapists explain how their mind has come to formulate an intervention (Aron, 1996; Renik, 1996). A more debated issue is instead if is appropriate that therapists purposefully and explicitly reveal aspects of their own real life, with some advocating it is useful (Gediman, 2006; Orange & Stolorow, 1998) and others arguing against (Meissner, 2002). Although using a different language, behaviour therapists have also made wide use of their own reactions as a way to overcome therapy problems or as a model for client appropriate responses.

The possible negative side of the coin of self-disclosure is that the client can, and often does, interpret the disclosures in a way unexpected by the therapist. An example is when the disclosure leads to negative self-judgment by clients who now feel they are confronting an idealized model they will never be able to achieve. The positive side of the coin is that clients can be relieved by the discovery that their problems are similar to ones coming from a supposedly authority figure, thus making the therapy relationship more egalitarian. We will not enter this theoretical debate further but simply stress that this is the moment to pass from theory to research and therefore to analyse how patients respond to therapist self-disclosures and why and when these are beneficial or of hindrance to the therapy process. Safran and Muran's (2000) suggestion is probably the best strategy: what really matters is not the disclosure in itself, but the therapist's ability to track its consequences and change intervention accordingly. For example, if, after a self-disclosure, a patient answers with a reinforced feeling that he/she merits criticism, by saying: 'You suffered but you were able to overcome the suffering. I'm too stupid and so I remain bogged down in my failures', the therapist can swiftly ask the patient how the disclosure contributed to this feeling and demonstrate an ability to recognize that his or her intervention caused the problem, thus preventing the tendency of the patient to bear the blame for all the problems (Aron, 1996).

Therapists first need to look for emotionally well-modulated episodes in their own histories, in which they feel they experienced something similar to the client, and reveal them with the aim of being seen as a peer involved in solving similar life problems.

Again, self-disclosure needs to always be carefully delivered, after the therapist has anticipated the client's potential reactions to it, and therapists need to be aware that the client may interpret it differently from their intentions.

The *validation* aspect, begun during Step 1, is a background theme throughout treatment. Each time clients talk about new themes, they acquire awareness of new parts of themselves and should try, on the basis of a suggestion by the therapist, to engage in new forms of behaviour to widen their limited relationship repertoire. Meanwhile, the therapist should look for signs of distress and relational problems and, if they appear, try to validate the experiences emerging. It is worthwhile for the therapist to validate any attempts by clients to concentrate on distressing topics or behave in a way they find unnatural, including self-disclosure in which they say they are engaged in similar efforts.

Overt discussion of problems and linking therapeutic to everyday life patterns

A key factor in change in clients with inhibited aspects is the awareness of the schemas driving them. Change is impossible if clients do not acquire awareness of the – often unconscious – repetitiveness with which they get taken over by ways of thinking about relationships and acting on the basis of underlying expectations. Although an egalitarian attitude in the therapeutic relationship is fundamental, with therapists acknowledging their contribution within the relational matrix (Aron, 1996; Mitchell, 1988), therapy serves to make clients aware of what there is inside themselves and how the therapeutic relationship has become another situation where there is repetition (Freud, 1914; Luborsky & Crits-Christoph, 1998). If therapists manage to uncover the patterns undermining the relationship and notice signs of recovery from ruptures in the alliance, they can explicitly link the patterns in the therapeutic relationship to those driving clients in their daily lives. This intervention needs to be performed carefully and tentatively, while trying to be as precise as possible when comparing specific in-session moments with extra-treatment narrative episodes: 'I reckon that not telling me that changing the appointment would have caused you problems was like not saying "no" to your colleague who asked you if he could use the work you did for his own selfish ends. In both cases you put another's interests before your own, avoiding any discussions for fear of hurting the other but then feeling angry and depressed. What do you think?'. The client can thus, on the basis of an as clear as possible raw material, evaluate the correctness of the hypothesis and rectify the problem.

With interventions of this sort it is possible to both identify the actions arising from the pattern and, in a safe environment, bring to the surface feelings and thoughts differing from the schema. This leads to previously inaccessible or repressed emotions surfacing, with the therapist having the chance to point out changes in expression or emotional tone and show how an awareness of the repetition is accompanied by signs of change, such as the willingness to behave differently or self-pride in a story that was previously laden only with guilt.

Self-disclosure in order to metacommunicate about problems in the relationship; overtly acknowledging the therapist's contribution to dysfunctional patterns

Discussing a problematical therapeutic pattern often occurs while that same pattern is active in a session. An optimal strategy would therefore be to first solve the relational problem and then increase clients' awareness of their functioning.

Therapists can self-disclose by recognizing their contribution to the creation of the problem. Self-disclosure has a different objective here, i.e., solving a relational rupture, compared to that described earlier, i.e., fostering a sense of sharedness and of not being criticized. We acknowledge that this distinction is partly artificial as self-disclosure, at the time when a therapist uses it, can achieve both objectives, depending on the client's perception. We retain it, however, as it is likely to prove a useful heuristic for therapeutic strategy.

The self-disclosure we are referring to here involves the revelation of the therapist's thoughts and feelings towards the client, with the assuming now – after the therapist has tried changing strategy, validated and disembedded him/herself internally from the problems – of a position in line with the idea that counter-transference is caused almost entirely by the client, with minimal contributions by the therapist's personality (Clarkin *et al.*, 1999).

The end goal of our model is not to improve relationship quality in itself but to help the client, via the relationship, to acquire self-awareness, express affects and construct more adaptive forms of relationship in a life with less symptoms. If therapists reasonably believe that their reaction towards clients depends only marginally on their subjective factors and consider the relationship solid enough, they can then metacommunicate to help the client understand more about themselves.

Clinical vignette 2

After various attempts spanning eighteen months of therapy, one of us was still unable to let Katja, a young professional woman with Narcissistic PD and severely alexithymic, adequately express her need for attention (see Dimaggio, Fiore, Salvatore, & Carcione, 2007, for a thorough description of Katja's therapy and fluctuations in the therapy relationship). She was not asking her partner for attention but felt a suppressed anger towards him for the attention she was not receiving. Repeated attempts by the therapist to show her how she behaved similarly with him, protesting about the futility of the therapy but denying she was suffering and not asking for help, provoked disdainful reactions: 'Why should I behave with you like I do with my boyfriend? You're just someone I see for one hour each week'. Any attempt the therapist made at making Katja think about the therapy relationship just led to increasingly overt disdainful reactions. During the umpteenth session in which she complained angrily about her boyfriend the therapist self-disclosed his feelings towards the client: 'You see, Katja, I realise that since I know you I've never felt the impulse to care for you. I'm concerned about you but I don't feel emotions like affection or tenderness, exactly like you say your boyfriend doesn't. This doesn't usually happen to me in therapy; I reckon it must in some way depend on how you keep me at a distance'. For the first time Katja responded with a facial expression showing need and, warmly and with a smile, she said to the therapist: 'But I do want to be cared for! You have to be fond of me!'. This intervention improved the relationship quality dramatically and from that moment on Katja began to explore her feelings of fragility and to become aware of her distancing and self-reliant style. We would point out that this type of self-disclosure also aims, via a knowledge of the therapist's inner world, at fostering awareness by the client of his/her own inner world and the reactions it provokes in others. The technique is to a significant extent similar to the use in dynamic psychotherapy of interpretations aiming at pinpointing projective identification. Therapists use their own experience as a marker of similar or complementary aspects in the client's experience, which are unknown to the latter

(Clarkin *et al.*, 1999; Semerari, 2010). This is a cognitively and affectively complex intervention and involves the risk of the client feeling criticized, so that it should only be used when the quality of the therapeutic relationship is solid and clients have achieved a sophisticated knowledge of their mind (Bateman & Fonagy, 2004; Dimaggio, Semerari, *et al.*, 2007). In this particular case, the therapy was in its second year and the therapist had the feeling that the therapy relation was stable, so that the patient, in spite of her constantly over-negative attitude, did have a bond with him. Moreover, the therapist made a theoretical assessment of the client's transference schema, in which she construed the other as controlling her as he came closer, so that observing that the therapist was distant helped the client to feel he was at a distance that made her feel safe. Only from this protective distance could she access her underlying wish for closeness. Furthermore, the therapist recalled that any attempt at stressing positive aspects, such as a sense of commonality or sharing between the two, caused the client to protest.

In other cases, metacommunication helps therapists to disembed from problematical patterns, by disclosing their negative feelings and taking responsibility for them, in line with psychoanalytic relational models (Aron, 1996; Mitchell, 1988; Safran & Muran, 2000).

Clinical vignette 3

Morgan, a PhD student with narcissistic PD and prominent passive–aggressive traits had been undergoing therapy for two and a half years and for the previous 6 months had been flat, devitalized and depressed, probably as a result of breaking up with his girlfriend and problems at work. Just before the summer holidays he attacked his therapist, saying the therapy was pointless and accusing him of acting in bad faith, by giving him false hopes, focusing the therapy only on what interested him, the PD, and neglecting the biological dimension of his depression and difficulties in concentration. He also accused him of having cunningly driven him to leave his girlfriend, which he would not have done independently, and of being a sadist for saying that he thought it important that Morgan express his sadness for the breaking up. He was considering whether to stop the therapy. Initially, the therapist responded with defensive enactments to these disdainful attacks and stressed the progress made by Morgan during his therapy, reminding the latter that, when he started, he was incapable of reading sports articles and risked not obtaining his PhD, whereas after 18 months he had achieved his PhD successfully. This exacerbated Morgan's disdainful attacks, to which the therapist responded with bouts of anger: 'Morgan, excuse me, I'm not letting anyone tell me what's in my head. When I tell you what's in yours, I make some hypotheses. I'd ask you to do the same with me'. Once he realized that he had entered a competitive pattern, the therapist exercised self-discipline, understanding that he was contributing to a worsening of the tension, and noticed an inner feeling that could be useful to disclose in order to metacommunicate: a sense of powerlessness: 'I realise that, if you feel the therapy is pointless, then it's pointless and there's nothing I can do about it. My point of view is not worth more than yours. It would be wrong for me to ascribe responsibility for what's happening to your way of functioning. I feel that at this moment I don't have any tool to help you to really recover your trust in the treatment and this is frustrating for me, but, if you decide to interrupt it, I'll totally respect your decision. Naturally if you're in, I'm in too'. Morgan started the next session saying: 'I come in peace'. Months later, in a group psychotherapy session, he jokingly said: 'It's fun arguing with the doctor; he's good at it. He joins in but knows how to step back and not raise the tension beyond a safe level'.

Conclusions

Clinicians and researchers are striving to understand what works for whom, and to tailor psychotherapy techniques to specific pathologies and in a way more and more suited to each single case, albeit carefully formalized. Our goal is to build a rational model for how to promote the ongoing regulation of the therapy relationship in many of its aspects, from the therapeutic alliance to transference–counter-transference dynamics, in order to treat clients with inhibited or constricted personality traits. We have tried to create a consistent framework for why, when, how and with what sequence to use elements in the regulation of the therapy relationship, such as validation of clients' experience, creating a sense of sharedness, and both intuitively and more formally assessing underlying problematic patterns in the therapy relationship, in order to readily disembed from these and later metacommunicate about them, and prevent alliance ruptures or repair them should they occur. The overall goal is to submerge the use of the relationship in therapeutic techniques aimed at treating the personality pathology. We are trying, therefore, to put together a rational model (Greenberg, 2007) of how to improve clients' awareness of their affects and relationship schemas, and explore new and more adaptive forms of social behaviour and coping with symptoms while problems in the relationship surface and get tackled.

At present our work, albeit developed in the context of current research on the construction of sophisticated therapeutical intervention models suited to verifying the therapeutic process (Castonguay & Beutler, 2006; Norcross, 2002), is only the first step in the construction of a rational–empirical model. A major limitation of the model proposed here is that it has until now been theoretical and derived from only qualitative analysis of the authors' clinical material. Research needs to investigate treatment conducted with different methods and adopting: (a) measures of PD pathology aspects, such as constricted interpersonal schemas or poor understanding of mental states; (b) measures of therapeutic change, such as improvements in symptoms, access to new memories, construction of a broader vision of the reasons behind one's actions, and so on; (c) operationalization of the overt elements in the model described and correlations between these interventions and the expected change. It is likely that after an extended set of studies on different populations in-patients treated with different approaches, this model will be thoroughly revised in line with incoming evidence.

Although the work remaining to do is substantial, we would suggest that this research programme has some important elements to offer for both our knowledge of the therapeutic process and the treatment of PDs with prominent inhibited or constricted traits, which are widespread, under-investigated and difficult to treat.

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