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The Approach of Metacognitive Interpersonal Therapy to Supervision of Therapists Treating Borderline Personality Disorder: The Key Role of Partial Counter Transferential Patterns

Gianpaolo Salvatore[1,2*], Omar Gelo[3,4], Luisa Buonocore[2], Maria Conza[2], Tania Di Somma[2], Nadia Di Sturco[2], Gerardina Fimiani[2], Nicoletta Manfredi[2], Raffaella Marciano[2], Antonella Pallotta[2], Maria Grazia Proto[2], Anna Sateriale[2]

[1]Department of Humanities, Education Sciences of University of Foggia, Foggia, Italy
[2]Department of Psychiatry, Psychotherapy Research Training, Torretta, Italy
[3]Department of Human and Social Sciences, University of Salento, Lecce, Italy
[4]Department of Psychiatry, Sigmund Freud University Vienna, Freudplatz, Austria

Review Article

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***For Correspondence:**
Dr. Gianpaolo Salvatore, Department of Humanities, Education Sciences of University of Foggia, Foggia, Italy
E-mail: gianpaolo.salvatore@unifg.it

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ABSTRACT

We are physiologically multiple, swinging among different self-states according to different circumstances; but we generally possess a superordinate point of view capable of monitoring our different self-aspects and integrating them into a coherent and complex sense of identity. Patients suffering from Borderline Personality Disorder (BPD) display a pathological self-multiplicity. They show multiple self-states which are dissociated or compartmentalized-each with idiosyncratic patterns of ideas, affects, regulatory strategies and representations of self and others - and have a limited capacity to form a coherent sense of identity; that is significantly correlated with high levels of emotional suffering, internal chaos and psychiatric symptoms. In the psychotherapeutic relationship, the patient's compartmentalized self-states have a strong tendency to elicit the therapist's non-integrated, difficult to regulate, self-states, giving rise to what we refer to as Partial Countertransferential Patterns (PCPs). PCPs hinder the therapeutic effort to promote an integration of the patient's identity and the therapeutic progress. In order to review a good clinical outcome with patients suffering from BPD, Metacognitive Interpersonal Therapy (MIT) emphasizes the role of a systematic supervisory process aimed to help therapists to face ones self-

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discontinuity experienced with BPD patients. The main elements of MIT approach to supervision are: 1) Supervisory relationship; 2) Promoting therapists' metacognitive abilities; 3) Case conceptualization and 4) Experiential techniques to unlock therapists' initiative. In this paper, we first describe how MIT conceptualizes and treats BPD, then describe PCPs and finally focus on how MIT supervision deals with the problem. Some implications for future research are discussed.

Keywords: Metacognitive interpersonal therapy; Supervision; supervisory relationship; Borderline personality disorder; Countertransferential

INTRODUCTION

Humans have multiple self-state (or self-"parts") by reason of the changing conditions of the relation between the person and his/her environment; and yet they remain capable of integrating these states into an overarching cohesive sense of self [1-5]. This happens because these multiple self-states are separated by non-rigid boundaries which, at least under ideal circumstances, make the individual capable of flowingly passing from one self-state to another, according to specific circumstances, relationships, and domains of life [5-7].

In this perspective, according to several authors from different theoretical positions, a certain level of "self-multiplicity" (term which we will use interchangeably with "self-discontinuity" and "self-fragmentation") can be considered the natural state of the human mind, varying along a continuum [8-12]. Individuals placed on more healthy "functional" levels of this continuum possess a superordinate point of view resulting from their ability to flexibly shift from one self-state to another; a metacognitive integration capability, making them able to monitor the different self-aspects arising in different contexts and to integrate an array of representations of self and other into larger and more complex and coherent representations [13,14]. Thus, for example, we may experience a sense of consistent identity even if we first feel irritable and pugnacious at work and later we become tender and gentle with our children at home [15].

On the contrary, some individuals can be placed on the opposite side of the continuum, showing a pathological level of self-fragmentation. This has been suggested to be a core feature of borderline pathology and is significantly correlated with high levels of psychiatric symptoms as well as higher anxiety, anger, and depression scores [15-20]. Patients with a diagnosis of Borderline Personality Disorder (BPD) do not seem able to integrate multiple and contradictory self-aspects and tendencies into a coherent, overarching and sufficiently diachronic sense of identity. The sense of self is impaired, disconnected or fragmented [21-25]. Patients show a multiplicity of self-states which are dissociated or compartmentalized, each with idiosyncratic patterns of ideas, affects, regulatory strategies and representations of self and others [21]. Each self-state is also characterized by peculiar representations of self and others. They swing between these different, inconsistent self-others representations with limited capacity to form unified and coherent representations of both [26-28]. For example, a man with BPD may rapidly swing between states of emotional detachment, anxiety and urgent requests for help, paranoia, and anger with aggressiveness towards

others or self-harm depression with shame and physical weakness. On the subjective level, from time to time they are totally identified with the present state of mind emerging from each contingent compartimentalized self-state which they consider an inevitable aspect of self [21]. This determines, also in absence of significant interpersonal stimuli, a sense of inner chaos, a chronic dysphoric feeling of inner emptiness, a dissatisfaction about the sense of self [21,22,25,29,30].

Different forms of repeated relational trauma experienced in the developmental history can place the borderline patient on the pathological levels of the self-fragmentation continuum. Such traumatic experiences are characterized by the frustration associated with fundamental need for the ontogenesis of an integrated identity: humans' need for significant others to be able to attune to their inner (somatic and affective) experience Ibrahim, [31-33]. Such relational trauma can take the form of a chronic lack of emotional mirroring, co-regulation of autonomic nervous system, empathetic attunement and can be exacerbated by abuse and neglect [34-39].

LITERATURE REVIEW

BPD patients' pathological self-fragmentation has a significant impact on the psychotherapy process. The therapist is called to continuously interact with the patient's compartimentalized self-states, i.e. "parts" of identity [21]. For example, in therapy a BPD patient may end a session grateful for feeling understood; then a few hours later the same patients would text the therapist saying that he/she only cares about money; and a little later still the patient would desperately and insistently beg for his/her forgiveness and attention. The patients' different self-states are peculiarly activated by the therapeutic relationship itself, with some parts idealizing the relationship which is thus invested of an absolute salvific power and therefore sought after while others tend to avoid and to discredit/dispraise/underestimate it [40,41].

What is the impact of this scenario on the therapist's internal states? Non-integrated patient's self-states have a very strong tendency to trigger non-integrated self-states in the therapist, producing what we call partial countertransferential patterns. We use the words partial and patterns in order to emphasize that the therapeutic relationship with BPD patients does not seem to presuppose a dialogue between the two "monolitich" selves of patient and therapist. Consequently, the countertransferential process is not unique or linear. Rather, we can observe a discontinuous multiplicity of countertransferential patterns taking form between the pathologically compartimentalized patient's and the multiple (variably compartimentalized) therapist's self. Therefore, in different moments of a session and a therapy, the patients' different/various self-states or "parts" contribute (along with therapists' idiosyncratic emotional and traumatic nuclei) to generate a specific countertransferential pattern which is part of the overall countertransferential process.

For example an aggressive patient's part could trigger a therapist's sense of vulnerability, hence generating in him/her a submissive or aggressive self-state as a reaction. Later in the same or in a following session, a patient's self-state characterized by depression and shame could trigger a therapist's hyper-caring, controlling-caregiving part, with the therapist trying to convince the patient of the salvific power of therapeutic relationship [43]. The more nuclear elements of relational trauma are present in the therapist's personal history, placing him/her in a possibly problematic position within the self-fragmentation continuum, the more likely it is for the therapist to experience higher degrees of self-continuity and the more he/she may tend to respond with non-integrated, difficult to monitor and regulate, self-states to the patient's non-integrated self-states. This can establish a sequence of partial countertransferential patterns that may hinder the co-regulation of patient's identity integration and, thus, the therapeutic progress.

While there is a certain amount of theoretical reflection and research about how fostering more coherent and integrated self-identity is an important mechanism of therapeutic change in borderline pathology, what seems to be underrepresented in clinical and empirical literature is the study of one intrinsic obstacle to this aim, namely, the therapists' frequent phases of identity discontinuity in response to BPD patients' pathological fragmentation and/or as consequences of the idiosyncratic potential therapist's self-discontinuity [44].

Metacognitive Interpersonal Therapy peculiarly considers as fundamental this aspect in the treatment of BPD patients [45,46]. More specifically, for MIT a systematic supervisory process aimed to help the therapist to face one's self-discontinuity experienced with BPD patients is essential in order to determine a good clinical outcome. MIT is a treatment initially manualized for Personality Disorders (PDs) with aspects of emotion inhibition and over-regulation and then adapted to individuals with schizophrenia to PDs with emotional dysregulation and recently described in detail for BPD patients [45,46]. MIT has demonstrated effectiveness in two single case series and one multiple-baseline single case series. Moreover, MIT in group (MIT-G) has demonstrated effectiveness via RCT and non-controlled routine care studies [47-52].

The present paper, after describing how MIT conceptualizes and treats BPD, focuses on how MIT peculiar approach to supervision faces the issue of partial countertransferential patterns with BPD. Finally, some implications for future research are discussed.

MIT PERSPECTIVE ON BPD

BPD Features according to MIT

According to MIT perspective, BPD patients feature:

1. Poor metacognition, which is difficulty in making sense of the mental states both of the self and of others, and in using knowledge about mental states to deal with suffering; for example, identifying an internal suffering, reflecting about its psychological causes and regulate it. Metacognition includes the ability to recognize and integrate different or incompatible mental states in an overarching sense of self, namely metacognitive integration [53-58].
2. Maladaptive interpersonal schemas [59,60]. According to MIT elaboration of evolutionary theory of motivation and CCRT case formulation repeated experiences in the developmental history of how others react to the individual's core wishes–namely basic human motivations such as attachment, social rank, group inclusion autonomy/exploration or sexuality - generate at least two nuclear self-images underlying each wish [61-64]. For example, the wish for attachment could be associated with the expectation that the other will reject us, which leads to a negative image of the self as unlovable, and alternatively a positive image of the self as lovable which others are expected to love and accept [45]. The greater the complexity and severity of PD, the harder it is for the individual not to make rigid schema-driven predictions on relationships and to access positive images of self and others. As a result, they end up forecasting that their wishes will be unmet and consequently tend to react with a series of maladaptive interpersonal coping strategies, such as withdrawal, contempt, excessive availability. In doing so, their interpersonal lives appear to be filled with problems and missed opportunities. BPD patients seem to enter into a relationship with a dominant negative self-image for the majority of their core wishes. For example, when in interpersonal transactions a wish of attachment, appreciation or exploration gets activated, predictions that the negative others' response (e.g., rejecting, abusing, mistrusting) will leave the wish unfulfilled, and the associated (underlying) painful self-image activate. Consequent emotional suffering arises, that the individual is unable to regulate. Consequent emotional suffering arises, which the individual is unable to regulate [65-67].

3. Self-discontinuity, the pervasiveness of the painful self-image, the negative emotions as well as the related arousal and reactions are amplified by a massive re-actualization of traumatic memories which the person does not consciously recall and thus experiences mainly at the sensorimotor level [21,63]. For example, a negative self-image as unlovable, elicited by the partner's impatient answer to a patient's question, awakens painful physical sensations derived from remote traumatic memories related to neglect. On this basis, patients experience a sense of internal fragmentation and deep psychic pain with intense shame, perceiving themselves as absolutely worthless and unlovable [64,65]. In order to soothe pain, maladaptive coping strategies are insufficient because the traumatic re-actualization silences the regulatory mechanisms of prefrontal cortex and the possibility to plan actions that is required by these strategies. Compartmentalized self-states take control of action. These self-states are characterized by primitive automatic behavior guided by the sympathetic system (e.g., aggressiveness, compulsive shopping, gambling, reckless driving, self-injury, urgent request for attention, clinging behaviors and frantic efforts to avoid abandonment) or the dorso-vagal parasympathetic system (dissociation, emotional anesthesia, depressive state with rumination) [37,66]. Moreover, maladaptive behaviors (coping strategies and primitive automatic behavior) evoke negative responses in the other, thus creating interpersonal cycles [67,68]. For instance, the other may feel overwhelmed, criticized, confused or worried, with corresponding reactions that may reject or criticize the individual, confirming patients' negative self-image, amplifying affect dysregulation and therefore further deteriorating the relationship. It should be clarified that our concept of partial counter-transferential patterns is only partly overlapping the concept of interpersonal cycle. Both concepts focus on vicious circles between patients' dysfunctional interpersonal attitudes and therapists' automatic reactions, which in turn reinforce patients' attitudes and pathology. But the concept of PCPs opens up the possibility to problematize two more elements: 1) the role of therapists' idiosyncratic (not rarely dysfunctional) aspects, which they are often unaware of, in feeding the interpersonal cycle; 2) the multiplicity and changeability of interpersonal cycles with BPD patients (hence the term "partial"), caused by patients' compartimentalizazion and its tendency to elicit a similar therapist's compartimentalization, generating a problematic discontinuity of the therapeutic relationship [68-72].

Basic treatment principles of MIT for BPD

MIT for BPD adopts a set of step-by-step procedures, divided into

1. Shared formulation of functioning and regulation; and
2. Change-promoting strategies. Shared formulation of functioning and regulation.

Concerning shared formulation of functioning and regulation, therapists

a) Modulate the relational atmosphere in a collaborative and not authoritarian way, and make soothing interventions (which will be made throughout the therapy) every time it is necessary, in order to make patients feel safe and to stimulate patients' social engagement mediated by ventro-vagal autonomic system (self-regulation, exploration, social communication) [66]

b) Elicit autobiographical episodes in which affect dysregulation occurred. These are used as exemplars to promote patients' metacognition, namely to help patients recognize their mental states, particularly the cognitive-affective antecedents of emotion dysregulation. More specifically, patients are helped in acknowledging that a crystallized self-image connected to these mental states exists, and that in order to avoid that self-image, maladaptive coping strategies and/or a succession of different compartimentalized self-states (with associated behaviors and symptoms) take from time to time the control of action;

c) Continuously act to validate patients' distress [73]. Besides this explicit form of validation, MIT therapists make substantial use of implicit elements of the therapeutic relationship (e.g., communicative signals such as facial expression, prosody and posture) to regulate patients' dysregulated arousal, validate emotions and attune with patients' psychological pain. Moreover, therapists foster patients' self-integration, recognizing and normalizing the compartimentalized self-states which take control from time to time also in the therapeutic relationship (e.g., an aggressive part complaining for the therapist's empathetic failure). More specifically, therapists validate dysfunctional self-states and behaviors as automatic reactions which–albeit maladaptive in the present-were aimed to increase the chances of survival in the traumatic past (e.g., the aggressive self-state is an instinctive defense against a negligent other who made the patient feel ashamed and unlovable) and to manage suffering generated by the re-actualization of the negative self-image

d) In parallel, after a discussion with the clinical eequipe, negotiate a therapeutic contract with the patient, including treatment goals, tasks, rules and reciprocal commitments.

e) Negotiate an ad-hoc engagement with the patient regarding between-session contacts aimed to master states of dysregulated suffering in the first phase of the treatment [74-76].

Change-promoting strategies-Regarding Change-promoting strategies, therapists

a) Continues to use the therapeutic relationship–in session and in between-session contacts–to reduce dysregulation and foster self-integration;

b) Promotes more autonomous and advanced emotional regulation strategies. Examples include re-activating the exploratory/play systems in order to engage patients in activities that foster well-being and curiosity, thus boosting the emergence of positive states [72]. Other strategies include mindfulness, grounding, or exercises derived from martial arts, for example, tai chi chuan and chi kung [76-80]

c) Once patients are able to better tolerate emotions associated with traumatic scenarios, uses experiential techniques (e.g., guided imagery, role play) to help patients rescript the meaning of their developmental history and change the painful self-image, integrating the traumatic past in the autobiographical memory;

d) Help patients to realize that their maladaptive views of self and others do not necessarily mirror reality but are mostly reflections of learned developmental traumatic experiences, and that there is room in the patient's identity for a positive self-concept. Therapists help the patient to pass from: "I am unworthy" to "I realize that I learned to think I am unworthy but now sometimes worthy, contrary to my past experiences";

e) When this positive self-image sometimes emerges in-session, therapists emphasize it, and then encourage patients towards experiential learning, consisting in a cycle of: planning change, performing new behaviors and reflecting about them in subsequent sessions [81]. New behaviors should be chosen in the direction of core wishes that were previously suppressed because of negative self-image. For example, patients could explore passions or interests frequently inhibited because of a sense of unworthiness and the expectation of being criticized. This is the main difference between MIT and classical interpersonal psychotherapy, since in MIT behavioral exposure aims to foster differentiation between self-image and reality, not to improve patients' problem-solving solutions to relational difficulties [81].

f) Later in therapy, promote in patients a more nuanced metacognitive ability to understand others' mind and how their behaviors contribute to problems and conflicts-which take the form of interpersonal cycles fueling distress-together with a sense of empathy toward others.

We emphasize that the above is not a phase-based model of treatment, but an iterative one. For example, if a patient enters a state of severe dysregulation during the change-promoting phase, the therapist can shift back to the regulation steps.

Throughout therapy, MIT therapists regulate the therapeutic relationship in order to minimize ruptures and repair them when they occur. For example, therapists are attentive toward identifying negative countertransferential feelings that BPD patients may elicit, such as overwhelming, anger, sense of ineffectiveness, and – in order to avoid that such problematic feelings generate iatrogenic interventions–try to modulate them in session. In the next paragraphs we specifically focus on the nature of peculiar partial countertransferential problem therapists experience in the relationship with BPD patients and how MIT faces them.

Partial countertransferential patterns with BPD

We focus on a peculiar problem frequently occurring in the therapy of BPD patients and briefly mentioned by some authors Van der Hart: In different moments of a session or therapy, different "parts" of a patient can elicit different "parts" of a therapist. We develop this aspect and characterize it as the problem of Partial Countertransferential Patterns (PCPs). With this term we mean that in different moments of a therapy, patients' maladaptive coping strategies or primitive automatic behaviors elicit therapists' maladaptive coping strategies or primitive automatic behaviors, ascribable both to therapists' reactions to patients' stimuli, or to therapists' idiosyncratic schemata and/or traumatic nuclei. Let us provide some examples. A patient's maladaptive interpersonal coping strategy characterized by emotional distancing could elicit a therapist's unresolved schema in which her/his wish for appreciation is associated with a criticizing response of the other, with an underlying self-image as incapable which may in turn boost shame; as a consequence of this, therapist's maladaptive coping strategy, pre-reflexively aimed to modulate shame through an authoritarian stance, could get activated. Similarly, a patient's compartmentalized primitive behavior like urgent request for attention could elicit first a therapist's maladaptive coping strategy characterized by prompt availability, then the patient's insistence could elicit a therapist's traumatic memory in which the therapist tried in vain to take care of a severely depressed mother, and this could determine a sudden shift towards a therapist's compartimentalized self-state expressing aggressiveness towards the patient. Finally, a patient's part which, in order to avoid a feared abandonment, appears appreciating and compliant towards the therapist could elicit a therapist's self-inflating part of feeling professionally valid [76,77]. The examples described could also represent different critical phases of the same therapy with a BPD patient, which cyclically happen on a repeated basis, with interludes characterized by a healthy collaborative interaction between patient and therapist.

PCPs are peculiarly activated by the therapeutic relationship itself. This happens because, as an intimate relationship capable to re-actualize traumatic scenarios of early intimate relationships, the therapeutic relationship can elicit the patient's compartmentalization, which in turn can elicit a sort of analogue therapist's discontinuity of self-aspects and mental states. The patient's different parts experience towards the therapist equally intense "phobia of attachment" and "phobia of attachment loss", reciprocally evoking in a vicious circle and manifesting themselves in a pre-reflexive, "all-or-nothing" way [78,79]. For example, a healthy part of the patient appears initially able to trust the therapist and to collaborate toward therapeutic goals, which in turn can elicit a therapist's adult motivated self-state experiencing exploratory spirit and a measured sense of self-efficacy. But easily the patient's experience of the therapist's attunement, or the growing need for the therapist's proximity, constitute a conditioned stimulus evoking a threat: implicit memories of traumatic experiences in which the need for proximity and proximity itself are correlated to aversive relational event such as rejection, abandonment, humiliation, abuse and lack of attunement [63]. This stimulus triggers a shift towards different self-states who fears the relationship, expressing as

relational withdrawal and blunt affects (e.g., the patient could think that appearing interested is part of her/his work), which could in turn elicit a therapist's prompt self-state trying to reassure the patient because she/he fears the sense of ineffectiveness he would experience if the patient left the therapy. Or the patient could shift to primitive defensive flight (e.g., substance abuse to anesthetize the need for proximity) that could respectively elicit a therapist's worried part, or fight strategies (e.g., getting angry with the therapist as a reaction to the latter's attunement attempt) that could elicit a therapist's agonistic part. The relational distance would in turn trigger a patient's succession of different self-states fearing the loss of proximity. For example, the patient could insistently ask for the therapist's attention by telephone, attack the therapist for not responding, and fall in a depressive shameful state in which she blames herself for feeling abandoned by the therapist, generating every time a different part of the therapist's [82,83].

The succession of different inter-subjective configurations or PCPs tends to come and go one at the time in different moments of the therapy or of a session, so that the therapeutic relationship suffers a sort of intrinsic discontinuity. This determines a series of consequences. First, the discontinuity of the therapeutic relationship can feed and stabilize patients' self-discontinuity.

Second, the therapist's compartimentalization inhibits her/his capability to attune with the traumatic reasons at the basis of patient's compartimentalization, and to "watch from above" the succession of one's self-states in the different phases of the interaction with the patient, namely metacognitive integration. A poorly integrated therapist cannot be attuned with and help a fragmented patient to achieve, in turn, metacognitive integration.

Third, such PCPs inhibit in both patient and therapist the individual's core wishes for exploration. In BPD patients, the continuous re-emerging of the traumatic self-image, consequent painful emotions, and the succession of primitive defensive strategies generating self-discontinuity, inhibit a healthy goal-directed planning and exploration of passions or interests. Similarly, self-discontinuity generated by the succession of PCPs in the therapeutic relationship, inhibits therapist's healthy and adult self-aspects as adventurous spirit, orientation to action, use of sense of humor, ironic irreverence that some authors consider an effective tool in the cure of BPD patient

In the next paragraph we focus on how MIT conceptualizes supervision as a process to face these criticalities.

MIT supervision of therapist engaged in therapy of BPD patients

MIT approach to supervision resorts to four strategies to face the consequences of PCPs:

1. Supervisory relationship,
2. Promoting metacognitive abilities,
3. Case conceptualization, and
4. Use of Specific techniques to promote disinhibit therapists' healthy wish for exploration

Supervisory relationship: Coherently with some authors emphasizing that the supervisory relationship is a kind of attachment relationship, in MIT supervisory relationship should also peculiarly function as a safe learning container, a kind of "secure base" for the supervisee. This has a series of implications [84,85]

The first implication is that MIT supervisors avoid every form of authoritarian stance and positively modulate the relational atmosphere in order to reduce the risk that the therapist feels intimidated or potentially judged. Not only because an over-inflexible or over-intimidating supervisor might determine a lack of self-disclosure and useful clinical information from the supervisee, but also because an authoritarian approach might reactivate and implicitly confirm maladaptive interpersonal schemata in the supervisee, instead of promoting their elaboration in order to neutralize their potential iatrogenic influence on the therapeutic process [86]. For example, in a difficult moment of the therapy with a BPD patient, a therapist could experience a sense of incompetence and impotence, (in part) due

to a personal therapist's unresolved schema in which her/his wish for help and understanding is associated with a criticizing response of the other, with an underlying self-image as unworthy. In the supervisory relationship, an authoritarian or excessively didactic supervisor when facing the wish for help of the therapist would confirm this schema, inhibit the therapist to share information, and prevent her/him from understanding and modulating the maladaptive schema activated in the relationship with the patient.

The second implication is that MIT supervisors, similarly to what MIT therapists do with patients, constantly monitor the effects of their interventions on the supervisory relationship. This is done in order to promptly recognize explicit ruptures (e.g., the therapist manifests with nuanced irritation disagreement with the supervisor), or implicit ones (e.g., the therapist's facial expression suddenly turns thoughtful or sad after a supervisor's intervention) and repair them. In this context, MIT supervisors largely use metacommunication namely promote clear and open exploration of interpersonal processes between the supervisor and supervisee as well as encouraging the therapist to freely express every aversive feeling towards the supervisor (e.g., disagreement, sense of being criticized or of not being understood or helped) [83,84]. This is coherent with how some authors consider metacommunication essential not only in psychotherapy, but also in supervisory relationship, where it promotes enhancing of the supervisory bond and repairing of relational ruptures, and offers therapists a model of how to use such important therapeutic skills with their patients [87-91].

The third implication is that MIT supervisors promptly promote therapists' emotional regulation and elaboration of the multiplicity of negative feelings and internal vulnerabilities which the relationship with BPD patients often elicits in therapists. For example, therapists may experience intense confusion, irritation and impotence facing patients' rapid switches among self-states; fear for patients' life or concerns about the possible legal consequences of patients' suicide; guilt associated to the idea of not being an adequate therapist for such severely disturbed patients. Therapists should have the chance to express these feelings in the intersubjective space of supervision and to receive empathy, respect, and genuine encouragement and reassurance from supervisors [92-96]. The supervisee should also know that it is possible to contact or to return to the supervisor when in need of support or emotional modulation in problematic phases of the relationship with patients.

Moreover, in order to promote supervisees' regulation of problematic emotions in the context of critical phases of their therapeutic relationships, MIT supervisors should frequently disclose examples of one's moments of difficulty and vulnerability experienced in one's life or with one's patients and how they tried to master them reflecting upon one's emotions and asking for help. This transmits to the supervisee the awareness that he can experience vulnerability without being considered as weak or incompetent. Through a process of modeling, the supervisee comes to trust in the mind and person of the supervisor, consolidates in the supervisee the representation of self as worthy of support, and of the supervisor as reliable and responsive, and internalizes the way the supervisor normally faces difficulties [96].

Promoting metacognitive abilities: On the background of the supervisory relationship, and similarly to what MIT therapist does with patients, the MIT supervisor has the aim to promote therapists' metacognitive capability to understand one's mental processes and possible maladaptive schemata or traumatic cores elicited in the interaction with patients. For this purpose, supervisors always tactfully divert therapists from narratives about the case that are abstract or intellectualized, and base their work on eliciting specific narrative episodes relating to problematic moments of the therapeutic interaction. Additionally, audio and video recording of sessions are useful to help therapists to re-live and tell details of key scenes of the therapeutic interaction [97,98]. As for patients' relational episodes, this kind of narrative is the most productive in exploring therapists' subjective experience,

problematic emotions, meaning-making style, and biased interpretations of the ideas and intentions of self and patients.

The more the therapist, helped by the supervisor, relives "flesh and blood" the clinical scene and silences the tendency to theoretically classify clinical events, the more the supervision can be source of fruitful insights. For example, a therapist could start the supervision generically describing a feeling of deadlock of the therapy, and the supervisor could ask the therapist for a specific scene in which she/he experienced that feeling peculiarly. The therapist could tell an episode in which a BPD patient in a phase of hypochondria (part of primitive defensive strategies based on flight) ruminated about his fear of getting a fatal illness and repetitively ask for reassurance from the therapist, despite the therapist having made several good psych educational interventions on the mechanism of hypochondria, which had initially comforted the patient. Then the supervisor could help the therapist to understand that, facing the patient's insistent requests, he/she angrily thought "How childish!" about the patient. At this point the supervisor, also resorting to experiential techniques as guided imagery which are largely utilized in therapy in order to bypass every trend to theorization about one's internal states, could promote a further increase of the therapist's metacognitive ability to understand one's mind, helping the therapist to deeply understand one's feelings and thoughts manifested in a meaningful "photogram" of the scene. For example, the supervisor could first "place again the therapist in front" of the patient's supplicant mimic expression; then the supervisor could help the therapist catch that "a moment before" feeling angry towards the patients, he/she thought I'm useless as a therapist" feeling shame. On this basis, the therapist could be helped by the supervisor to understand that these cognitive-emotional antecedents are part of the therapist's maladaptive schema, according to which the wish to be appreciated is associated to a dominant positive response of others which generates joy, but also to another traumatically humiliating response of others "in the shade" which causes shame and a painful self-image as unsuccessful and useless. Insight the therapist would gain the following insights: increasing the per formative effort towards the patient, striving to make the patient feels better "at all costs", experiencing the interaction with the patient as a "testing ground" of one's value as an individual, and feeling frustrated and angry when the patient doesn't seem to respond to the therapist's interventions–these are the consequences of the pre-reflexive attempt to modulate the painful self-image as useless and negative emotions associated to it Case conceptualization. The clinical information about the patient, provided by the therapist, along with the shared exploration of a series of interactions between therapist and patient, make the supervisor able to share with the supervisee an accurate case conceptualization. A fundamental aspect of this conceptualization is the recognition of the patient's schemas and peculiar succession of the patient's self-states, and the consequent PCPs, namely how every therapist's parts "dances" with every patient's one. For example, a conceptualization could reconstruct that the patient's wishes for attachment and appreciation are associated with the expectation that the other will humiliate them, which leads to a dominant negative self-image as unworthy, usually modulated through maladapting coping strategies as contempt and workaholic. But when interpersonal transactions seem to powerfully confirm this prevision and the painful self-image, coping strategies seem to fail suddenly, and implicit traumatic memories of abuse and humiliation get re-actualized, "turning off" prefrontal regulatory processes and boosting emotional suffering that the patient is unable to regulate. At this point different compartimentalized self-aspects can take sequentially the executive control: aggressiveness, the attempt to regulate suffering through binge eating, urgent request for attention, numbness exiting in skipping therapeutic sessions in the therapeutic relationship, these patients part tends to correspondingly elicit therapist self-aspects. For example, paranoid preoccupation for the legal consequences of the patient's aggressiveness; authoritarian agonistic trend which expresses itself with a

therapeutic shift to rigid behavioral protocols, as reaction to binge eating; salvific availability, followed by irritated overwhelming as a reaction to the patient's urgent request for attention; dismissing attitude as a reaction to the patient's numbness and disrespect of setting.

A good case conceptualization, emotionally resounding for the therapist, and progressively enriched over the supervisory process, contributes to promote the therapists' metacognitive integration of one's self-states interacting with the patient's, and helps the therapist to overcome the trend towards PCPs. Specific techniques to disinhibit therapists' wish for exploration. The aspects of the supervisory process above described provide the supervisee emotional support, metacognitive capacities, clinical knowledge, forecasting ability, and self-confidence to unlock his/her wish for exploration, inhibited by PCPs. Nonetheless, therapists could yet feel a difficulty in filling the gap between the understanding of the case in the secure atmosphere of the supervisory relationship to one hand, and the hard emotional requests of the therapeutic relationship to the other hand. In order to help therapists "to make a run" with the patient, MIT supervisors also utilize experiential techniques of dramatization of the clinical scene, like role-play [95,96]. For example, the supervisor could play the role of the patient, and the therapist the role of him/her herself in the simulation of different therapeutic interventions, like the first shared formulation of functioning, in which the therapist shares with the patient the case conceptualization learnt with the supervisor, or like a meta communication aimed to repair a rupture in the therapeutic relationship. As therapists do with patients in the clinical context, and coherently with Emotion-Focused Therapy and Sensorimotor Therapy, after the role play MIT supervisors ask for the therapist's feedback about emotions and thoughts experienced during the dramatization, and promote a meaning making process of therapists' expressive markers [97,98].

For example, supervisors may ask: "How did you feel while you were telling the patient…" or; "We noticed that in that at that point while you were validating the patient's aggressive part, you lowered your gaze and your breathing quickened. Can you intercept what were you were feeling?" This is considered to, helping the therapists to come in contact with the fear of mistakes and the thought of not being able to be effective. In order to regulate these feelings and beliefs, and to foster the emergence development of the therapist's healthy exploratory self-aspects, MIT supervisors also combine a sensorimotor regulation to role-play. For example, after sharing and validating fears and problematic beliefs, supervisors could ask the therapist to re-act the role-play, but this time consciously modulating breathing, with broad diaphragmatic movements and deep phases of exhalation, and adopting a more tonic posture (raising her/his eyes and looking into the supervisor's eyes). During this second dramatization the therapist could experience that it is possible to regulate the fear of mistakes, that this does not necessarily affect the efficiency of actions, and could expose a self-image as competent and relaxed, that which the supervisor promptly emphasizes, as well as an increased awareness of one's objectives and the willingness to pursue them [99-102].

Suggestions for future research on PCPs

Our theorization opens up many potential developments for empirical research. Coherently with a theory-building perspective, a qualitative approach might allow to more systematically explore the subjective experience of therapists and/or supervisors regarding, for example, the nature of different PCPs with BPDs, how these relate to the quality of the supervisory relationships, which PCP poses the biggest clinical problems, and how these may be faced dealt with through case conceptualization and clinical supervision [99-101]. Moving along the theory-building/theory-testing continuum, mixed-methods approaches combining qualitative and quantitative research might allow to further develop and refine the theoretical model and, at the same time, start to test specific hypotheses about it. The microanalytic sequential design might be used to this aim. Through a series of intensive

(multiple) single-case studies it might be possible a) to focus on the within-session dialogical relationship between clients-therapists and/or therapists-supervisors processes (e.g., client's or therapist's metacognitive integration, therapist's or supervisor's self-efficacy, therapist's or supervisor's interventions, therapeutic alliance) over the whole treatment; b) to track clients' outcome over time (from post-session to final outcome); and c) to explore the relationship between the sequential processes and post-session/final outcome [102-105].

DISCUSSION

A more complex mixed-methods design which could be implemented is known as significant event approach, which combines the main features of the qualitative and sequential design described above. The first step of this design is the within-session identification of very specific significant moments along the therapeutic and/or supervisory process; to this aim, post-session questionnaires (e.g., Helpful aspects of therapy) [103]. And/or observational methods (e.g., tape- or video-assisted interview methods can be used. Second, qualitative and/or quantitative observational methods (e.g., conversational analysis, quantitative rating-scales) are used to provide a detailed and rich sequential description of client-therapist and/or therapist-supervisors processes taking place during the significant events within and across sessions (similarly to what happens in the discovery-oriented phase of task analysis. Third, the investigated within-session process can be tied to the client's post-session and post-treatment outcomes. In the context of the conceptualization proposed in this paper, the main focus might be on the main difficulties the therapist faces in topic phases of the therapy, with particular reference to the problem of the therapist's tendence to incur in PCPs with the compartimentalized self-states of the patient; how this impacts on the therapist's ability to conceptualize and understand the patient and on the quality of the supervisory relationship; the way MIT style of supervision proved useful to help the therapist; to what extent the complex relationship between these processes eventually lead to a BPD patient's clinical change in symptoms and personality from intake to therapy termination over the whole treatment [106-109].

Finally, approaching the theory-testing continuum end, quantitative process-outcome studies could be implemented on larger samples. On one side, it might be possible for example to test which dynamics of within-session therapy processes are associated with different PCPs and their adequate management, and how this relates to treatment outcome. On the other side, it would be interesting to test if therapists treating BPD with MIT and receiving supervision as the one described in the present paper promote a better outcome, similar therapists with similar clients, but with different supervision setting.

CONCLUSION

Therapist and patient as human beings both have in common a variable level of self-multiplicity. Moreover, both possess a variable level of metacognitive integration capability, namely the ability to monitor the different self-states taking form in different contexts and to integrate them into a more complex, coherent and flexible representation of one's identity. As a result of repeated relational trauma, patients suffering from BPD show a pathological level of self-multiplicity, with rigid boundaries among different self-states. They are face considerable problems in integrating multiple and contradictory self-aspects and tendencies into a coherent, overarching and sufficiently diachronic sense of identity, and show a multiplicity of self-states which that are dissociated or compartmentalized, each with idiosyncratic patterns of ideas, affects, regulatory strategies and representations of self and others. Therapists are thus called to continuously interact with BPD patient's compartimentalized self-states, or "parts" of identity, some of them peculiarly activated by the therapeutic relationship itself.

What impact does this have on the therapist?-he/he will show a tendency to respond with not-integrated-and thus difficult to monitor and regulate – self-states to the patient's non-integrated self-states, giving rise to what we called PCPs. The more nuclear elements of relational trauma in the therapist's personal history, the more likely is for the therapist to run into a self-discontinuity, and the more the therapeutic relationship will be characterized by a sequence of PCPs that may hinder the co-regulation of patient's identity integration and, thus, the therapeutic progress. MIT considers a systematic supervisory work on this problem as a fundamental part of the therapeutic process in the treatment of BPD patients. On the basis of the concept of PCPs, MIT supervisors aim to help therapists to face one's self-discontinuity experienced with BPD patients through a sequence of specific interventions aimed to promote: a) A safe and not authoritarian supervisory relationship, in which supervisors constantly encourage bi-univocal metacommunication on the relationship itself, and prevent and repair relational ruptures; b) Supervisees' capability to return flesh and blood to scenes of problematic moments of the relationship with their patients, avoiding an intellectualized and not-involved perspective on the clinical scenario – experiential technique as guided imagery and audio-taped session are useful to this aim; c) Supervisees' ability to regulate painful emotions generated by the therapeutic relationship and by the severity of the patient's pathology; d) Supervises' metacognitive abilities to understand one's mental processes and possible maladaptive schemata or traumatic cores elicited in the interaction with patients; e) An accurate case conceptualization, emotionally resounding for the therapist, and progressively enriched over the supervisory process, including the patient's schemas, the peculiar succession of patient's self-states, and the consequent PCPs; f) A functional regulation of therapists' fear of mistakes and sense of incompetence or impotence, and the unlocking of their wish for exploration and willingness to pursue objectives, with experiential and sensorimotor techniques being useful to this end.

We are confident that a supervision process structured in such way is central to help MIT therapists to address the needs of patients with severe BPD, rather than an ancillary element. Although our theoretical reflections start from a careful observation of many clinical and supervisory processes, they suffer the intrinsic limits of a mainly theoretical and clinical approach. Future research, both qualitative and/or quantitative, should further develop, enrich, corroborate and/or confute our model, along a continuum cycling between empirical theory-building and theory-testing.

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