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Addressing maladaptive interpersonal schemas, poor metacognition and maladaptive coping strategies in Avoidant Personality Disorder: The role of experiential techniques

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Abstract

Avoidant Personality Disorder (APD) is the most prevalent diagnosis amongst the personality disorders. However, it remains under-researched, and few psychotherapeutic approaches have proven effectiveness in treating the disorder. Focusing on specific elements of psychopathology may therefore help in refining treatments for this disorder. Here we present a case where Metacognitive Interpersonal Therapy (MIT) was used to directly address the negative metacognitive schemas held by clients with APD. We also describe the theoretical background of MIT and why it may be effective in the psychotherapeutic treatment of APD.

Keywords: Maladaptive interpersonal schemas; Poor metacognition; Coping; Experiential techniques; Imaginative techniques; Avoidant Personality Disorder.

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Introduction

Avoidant Personality Disorder (APD) is characterized by withdrawal from social relationships, social isolation, a sense of the self as inadequate, hypersensitivity to social judgement, and feelings of group exclusion. Individuals presenting with APD simultaneously long for inclusion but fear connection. This anxiety is underpinned by maladaptive cognitions such as chronic self-doubt, a poorly integrated sense of self-identity, difficulties in managing negative emotions and poor agency (Sorensen et al., 2019). In terms of psychotherapeutic treatment, evidence for the effectiveness of psychological interventions for APD is limited (Simonsen et al., 2019), and studies report mixed results. A number of therapeutic models, including Interpersonal Therapy (IT), Acceptance and Commitment Therapy (ACT), Dialectical Behavior Therapy (DBT) and Schema Therapy (ST) have yielded positive results for symptom reduction, with evidence of stability at follow-up (e.g. Chan et al., 2015; Bamelis et al. 2014). There is also evidence that group-CBT was associated with better outcomes than short psychodynamic psychotherapy (Emmelkamp et al., 2006). However, CBT for this group has also been associated with high relapse rates (Seemüller et al. 2014). The emotion regulation difficulties that APD-diagnosed patients present with may also have influenced early drop-out rates (Weinbrecht et al., 2016). Overall, psychotherapy can be effective in this population, but results are generally reported for specific, targeted outcomes, and taken in the context of elevated rates of treatment non-responses and drop-outs. Therefore, there is significant room for improvement in the specification and effectiveness of interventions.

We propose that in order to increase effectiveness, psychotherapies for APD need to better attend to: a) maladaptive interpersonal schemas, both implicit/automatic and conscious; b) impaired metacognition, which hampers the understanding of cognitive-affective processes that lie behind maladaptive schemas; and c) dysfunctional behavioral coping strategies such as avoidance, submissive compliance or perfectionism. Unaddressed, each or all of these elements may reduce therapy adherence, reducing potential for achievement of broad, stable therapeutic outcomes both in terms of symptoms and social functioning.

Maladaptive interpersonal schemas, metacognition and maladaptive behavioral coping strategies in Avoidant Personality Disorder

Maladaptive interpersonal schemas

Schemas are stable meaning-making structures. Humans use them to select relevant information in order to meet their goals, and to make predictions about how others may react to their requests and wishes. Examples of such schema include core ideas about the self and others - with cognitive, affective and embodied aspects - as well as relational procedures for fulfilling wishes or to manage predicted negative responses of others (Dimaggio et al., 2020; Odgen & Fisher, 2015). These structures are mostly sequelae of one's developmental history. From a psychopathological perspective, experiences of abuse and abandonment are predictors of personality disorders (Johnson et al., 1999). Emotional neglect is particularly associated with the former Cluster C PDs, including APD (Zhang et al., 2012; Johnson et al., 2000). That said, research into the formation of schemas in APD has thus far only investigated attachment related-schemas, whereby the presence of attachment figures perceived to be neglecting or lacking attunement are related to an individual's sense of self as unworthy and unlovable (Eikenaes et al., 2016).

The structure of schemas that we adopt here (Dimaggio et al., 2020) is derived from the formulation described by the Core Conflictual Relational Theme (CCRT) (Luborsky & Crits-Christoph, 1990) and takes into account the concept of relational testing proposed by Control Mastery Theory (CMT; Weiss, 1993; Gazzillo, Genova et al., 2019; Gazzillo, Kealy et al. 2020). They include a) a core *wish,* which corresponds to the activation of basic evolutionarily selected motives (Gilbert & Gordon, 2013; Liotti, et al. 2017; Panksepp & Biven, 2012); b) core self-images, with prominent negative self-images, e.g. self as unworthy, or unlovable, which go alongside over-modulated but still accessible positive self-images, e.g. the self as worthy, self as lovable. The schema also include *Other Responses*, (expected or perceived) e.g. rejecting, neglecting, critical. Again, positive types of *Other Responses* often exist but are overshadowed by the negative appraisals. Finally, after assessing the *Other Responses*, there is a *Self-Response* which includes cognitive, affective, behavioral and somatic reactions.

In this model, the presentation of APD is driven by a range of different schemas, depending on the core motive at stake in a specific episode. For example, when driven by an attachment schema, patients may hold a core self-belief of the self as unlovable and others as rejecting or disengaged. The Self-Response is one of sadness, as the core self-belief is confirmed, leading to anergia and apathy. Therefore, the individual may use behavioral avoidance in order to prevent ongoing frustration, for example, where the individual suppresses their tendency to ask for care in order to avoid rejection.

When social rank schema are active, the dominant core self-image is of the self as unworthy and inferior, vis-à-vis a critical and contemptuous other. After being confronted with impending or actual rejection, or when the individual interprets others' reaction as signs of impending rejection, the individual may feel ashamed. In this situation, they experience their core-idea of being unworthy and flawed as being made public. This leads to coping strategies including avoidance, submissive compliance (in order to please the other and avoid further criticism), or perfectionism. At times, when the positive self-image of self-as-worthy comes to the fore, APD diagnosed individuals react with anger to criticisms that they perceive as unfair.

When autonomy/exploration schema are active, individuals diagnosed with APD represent themselves are impotent, paralyzed or deprived of energy. They imagine that the other will not support them, will constrain them, set limits upon them, or will suffer because of their independent deeds, e.g. the mother will get depressed if the son with APD expresses the idea of moving to a different town for study or work. Typical

self-responses are frustration, increased impotence, a sense of constriction and guilt. These individuals tend to abandon their plans, but harbor resentment because they expected to be supported or blame themselves for their passivity. Alternatively, they still pursue independence, but lie in order to avoid facing the predicted or actual negative reactions of the others. Finally, when the individual is driven by the wish for group inclusion, they may portray themselves as different, alone, and alienated; and others as rejecting and linked by bonds that they (the individual diagnosed with APD) will never be able to share.

Metacognition

Metacognition denotes the capacity to identify mental states, both in oneself and in others, reason about these states, and to regulate them (Dimaggio & Lysaker, 2015; Semerari et al., 2003). It is broadly impaired in personality disorder (Semerari et al., 2014). For individuals diagnosed with APD, there is a pronounced difficulty in the individuals awareness of their feelings, identification of these feelings and labelling of them (Bach et al., 1994; Nicolò et al., 2011). Patients with comorbid social phobia and APD also have poorer self-reflective capacities compared to individuals with social phobia only (Eikenaes et al., 2013). In addition, a reduced capacity to identify one's own thoughts and feelings hampers the capacity to identify and integrate the interpersonal trigger of their distress in a given situation. In therapeutic interactions this is reflected in the individual struggling to effectively convey their inner experience, speaking in abstract, vague and confusing ways, and often resorting to intellectualization (Colle et al., 2017; Dimaggio et al., 2007a). Individuals with APD presentations tend to have problems in realizing that their ideas about the self and others are mostly subjective hypotheses, instead are likely to consider them as objective facts – evidenced via deficits in metacognitive differentiation (Dimaggio et al., 2007b; Semerari et al., 2003). They also have difficulties in forming a mature and decentered theory of others' minds (Moroni et al., 2016; Pellecchia et al., 2018).

Maladaptive bahavioral coping strategies

In response to interpersonal stressors, individuals with APD diagnoses often display emotion dysregulation (Dimaggio et al., 2018), enacting a series of dysfunctional coping behaviors (Lynch et al., 2016). In particular, they tend to over-use avoidance and emotion inhibition (Arntz, 2012a; Dimaggio et al., 2018; Popolo et al., 2014); or alternatively disguise their feelings to avoid negative judgments (Grandi et al., 2011). These strategies both increase alienation and loneliness and may also precipitate negative reactions from others (Lampe & Malhil, 2018).

In order to distance themselves from negative emotions, individuals with APD also tend to procrastinate, which may reduce the impact of shame or inadequacy related cognitions (Dimaggio et al., 2015b); or they may overuse online videogames (Li et al., 2016) to numb themselves from the impact of distressing cognitions. Individuals may also resort to perfectionism (Hewitt & Flett, 1991; Dimaggio et al., 2018, being highly concerned with their perceived mistakes or may hold significant self-doubt regarding their actions (Taylor et al., 2004). Furthermore, individuals may also harbor ideas that others hold negative views of them (Hewitt & Flett, 1991) - a further trigger for behavioral avoidance (Shahar et al., 2003).

The outcome of most of these behavioral strategies is reduced emotional experience and an accompanying diminished capacity to label emotion arousal – consistent with alexithymia (Constantinou, et al, 2014; Nicolò et al., 2011). Moreover, individuals with APD also tend to disconnect themselves from positive affect, thus leaving them less likely to seek out new experiences (Wilberg, et al. 1999).

Targeting interpersonal schemas, metacognition and coping in avoidant personality disorder

Based on our understanding of APD psychopathology, an effective treatment will likely need to: a) counteract behavioral coping; b) promote metacognition to the point of understanding that one is guided by schemas; and c) help patients realize they are guided by schemas, both at the level of cognitive representations of their social interactions and with regard to automatic procedures for relational behavior. The aim for treatment is that intervention yields incremental benefits in terms of adherence and outcomes.

Metacognitive Interpersonal Therapy (MIT; Dimaggio et al., 2015a; 2020) follows a series of semi-structured procedures, divided into two phases: a *shared formulation of functioning* and *change promoting.* Therapists first collect and explore narrative autobiographical episodes, with the goal of forming a shared understanding of their maladaptive interpersonal schemas with their clients. In the early phase of therapy, behavioral experiments are designed to counteract coping strategies such as avoidance, perfectionism or procrastination. The explicit goal here is to explore the inner experience of clients when they abstain from using these coping strategies, thus strengthening their metacognitive self-awareness. Once patients with APD become aware that they are guided by a set of ideas of self and others, the next step, *change promoting*, is to promote differentiation. Here the patient's goal is to realize that these ideas are mostly subjective, and are schema-driven, rather than actual representation of real-life interactions. In parallel, therapists help patients to become aware of their positive ideas about self and others, to connect to their underlying schema-driven thoughts and to form a sense of agency. This enables them to act based on preferences that they themselves endorse and take ownership of, whilst simultaneously developing a sense of self as worthy of pursuing these goals.

There is growing evidence for the effectiveness of MIT in the treatment of APD using small case and small sample approaches. With regards to individual therapy, in a first case study one client with APD was treated successfully (Dimaggio et al., 2017). In a second study, all three patients with APD treated in a multiple-baseline case-series no longer met criteria

APD diagnosis after 1 year of treatment (Gordon-King et al., 2018; 2019). Furthermore, for patients with mixed PDs including APD, there are also outcomes from two non-controlled studies and one pilot Randomized Controlled Trial of MIT delivered in a semi-structured psychoeducational/ experiential program (MIT-Group) (Popolo et al., 2018; 2019; Inchausti et al. 2020). Summarizing across these treatment studies, patients with PDs (including APD diagnoses or prominent APD traits) demonstrated robust adherence to therapy and therapeutic improvements in terms of symptoms, social functioning, and metacognition.

Experiential techniques in MIT for APD

In its most recent manualized form, MIT adopts a wide array of experiential techniques, including guided imagery and rescripting (Hackmann et al., 2011), role-play and two-chair approaches (Moreno, 1975; Greenberg, 2002; Perls et al., 1951), bodily exercises (Lowen, 1971; Ogden & Fisher, 2015) and behavioral experiments (Dimaggio et al., 2020). Selection and use of appropriate techniques is guided by a shared decision-making process within therapy and the goal of using these techniques changes through the course of therapy via an ongoing re-evaluation of the case formulation.

One example of this is the extensive use MIT makes of guided imagery and rescripting. Usually we first ask the patient to focus on a specific autobiographical memory. We ask him/ her to return to the episode 'as if' it was happening in the here and now. During the first recollection we try to increase emotional arousal by guiding the patient towards greater connection with the specific distressing emotion (such as fear, sadness, grief, guilt or shame), generating a richer awareness of how an interaction with the other has impacted upon the client. Then, during rescripting we ask the client to a) abstain from maladaptive coping strategies, for example reducing tendencies towards avoidance, perfectionism, overcompliance, inverted attachment, and over- dependence; b) connect himself/herself with ones primary wishes, such as the desire to be valued, cared for, being autonomous, or playful; c) express the primary wish to the other(s) in the episode until they experience emotion resolution, or to the point that they realize they have agency over their actions, even if it is difficult to enact different behaviors; and finally d) we often ask the client to acknowledge a more benevolent, supporting, compassionate self-aspect, counteracting the influence of the negative self-aspect in sustaining dysfunctional schema.

MIT has also adopted experiential techniques on the basis that emerging evidence suggests that they yield a unique contribution to psychotherapeutic change, beyond focusing on relational factors alone. For example, Stiegler et al. (2018) reports that adding two-chair work was associated with greater change in depression and anxiety compared to a baseline phase where it was not used. Arntz (2012b) noted how guided imagery rescripting may be as effective as imagery exposure and has less potential for adverse effects, though dismantling studies are still needed to evaluate its unique contribution to psychotherapeutic change. Recently, Romano et al. (2020) noted that, for patients with social anxiety disorders, imagery rescripting was associated with more effective change in autobiographical memory content than simple imaginal exposure or supportive counseling, with the latter condition generating no change at all.

With regard to APD, the rationale for the use of experiential techniques is that these clients resort to emotional and behavioral avoidance to the point that it is: a) difficult for the clinician to understand their cognitive-affective processes; and b) they are unable to pursue behaviors in real-life that will help them break their schema-driven patterns and fulfill life goals - such as working productively, engaging in stable romantic relationships, or belonging to groups. As a consequence, the combination of in-session experiential work such as guided imagery and rescripting, and of in-vivo behavioral experiments has two goals.

First, these techniques help individuals with APD to better understand their cognitive-affective processes, to the point that they can understand that their predictions of how others will respond to them are schema-driven; and that these cognitions lead to behavioral coping strategies that hamper the fulfilment of their core wishes. Second, experiential techniques have the purpose of both helping patients with APD connect to healthier self-aspects and adaptive schema; and in facilitating the individual to adopt different, more benevolent perspectives towards both the self and others.

For the sake of brevity, we illustrate the above position with a clinical vignette of how MIT adopts experiential techniques in order to address the aforementioned aspects of APD psychopathology. Specifically, we focus on how techniques counteract behavioral coping, improve metacognition and change maladaptive interpersonal schemas whilst also fostering access to healthy self-aspects.

The case of Gianluca

Gianluca is 32 years old man who works in a warehouse and lives alone. He reports that he is depressed and also anxious about the idea of meeting people, therefore he spends most of his time at home. He lost his mother when he was 18. He describes his father as always humiliating him, aggressive and frequently neglectful. Consequently, they have minimal contact. He referred himself to psychotherapy with one of us (V.V.) because he longed for a richer and more fulfilling social life. He had a few acquaintances, mostly relating to biking (his passion), but he rarely toured with them as he avoided group meetings. Furthermore, he had never managed to establish an intimate long-term romantic relationship.

Therapeutic relationship

Gianluca had difficulties forming a connection with his therapist, who in turn felt estranged, distant and at times felt bored and confused. She did not know how to help him. For example, during the first few sessions, he abruptly stood up before time was up and asked for the next appointment without giving any explanation for the premature termination.

By the third session the therapist directly enquired about what Gianluca felt was happening between them. Gianluca said he felt ridiculous, unworthy and was convinced that therapist despised him. He revealed this was the reason why he avoided greeting her, as he mostly wanted to avoid contacts where he might experience humiliation. The therapist tactfully explored if she had given any signs of condescending or shaming him and Gianluca acknowledged she had not. By the second month of therapy he started feeling more relaxed in therapy and realized that he could enjoy talking with her about things that interested them both, e.g. their shared interest in a TV series.

Therapeutic contract: goal setting and tasks

Gianluca requested therapy in order to overcome his depression, have more social contacts and form a romantic relationship. In order to reach these goals, the therapist introduced an intermediate goal: improving awareness of inner states (i.e. metacognitive monitoring) in order to better understand his inner functioning. She also pointed out that one relevant psychological goal within therapy was to explore whether the negative ideas Gianluca held about himself and others were incontrovertible facts or whether he was able to access more benevolent alternatives.

During the drafting of the therapy contract, the therapist and Gianluca agreed that counteracting avoidance through graded exposure was necessary, both in order to break Gianluca's reliance on maladaptive coping, and to better understand the cognitive-affective antecedents that Gianluca was unaware of. They also agreed to use in-session experiential techniques (e.g. guided imagery and rescripting). As therapy progressed, once Gianluca was aware of how he was driven by maladaptive schemas, the contract was updated and he agreed to commit to actions consistent with his underlying wishes and to act accordingly.

Case formulation

During the first sessions, using the behavioral experiments described in the next section, a shared understanding of Gianluca's functioning was formed. His core wish was for group belonging, but he was guided by a negative core image of himself as different and an outcast. He portrayed others as superior, spiteful and willing to discriminate. When facing these perceived aspects of others, he switched to a different motive - social rank. He felt inferior, ridiculed and longed for appreciation, through which he felt he could restore his low self-esteem. These schema were rigid and shaming, as even at times others actually included him, he still worried about rejection: "What do they think of me? I don't say anything interesting, I'm dumb, boring". When he ruminated on these thoughts and feelings his body became stiff, deprived of energy, experiencing a sense of alienation and estrangement. To alleviate these negative states of mind he would retreat from the group and avoid further contact. Alternatively, when he switched to social rank motives he also experienced a sense of self as weak facing another stronger and aggressive. This would invoke fear in him, which served as a further trigger for behavioral avoidance. Gianluca noted that there were times in which he was cognizant of a healthy sense of his self as interesting, worthy and deserving to belong, but he still appraised others as rejecting and humiliating, triggering a cognitive appraisal of unfairness, accompanied by anger.

Application of experiential techniques

In order to counteract behavioral coping and open a more in-depth exploration of Gianluca's inner world, the therapist proposed several behavioral exercises. Gianluca agreed to try and stay with his colleagues by the table during lunch break, instead of eating alone. Staying with others enabled themes relating to group exclusion, unworthiness, weakness and shame to emerge into the therapeutic space. However, Gianluca's improved metacognitive capacity also gave him a clearer picture of his inner world, licensing the therapist to ask him for associated autobiographical memories. He remembered an episode in which his father lectured him in front of his friends when he was 7 years old, and also episodes in which his primary school friends isolated him or mocked him because of his physique. When describing these memories in session he re-experienced a sense of powerlessness – relating that he stayed silent and did not react.

The therapist proposed a guided imagery and rescripting exercise around the experience of group exclusion at primary school, which Gianluca agreed upon. This time the idea was to try and counteract the maladaptive coping of avoidance and surrender whilst accessing a different sense of self.

The following dialogue is taken from the imagery exercise. Gianluca has just performed a brief mindfulness exercise and is now exploring his memory whilst his eyes are closed.

G: "I'm in the classroom, I'm 7. It's playtime. My schoolmates all sit at the same table, I enter the room but no-one invites me to have a snack with them".
T: "What are you thinking at this moment?".
G. "I want to play with them, but no one wants me. I watch them, they play, they have fun, some friends of mine look at me but say nothing".
T: "What do you think and feel? How do you see yourself?"
G: "Alone. I'm so ashamed, my cheeks are on fire, I feel hot, short of breath. What's wrong with me? What is it that makes me different?"
T: "... what is happening now? What do you see?"
G: "I'm leaving, I can't go where they are sitting. I go back to my classroom, luckily there is not much time to wait, the break won't last for long"

The therapist now stops the imagery exercise to allow Gianluca and the therapist to jointly reflect on the experience and agree the direction of a possible rescripting. They decide that Gianluca will try to rescript the episode acting according to his wish to belong. In order to do so, the first step is to counteract avoidance. The therapist offers to speak as an 'off-stage voice', helping Gianluca to label and regulate his experiences, and offering suggestions as to how to move

towards goal fulfilment whilst still accessing healthy self-representations. Gianluca returns to the imagined memory, his eyes closed. In the rescripting exercise the therapist asks him to approach his schoolmates.

T: "So, Gianluca, do you feel like trying this? What do you say to them?"
*G: "Hi guys, what are you doing? Are you having a snack? (*His voice is low and tremulous*)"*
T: "Good. What do you think and feel? How does it feel in your body?"
G: "I feel Ashamed! My hands are sweaty... I can hardly speak, and I can't look at them in the eyes, I feel like I'm blushing".
T: "Ok. Now focus on what they are doing. Are they playing?"
G: "Yes, they are having fun".
T: "How does that feel?"
G: "They are laughing, playing with football cards. I want to join them!".
T: "Very good. So, let's try. Breathe, take your time and approach them… pay attention to your voice, try to put energy in it, raise your chin. Ok?".
G: "Yes, I can try".

During repeated rehearsals, Gianluca became progressively more capable of approaching his friends. With repeated trials his voice became louder, he stands up, raising his shoulders at the suggestion of the therapist. Gianluca notes that the more he adopts these attitudes, the more he feels empowered and strong. When looking at his schoolmates he notes fewer signs of rejection and focuses instead on the observation that they are having a lot of fun.

G: "Hey guys, can I join? I have a new set of cards".
T: "What do you notice? How do you feel now?".
G: "They don't invite me... but... well I'm sitting next them, and they are ok, they leave me to play, one of them talks to me and… well another one asks to see my cards and… we play now".
T: "How do you feel now?"
G: "It's like... I'm one of them… just playing the game…"

The therapist invites Gianluca to explore the bodily components of this experience, and in doing so he develops a stronger awareness of this sense of belonging and playfulness.

In response to the therapist checking in with him, Gianluca says he has experienced a sense of greater confidence, and he thinks he can interact better with others. The therapist finishes the exercise and invites Gianluca to open his eyes, after which they discuss his awareness of his internal state. He is aware of feelings of shame and inferiority, but he now realizes this awareness does not mean that he will inevitably succumb to negative thoughts and feelings, and he can instead access a healthier sense of self as being motivated, possessing self-worth and able to connect. He also remembers a memory of being included in a group and other instances in which others were welcoming towards him.

As an example of a typical sequence within MIT therapy (Dimaggio et al., 2020), the treatment plan continues with *in vivo* behavioral exposure. Therefore, as homework Gianluca will try to counteract avoidance between his weekly sessions, while also trying to connect with others. In the above vignette he went on to try to do so and was partially successful. He realized that he *was* able to make contact with others, but when he did make these connections socially he was non-assertive and did not speak about very much with his peers. Role-play with the therapist was therefore used in order to model a range of more assertive conversation expressions and approaches, which formed the basis for further *in vivo* exposures. After 12 months in treatment Gianluca reported an improved, more stable sense of belonging and worthiness.

Therapeutic outcome

Therapy proceeded on a weekly basis for 18 months and was then stepped down to one session every three weeks. Gianluca became more aware of his schemas and when they surfaced again he labelled them as his "old habits". With some effort he could take a critical distance from them. "I feel unworthy, but I know it's not really me, it is something I used to think for such a long time, but now I know I'm ok". He reported frequent experiences of group inclusion, starting with his bike group, whom he now frequently tours with. He had not yet established a romantic relationship, but felt confident enough to agree to end therapy, albeit with follow-up reviews every 2 months.

Six months after therapy termination Gianluca's improvements were sustained. His social network was now broader, he was no longer depressed and instead reported feeling energized. At work he felt better able to express his own point of view, with a corresponding decrease in expectations of criticism, social anxiety and shame. He had just started a romantic relationship, which he was positive about, and was considering moving abroad to improve his employment prospects.

Discussion

The core psychological elements of APD include maladaptive interpersonal schemas, poor metacognition and over-reliance on behavioral coping strategies such as avoidance, perfectionism and procrastination. We hypothesized that including these elements in case formulation of patients diagnosed with APD will deliver benefits in the form of improved treatment adherence and outcomes. We illustrated this with a case vignette from the course of a 2-year treatment with MIT. We highlighted how adopting experiential techniques, such as guided imagery and rescripting, body-oriented work, mindfulness, role-play and behavioral experiments, both in-session and in real life could be fundamental to successful treatment. In particular, these techniques help the patient to change maladaptive interpersonal schemas and incorporate more benevolent and positive images of self and others into one's sense of identity.

These elements of formulation, besides ongoing regulation of the therapy relationship (Safran & Muran, 2000) may well have been key to treatment success, however the single case,

non-structured nature of this approach limits generalization. The above case presentation suggests that in order to change, patients with personality disorders, including individuals with APD diagnoses, need to create new experiences which enable them to discover that their core wishes can be met, and that they do not inevitably have to resort to maladaptive coping strategies to protect themselves from the psychic pain of expected or actual responses from significant others. The key mechanisms of change may happen both at the level of the therapeutic relationship (Gazzillo et al., 2019; 2020) or via a wide array of techniques both in-session and between-session (Arntz, 2012a; Greenberg, 2012; Ecker et al., 2012).

Future work, including structured research designs is planned in order to explore whether MIT, as an integrative third-wave cognitive-behavioral approach, has the potential to offer incremental benefits to existing treatments for APD. Therapeutic targets include maximizing treatment adherence, reducing associated distress; increasing the likelihood that individuals with these difficulties can live a richer and more fulfilling social life.

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The authors contributed equally to this manuscript.

Compliance with Ethical Standards

Conflict of interest
The authors declare that they have no competing interests.

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