Working through the body in Metacognitive Interpersonal Therapy to change relational patterns in dependent personality disorder: The case of Lia

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Abstract

Persons with dependent personality disorder (DPD) have difficulties describing their inner world, and in realizing their negative ideas about the self, such as being weak, unworthy or powerless are just ideas. As a consequence, they tend to over-rely on others and may lose control over their emotions. Treating these persons can gain benefits from including body-focused techniques as they can promote a) awareness of internal states, b) better emotion regulation, c) the capacity to consider their negative ideas about themselves as not necessarily true, and d) gain power of and agency. We will describe the therapist used body-focused techniques in the context of Metacognitive Interpersonal Therapy when treating Lia, a 40-year-old woman suffering from DPD who also suffered from generalized anxiety disorder and had difficulties in making autonomous choices. She had a romantic relationship with a man she described as distant and judgmental so she felt lonely and not entitled to express her discomfort or capable to break up. The therapist used body-focused techniques, together with behavioural exposure, mindfulness and guided imagery, in order to let Lia be more aware of her thoughts and feelings, and then to regulate affects and realize she had previously capacities. At therapy termination anxiety diminished and she could break up with the partner and start a new one where she felt free to express herself. We suggest how bodily-focused techniques can be used to enhance therapy effectiveness in DPD.

Introduction

A major reason underlying suffering and dysfunctions in patients with Dependent Personality Disorders (DPD) lies in their tendency to predict that some of their core, evolutionarily selected wishes will remain unmet (Dimaggio et al., 2015; 2020). They are driven by the need for care, that is attachment and think they are weak and powerless. Consequently their capacity for self-soothing and self-regulation is diminished and they over-rely on caregivers when they feel in distress (Bornstein, 2020; Perry, 2005). Consequently they are prone to experience intense anxiety (Bonstein, 2005; McClintock & McCarrick, 2017), and develop a series of proximity seeking behaviours, such as conformism and surrender, though there is much individual variability (Bornstein, 1997, 2005; 2011; Miller & Lynam, 2008). Moreover, patients with DPD are poorly aware of aspects of their inner world, in particular of their own wishes and goals and their autonomy and self-efficacy are limited (Beck et al., 1990; Dimaggio et al., 2007). Such those wishes, also termed goals or needs, include: attachment, social rank, autonomy and exploration, group inclusion and so on (Liotti & Gilbert, 2011). More in general, DPD sufferers hope that others will express appreciation when they show their deed or take care of them when they are in need, but mostly due to their life history, they predict that the others will neglect

or humiliate them when they suffer or will despise them when they seek for appreciation. These predictions easily trigger feelings such as anxiety, fear, shame, guilt and so on. They are driven by core self-ideas such as "I am inferior", "I am powerless", "I am alone and fragile and deserve abandonment", which are coupled with idea of the others as "spiteful", "neglectful", "threatening" and so on. These ideas about self and others are more than just thoughts. They are associated with bodily sensations and behavioural automatisms. This means that when a person with DPD is driven by the need for approval, which is part of the social rank system (Liotti & Gilbert, 2011), not only thinks he is inferior and that others will despise him. He also feels weak, his posture is tense, he lowers his head and shoulders, and his actions tend toward withdrawal, flight and avoidance.

Patients with DPD are very often unable to realize what they are thinking and feeling and to understand that they are acting guided by their negative predictions. In the absence of full awareness of the reasons for their suffering and social problems, the clinician must first allow them to become aware of their own thoughts and then try to change them. But at another level, change is difficult because it involves not only adopting a different and more optimistic or realistic perspective; it also involves adopting different postures and acting differently in order to counteract automatisms, the basic elements of their attitude.

Recently, many therapeutic approaches for a wide array of PD include techniques aimed at working through these embodied core elements (Matos et al., 2023; Goldman & Goldstein, 2023; Ottavi, 2019), thinking they can increase therapy effectiveness (Heyen, 2022). Psychotherapy does not just work through conversation, but it includes guided imagery, chairwork, role-playing and other forms of dramatization, which means that clinicians ask patients to re-enact, as in a theatre, their problematic episodes. In this way the whole body is involved in reenacting a memory, and the change itself involves the whole body. It is not just a matter of: "Think you can respond to your mother differently". "The therapist's action is more like: "Your mother is in the room, I will play her. I will criticize you, then try to respond to me by standing still, try to look me in the eye, and when your voice trembles try again, until you feel more confident and stronger". In the same time, the body is called into action into the therapy room. Therapist invites patients to adopt specific postures, for example asking patients to adopt some yoga-position in order to feel stable and present or to regulate affect. They also asks patients to change their posture during rewriting, for example when a patient is trying to express a wish to her partner during a guided imagery, the therapist can ask her to breathe deeply, to raise her chin, and expand her chest so to feel her wish a valid and meaningful and let any doubt vanish.

People with DPD are no exception. They are driven by internal and procedural automatisms characterized by an idea of themselves as fragile, inadequate and weak. As a consequence, when they experience either a desire for closeness or for autonomy, they anticipate that the other will respond belittling or rejecting them. This triggers sadness, anxiety, fear and emptiness. They are unable to calm themselves resorting to an inner sense of worth or of deserving love, so in order to regulate painful affects they adopt maladaptive behaviours such as pleasance the other, passive-aggression, caregiving in order to make sure the other does not abandon them and perfectionism. They experience diminished agency, that is they are unable to recognize their own desires, ones they know stem from within and then let them guide their actions. Overall, they have poor awareness of their own wishes and needs and if they recognize what they would like to achieve they often criticize it to the point of self-invalidation. As regard somatic states, they often feel weak, devitalised or hyperaroused and hypervigilant to signs of possible rejection, abandonment and criticism.

Metacognitive Interpersonal Therapy for dependent PD: working with experiential practices.

MIT is a third wave integrative psychotherapy, specifically designed to treat personality disorders (PD) (Dimaggio et al., 2007, 2015, 2020). There is growing evidence of the effectiveness of MIT in treating PD in both individual and group therapy (Dimaggio et al., 2017; Gordon-King et al., 2018; Inchausti et al., 2023; Simonsen et al., 2021; Popolo et al., 2018, 2019; 2022). These studies demonstrated robust treatment adherence and therapeutic improvements in symptoms, social functioning, and ability to reflect on mental states.

When specifically applied to DPD (Dimaggio et al., 2007) MIT attempts at increasing awareness of inner states, realizing own negative ideas about the self are not necessarily true, forming and sustaining healthy self-images, increase emotion regulation, sustain agency and autonomy and adopting more socially adaptive behaviours.

MIT follows a series of semi-structured procedures, divided into two phases: (1) a shared formulation of functioning and (2) the promotion of change (Dimaggio et al., 2015, 2020). During the shared formulation of functioning, therapists first collect and explore autobiographical narrative episodes, with the goal of forming a shared understanding of maladaptive interpersonal patterns with their client patients (Dimaggio & Lysaker, 2010). In its most recent form, MIT adopts a wide range of experiential techniques, including, mindfulness-based exercises, guided imagination and rescripting, role-playing and the two-chair approach, body exercises, and behavioral experiments (Dimaggio et al., 2020). These techniques are used on the basis that emerging evidence suggests that they make a unique contribution to psychotherapeutic change beyond focusing on relational factors alone. Bodywork is also essential when access to internal states and critical distance cannot be achieved through clinical dialogue. Several authors (Dimaggio et al, 2020; Haeyen, 2022; Haeyen & Dimaggio, 2024; Ogden & Fisher, 2015), in fact, highlight the importance of working with body techniques to help patients overcome their automatisms, reduce suffering and pursue well-being. For example, bodywork allows observing and exploring how the body reacts in the course of memories related to problematic episodes, and this way developing a richer awareness of self-states. When focusing on the body instead of on the behaviors of others, the person is more leaning to consider suffering coming from an inner source and so try and regulate emotions and overcome distress. Moreover, proposing patients to repeatedly change posture or movements helps them discover how their thoughts change accordingly, and they have the power to change ideas and regulate affects, instead than repeating the same patterns or remaining prey of negative ideas and emotions out of control.

Summing up, in the context of MIT for DPD, body work has 3 main goals: 1) increasing awarenss of inner self and in particular their wishes and goals; 2) promote autonomus emotion regulation instead of over-relying on others; 3) realize own ideas about the self and the others are mere ideas and are not necessarily true; 4) increase experience and awareness of healthy aspects of the self and use them as a guide for 5) more adaptive social behaviours, based on their core wishes and goals instead than acted with the sole goal of granting the proximity of the others.

Case illustration

The therapist

Psychotherapy was delivered by the first author of the paper (TP), a 45 years old woman, a licensed CBT therapist with 15 years of experience in MIT. She is specialized in treating PD, with a special focus on using mindfulness, experential techinques and body oriented work for treating co-morbid post-traumatic symptoms.

Current problem and client description

Lia is 40 years old, lives in Florence and is employed in an international company. She enters therapy filled with fear, alarm, and confusion to which she cannot give an explanation. She feels anxious, but when the therapist tries to understand what she fears and why, Lia cannot answer, and besides a generic sense of "anxiety" she cannot say what she is anxious about nor she can name other emotions. She reports only a state of alertness whenever she perceives bodily arousal or disturbing physical sensations.

The only issue she clearly exposes is the doubt about whether or not she wants to have a child as a single woman. She is considering undergoing In Vivo Fertilization (IVF) as a single, but she is unsure if she really wants it and is therefore stuck. The confusion itself frightens her and again she cannot explain why. Overall,

after the first sessions the therapist realizes she has very poor information about what Lia desires, thinks and feels.

She is in a conflicting relationship with a man much older than her. He lives in Venice and they have never lived together. She is unhappy about the relationship, because she sees him as contemptuous, distant, and not interested in making any life plans with her, though she calls it "my partner". She feels lonely and not entitled either to complain or to be frightened about the idea of splitting up and again, she cannot explain what she fears. Her social life is characterized by a few friendships in which she tends to be compliant, and does not disclose her true feelings and vulnerabilities. She constantly monitors others to see if they neglect her, and after a few sessions she becomes able to say that if she notices signs of indifference and rejection she feels very sad.

She works out of a strong sense of duty with no real passion, and has a conflictual relationship with her boss by whom she feels underrated. Overall she can be diagnosed as having both Generalized Anxiety Disorder (GAD) and Dependent PD Signs of the latter are: she feels lonely, has difficulty perceiving and valuing what she wants and feels, she is prone to guilt and fear about abandonment and rejection. She is confused about what she really wants and hardly pursue any goal without having asked for approval first. She discontinued a previous psychodynamic psychotherapy because she felt pressured to decide to try and have a baby or not, and criticized by her therapist for lack of progress.

Case formulation

Very early, Lia had difficulties in describing what she thought and felt. The therapist therefore had to work in order to gather information on her mental states in order to understand patient's functioning and share the formulation with her. We therefore summarize here the formulation that emerged after this preliminary work where the therapist tried and collect the needed psychological information on which to ground her formulation upon.

The main desire that moves Lia is to make choices she feels authentic. However, when she tries to listen to what she feels and thinks, she is puzzled about what she really desires. This confusion scares her and negative arousal mounts. She fears that if she makes a choice that is not truly hers, she will be unhappy, forced to live a life that is not hers. She fears she will be guilty of self-inflicted suffering. She also feels fragile and inadequate, and fears that she will make choices for which others will criticize her and ridicule her. Finally, she fears that her choices will make herself and others suffer and thus she feels guilt at idea of harming others.

As a result of these ideas and emotions, Lia experiences a sense of anaesthesia throughout her body, feels almost physically paralyzed, criticizes herself and broods about the dangers she will face the moment she chooses. When she finds herself brooding or feeling physically sick, she becomes even more convinced she is too fragile.

In order to cope with these experiences, Lia over time has learned to enact various strategies. The main one is cognitive and behavioural avoidance; for example, she shifts her attention to other things in order to detach from negative physical sensations, or she avoids talking about herself to friends and family members in order to prevent neglect or criticism; perfectionism serves the same goal of preventing negative judgement. Moreover, in order to cope with the idea that she will make others suffer, she does not ask for care when she needs them and instead resorts to self-soothing. When her desires are at odds with others' she swiftly gives up and let others decide. When she suffers, she swings from minimizing what is causing her pain by telling herself: "Nothing really tragic after all" to brooding over her own inadequacy and the dramatic consequences of her choices. The result, as we noted, is that she becomes even more confused which in turn scares her more. At the end of the day, she is an alien to herself and this triggers anxiety, to the point of panic.

Lia thinks she is only "playing a role" of "daughter, sister, employee, and best friend". When others give appreciate her, she thinks she is a good actor, and this boost her self-esteem but only for a short while, as the sense of dissatisfaction and absence of desires quickly returns.

Course of treatment

Lia's therapy took place in three phases: an initial assessment, a second phase in which her psychological functioning was reconstructed and shared, and a third phase focused on changing. We now take up the aspects of her functioning previously exposed by describing the formulation and show how the therapist worked to bring them out and then to change them.

Assessment

Lia comes to therapy with a request to be helped understanding whether she wants to have a child on her own or not, as she needs to choose and find a way out from stagnation. Confusion is the major issue in the first sessions. The therapist asks early on for specific episodes in which Lia feels paralyzed and confused, and only after some struggle Lia reports one recent memory. The past week she was at home on the couch, with her mobile in her hand, and thought about calling a Spanish clinic for IVF for an appointment, in order to start with the fertilization process. Lia felt alarmed and paralyzed and then gave up calling. The therapist asks Lia what she thought and felt a moment before giving up making the call, and Lia manages to contact for a few moments the sense of paralysis and alertness. The therapist asks what she thinks ad feels but Lia cannot answer. As soon as she retrieves the episode, she becomes frightened, physically stiffens, loses focus on understanding her inner world, and again ruminates over her inadequacy.

Lia becomes more capable to report specific memories and reports several other similar episodes, in which the difficulty in exploring her internal experience recurs. The therapist notes: "Lia, when I ask you to recall a moment where you felt blocked or scared, you are afraid about what you feel, and immediately withdraw. It is like you are trying kind of protecting yourself from knowing more about your inner experience, is that correct?" Lia feels understood, but nevertheless when the therapist asks why she is scared about the sensations of trembling and tension, she patient fails to answer.

Preparatory work for exploring cognitions

The therapist explains to Lia how she cannot understand what she thinks and feels just on the basis of what she says. Lia is not used to think in terms of mental states, so that her capacity to describes them is reduced, something we refer to as poor metacognition (Semerari et al., 2003). One first therapy goal is therefore to overcome avoidance of physical sensations and then focus on them until Lia becomes able to understand if they lead to specific emotions. Once this operation is successful, a next agreed upon goal is to explore cognitions. What thought triggered a specific emotion in a specific situation?

Lia agrees with these steps. During the first sessions the therapist invites her to practice mindfulness; when Lia focuses on physical sensations during meditations she will try to describe them in words, trying to be non-judgmental. Every time Lia will be afraid of what she experiences, the therapist will remember her to regulate her breath and bring her attention to the contact points between her body, the chair and the floor, as typical of mindfulness practice.

Lia recalls a Saturday afternoon when she was home alone. She did not understand what she wanted to do and became anxious at the idea of making the wrong decision. Lia cannot articulate her thoughts further.

T: "Close your eyes, turn back to the very moment before anxiety mounts and recover what is passing through your mind".

L: "... my shoulders are shaking... I'm scared".

T: "Ok, it's ok. Don't run away from these sensations, stay here, what are you thinking now that scares you?"

L: "I- I still don't know".

T: "Explore your body, where is anxiety?"

L: "Can't connect it anywhere... I am not really able to understand my mind... this is typically me... it's bad".

Lia is ruminating again. This is likely a sign that she had started the task not from a position of curiosity about her inner world, but as duty to be performed correctly. The therapist notes this shift.

T: "Lia, this is typical you are again prey of your perfectionism that makes you worry. Are you willing to try and let this train of thoughts fall into an imaginary waterfall instead of keep worrying?"

L: "You are right. Let me... her... it's difficult..."

After repeated attempts, Lia is able to let self-critical thoughts fall into the imaginal waterfall and started to explore her experience.

L: "Maybe I will go out for a walk... or... I can fix up the house, do the laundry, I need to do them... I can invite Giulia for an aperitivo... what is better... I am confused... can't tell what matters more... I can't decide you see... there's something wrong in me... I'm scared".

T: "How do you feel now".

L: "Paralysed... empty, you see I can't do such a small thing such as understanding if I prefer do the laundry or going for a drink with a friend. How can I ever do it alone?"

After more discussion she chooses to go helping her mother shopping. Paradoxically, resorting to her usual caregiving behaviour calms her down and grants her a renewed sense of self-efficacy. This pattern reappears over and over again across many episodes. The therapist realizes that until Lia is in this negative state, Lia's capacity to know herself will hardly improve. Actually, negative emotions and thoughts tend to diminish human capacity for reflection on psychological states (Fonagy et al., 2002; Semerari et al., 2003) so the therapist tries a different strategy, which is typical of MIT (Dimaggio et al., 2015; 2020). She tries to elicit a positive state first, passing through the body channel, and then see if Lia becomes more able to describe her inner world without neither judgment nor anxiety.

First, the therapist explores in which areas of the body Lia perceives that she is free from the feeling of bewilderment, confusion, and fear. Then she asks Lia to refocus on her foot and the point of contact between her body, the chair and the floor. Lia realizes now she feels a sense of slight presence and stability and worrying is gone. She notes that the positive states are related to the pressure the body exerts on the contact points, "It's a feeling of being here". The therapist asks if these feelings are associated with specific thoughts, but Lia remains unable to identify them and turns to self-criticism. Another moment of mindfulness helps Lia detach from negative thoughts.

T: "Now use your hands to squeeze the muscles in her arms and legs... how does that feel?".

L: "Present... it's fine... stable... I feel it not just... it's all over the body now".

In the following weeks Lia reports several brief moments of positive experiences, both in her mind and in her body, alternating with negative states. Now Lia responds better to attempts at calming down in session thanks to body oriented work. Once she enters the session feeling lost the therapist invites her to touch her warm, soft scarf and observe her feelings until she calms down. In another moments she says: "I feel like vapor" and the therapist suggests to visualize herself as a tree, with a powerful trunk and strong roots starting at her feet and going down to the centre of the earth, until she regains a sense of solidity.

Session after session, Lia becomes familiar with the feelings of solidity, stability, presence, and she says: "I feel whole for the first time". One day at work, Lia is startled by a shoulder tremor whose reason she cannot tell. She realizes she is frightened though, and brings her attention to the areas of her body that are in contact with the world. Then she spontaneously clasps her arms with her hands and recovers the sense of solidity she now knows well, until fear of physical sensations recedes. She now considers ungrounded. Lia is now aware she considers these sensations as signs of her weakness, which implies risking criticism, but no longer firmly believes that weakness is a negative trait.

Understanding the roots of self-criticism.

At this point the therapist shares with Lia the need to begin reconstructing how much this way of feeling and acting characterizes her beyond the choice of whether or not to have a child on her own. The therapeutic task is to collect repeated episodes over the next few weeks and see if this pattern repeats. Lia accepts the task and is already sure that feeling wrong is something she has always experienced. The newly collected episodes confirm how Lia relies on self-criticism as an automatism.

During a Sunday lunch she is sitting at the table with her mother, sister, and brother, talking about the pregnancy of her sister's friend. Lia has not yet told her mother and sister about her idea of having a pregnancy on her own for fear of criticism. During this episode Lia feared they would abandon if they knew, so she will remain alone and, fragile as she is, unable to take care of herself. Lia also realizes that she feels guilty about making her relative suffer while she ruins her own life. She becomes aware she have the same ideas and emotions with her partner, friends, and at work.

For example, she is on the phone with her partner and feels like wanting to tell him that she has gathered information about the clinic in Spain for in vitro fertilization. She fears he will abandon her, and she will remain alone, so she does not tell him anything. At this point Lia is more able to report the cognitive antecedents of her emotions and behaviours. The decision-making paralysis stems from the idea she is fragile and inadequate which makes her give up with any autonomous plan out of fear of criticism and abandonment.

Time is ripe to try to help her Lia form a more benevolent perspective. She now wonders why she so firmly beliefs she is so weak, but cannot find any answer. The therapist, consistent with MIT procedures (Dimaggio et al., 2015; 2020), invites her to retrieve older memories in which something happened that shaped her idea of being lonely, fragile, and wrong. Initially, no memories come to mind, she just tells her life was "painful". Lia is the second of three children and reports that while her sister had her father's attention and her brother her mother's, she felt invisible, treated with indifference and coldness, as if she did not exist. In spite of awareness of a pattern, no specific memories appear. The therapist hypothesizes that access to past episodes may be facilitated by increasing negative arousal. When Lia explores the past, she experience no affect, a likely sign that she is protecting herself from something painful. Therefore, if arousal increases, associations with episodes in which she experienced similar affects may emerge. The therapist first let Lia focus on a recent episode where a friend criticised her. Once Lia feels anxious and ashamed the therapist asks for past memories. A memory appears. She is 5 years old and is in the living room. The light is dim, on one side her mother is talking to her brother, on the other side her father is playing with her sister. She first approaches her mother then her father but no one listens to her. She shows them her doll, but no look at her. Suddenly something happens.

L: "I feel lost, the living room is so big and I am so small. I'm scared. I am in the middle of the room and there is no one for me. I am in a faraway land, everything is empty, I am afraid".

T: "What are you afraid of right now, Lia? What could happen?".

L: "I can disappear. I'm not there. No one is looking at me... and then I see my father getting up and going to work in his office... I'm even sadder, there is no connection, I only sense his presence from the light that filters through the crack under the door... I don't know how to say it... It's like that light is the only connection to my father".

T: "And how do you feel now?"

L: "Completely alone and lost".

Once the imagination is over, despite the painful quality of the memory, Lia feels calmer: "It's as if something has lit up in my mind.... I know now why I still feel alone and lost. It's my story".

Other memory appears: she was 8 and found herself writing her name everywhere, on furniture, on glass, on walls. After being repeatedly scolded, she began to write her name under the soles of her shoes and slippers. When the therapist asked her what thoughts or emotions motivated this behaviour, Lia could not answer.

Between the age of 10 and 18, when she asked her father for permission to play basketball, and later drums, to go paragliding, he always told a rigid: "Because it is just no".

The patient and therapist share how, as a result of all these experiences, Lia progressively inhibits access to her own desires and emotions. She enters relationships guided by the expectation that others will discard her thoughts and desires as they are immersed in their own worlds. Lia now understands how perfectionism was an attempt to be appreciated, not for who she was, but at least for what she did. She also remembers her mother felt frequently bad and she learnt to care for her as the only way to gain proximity.

At 16, her father leaves home. Lia experiences this moment as a liberation, but after a few months he fell ill, disabled, and returned home. She perceived family expectations she took care of him and she complied. She wanted to run away, but at the idea of refusing to take care of him she felt mean and guilty and, as the ultimate consequence, abandoned and alone. She took care of her father for a year and a half and, when she turned 18, chose to leave the family home to live and work in Berlin. The therapist tries to explore what allowed Lia to move away from home, as this seems like a healthy behaviour, but Lia has no answer. She remembers she felt good in Berlin but appears distant now and her expression is flat. While she was abroad, her father died, but she remained in Berlin. She was conflicted about coming back home to see him alive one last time, but she chose to stay abroad motivated by the idea that, after all, there had never been any relationship with that father.

After about a year, her mother begins to express concern about Lia's work, calling her in tears at night to be reassured about how her day had gone and begging her to move back to Italy by changing jobs. After a few years her mother falls ill and the doctor tells Lia that her mother should not be subjected to stress, and Lia, overwhelmed by guilt, returns to Italy and starts her current job.

At this moment in therapy, the therapist and Lia are aware of how Lia's history has shaped the way she thinks and feels: deeply lonely, vulnerable, wrong and also unable to bring her own projects to life.

Identifying resources and capacities

An important stage of psychotherapy for PD is to help patients become aware of their healthy aspects, strength and resources (Dimaggio et al., 2020). Despite her suffering, Lia experienced moments when she allowed herself to follow her own desires. We have already noted, for example, the moment when she decided to work abroad and the moment when she managed not to return home while her father was dying. Against the background of these positive memories, the new goal is help Lia focus on her desires during the day and try to act consistently, instead of letting herself get stuck in a guilt and passivity. Lia agrees, although she thinks it will be very difficult "because moving is scary for me, I feel out of balance".

Lia needs not only to remember that a part of her is able to choose according to her own desires, but also to re-experience that part. The therapist therefore invites her to recall in imagination an episode in which she was driven by something she felt deeply own and authentic, and to focus on the emotions and sensations she felt during recall. Lia remembers one time when she told a colleague about her weekend. She did it so spontaneously and fluently that she is amazed. Lia experiences again stability, presence and "feeling whole". The therapist asks Lia to experience solidity and fullness in the body, "holding them together with the rhythm of the breath", imagining that the area she experiences as solid and stable expands throughout the body with each breath. Lia feels progressively stronger and her mood turns positive, she perceives her body as eager to move.

Functioning reconstruction phase

With the information gathered so far, the therapist summarizes Lia's functioning as follows:

T: "Lia, from what we have reconstructed I understand that you have a desire to grasp what you want and make choices accordingly, doing what really interests and pleases you".

L: "Yes that's right".

T: "When you try to choose according to what you want, however, you feel inadequate and unable to grasp what you do wants. You think you are fragile, inadequate, lonely and guilty in relation to another who is absent, distracted or preoccupied. Do you agree so far?"

L: "Yes, I anticipate that people will not take in what I want and in any case I feel unable to stand up for my choices".

T: "All of this causes confusion, fear and shame, and you are afraid of those states and you try to keep them at bay. You also become perfectionism, you comply with others, you avoid social exposure, you avoid choosing and let the other choose..."

L (laughing): "I'm a mess"

T (laughing): "Exactly!"

T: "But we also know there are moments you feel secure, feel active, solid, stable and full, and we can build on that, agree?".

After this shared formulation, in an very good therapeutic atmosphere, the new goal is help Lia regain a sense of agency and pursue her own authentic desires. The first task is try and during the day when she is again prey to negative ideas and feelings about herself, and not recognize there are just the same old thoughts and nothing more than that. Then Lia will try and note when she feels desires and positive emotions and stay in touch with them instead of letting them disappear, covered by fear and self-criticism. Lia still needs support in session, as the task is difficult. Let see how the therapist helps her let suffering lose control of her mind.

T: "Feel your body now you are seated. It occupies a limited space and it has a weight, you are not vapor. Notice the boundaries of your body, it is three-dimensional. Within your three-dimensional body notice where fragility is located."

L: "I feel a sense of emptiness in my stomach".

T: "Notice the boundaries of this feeling, as if it were an object that is in your stomach. Now perceive the space occupied by this object, much smaller, along with the space occupied by the whole three-dimensional body".

L: "The sensation in the stomach becomes smaller".

This new somatically anchored experience, together with the perception of herself as safe, stable and "full", becomes the basis on which to build subsequent therapeutic actions aimed at promoting change.

Behavioural change phase

Behavioural experiments are now crucial. They agree Lia will try and act to her wishes, even if worry and anxiety mount. If they do, Lia will try and retrieve the positive states she has experiences during her sessions and use them to calm down first, and try again later. During a work meeting Lia tries to have her say on a document she feels is wrong. The boss disagrees, criticizes Lia and discards her opinion. Lia realizes she suddenly feels vulnerable, wrong and scared.

L: "I was in a fog when he ignored me, I felt confused, lost. But it was only for a while. Then I recovered the memory of when in session I felt that a large part of me felt firm and secure. It was as if the fog in my mind had cleared.... I was anxious but I also felt strong ... I didn't feel helpless, I felt in control... I said to myself, Lia, this is your story, it's you alone in the living room at home".

Lia then accesses feelings of well-being: she feels in control of the situation and feels solidity in her legs. In the next weeks Lia finds easier to access the state of solidity and security, even under stress. She feels the urge to tell some friends and her partner about her plans to have a child and "feel in my body the decision to tell them". They role-play the scene until she feels able to doing it effectively. Lia returns home with the homework of trying and tell her partner first and her friends later she wants to undergo IVF.

The next session Lia reports she did and her partner got angry in response: he does not want to be involved. He then scolded and scorned her, accusing her of being a fool. Yet Lia remained stable, she did not feel stupid, and is able to tells her friends about her project. They supported her idea and she did not feel judged.

By the end of these behavioural experiments, she is more aware that her idea of being inadequate and fragile is a result of her learning experiences, but it is not necessarily true and she can also see herself as safe and right. After two months she separates from her partner by letting him go when he moves away and beginning to feel, along with the initial loneliness and sense of loss, a newfound possibility of acting and feeling solidity and presence despite the other's loneliness and distance. An initial sense of strength begins to emerge, made up of awareness of bodily boundaries, solidity in the legs and deep breathing.

L: "I feel like a straight line inside, a beam of light that is warm and solid and goes from the throat to the belly and I feel that I am there". Lia reports that for the first time in her life she thought of herself in terms of "me" instead of "the couple" and "if my partner..." and she begins to take care of herself by trying to follow her desires and making room for positive emotions. She starts taking care of the house, cooking with care, going out more with friends. She finds that she really enjoys meeting new people, becomes talkative with friends and new acquaintances, and focuses less on signs of criticism. Within about three months she discovers that these new feelings, bodily sensations, and habits are becoming automatic, a kind of new Lia now driving her choices.

When Lia faces alone moments of vulnerability the therapist considers that Lia needs to figure out some other character than can take care of her and asks her if she can retrieve some memories where someone, maybe some friend, cared for her and she sensed it. For the first time in therapy Lia remembers her grandmother: she was the only one who loved and understood her during her childhood and adolescence. They recall her presence during a guided imagery focused on a childhood memory.

As often happens in patients with dependent and other PD, the imagined presence of a positive other is unstable. Lia does not feel her grandmother is really there for her and feel scared like at treatment beginning. After the usual moment of somatic regulation, the therapist asks Lia if she can picture in her mind a "compassionate" figure in front of her, one that is very large and solid and at the same time welcoming and validating. This time Lia manages to portray it and feel its stable presence. It has some feature of her grandmother, but some aspects of Lia herself. This time she succeeds bringing back this character in the living room when she was 5. The character hugs the girl who was sad and silent, until she burst into tears and reciprocate the hug. Lia now feels warmth throughout her body: "it is like a ball of light in the centre of my body that makes me feel stable".

Behavioural homework can now continue: Lia joins a hiking group. During the first meeting she is able to talk openly about herself, telling about her job and the work she was doing abroad. Lia now realizes that she likes her job: she holds a relevant position with a role in managing humanitarian corridors in war zones. For the first time she says to the therapist she perfectly speaks four languages and that she feels passionate about those missions. Lia describes herself as capable, effective, able to make responsible decisions, and thinks she is able to deal with the risks and consequences of her work, such as going into war zones even if others will worry for her.

Behavioral tasks can now continue: Lia joins a group of walkers. During the first meeting she is able to talk openly about herself, telling about her job and the work she was doing abroad. Lia realizes that she liked her old job: she holds an important position with a role in managing humanitarian corridors in war zones. For the first time she tells the therapist that she speaks four languages perfectly and feels passionate about these missions. Lia describes herself as capable, effective, able to make responsible decisions, and thinks she is able to deal with the risks and consequences of her job, such as going to war zones even if others worry about her.

Outcome and prognosis

The work of strengthening this steadfast, centered, full, yet joyful and energetic part of herself continues during the sessions, and gradually many changes occur in the way Lia copes with new decisions. At present Lia cannot be any longer diagnosed with DPD, her anxiety is reduced and most of the times she can control it. She currently cannot go back to her old job but applies for a competition for the role of manager to perform a task very similar to what she did in the past, but from Italy. Lia passes the first test and experiences this prospect of change with serenity and joy. After a year of separation from her former partner, she begins dating a man who lives in a distant city and with whom she feels free to express herself. Now she is no longer driven by the need to form a stable bond and have a child, but is eager to experience a more independent life. She travels a lot with old and new friends and feels that she belongs to a group. She reflects more consciously on her past history and makes sense of the times when she wrote her name everywhere as a child: "I needed to say I existed". After a few months she tells the therapist that she decided not to go ahead with IVF because she realized that "I wanted a child to feel like myself.... I realized that having a child would give me a role and therefore an identity.... but I don't need that anymore, as I exist and I want to give space to me. If I ever have a child someday, it will not be to feel me, but it will be me and him". During the last therapy session, Lia told the therapist that the following week, as she had wanted since childhood, she would go paragliding.

Clinical Practices and Synthesis

Changing features such as sense of weakness and unworthiness may be challenging in any patients, and sure it is in persons with dependent personality disorder. Their ideas of being unworthy, unlovable and fragile are more than mere thoughts, they go along with negative bodily sensations which are hard to change. When patients are prey of negative somatic states, their feelings and thoughts are easily stirred towards the negative as well and are hard to change. Using a combination of fine-grained formulation and practices focused on relieving past memories and changing their plot, as well as working with body based techniques can be effective in changing resistant maladaptive patterns. Body work serves also as the main gateway to the patients internal world, that is, it helps them accessing previously unacknowledged beliefs and emotions that lies at the roots of suffering. In spite of the single case nature of our paper, and of absence of formal measures of therapeutic change, we contend that including body work, as well with other experiential practices, e.g. guided imagery and rescripting and mindfulness, (Heyen, 2022; Hayen & Dimaggio, 2024) can be part of the toolbox of clinicians treating dependent PD and PD in general.

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