



# Metacognitive Interpersonal Therapy for Personality Disorders: The Case of a Man with Obsessive–Compulsive Personality Disorder and Avoidant Personality Disorder

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Published online: 12 September 2018

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## Abstract

Personality disorders have a deleterious impact on individual quality of life, and are associated with a significant social burden. Despite a broad range of presentations across the various personality disorders, clinical research has shown a strong bias toward borderline personality disorder. In contrast to the emotional dysregulation of borderline personality disorder, a number of personality disorders are characterised by emotional inhibition and alexithymia. Research increasingly suggests that these deficits in emotional regulation may be symptomatic of problems with metacognition—the ability to identify, understand, and influence mental states. Research and specific treatment approaches are needed which target personality dysfunction characterised by emotional inhibition, rather than dysregulation. Emerging evidence suggests that metacognitive interpersonal therapy may be an effective treatment approach for personality disorders characterised by emotional inhibition. The current case study provides an in-depth examination of the application of metacognitive interpersonal therapy for a man diagnosed with comorbid avoidant personality disorder, and obsessive compulsive personality disorder. The patient described a history of bullying and unmet needs throughout his childhood, resulting in maladaptive interpersonal schemas and metacognitive deficits. Treatment focused on building the patient’s ability to identify and understand his mental states, and targeted schema-driven behaviour. The patient reported experiencing the therapy as helpful, and stated that it contributed to a marked improvement in his quality of life. Results indicate that a 1 year intervention was successful in achieving diagnostic recovery and symptom reduction, supporting metacognitive interpersonal therapy as an effective intervention.

**Keywords** Avoidant personality disorder · Obsessive–compulsive personality disorder · Treatment · Intervention · Metacognitive interpersonal therapy

Individuals with personality disorders (PDs) typically experience significant suffering. Persons diagnosed with PDs report high levels of interpersonal difficulties, poor self-concept, and deficits in functioning across multiple domains (Chang et al. 2010; Samuels 2011; Soeteman et al. 2008). PDs are also associated with more frequent hospitalisation and medical morbidity, compared to other mental disorders (Samuels 2011). Considering the significant impact of PDs

on individual wellbeing and society as a whole, it is of great importance to develop effective treatment approaches.

Over the past several decades, there has been increasing research into psychotherapeutic interventions for persons with PDs, however the majority of clinical research has focused on the treatment of borderline PD (see Widiger 2016 for review). This research bias is problematic due to differences in presentation between borderline PD, and other PDs (see Popolo et al. 2014). In particular, marked differences can be observed between PDs featuring emotional dysregulation as opposed to emotional inhibition. All PDs feature some level of difficulty with emotional processing and emotional regulation (Coker et al. 2002). In the case of borderline PD, these difficulties are characterised by dysregulation. Emotions are experienced as chaotic and overwhelming, resulting in self-destructive, acting-out behaviours. By contrast, a number of PDs are characterised

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by emotional inhibition (Popolo et al. 2014) and a combination of inhibition and perfectionism is key to predicting PD severity (Dimaggio et al. 2018). Persons diagnosed with emotionally inhibited PDs may experience alexithymia, or difficulty identifying emotions. Individuals may feel distant from their feelings, and experience distress when they do notice a strong emotion. Rather than acting out behaviours, individuals with emotionally inhibited PDs may engage in over-controlled behaviours, withdrawal, and avoidance (Dimaggio et al. 2015; Popolo et al. 2014).

Emotional inhibition characterises obsessive–compulsive PD (OCPD; see Dimaggio et al. 2011). OCPD is evidenced by extreme perfectionism and unrelenting standards imposed on self and others. Individuals diagnosed with OCPD may struggle with perfectionism which impedes efficiency in work roles (Dimaggio et al. 2015). Sufferers may also struggle to maintain interpersonal relationships, due to difficulty with the expression of feelings, and a tendency to engage in criticism when standards are not met. Persons with OCPD may experience rage and anxiety when confronted with perceived loss of control (Dimaggio et al. 2015).

Similarly, persons with avoidant PD often present with emotional inhibition (Dimaggio et al. 2015, 2018). Persons with avoidant features suffer from a pervasive sense of shame, perceived personal inadequacy, and crippling social anxiety. These maladaptive interpersonal patterns contribute to withdrawal and avoidance behaviours (Dimaggio et al. 2007).

Despite the functional impacts of these disorders, very little clinical research has been conducted on the effectiveness of therapeutic interventions targeting obsessive–compulsive and avoidant personality features. Research is needed to examine the experience of psychotherapy and clinical outcomes for people diagnosed with PDs featuring emotional inhibition.

## Metacognitive Interpersonal Therapy

To address emotional inhibition, treatment approaches are needed which focus on increasing skills around recognising, expressing, and skillfully regulating emotions. Metacognitive Interpersonal therapy (MIT) is an integrative, psychotherapeutic approach, developed for the treatment of PDs featuring emotional inhibition (Dimaggio et al. 2015). MIT aims to improve self-concept, enhance interpersonal functioning and reduce the severity of PD symptoms. The therapy focuses on building skills in metacognition—an individual's capacity to recognise, understand, and influence mental states. Metacognition can be conceptualised as a series of semi-independent skills. These skills include the capacity to identify thoughts, feelings, and memories, and to understand the causal reaction chains between these different

internal experiences. Differing skill sets are required for understanding the self, as opposed to understanding the internal experiences of others (Dimaggio and Lysaker 2015; Semerari et al. 2003). In addition to understanding mental states, metacognition also denotes the ability to consciously influence one's internal experience (Semerari et al. 2003). For example, one may recognise a sense of hurt in response to a perceived criticism, and deliberately alter this mental state through redirecting attention to one's breathing.

MIT is an integrative therapeutic approach incorporating elements of cognitive-behavioural, psychodynamic, mentalisation, and narrative based approaches (Dimaggio et al. 2015). The therapy focuses on developing metacognitive skills through examining detailed recounts of interpersonal episodes. The patient is encouraged to recall the details of interpersonal interactions, and practice identifying the relationships between thoughts, feelings, and behaviours involved in these scenarios. Over time, these episodes form the basis of developing an understanding of recurring interpersonal schemas. Incorporating elements of psychodynamic therapy, over time the patient is encouraged to consider the impact of early attachment experiences in establishing these schemas. Between session exercises focus on metacognitive skill development, and behavioural experiments intended to interrupt maladaptive interpersonal cycles. Drawing on techniques used in narrative therapy, the patient is encouraged to develop a richer narrative, incorporating a strengths-based perception of their past experiences and current sense of self. To this end, the therapist focuses on highlighting schema-discrepant experiences and achievements, encouraging the patient to build a more nuanced narrative of themselves and their relationships.

## Current Research Regarding MIT

A number of case studies indicate that MIT may be a useful intervention for individuals diagnosed with a range of PDs. Reported outcome measures indicate improvements in metacognitive skills, PD symptoms, and interpersonal difficulties (see e.g., Dimaggio et al. 2011, 2013; Salvatore et al. 2016). Despite these promising results, significant limitations have been identified in existing case studies. In most case studies, no statistical data analysis was undertaken. No baseline data was collected, making it impossible to determine pre-treatment symptom trajectories. In addition, case studies to date have not included measures of treatment fidelity, making it difficult to ascribe the observed gains to the manualised intervention. A first, more structured, case-series yielded good-outcomes in three cases with different PDs (Dimaggio et al. 2017).

Addressing the limitations of previous studies, a multiple-baseline case series examination of MIT was recently

completed. With seven participants, the study included baseline data collected over 3 weeks, a defined 1-year intervention period, statistical analysis of results, and the development and implementation of a fidelity measure. Results indicated that a 1 year MIT intervention was associated with recovery from the diagnosis of PD, and reliable change in measures of general functioning, anxiety and depressive symptoms, and alexithymia (Gordon-King et al. 2018).

## Current Study

Building on the clinical outcomes reported by Gordon-King et al. (2018), the current paper provides an in-depth single case study, examining the treatment response of a patient who participated in a larger case series. The patient was diagnosed with comorbid avoidant PD and OCPD. The current study describes how MIT contributed to change in different outcomes, both at the level of personality-related issues and symptoms. Outcome variables comprised diagnostic recovery, symptom severity, and alexithymia.

## Method

### Design and Procedure

Identifying participant details have been anonymised. Charles took part in a case series, 12 months trial of MIT, conducted by Gordon-King et al. (2018). After a clinical interview, baseline measures were undertaken weekly, for 3 weeks prior to commencing the intervention. The intervention comprised 50 min weekly sessions. Outcome measures were repeated 3 months, 6 months, 9 months, and 12 months after beginning the intervention. Measured variables were recovery, symptom severity, and alexithymia. A fidelity rating scale assessed the implementation of the manualised intervention. Once the therapy was concluded, a qualitative interview was undertaken to explore Charles' experience of therapy.

## Measures

### Clinical Diagnosis

Personality disorder diagnoses were established using the Structured Clinical Interview for DSM-IV PDs (SCID-II). The SCID-II is a structured diagnostic interview for PDs as defined by the Diagnostic and Statistical Manual of Mental Disorders, 4th Edition. Interviewers assess PD criteria, and judge each criterion (1 = symptom absent, 2 = sub-clinical symptom present, 3 = symptom met). The SCID-II has good

inter-rater reliability and good inter-rater and internal reliability (Maffei et al. 1997).

### Outcome Questionnaire-45.2 (OQ-45.2)

The OQ-45.2 is a self-report measure with 45 items, measuring change over time in therapy. Participants rate their experience of various symptoms over the past week on a five point Likert scale (0 = never, 4 = almost always). Reliability for the OQ-45.2 has been found to be good with regard to internal consistency and test–retest reliability,  $\alpha = 0.93$ ,  $r = .84$ , respectively (Doerfler et al. 2002).

### Toronto Alexithymia Scale (TAS-20)

The TAS-20 is a self-report scale with 20 items, assessing alexithymia—difficulty identifying and describing emotions. Participants rate items on a five point Likert scale (1 = strongly agree, 5 = strongly disagree). Studies indicate that the TAS-20 has good internal consistency ( $\alpha = 0.81$ ; Ciarrochi and Bilich 2006).

### Depression and Anxiety Stress Scale, 21 (DASS 21)

The DASS 21 is a 21 item self-report measure assessing depressive, anxiety, and stress symptoms. Participants rate items from 0 (did not apply to me at all over the last week) to 3 (applied to me very much or most of the time over the past week). The DASS 21 comprises three subscales (depression, anxiety, and stress), and the raw score for each subscale is doubled to provide the final score. The DASS 21 has shown factorial validity and good reliability (Yusoff et al. 2013).

### MIT Fidelity Scale

Gordon-King et al. (2018) developed a fidelity scale to assess therapist adherence to the MIT manualized intervention. The measure assesses five core competencies in MIT: management of the therapeutic relationship; focus on narrative episodes; facilitating emotional awareness; focus on interpersonal schemas; and developing healthy self-narratives. Competencies are assessed by reviewing a 20 min video segment of a therapy session, with two raters rating each competency from 1 to 5 (1 = no evidence of competency, 3 = evidence of satisfactory competency, 5 = evidence of very strong competency). Reviewers scored segments independently, and were blind to the other's scoring. Item scores are averaged to produce a final score. Gordon-King et al. (2018) found that the measure showed good inter-rater reliability ( $r = .79$ ,  $p = .034$ ).

## Case Summary

Charles is a 22 year old Caucasian man, who at the commencement of therapy was living with his male partner of 2 years. Charles worked in marketing, and was referred to the study via a psychology clinic. He presented seeking support with chronic anxiety and interpersonal difficulties. Charles described himself as a highly perfectionistic person, who could be judgmental and critical of himself and others. He reported that he struggled to form meaningful emotional attachments, often feeling disconnected in during social interactions. These presenting difficulties occurred against a background of peer bullying and family dislocation throughout his childhood. On a SCID-II interview, Charles met criteria for avoidant PD and obsessive–compulsive PD. A clinical interview indicated that Charles met criteria for social anxiety disorder. Although Charles did not meet clinical criteria for narcissistic personality disorder, qualitative observations and discussion with Charles' therapist appeared to indicate that he may have had narcissistic traits. This included examples of grandiosity, a tendency to devalue others, and hypersensitivity to criticism.

## Client History

Charles is the younger of two siblings, with an older brother. He described his parents as overbearing and controlling. He recalled a culture of high expectations within his family with regard to school performance, and reported that both of his parents frequently appeared anxious and tense. His family moved several times throughout his childhood, and Charles found it very difficult to adjust and form peer groups after each move. When Charles was 14 years old, his parents informed him and his brother that they were going to divorce. Charles described feeling very disconnected during this conversation, and the separation was not openly discussed again. Charles lived with his mother after the divorce. His mother re-partnered, and Charles had a difficult relationship with his mother's partner, whom he described as aggressive and 'hyper masculine'. Charles suffered severe bullying and ostracism throughout his primary and high school years. He recalled feeling ostracized for being 'effeminate', and that he struggled to relate to his peers. During his primary school years, he began to experience episodes of rage when he felt overwhelmed, physically lashing out at other students. School staff attempted to address these behavioural issues by isolating Charles, instructing him to remain in a walled area during lunch and actively discouraging fellow students from interacting with him.

Charles performed well throughout school, however developed severe social anxiety in his adolescence. He reported extreme pressure to perform well academically. After graduating from school, he studied two undergraduate degrees simultaneously, then began working full time in a high pressure marketing role. He reported struggling at work due to his perfectionism interfering with task completion, and conflict with colleagues. While working full time, he began studying a postgraduate degree.

During his adolescence, Charles reported that he developed an awareness that he was same-sex attracted, and commenced a number of romantic relationships during this time. Over the previous 2 years he had been in a relationship with a 31 year old male. He reported experiencing this relationship as unsatisfying. He felt that his partner lacked drive and intellectual depth. He reported a sense of distance, and difficulty expressing his feelings within the relationship.

Prior to his involvement in the MIT Trial, Charles had engaged in several psychotherapeutic treatments over the previous 3 years. Most interventions had been short term, and focused on cognitive-behavioural strategies. He had also engaged in a longer, 6 months psychodynamic intervention immediately prior to commencing MIT. Charles reported that, although he had appreciated the opportunity to speak to a therapist about his feelings, he had not experienced any symptom relief.

## Formulation

Charles' difficulties were long standing, derived from early experiences. Throughout his childhood, his need for unconditional acceptance was not met. He recollected his parents being focused on external achievements, resulting in a perceived link between external validation and self-worth. To Charles' knowledge, his parents were never formally diagnosed with a mental health condition. However, based on his recollections of his family history, it is possible that Charles had a familial vulnerability to developing personality disorder symptoms, as his parents reportedly displayed difficulties with emotional dysregulation. His poor self-concept was reinforced by a perceived lack of acceptance and friendship from school peers, and isolation-based punishments from his teachers. It is also possible the social ostracism he experienced may have been compounded by a general environment of social prejudice surrounding his sexuality. Charles internalized a sense of shame and a sense of personal inadequacy, contributing to increasing anxiety in social situations.

A schema was developed, in which Charles wished to feel 'good enough' and accepted by others. He constructed the others as critical and rejecting. His response was a form of coping with this criticism, as he continually attempted to meet this wish by pushing himself toward external

achievements, and by holding himself to unrealistic standards. His efforts fell short of perfection, with others not providing the wished for validation and acceptance. Charles responded by distancing himself from significant others, and focusing again on pursuing external achievements. This became a self-maintaining cycle, resulting in Charles working upwards of 70 h every week, while feeling inadequate, anxious, distant, and isolated. Rather than embracing vulnerability within relationships, Charles' difficulties were maintained by self and other directed criticism, perfectionism, and unrealistic standards. His difficulties were further maintained by metacognitive deficits. In terms of metacognitive impairments, Charles demonstrated a highly intellectualized understanding of himself and others, focusing on cognitions with little access to emotional experience, evidenced by very limited use of emotion-focused language. He often spoke in terms of metaphors and stories to describe his internal experience, indicating a reluctance or inability to make direct contact with, or express intense feelings. In addition, Charles struggled to understand the experience and motivations of others, and had difficulty regulating his own mental states. This resulted in Charles experiencing interpersonal interactions as frustrating, and his own reactions as overwhelming.

## Treatment Plan

Following an in-depth assessment and formulation which included the formation of an effective therapeutic alliance, weekly sessions focused on developing his metacognitive skills, particularly with regard to identifying, understanding, and expressing emotions. By repeatedly reflecting upon interpersonal episodes and linking these to past experiences, the therapist aimed to help Charles develop an awareness of his interpersonal schemas. Between sessions, homework exercises encouraged Charles to experiment with engaging in schema-discrepant behaviours, and building a sense of identity outside of work and external achievement.

## Treatment Progression

Early sessions focused on targeting Charles' tendency to intellectualise his internal experience and distance himself from emotions. Sessions focused on recalling interpersonal episodes, and encouraging Charles to identify emotions associated with these experiences. Charles showed a strong tendency to rely on metaphors to distance himself from his internal experiences. In his second session, he described his experience of completing an interview with a researcher in order to enter the study. He described the experience as triggering strong feelings, but was unable to identify specific emotions. He stated 'it was like suddenly starting walking

along a bridge, and you know the next steps but not the destination'.

Over the next few sessions, the therapist attempted to use body (or somatic) awareness to help Charles identify feelings, rather than relying on metaphors. This was initially a painstaking and methodical process. For example, when describing an episode in which he had gone to bed and felt overwhelmed with anxiety, he reported 'it was like I was running a marathon, pounding away on the pavement'. The therapist replied 'what in your body told you that you were running a marathon, what was your body feeling in that moment?'. Charles said 'my heart, beating so fast', to which the therapist responded 'do you think perhaps you may have felt panic in that moment?'. In this way, the therapist began assisting Charles to recognise the impact of emotions on his physical body, gently introducing him to naming feeling states.

Charles found this process of connecting somatic experiences with emotional descriptors challenging, and often rejected that therapist's suggestions. During the early phase of therapy, he would frequently assert that he had not experienced any strong emotion during interpersonal episodes. For example, when discussing the moment his parents had informed him of their divorce, he stated 'it didn't bother me'. To this, the therapist replied 'and how does it feel for you now, reflecting on it in this room with me?'. In this way, the therapist aimed to bypass the dismissal of difficult feelings by focusing on present moment experience. It is likely that issues in the therapeutic alliance interacted with Charles' metacognitive difficulties and interpersonal schemas, contributing to these events within the therapy. When Charles provided an initial recount of an interpersonal event, his therapist would encourage him to identify and explore his emotions. It is likely that this initially led to resistance, as the struggle to learn how to identify feelings triggered a sense of inadequacy, and challenged his usual reliance on intellectualization as a coping mechanism. Charles also expressed a sense of contempt toward others in his life who expressed strong emotions, describing them as 'without self-control'. It is thus likely that turning toward difficult emotions triggered distress for Charles, who associated feelings with a loss of control. The therapist addressed this process issue by openly discussing with Charles his relationship with emotions, and how current experience may relate to previous experiences with significant others, particularly his mother who reportedly had limited ability to regulate her feelings. These experiences had resulted in Charles associating strong feelings with perceived weakness and lack of control. Over time, Charles began to develop an increasing awareness of his emotions, and showed a greater capacity to identify and make sense of feeling states.

After approximately 3 months, the focus of therapy shifted to developing a joint formulation of Charles'

interpersonal patterns and schemas. Through analysing detailed interpersonal episodes and linking these to memories of earlier developmental phases, Charles developed an understanding of his core wish to feel ‘good enough’ and appreciated by those around him. Through recollecting past difficult experiences, Charles recognised that he had formed a belief that if he showed his work or made himself vulnerable, significant others would reject and criticize him. This resulted in a self-concept centred around feeling unworthy, triggering feelings of sadness. He came to understand his tendency to overwork and control external circumstances as an attempt to meet his underlying needs. Charles also developed an increased understanding of his unhelpful coping behaviours. Through examining narrative episodes, he recognised that he was motivated by a belief that if he could improve his performance and meet external goals, then he would gain conditional approval and acceptance from others. However, his core wish to feel accepted as simply himself continued to go unmet, as he felt that acceptance was conditional upon his being ‘perfect’.

Despite the dominance of this maladaptive schema, therapy also focused on exploring schema-discrepant memories, where Charles experienced himself as competent and valuable. With assistance from his therapist, Charles was able to identify an episode where he felt accepted by a close friend in a moment of emotional vulnerability. The therapist attempted to underscore this schema-discrepant experience by stating ‘can you tell me, in detail, about how that acceptance feels? What is it like compared to the experience with [another friend], where you felt more rejected?’. He could also identify episodes at work, where his boss had provided him reassurance that he was a valued and competent team member, even after he had made an error. These memories allowed Charles to explore the possibility that his self-concept may have developed in response to early experiences, rather than representing an objective truth. This helped him to develop greater metacognitive capacity to view thoughts and feelings as subjective experiences, rather than objective facts. It also allowed him to enrich his self-narrative by building a sense of himself as competent and valued.

Between sessions, Charles’ therapy focused on self-monitoring exercises to promote metacognitive skill building. In session ten, Charles discussed a sense of overwhelming frustration which he experienced when he felt that his partner would not take his advice. His therapist suggested ‘do you think over the next week or so, you know, before our next session, perhaps you could see if this situation comes up again? ... And if it does, then see if you can notice if there are any other feelings there, as well as frustration, or just notice what happened in the lead up before you were feeling frustrated’. In this way, the therapist encouraged Charles to develop skills in identifying internal reaction chains, and to gain an experiential understanding that anger

is often a secondary emotion, in response to underlying sense of hurt or anxiety. Toward the end of therapy, Charles was encouraged to experiment with engaging in schema discrepant behaviours, such as expressing his feelings to his partner, and also reducing his workload. These changes helped to interrupt his schema-driven pattern of striving for conditional acceptance through perfectionism, assisting him instead to meet his wish to feel accepted, even with his imperfections. At the same time, he was supported in recognising the consequences of engaging in what was, for him, a novel behavior which involved risk of experiencing painful emotions.

Over the last several months of therapy, sessions focused on exploring the therapeutic relationship in the lead up to therapy termination. Charles expressed significant anxiety when anticipating the end of therapy, however at the conclusion of therapy stated that he was feeling ready to finish. Overall, accounting for several brief breaks due to Charles’ study commitments, illness, and holidays, Charles participated in 36 sessions of psychotherapy.

## Results

### Diagnostic Recovery

The primary outcome variable was diagnostic recovery. SCID-II interviews were conducted before commencing the intervention, and after completing the intervention. Before commencing the intervention, Charles met a total of 22 clinical criteria across all DSM-IV PDs. He also met diagnostic criteria for avoidant PD and obsessive–compulsive PD. At the conclusion of therapy, Charles met a total of four clinical criteria, and did not meet criteria for any PD diagnosis.

### Secondary Outcome Variables

Secondary outcome variables were assessed by examining data trends over time, and by examining the reliable change index for all scales. The reliable change index (RCI) is a statistical measure of change over time, widely utilised in case study research. The RCI is defined as the change in the patient’s score, divided by the standard error of the difference for the scale. This is a measure of statistical significance, rather than clinical significance. Charles’ RCI was calculated by comparing his mean baseline score to his final score after the 12 months intervention.

As shown in Table 1, Charles demonstrated reliable change across all measured variables.

Based on his mean baseline score, at the commencement of therapy Charles fell in the clinical range of severity for the OQ 45.2, while at the conclusion of therapy he fell into the non-clinical range. On all of the DASS 21 subscales, Charles

**Table 1** Secondary outcome variable results over time

	B1	B2	B3	B <sub>Mean</sub>	M3	M6	M9	M12	RCI (yes/no)
OQ 45.2	114	104	107	108	104	76	59	43	7.81 (yes)
DASS 21 (depression)	26	26	30	27	30	10	8	6	7.10 (yes)
DASS 21 (anxiety)	20	20	18	19	26	10	6	6	6.12 (yes)
DASS 21 (stress)	22	24	34	27	28	16	8	6	5.94 (yes)
TAS-20	65	63	62	63	47	52	49	46	2.83 (yes)

fell in the severe range at the beginning of therapy, shifting to the normal range for symptom severity at 12 months. On the TAS-20 measure of alexithymia, before commencing therapy Charles met the cut off for alexithymia however the conclusion of therapy was no longer in the clinical range for -alexithymia.

Examining trends over time, Charles' baseline scores on each of the above measures indicate consistent severity of symptoms throughout the baseline period. Changes were noted after 6 months of therapy, with a consistent decline in scores seen after this point.

### Fidelity Ratings

Ratings from the fidelity measure indicated that Charles' therapist showed a satisfactory level of adherence to the manualised intervention. Rater one gave the therapist an average score of 4.30 out of a possible 5, while rater two gave the therapist an average score of 4.50. These results indicate that the intervention was carried out as manualised.

### Qualitative Gains and Feedback

Charles reported that he experienced therapy as very helpful. Over the course of therapy, he reported significantly reduced social anxiety, and increased confidence. He stated that he had formed a number of new social connections, and felt more confident asserting his needs at work.

Over the course of therapy, Charles chose to end his relationship with his partner, stating that he realised he had relied on his partner to avoid feeling lonely, rather than feeling a genuine emotional connection. He perceived his course of action as a positive outcome of therapy.

Sharing his experience of therapy in a post-intervention interview, Charles stated,

The changes that I've noticed within myself...the really visible one would be anxiety... before I went into therapy I was having what you could call an anxiety attack... now I can't remember the last time I had one of them at all....I feel like that there was such a negative weight on my shoulders, and that negative weight hasn't been removed as much as it has been balanced... as a person I'm generally way more under-

standing and patient... I feel like now I can understand why people don't do things... I'm more empathetic and I'm patient and caring... I feel more aware of what ingredients go into those situations.

### Discussion

The current case demonstrates the importance of a new integrative treatment approach targeting emotional inhibition which is characteristic of specific to PDs. Charles very seldom suffered episodes of dysregulation or rage. Rather than being overwhelmed by a tangle of feelings, Charles experienced himself as distant from his emotions. At the commencement of therapy, he struggled to express himself, and viewed the expression of emotions as a sign of personal weakness. He focused on meeting self-imposed, unrealistic standards at work and in his studies, in an attempt to meet an unrecognised need to feel 'good enough'. Although he frequently found himself experiencing symptoms of panic and anxiety in social situations, he struggled to link physical experiences to emotions. Charles' presentation was typical of persons presenting with avoidant PD and OCPD (see Dimaggio et al. 2011, 2015). Given the over-controlled and inhibited features of his presentation, it is unlikely that he would have benefitted from therapies targeting emotional dysregulation.

The current report supported by detailed assessment over time highlights the importance of metacognitive interventions in the treatment of PDs. It is not surprising that Charles had not benefitted from previous cognitive-behavioural or psychodynamic interventions, which require a patient to have capacity to identify their internal experiences (although it should be noted that a 6 months psychodynamic intervention may not have been sufficient to produce therapeutic results). Before challenging his reaction patterns or core beliefs, Charles first needed to identify and develop a metacognitive skill set and practice identifying and naming emotions. This supports previous findings which increasingly support the role of metacognitive deficits as a key risk factor for, and presenting feature of PDs (see Dimaggio et al. 2010). It is also likely that Charles' experience of feeling accepted unconditionally by his therapist contributed to his

capacity to challenge previous schemas regarding his sense of inadequacy.

The current study builds on existing literature supporting MIT as an effective intervention for PDs featuring emotional inhibition (see e.g., Dimaggio et al. 2011, 2012, 2017; Salvatore et al. 2016). Charles took part in the largest and most rigorous case series examination of MIT to date (Gordon-King et al. 2018). Results from multiple baseline measures strengthen the likelihood that the intervention was a causal factor in the observed changes, as Charles demonstrated a consistent symptom pattern before commencing therapy. In addition, fidelity ratings indicated that the intervention was carried out as manualised, further supporting the likelihood that MIT includes therapeutic ingredients representing a causal mechanism of change.

The intervention was time limited, with Charles participating in 36 sessions over 12 months. Building on previous case studies, this finding demonstrates the feasibility of achieving diagnostic recovery and reliable change in a limited time frame. While previous case studies have implemented interventions over 2–3 years, in the current study Charles demonstrated marked symptom change after 6 months supporting the notion that MIT may be a resource-effective intervention.

The single case study design allows for a detailed analysis of one individual's clinical formulation and response to therapy. This demonstrates the implementation and adaptation of an intervention to individual circumstances, as occurs in 'real world' clinical settings. However, while single study designs show a high level of clinical utility, broader trials are needed to determine the overall effectiveness of the intervention. The results of the current case cannot be extrapolated to general conclusions regarding the efficacy of MIT. In addition, the integrative nature of MIT makes it difficult to identify mechanisms of change. In a qualitative interview following the conclusion of therapy, Charles echoed this difficulty, stating "therapy has been extremely rewarding for me. It's difficult for me to map out how it has been rewarding, you know it's difficult for me to map out where the narrative went... but it's been rewarding". A further limitation of the current study was the failure to measure the therapeutic alliance. The decision was originally made to minimise the burden on the participants by limiting the number of measures administered. However, tracking the quality of the therapeutic alliance over time would have allowed for more detailed examination of process issues in the therapy.

Future studies could build on current research by conducting effectiveness clinical trials. Studies should also focus on examining potential mechanisms of change, to identify whether symptom change is driven by particular interventions within the MIT approach. In addition, future research could provide follow up data, to determine whether gains are maintained after the conclusion of therapy. Overall, the

current study demonstrates the importance of interventions for PDs featuring emotional inhibition. Such interventions have the potential to significantly improve the quality of life for individuals suffering from personally based disorders characterised by emotional inhibition.

## Compliance with Ethical Standards

**Conflict of interest** Dr. Gordon-King, Dr. Schweitzer and Dr. Dimaggio declares that they have no conflict of interest.

**Ethical Approval** All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. This article does not contain any studies with animals performed by any of the authors.

**Informed Consent** Informed consent was obtained from all individual participants included in the study.

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