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The intertwined path of perfectionism and self-criticism in a client with obsessive-compulsive personality disorder

Abstract: Psychotherapy for Obsessive-compulsive personality disorder (OCPD), where perfectionism is a defining criterion, is understudied. Despite a high prevalence few evidence-based treatments are available for the presentation. Here we describe the course of a 6-month program of Metacognitive Interpersonal Therapy with an OCPD patient with prominent perfectionism and self-criticism, wich were considered primary outcomes of the case-study. Therapy aimed initially at increasing awareness of maladaptive interpersonal schemas and promoting the healthy self. First, behavioral experiments were used in order to try and counteract perfectionism. Second, experiential techniques, such as guided imagery and rescripting, were used to help the client in connect with different, healthier aspects of the self, thus increasing personal and interpersonal wellbeing. Qualitative and quantitative outcomes at the intervention end and at 1-month follow-up are summarized. Finally, we reflect on how this case study can inform treatment of perfectionism in OCPD.

Keywords: imagery; metacognitive interpersonal therapy; perfectionism; obsessive-compulsive personality disorder; self-criticism.

1. INTRODUCTION

Obsessive-compulsive personality disorder (OCPD) is defined as a pervasive preoccupation with orderliness, perfectionism, and mental and interpersonal control. Lifetime prevalence rates range from 2.1 to 7.9% (American Psychiatric Association, 2013) and OCPD may be the most prevalent personality disorder (PD) in the general population (Volkert, Gablonski, & Rabung, 2018). OCPD causes significant distress and co-occurs with anxiety disorders, affective disorders and/or substance related disorders (Dietrich & Voderholzer, 2015). It is often comorbid with Cluster A PDs (Dietrich & Voderholzer, 2015) and may be misdiagnosed as Avoidant or Schizoid personality disorder (American Psychiatric Association, 2013).

The construct of a personality pattern characterized by feelings of incompleteness, impacting on wellbeing through perfectionism, guilt, and counterfactual thinking, resembling today's OCPD stems back to Pierre Janet (see Pitman, 1984). Psychodynamic models highlight how core characteristics such as orderliness and perfectionism provide an illusion of security in a threatening world (Rado, 1959; Saltzman, 1985). In contrast, cognitive models (Simon, 2015) describe how individuals develop schemas relating to control, responsibility, and systematization while neglecting schemas underpinning spontaneity and playfulness . However, evidence for the effectiveness of psychological interventions for OCPD is scarce. Across a number of trials, interventions using Cognitive Therapy, Cognitive-Behavioral Therapy, Interpersonal Therapy, and Schema Therapy have all reported significant reductions for outcomes relating to depression, anxiety, general functioning and/or interpersonal problems (Dietrich & Voderholzer, 2015). Interpersonal Therapy was identified as superior to Cognitive Therapy in reducing depressive symptoms (Barber & Muenz, 1996), whereas Schema Therapy was found to be more effective than treatment-as-usual and clarification-oriented therapy in both reducing depressive symptoms and

improving general functioning (Bamelis et al., 2014). Regardless of intervention length (ranging from 12 to 53 sessions), all trials to date show limited rates of remission for OCDP. Furthermore, few if any studies have specifically targeted perfectionism within the therapy.

Metacognitive Interpersonal Therapy (MIT) is an integrative third-wave oriented psychotherapy specifically developed for PDs (Dimaggio et al., 2007; Dimaggio, Montano, Popolo & Salvatore, 2015; Dimaggio, Ottavi, Popolo & Salvatore, 2020), displaying preliminary evidence for success in remission of OCPD. Three different case series' report outcomes for OCPD patients with different comorbidities: a single case reported the remission of OCPD and other comorbid PDs after a 3-year intervention (Dimaggio et al., 2010); an OCPD patient included in a 2-year intervention cases series demostrated remission (Dimaggio et al., 2017); and in a 12-month cases series for inhibited personality 2 OCPD patients were assessed as remitted (Gordon-King, Schweitzer & Dimaggio, 2018).

MIT aims to improve interpersonal functioning and symptom severity in PDs. Core elements of change in MIT are firstly, improving the capacity to better understand mental states. Clinicians try to help patients to name their emotions, describe their cognitive contents and realize how they interpret events according to a pre-defined set of ideas. The capacity to understand mental states, both in the self and in the others has been named *metacognition* (Semerari et al., 2003). This construct includes the capacity to use the understanding of psychological processes as a basis for purposeful problem solving, for example realizing that if one enters an argument when angry the outcome will be negative, and it is therefore better to postpone the debate to a point when one is calmer. Secondly, realizing that the typical set of expectations about how others will react to one's wishes and requests; and further realizing that this does not necessarily mirror reality. For example, a patient may be guided to realize that she is driven by the need to be praised, a core idea of the self as flawed, and expectations that others will criticize. Therapy may help the client take distance from these ideas and access more benevolent ideas about self

and others. Finally, MIT enables individuals to acquire agency over his or her choices. Clients with OCPD often begin therapy believing that they have no other option but to stick to rigid moral and societal norms. With therapy they discover they have choices and they have power over their actions, instead of thinking that they are forced to adhere to norms. Though belonging to third-wave cognitive-behavioral approaches, MIT integrates elements of psychodynamic, mentalization, and narrative based approaches (Dimaggio et al., 2015). It has been recently revised to improve the specification of intervention procedures and to incorporate the promotion of healthy parts of the self through experiential and mind-body techniques (Dimaggio et al., 2020).

In OCPD treatment, for example, a therapist may ask the client to recall a life episode where they experienced the burden of perfectionism in a relationship with a significant other (e.g. a partner). In doing so, therapists ask clients to close their eyes and imagine being there again, exploring how they are feeling in regard to ideas, affects, and somatic states. Once the person is re-experiencing the episode, as if it is happening in the here-and-now, the therapist tries to support the client in exploring new ways of looking at the experience and the relationships, trying to explore a different meaning. A therapist, for example, may suggest adopting a different bodily posture in session (e.g. "please focus on how your feet lay on the ground"; "try to assume a relaxed posture, straightening your back and opening your shoulders"), with the goal of exploring how cognitions and affects change according to alterations of posture or vocal tone. Interventions of this kind often help the client in blocking or postponing the perfectionist stance and its accompanying psychological and physical correlates, enabling a new stance to emerge. A client may report, for example, how she feels more relaxed, less anxious and more psychologically open so to consider different relational and communication alternatives. She may avoid self-critical doubt about not being capable enough and instead imagine quietly asking her partner for help. For OCDP patients, narratives revolve around rigid perfectionism (Hewitt, Flett & Mikail, 2017), self-criticism (Gilbert, 2009) and overcontrol (Lynch, 2018). These recurring patterns are maintained through a vicious cycle

where distress both inhibits the ability to see things from a different perspective and look for alternatives, and hyperactivates the perception the individual has of being a threat to themselves and to others (Petrocchi & Cheli, 2019): "I am the one who causes my own suffering, because I am not capable enough, therefore I must try harder to do the right thing and avoid causing harm". The relationship between self-criticism and perfectionism ca conceptualized differently according to specific theoretical models. On the one hand, Paul L. Hewitt and colleagues (Hewitt et al., 2017) have focused on developmental pathwasys towards these two constructs from a broader personality perspective. Here, perfectionism is conceptualized as a personality based vulnerability factor, and self-criticism emerges as a potential response to perfectionistic social disconnection, together with intensification of shame, humiliation, censure of oneself of others. On the other hand, other authors have highlighted the mediating (Gilbert, 2008) or predictive (Shahar 2015) role of self-criticism upon perfectionism. For instance, Shahar highlights the overlap between the two constructs, even when considering self-criticism as a predictor of perfectionism (Shahar, 2015, pp. 33-35). Contrastingly, Gilbert positions self-criticism as mediating between perfectionism and psychopathology, suggesting that "only socially prescribed perfectionism is related to self-criticism, self-blame and depression" (Gilbert, Durrant & McEwan, 2006, p. 1307).To illustrate how MIT addresses perfectionism as a core component of OCPD, we describe the course of a 6-month psychotherapy (24 weekly sessions). Primary outcomes were the reduction of OCPD criteria and general symptomatology. Secondary outcomes were the reduction of perfectionism (as the hypothesized mechanism of change). We were particularly concerned with the self-evaluated impact of perfectionism on patients' suffering and coping strategies.

2. CASE ILLUSTRATION

2.1 Presenting Problem

Lea is a 23-year-old woman, who lives alone. When she commenced therapy, she was a 1-st year PhD student on a highly competitive training program. She reported anxiety and worry triggered by program responsabilities. Lea also reported depressive symptoms such as hopelessness, low self-esteem, and an inability to make decisions. She disclosed sexual abuse that has occurred when she was a teenager, which included her first sexual experience. Lea described how her entire life was characterized by an overwhelming sense of duty and inadequacy, and a recurring sense of "not being enough" when with colleagues, partners, friends, and relatives. At work, she thought she had no right to express her own ideas, thus she progressively reduced contacts with students and professors. When confronting others, she took for granted that being useful, supportive, and self-sacrificial were the only ways to maintain such relationships. The more she pursued this aim, the less she felt able to satisfy others' needs. A constant self-critical theme was that others' desires were shaping her life, forcing her towards an unachievable bar that she considered the only way to be forgiven for her self-perception of failure. She had disengaged from a previous psychoanalytic treatment because she did not feel able to do what the analyst requested.

2.2 Research Assessment and Methodology

Prior to the initiation of therapy, the patient was assessed with self-report questionnaires and structured interviews, administered by a research assistant blind to the identity of the referring therapist. The same assessment was repeated at the end of the 6-month intervention and after 1-month follow-up. Diagnosis was made using the Structured Clinical Interview for DSM-5 Personality Disorders (SCID-5-PD; First, Williams, Benjamin & Spitzer, 2016). General symptomatology was assessed with the Global Severity Index (GSI) scale of the Symptom Checklist-90-Revised (Derogatis & Unger, 2010).

To assess recurring perfectionism and self-criticism we used the Multidimensional Perfectionism Scale (MPS; Hewitt & Flett, 1990) and the Functions of Self-Criticizing/attacking Scale (FSCS; Gilbert, Clark, Hempel, Miles & Irons, 2004). The MPS is a 45-item measure with a 1-to-7 Likert scale, designed to measure three dimensions of perfectionistic behavior: self-oriented perfectionism (MPS-SO), other-oriented perfectionism (MPS-OO), and socially prescribed perfectionism (MPS-SP). The FSCS is a 22 -item measure using a 5-point Likert scale, which measures self-reassurance (reassured -self; FSCRS-RS) and two types of self-criticism: inadequate-self (FSCRS-IS) and hated-self (FSCRS-HS). We also assessed worry (The Penn State Worry Questionnaire, PSWQ; Meyer, Miller, Metzger & Borkovec, 1990), rumination (Ruminative Response Scale, RRS; Treynor, Gonzalez & Nolen-Hoeksema, 2003), and experiential avoidance (Acceptance and Action Questionnaire II, AAQ-II; Bond et al., 2011). The PSWQ (16 items), RRS (22 items), and AAQ-II (7 items) generate general scores measuring the target construct, that is worry, rumination and avoidance respectively. To assess if change was both present and clinically significant, we calculated a reliable change index (RCI; Jacobson & Truax, 1991).

The case-study was approved by the Ethical Committee (Ref. No. 03-2019/080319) of the Center for Psychology and Health, Tages Charity and the patient gave written informed consent. During the 6-month intervention and the 1-month follow-up she received no concurrent psychological or pharmacological treatment. The intervention was delivered by a trained MIT therapist with 5 years of experience in the therapeutic model.

2.3 Case Formulation

Lea's personality featured a sense of duty and perfectionism which were constantly directed against herself and her choices. She thought performance standards were imposed both by herself and by her social network. Specifically, she took it for granted that she was undeserving of any support from

others. Lea considered that asking colleagues for help would be unacceptable, as she considered herself to be totally unprepared, and thus unworthy of receiving any advice. Lea worked constantly to try to satisfy the needs of others, assuming that as an unworthy person she could only support more deserving individuals. Moreover, she imposed strict rules of behavior and unattainable standards upon herself. For example, she explained that she always had to read all the references of an article in order to believe that she understood what the authors presented. In doing so, she expended substantial mental resources in these ruminations, constantly questioning what she would do and what she had done, leaving little time for her own academic studies.

Her personal performance standards were reinforced in the social sphere through a challenging academic environment, which negatively affected her somatic and relational experiences. She reported recurrent somatic symptoms including headache, gastrointestinal problems, and uncontrolled crying. Lea discussed that, with great effort, she hid these symptoms from her external world through overcontrol of her verbal and non-verbal behaviors. She stated that she was frequently described as cold and sometimes awkward, with a silent 'frozen' interpersonal style. Lea desired to be cared and accepted by significant others (e.g., relatives and partner), but her feeling of academic inadequacy was interwoven with her strong belief that she was not lovable enough. She believed that academic achievements were the most effective avenue to being appraised as worthwhile and also to have a romantic relationship.

Her core wish - that others considered her worthy and valid - was constantly frustrated by her underlying belief that she was inadequate and ordinary. Lea thought that if she did not achieve her socially prescribed, personally imposed high standards, others would punish her by marginalizing her (both emotionally and relationally). These fixed ideas and expectations formed components of what we define as her maladaptive interpersonal schema. As part of this problem, she concurrently held healthy

representations of herself as worthy and valid, but she struggled to consciously attend to these, and when she did, she discarded them as unlikely to be accurate self-representations.

When she thought others could criticize her (or perceived they had criticized her), Lea was also vulnerable to cognitive representations of the self as unworthy and unlovable. Consequently, she either experienced either anxiety if she anticipated criticism, or sadness and shame if she thought criticism had already occurred. To cope with her negative self-image and the associated distress, she resorted to perfectionism and self-criticism. Perfectionism offered her a way to improve the outcomes of her choices: "If I study all the books connected with this topic, then I will be worthy of being listened to by colleagues". Self-criticism was a strategy, in her own words: "To never rest on my own laurels"; "If take a rest and go to a party, then it means I am not a perfect scholar". She was unable to define her own goals and needs, as her goals, after exploration, were revealed to either be reflections of acquaintances whom Lea respected e.g. "I have to reach for the same status of my mentor and of the Ph.D. student who graduated last year"; or alternatively reflected abstract rules and norms: "Of course a researcher can't have a hobby". These patterns were constantly reinforced by the academic environment and by her family. On the one hand, she reported how other Ph.D. students were extremely competitive and judgmental about any small typographical errors in a slide or a speech. On the other hand, her father was a cold, distant and critical professor who considered achieving high academic standards as the only 'real' thing that mattered. Lea recalled her father telling her there was not an alternative to receiving "at least one annual prize" as the best Ph.D. student.

3. COURSE OF TREATMENT

3.1 Sessions 1-10

Early in therapy Lea tested whether her therapist was both trustworthy and non-judgmental as she hoped, or as critical and scornful as she would expect (Gazzillo et al., 2020). Her first test was the question she frequently asked the therapist: “Is there an easy way to learn a technique to solve this problem?”. When exploring these types of questions, Lea seemed to imply, as usual, that she had to solve any problem by herself. In parallel, as she made clear later on, she expected the therapist was perfect, and thus could rapidly, skillfully and successfully treat her. The second test emerged after 5 sessions, where she explicitly asked the therapist: “Am I allowed to say how bad and shameful I feel?”. She considered this kind of statement proof of her unworthiness, and just the idea of forcing someone to listen was inappropriate. In doing so, Lea was also testing whether the therapist would end up judging her as she feared or could compassionately accept her as she hoped.

In the first session Lea brought a written summary of her goals and expected timeline for therapy with her to the session, which were all aimed at improving her academic performance. She particularly highlighted her need to be able to offer better questions and comments during seminars, and to improve her writing of academic papers. The therapist did not reject these requests, but instead asked for autobiographical memories related to these topics. He asked Lea to recall similar episodes where she felt inadequate, both in her recent years and in her childhood. The therapist was especially interested in understanding what “not being enough” and “being inadequate” meant for her, both in terms of how these beliefs emerged and how they affected her academic and relational experiences. These steps were the first towards an MIT shared formulation of functioning aimed at identifying the elements of the subjective experience and reconstructing psychological cause-effect links between events, thoughts, and feelings (Dimaggio et al., 2015; 2020). Lea was always able to recall feelings of shame or guilt but could

not remember episodes when she was successful or felt content in close relationships. Looking back at her choices she always blamed herself for 'bad' choices. This constant self-critical pattern was one in which she rapidly moved from initially describing a problematic situation she was involved in, to a repetitive and distressing reaffirmation of her weakness and inadequacy. If something negative happened, such as an argument with her boyfriend or tutor, she quickly started talking about how bad a partner or a Ph.D. student she was. Concurrently, she seemed almost unable to acknowledge her qualities. Whenever the therapist tried to focus on her achievements, she demonstrated attributional biases, either belittling them as mere momentary goals, or insisting that her success was entirely due to good luck.

During session 3, healthy self-aspects began to emerge as she noted she was the youngest Ph.D. candidate on an internationally renowned program. The therapist noted nonverbal markers of pride, but when he explicitly noted this to Lea, she shifted focus to a different topic. To foster contact with the healthy self, the therapist asked her to return to the moment of the narrative when she was describing her success. He also asked her to adopt a grounding posture, a technique aimed at stepping away from negative thoughts by focusing on 'here and now' perceptions of the connection of her body to the ground. The goal was to help her sustain positive self-ideas long enough to move them into long-term memory.

As she started to trust her therapist and understood he would not criticize her for perceived weaknesses, Lea began to dwell more on distressing details in her autobiographical experiences. She reported that during a university meeting she felt frozen and unable to speak, and also that she silently panicked when together with her boyfriend. These experiences were typical of Lea's reaction across several situations to triggers that activated her perceived sense of inadequacy e.g. providing a scientific opinion to a professor or discussing a movie with her boyfriend. Moreover, the recurrent vicious cycle of perfectionism and self-criticism was becoming clearer. The more Lea yearned to do things to the best of her ability, the more she felt inadequate, and had to raise the bar: "If I do something good, then I have to

do the next thing better. And if I didn't deliver, then I have to fill the gap, again by raising the bar". This revealed a relentless sense of 'never-ending' inadequacy.

Lea reported how, as a 1st PhD year student, she was supposed to meet with her supervisor to discuss her research project. She described going to her supervisor's office filled with paralyzing doubt, accompanied by a sense of her body as physically blocked, thus generating a "devastating storm" of anxiety, self-blame and uncertainty. While recalling this, she took a long, intense pause, then she stared at her therapist's face and began talking again. She was almost in tears and her breathing became agitated. Lea then started crying and recalled an autobiographical memory about her father. The walk toward her tutor's office reminded her of the walk to her father's office at her family home. She remembered how critical and judgmental her father was and how she was scared. In the moment she avoided eye contact with her therapist. The therapist considered this a sign that she was testing him as to whether he was harshly judging her weaknesses (consistent with her father's attitude), or instead was accepting her in a benevolent way, allowing her to show vulnerability, consistent with her desired for response from the other (Gazzillo et al., 2020). Accordingly, the therapist decided to validate Lea's emotions, saying he was sorry to hear her distress and that they could talk about these memories whenever she felt comfortable to do so. This was Lea's first explicit display of distress to her therapist. In order to understand if he had passed the test, the therapist asked how she felt telling him the memory, and how she perceived him. Lea said that it was painful, but she got the impression that she could finally express her suffering, noting that he seemed caring and genuinely curious about her inner experience.

3.2 Sessions 11-20

In subsequent sessions therapy was targeted towards honing a shared understanding of Lea's functioning and simultaneously moving towards promoting change. In the early stages of these sessions

it became apparent thar Lea's limited ability to consider the influence of external factors upon her performance was a substantial maintaining factor for her distress. Over these session, she began to appraise her therapist as trustworthy, disclosing more distressing memories that had putatively formed the template for her maladaptive interpersonal schema. As she began to endorse the emergent schema though that her therapist was benevolent, she become more willing to disclose details of past memories. As she no lorger anticipated the therapist to criticize her for perceived weakness, she became more open to re-experiencing distressing details during sessions. The therapist proposed an imagery technique without rescripting, but preceded by a mindful breathing and grounding exercise. The main aim was to collect early episodes of her life, exploring how her maladaptive habits evolved. More specifically, the exercise sought to help her recognize on the one hand how these habits were connected to her relationship with her father, and on the other hand how these episodes reflected her implicit uncritically assumption of her father's viewpoint. She did not consider different wishes or emotions; or indeed whether her father was able (or not) to consider alternative viewpoints to his own.

The mindfulness-evoked safeness exercise was explicitly presented as a basis from which to explore the past episode. During the imagery technique, the patient focused on an episode from the previous summer when she was at her father's home. She had arrived at the family house, and describe how, as she happily walked towards her father's library, she was stopped by him at the entrance, asked not to disturb his work and to wait for lunchtime to say hello. She focused on her father's sentence: "You really didn't learn anything at university. Focus is everything". She recalled a pain in her stomach and a sense of shame at not being able to cry. Lea felt inadequate and guilty, stating "I'm not worth anything".

Once again Lea's self-blaming representations emerged as deeply rooted in her childhood experiences. Through these imagery exercises, aspects of Lea's functioning become clearer. The therapist and Lea shared a reformulation of her functioning. Lea realized that she was motivated by two core

wishes: to be loved by her father, corresponding to the activation of attachment, indicating her deep need to be cared for and to be emotionally supported in her choices, regardless of the possibility of making mistakes. In contrast, her father's reaction was rejecting and contemptuous. In the face of this response, Lea felt sad, ashamed, and gave up asking for emotional support and care (reminiscent of a dismissing attachment representation). She adopted perfectionism as a coping strategy: "At least if I am perfect my father will appreciate me even if he doesn't take care for me". With regard to her second core wish for support and encouragement in her pursuit of autonomy (again consistent with the exploratory phase of attachment), her father's harsh reaction gave Lea the idea she could not achieve autonomy. She froze, abandoned exploration, and again resorted to her secondary wish for approval, further reinforcing her perfectionism.

The therapist worked to help Lea recognize that her habits were the result of her personal story, a story in which Lea had learned to give up her own needs whenever she felt criticized. She had progressively developed a dysfunctional coping strategy of perfectionistic striving ("if I could be good enough, then I would be valuable) coupled with chronic self-criticism (if I am never self-indulgent, I could be lovable). Overcontrol, as a form or self-discipline to regulate personal and interpersonal experience, thus emerged as Lea's only viable way to cope with a threatening, unpredictable world.

Gradually, Lea reported several, detailed autobiographical memories, deepening the formulation whilst the therapeutic alliance was strengthened. She eventually disclosed a traumatic memory in response to an explicit request to create an association between one of the more recent episodes and an earlier memory. When she was fourteen, she was sexually abused by a friend during a party. She recalled feeling paralyzed, either by the event and/or by drinking alcohol. The most distressing part of the episode, which became the target for an imagery rescripting technique, was the following: after the party, she returned home and went to her father's office to seek help. She was still unable to understand what had

happened at the party and wanted him to help her. Her father stopped her and made her wait. Meanwhile, she started ruminating on the abuse, questioning if and how she contributed to what happened. Once her father admitted her to his office, she started talking insecurely about having had an unwanted first sexual experience. She recalled her father angrily blaming her, shouting: “Shame on you! You must have provoked him; the guilt is yours”.

This event represented a turning point in Lea’s developmental narrative. She perceived that thereafter her relationship with her father progressively deteriorated. Lea related that her abuser started talking about having had consensual sex with her. As Lea lived in a small conservative village, this news led to her being labelled by peers and local society as a ‘shameful teenager’. The therapist and Lea agreed that this event had frequently been a trigger for her in feeling ashamed and guilty. They decided to work on an imagery rescripting technique - whereby the client is asked to recall and explore a past episode in detail, and then to rescript either the whole or a part of the episode. In MIT, the goal is to help the patient connect with core, adaptive wishes and pursue them, instead of using maladaptive coping. In this episode, the therapist aimed to help Lea connect with her adaptive attachment wish, instead of accepting her father’s rejection and criticism as deserved.

The therapist asked Lea to re-experience the moments after talking with her father, when she was finally alone in her own room. In order to effectively rescript in MIT, the patient returns to the traumatic/distressing event with the therapists support, using her newly developed coping strategies. The technique requires the therapeutic relationship and the therapist to be perceived as sufficiently safe and for the patient to have a basic ability to recognize his or her maladaptive schemata. At this point in therapy, Lea was starting to recognize her perfectionist and self-critical patterns, balanced against her desire to pursue her own needs. Moreover, she was able to recall episodes where she felt self-compassionate and non-judgmental in respect to her choices and emotions. In those episodes a healthy

self-aspect emerged, where she experienced bodily sensations - e.g. muscle relaxation, positive emotions (e.g. kindness) alongside empowerment. The rescripting corresponded to a dialogue between this healthy-self Lea and the 14-year-old girl who had just been raped. The imagined dialogue was highly effective. The teenage self was able to express her painful sense of loneliness and her urgent need for help. The healthy-self quietly said she was there waiting for the teenager to be ready to talk. The healthy-self imagined touching the teenager on the shoulder, assuming she would not be able to accept a hug. Indeed, the teenager-Lea thanked healthy-Lea for being close and compassionate without forcing her.

3.3 Session 21-24

The final phase of therapy was aimed at promoting, testing, and validating new ways for Lea to fulfill her wishes, capitalizing on her increased awareness of her functioning. Once Lea had recognized her dysfunctional coping styles, she was able to start thinking of new way to pursue wellbeing. The therapist and Lea agreed on behavioral experiments aimed at fulfilling her core wishes. She observed that she never aspired to goals that were not aimed at gaining respect and acceptance from others. Lea acknowledged that the very act of focusing on these wishes and considering them as human and valid, was terrifying to her. Therapy allowed her to progressively construct how to do so, by confronting her automatic and dysfunctional coping style in significant relationships. Having understood how early experiences had conditioned Lea's representations of herself as inadequate and unlovable, she discovered how her coping style had contributed to the maintenance of these painful schema. She realized that the strategy of devaluing her own needs and concealing them had reinforced her belief that she did not deserve care and support. Moreover, her recurrent focus on high standards of performance had frequently alienated others. Therapy thus allowed her to express her healthy needs. She was able to present her research project to her mentor and colleagues, focusing on the presentation as an opportunity for feedback

and to outline future steps for her project. Equally, she allowed herself to express her vulnerabilities and her concerns about their relationship to her partner. She realized these discussions need not lead to her partner abandoning her. Moreover, she started explaining to her boyfriend that some of his habits hurt her. For example, her boyfriend was frequently judgmental, taking for granted that he was the one in charge of choosing where they went socially. Lea learned how to highlight that they both had preferences and should consider this when making choices.

The end of therapy was co-constructed by client and therapist. They reviewed the timeline of therapy. In doing so, Lea recognized a relevant lesson that had progressively come to her awareness. She realized her creativity was a powerful resource to her but was frequently inhibited by her perfectionism. The young woman who came to psychotherapy with a sense of overwhelming anxiety due to self-blaming doubts about her choices and painful concerns about abstract high standards, had learned to creatively express herself. The research project she presented was judged by her group as highly innovative, and her suggestions for social activities with partner and friends were often successful. At a 1-month follow-up session, where she reviewed her changes, Lea reported she had convinced her partner that their next holiday would be to travel the Trans-Siberian Railroad.

INSERT TABLE 1

4. OUTCOMES AND PROGNOSIS

At the end of the therapy there was a complete remission of OCDP, as indicated by criteria on SCID-5-PD at both the end of the 6-month intervention (from 6 OCPD criteria to 3), and at 1-month

follow-up (2 OCPD criteria) There was also an extensive reduction on the dimensional score (from 13/16 at initial assessment to 6/4 and 4/16 for final and follow-up assessment respectively). The SCL-90-R general symptomatology index (GSI) also indicated remission remitted (Table 1; Wise, 2004). Two major components of perfectionism showed significant reduction at the end of the intervention. Lea reported a reliable change in both self-directed perfectionism and as perceived by the social environment. Oher-oriented perfectionism did not reach the level of significant change, consistently with the lack of this subtype of perfectionism in Lea's shared formulation. Finally, self-criticism, worry, rumination, and experiential avoidance also significantly decreased by treatment end.

The therapist's qualitative observations indicated progressive improvement in Lea's metacognitive capacity. In her first sessions she had struggled to create meaningful links between emotions, thoughts, and feelings in her daily life. By the end of therapy she could integrate different points of view as she reflected on daily events. Lea recognized how her sense of inadequacy emerged from past experiences and that her interpersonal stance when criticized was not somehow preordained, but instead reflected automatic thoughts and choices she often made. Lea became able to identify and accept the possibility of making errors and even experience negative emotions, and even reassured herself that at these times she could use these errors as opportunities to learn from experience. By the end of therapy, she was also able to use a psychological understanding of her functioning, according to her context and circumstances, to better define the standards and goals she intended (and was able) to achieve, and plan to act accordingly. In terms of Lea's subjective experience of psychotherapy, at follow-up she reported that she had experienced the therapeutic relationship as a safe place to explore and test out new ways of behaving. Lea also said she had now developed a more self-compassionate stance. She remained ambitious and self-enhancing, but Lea no longer experienced distress. Indeed, she considered these changes as a feature of her maturing personality. Reflecting on her romantic relationship, Lea reported she now understood that some of her partner's behaviors (e.g. he always decided which

restaurant to go to, without asking for Lea's opinion, partially reinforced by her non-committal silence) contributed to her sense of inadequacy. She had learned how to disengage from the thoughts of unworthiness he evoked and instead to express her core wishes, making him understand they were reasonable. Accordingly, she was happy about how her partner responded, becoming less critical and more respectful of her ideas and preferences.

Finally, a further component of the therapeutic process to take into account is the therapist's personal and countertransferential experience. From a MIT point of view, what the therapist feels, perceives and, generally speaking, experiences constitutes a core component of the intervention. On the one hand, the therapist was able to understand the defensive and somehow avoidant reaction that Lea's significant others may have had in response to her permanent need to strive for perfectionism. Once the therapeutic process promoted an interpersonal safety (McCullough, 2000) between Lea and the therapist, the latter disclosed this countertransference, and in doing so increased the patient's awareness of the other's mind. On the other hand, listening to his own personal feelings, the therapist was able to perceive and share the emotional, and empathetic resonance that Lea's traumatic past activated. This empathy was a crucial signal towards proposing, conducting, and modulating the experiential techniques with the patient's safety always in mind.

5. CLINICAL PRACTICE AND SUMMARY

Perfectionism is a predominant feature of OPCD. After 6-months of MIT, (incorporating MIT's recent revision to include experiential techniques such as guided-imagery and rescripting, bodily-techniques, and behavioral experiments; (Dimaggio et al., 2020), the client was no longer diagnosed with OCPD and presented with significantly reduced symptomatic distress. At therapy end she no longer held

perfectionistic expectations, aside from retaining high personal standards that could themselves be considered as an adaptive aspect of this personality type. Experiential techniques (grounding; imagery with rescripting and behavioral experiments) were well accepted by the patient; and after establishing a robust therapeutic relationship, these could be safely delivered, emerging as prominent in promoting change. The two dimensions of perfectionism that negatively affected the client's functioning (self-oriented and socially prescribed) were significantly reduced at intervention end. This is a possible signal that if perfectionism is formulated as a form of maladaptive coping previously used to regulate a client's innermost wishes, scaffolding therapy to enable the client to no longer resort to perfectionism may neutralize the pathological effect of the trait, to the point where it is no longer necessary. Consequently, we hypothesize that MIT represents an effective approach to targeting perfectionism in the treatment of OCPD clients.

There are a number of limitations to the case. We acknowledge the patient was a highly-educated young woman. Her access to, and engagement with, therapy and her daily life may not generalize to others with presentations with different socio-economic, professional, educational or gender characteristics. The client also did not present with personality disorder comorbidities, as OCPD patients often do. Patients with co-occurring personality disorders and perfectionism may not show the same positive treatment response.

Against the background that OCPD may be hard to treat, our paper brings hope for improving targeting and delivery of effective treatments. We propose the following elements are important: a) addressing perfectionism as a maladaptive form of coping as the primary mechanism in treatment; b) inviting the client to access aspects of the self not related to achieving perfection, whilst concurrently understanding that ideas such as holding the self as unworthy and unlovable, or others as spiteful and rejecting, are rooted in one's personal history, rather than current realities; and c) using experiential

techniques. Further research should explore both the effectiveness of MIT in larger samples of OCPD patients and the impact of the specific techniques outlined above ad a mechanism of change.

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