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Changing embodied dialogical patterns in Metacognitive Interpersonal Therapy

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ABSTRACT

According to proponents of Dialogical Self Theory (DST), the self is made up of a series of I-positions, which continuously interact, negotiating potential courses of action, and attributing meaning to events. Individuals with personality disorders tend to attribute meaning according to stereotyped dialogical relationship patterns which prevent them from achieving social adaptation and fulfillment. These patterns do not just take a discursive form, but are instead embodied and rooted within internalized processes; which are themselves laden with affect, behavioral dispositions and somatic experiences.

Using a case study we demonstrate how Metacognitive Interpersonal Therapy (MIT) provides a platform for changing embodied dialogical patterns, via imagery and body work. These techniques enable revision of the embodied component of the dialogical pattern, promoting the emergence of new I-positions. These new patterns comprise more adaptive aspects and correspondingly impede the enactment of previous maladaptive coping strategies, that were driven by pathological I-positions. Finally, we discuss the implications of experiential work in this context, as a crucial component of dialogical oriented therapies for people experiencing severe interpersonal problems such as personality disorders.

Keywords: Personality Disorders; Dialogical Self Theory; Metacognitive Interpersonal Therapy; Embodied Cognition; Psychotherapy

Introduction

Humans make meaning in their social life via an ongoing dialogue between different aspects of the self, named 'I-positions' in Dialogical Self Theory (DST; Hermans, Kempen & van Loon, 1992; Hermans & Dimaggio, 2004; Konopka, Hermans & Gonçalves, 2018; Lysaker & Lysaker, 2002). These positions interact continuously as they create predictions of the likely outcome of one's own wishes and drives, guiding the best course of action to undertake. Healthy functioning and adaptation require flexibility, so in ongoing dialogues there needs to be room for consideration of different perspectives, and openness to innovative moments (Gonçalves, 2017), rather than relying on crystallized interactional patterns.

For individuals with psychiatric disorders, interactions between I-positions may lack the capacity for openness and innovation, leaving individuals' meaning-making activities guided by fixed and rigid patterns, which take the form of maladaptive schemas (Dimaggio et al. 2015; Luborsky, 1984; Luborsky & Crits-Christoph, 1990). For example, a woman is driven by the wish to be cared for, but her representation of the other is almost exclusively experienced as neglecting, and consequently she feels chronically unloved and 'shuts down'. At this point she may resort to the position of caregiver in order to sustain contact with the other, adopting self-sacrificing behaviors. These may help her to cope with her feelings of loneliness, but do not help her restore a position of I-as-lovable and cared for. Of note, these maladaptive patterns are dialogical in form, that is they represent internalized, real-world interactions between two or more characters adopting different positions. These patterns are crystalized, in the sense that they are repetitive and (usually) end with the same, disappointing, outcome (Dimaggio, et al, 2007) .

According to Metacognitive Interpersonal Therapy (MIT; Dimaggio et al., 2015), these patterns are best framed using the following structure, based on a modified version of the Core Conflictual Relational Theme (Luborsky, 1984; Luborsky & Crits-Christoph, 1990): a) a wish or motive, for example attachment, social rank, group inclusion and autonomy/exploration; b) core I-positions underlying the wish, e.g. *I as unworthy* vs. *I as worthy*, *I as thwarted by others* vs *I as autonomous and supported*; c) the expected or appraised *response of the other*, which in DST terminology denotes the way the other is positioned. In psychopathology the response of the other usually confirms the underlying negative I-

position – e.g. the neglecting other confirms the idea of self-as unlovable. Simultaneously, these individuals are continuously testing, both their own mind and their interactions with others, whether the response of the other will be positive, thus supporting more benevolent self-positions. In the above example the individual is testing whether the ‘I as autonomous’ meets the other in the supporter position.

These patterns represent more than just cognitive representations; they are also affect-laden and embodied (Dimaggio et al., in press). Building on early observations by William James (1884), embodied cognition theory (Shapiro, 2010; Osypiuk et al., 2018) positions the body as central to cognitive processing. Individuals understand their emotional experience via interactions between one’s awareness of bodily and behavioral signals (Damasio, 1995). Embodied cognition theory gives us multiple examples of these types of reciprocal interactions, such as emotions/mood and its interaction with posture/body movement. If we listen to sad music, our posture is similar to an individual suffering from major depression (Michalak et al., 2009). Height, related to posture, is lower when persons speak negative words related to disappointment as opposed to positive words related to pride (Oosterwijk et al., 2009).

Conversely, changing posture and movement help modulate emotions and mood. For example, hunched postures may temporarily undermine confidence in one’s self-evaluations (Briñol et al., 2009) triggering evaluations of self as less creative and more stressed (Kwon & Kim, 2015). On the other hand, adopting so-called “power poses” (Carney et al., 2015; Credé & Phillips, 2017; Simmons & Simonsohn, 2017) are associated with self-evaluations of higher self-esteem and better mood (Nair et al., 2015). In terms of DST, these poses represent the embodied aspect of I-positions, which go alongside cognitive and affective elements. For example, I may adopt a position in which I think I am strong, and feel proud, alongside an open, energized pose.

When we talk of embodied cognition we include imagery processes, characterized by the involvement of sensory and proprioceptive experience, moving beyond cognitions and emotions (Hackmann, et al., 2011). When individuals imagine specific memories, they form subjective experiences rich in emotional and sensorial elements, which go beyond simply describing the same memory verbally (Holmes et al., 2006). Finally, imagining actions is associated with neural activation of the premotor

cortex, as well a number of other neural networks linked to actual action (Cattaneo et al., 2009; Pilgramm et al., 2016).

What are the clinical implications of the above? First, in session, if we ask a client to imagine a specific relational memory, we are not just evoking recall (Sicter et al., 2012). At this point the mind is retrieving and synthesizing multimodal elements, including sounds, smells, tactile sensations, and integrate them into a micro-narrative (Damasio, 1994). The aforementioned theories provide a rationale for working from a ‘bottom-up’ perspective to work to change cognitive-affective processes related to interpersonal patterns (Dimaggio et al., in press; Ogden & Fisher, 2015). Put simply, if we ask individuals to write different endings to imagined scenes, or to adopt different bodily postures when facing problematic relational interactions, we are facilitating the individual in taking steps to change the process by which they make meaning from their interactions, forming the first step in rewriting dialogical relationship patterns.

Using imagery and body work in MIT

MIT uses a carefully manualized procedure to foster therapeutic change. We do not use imagery and bodily oriented techniques in an eclectic way, but as a part of a formalized decision-making therapeutic procedure (Dimaggio et al., 2015; in press). We now describe how imagery and bodily techniques are used according to the procedure. The main goals are:

1) *Improving knowledge of own inner states*, which we have labelled metacognitive monitoring (Semerari et al., 2003). For example, we use these techniques to increase awareness of affective experiences and then help patients label them.

2) *Fostering agency*. Through both imagery and bodily exercises, patients are guided to discover that they have power and control (agency) over their own mental states. This aids them to discard maladaptive positions such as “I as passively responding to others” and embody more adaptive meta-positions such as: “I have power over my experiences, and am not simply hostage to my thoughts and feelings. I want to act according to my own view and I have the power to do so”. Taking a specific pose fosters the connection with healthier I-positions and metapositions.

3) A key step is *promoting differentiation*, that is discovering that one's idea about self and others are subjective, bound to one's own perspective and may therefore be amendable to change. In doing so, the individual realizes that his or her ideas about social relationships do not necessarily mirror reality. Of note, the second step, promoting agency, includes a first element of differentiation, in the process of moving from "I cannot control my reactions" to "I believed that I was a passive recipient of others' intentions; but now I realize that this is not true as I have power over myself".

4) *Accessing healthy self-positions*, relates to helping individuals to gain awareness of I-positions imbued with positive qualities such as 'I-as-lovable', 'I-as-worthy', 'I-as-strong', 'I-as-energy-driven' and so forth. Usually, the more severe the patients' difficulties, the poorer their self-awareness of their capacity to use these positions, leading to them under-utilizing such positions in tasks or interactions or even having no recall of the availability of these positions. If the individual is able to access these positions, they are not sustained within the inner dialogue and are overshadowed by problematic, dominant positions. The techniques we describe in the next sections are effective in facilitating access to healthy I-positions, as we will demonstrate in the clinical part of the paper.

Imagery and body work

Guided imagery with rescripting (Hackmann et al., 2011) has become of increasing importance in MIT over recent years (Dimaggio, Popolo, Ottavi & Salvatore, 2018). Of note, rescripting within imagery is somewhat different from restorative storytelling, as the former does not just ask the client to simply recall the story, but also to re-inhabit in the present moment, so affects are experienced almost 'as if' the event was happening for real. The technique consists of supporting the patient to relive trauma specific memories, often with their eyes closed. The scene is first re-experienced with as much detail as possible. The therapist helps the patient to retrieve any details of the event and then tracks thoughts, affect and somatic states as they unfold over the episode. After discussion, the therapist invites the patient to alter the course of the events, with the goal of promoting new ways of meaning-making, or 'innovative moments' (Gonçalves, 2017).

Rescripting does not mean changing the past. Instead, the rewriting is of the core affect-laden structure of meaning-making structures, so that the new endings (with the accompanying affects) can act as a new psychological map for negotiating the relational world. The rationale here is that this imagery is not an act of fantasy, but activates several neuroanatomical areas concerned with movement. In short, when the person changes a scene he or she prepares the body to *act* differently (Dimaggio et al., in press).

Bodily work, in the tradition of gestalt (Perls et al., 1994), bioenergetic (Lowen, 1971) and sensorimotor therapies (Ogden & Fisher, 2015) aims to first promote higher metacognitive awareness of own inner states. For example, when patients are guided by the ‘I-as vulnerable and weak’ position, therapists can invite them to note where in the body they locate sensations of weakness and vulnerability. The patient may track them in posture or note a sensation that she/he is not strong enough to raise her arms. This way it becomes easier to identify I-related positions as embodied and most importantly identify them as self-states, rather than mere reactions to external stimuli.

When patients have gained sufficient knowledge of what they think, feel and experience, bodily work secondly aims at changing the procedural aspects of maladaptive dialogical patterns (Dimaggio et al., 2018). Asking the patient to adopt different poses, behavior, to breathe mindfully, and to perform yoga exercises means asking them to position themselves differently vis-à-vis problematic others in the imaginal landscape. We mostly build these imagery and body techniques from a basis of very specific narrative episodes (Dimaggio et al., 2018; Neimeyer, 2000). If the episode is lacking the required knowledge of mental states, the goal of these body experiments is to enrich it. If the episode provides a good insight into the narrator’s mind, the goal is to rewrite the episode.

First we ask the patient to sit down - often with eyes closed, unless the patient does not feel comfortable. We then use a short mindful breathing meditation. To ensure the practice commences from a state of good regulation we often start these exercises with *grounding* (Lowen, 1971) – whereby individuals adopt an upright posture, legs slightly open and knees slightly bent. After a few minutes this stance generates a sense of anchoring, presence in the world and stability.

We ask individuals to use the present tense in order to avoid distancing from the story that the client is placing in the past. This approach makes it easier to recall specific, vivid details, as the episode needs the spatial and temporal coordinates to be as precise as possible. We then seek details of the environment: landscape, walls, furniture, sounds, smells and so forth. Following this, we then ask the patient to scan for human details: the face, dress, posture, voice of the characters in the episode. In parallel we probe for moment-by-moment cognitive-affective resonances, e.g.: “So your mother looks stern, inflexible, which you see from her eyebrows and lips. How do you feel in this moment? What are you thinking in reaction to her expression?”.

Sometimes patients can momentarily lose emotion regulation, in particular when exploring traumatic memories. Before the practice the therapist shares some signals the patient can use to indicate: “Stop”. If emotions spiral out of control, the clinician can use mindful exercises, body practices or strategies to divert attention until effective regulation is re-established. It is important to attend to these increases in emotion arousal, as they may indicate that the patient entered into the scene while still deploying coping strategies, thus limiting access to the full range of sensory material from the episode.

Once the scene has been scanned for details, the exercise is complete, the patient breathes deeply and then opens his or her eyes. During the exercise the clinician must tactfully keep the patient in the experience, therefore there is no scope for reasoning, reflections or associations. Some non-directive prompts are appropriate. The clinician may say: “This idea is fine, we can focus on it after the exercise, now please consider your partner’s face and voice again, what do you note? How do you feel?”.

When the exercise is concluded, the therapist invites the patient to reflect and to enquire whether any further associations emerge. New memories coming to mind are welcomed, as these enrich formulations of the schemas, ensuring they are grounded in richer material. This also makes it likely that the patient recognizes his or her functioning, and it’s representational quality, rather than perceiving the episode as an ‘objective truth’. After formulation of the schema is agreed, rescripting commences.

Next, we again ask the patient to close his or her eyes and relive the episode a second time, however this time we request that they change the plot. MIT therapists are very active at this stage, as

they are likely to need to ask for specific actions, unless the patient has capacity to offer their own ideas for healthier, adaptive new actions or endings. Within **this** stage it is mandatory that the therapist suggests actions consistent with the patients' basic motive. For example, we ask patients to persist in pursuing wishes connected to autonomy, playfulness, exploration. When they ask for care, we invite them to do so without adopting a submissive position; when they are driven by the social rank motive we invite them to persist in their strivings while staying in touch with their *self as worthy position* instead of giving up because they position the other as critical. Additionally, we ask the patient to interrupt any maladaptive coping behaviors, such as abstaining from perfectionism, over-dependence, aggression and so forth. Based on these adaptations, usually, new, more detailed emotions and thoughts appear, progressively increasing patients' awareness of their inner world. In dialogical terms, we ask the patient to embody healthier I-positions and to speak from these perspectives, describing how the inner experience change due to these new forms of dialogical positioning.

Dialogical rescripting does not mean talking differently. It *may* involve behavioral change, for example moving away from a mother who hampers autonomy. It also involves bodily work, for example adopting different poses, prosody, or voice intensity when retorting to aggressive or neglecting characters. After rescripting, there is a further reflection phase, where patients become aware of new experiences, realize they have agency and power over their mind, and identify areas for future work. The proposed mechanism of change here is that the individual realizes that the kernel of the problem is located more in their inner space than in the external world. One notable exception to this is where the individual continues to live in a **dangerous** environment, e.g. with a violent partner. In this case one goal is striving to build a safer human environment, which includes for example deciding to break an abusive relationship if necessary. Of note, unless the outside world is extremely toxic for patients' health, in terms of safety and nourishment of basic needs, we tend to promote change at an intrapsychic level first, only later guiding patients to become aware that they are living inside dysfunctional relationship they would better distance themselves from. In cases where patients face violence, tyranny, oppression and starvation,

clearly the problem is located mostly in the outside world. In all other instances, we first promote change in the inner world and then discuss with the client about affecting the ecological niche they live within.

A case study¹

The current case was treated by the first author, a female psychologist with about 15 years of experience as a psychotherapist and 5 years in MIT. Valentina, 22 yrs. old, resides in a village near a big city. She has diagnoses of avoidant personality disorder, social phobia and generalized anxiety disorder. Valentina asked for therapy because she felt stuck in her university. She is studying a second humanities subject, having left her first option, which she stated she was not interested in, and had only chosen at her parent's insistence. Valentina had not attended her exams for 6 months, because she felt ashamed of the idea of "looking bad". Three days before the last exams she started worrying about **being** asked questions that she could not answer, catastrophizing that this would result in public humiliation. Her worry increased anxiety and she used behavioral avoidance as a coping strategy for calming herself down. Cognitively, she perceived herself as "cowardly, stupid and ineffectual". These negative self-attributions became so intrusive and dominant that she stopped studying before the exams, expressing hopelessness.

As a first step, the therapist negotiated with **Val**entina to adopt attention-regulation techniques in order to reduce her worry (Wells, 2009; Dimaggio et al., in **press**). **She** used these consistently, with corresponding reductions in the frequency and intrusiveness of her worries. However, Valentina continued not to study. She now cited different reasons – now she felt bored, shut down, and lacking motivation. Furthermore, she could not foresee a positive future: she either saw herself as a failure, or imagined that there would be no chance of getting employment at the company she desired to work for.

In parallel, it appeared that her social phobia became generalized. Valentina was worried about almost all her relationships, except for a few female friends she had known most of her life. **Social** avoidance sustained her passivity, which she articulated as follows : "What's the point in making plans? I won't be able to form a social network".

¹ Personal information has been significantly altered to preserve patients' anonymity.

After collecting detailed recent narrative episodes, the therapist understood that Valentina was driven by motives for autonomy and exploration. She positioned the other as *critical* and *an obstacle*. As a reaction she adopted an I-position of self as inadequate, awkward, and inferior. Consequently, autonomy goes offline and Valentina remained trapped in passivity. Using MIT procedures, the therapist then asked Valentina for associated memories that supported the following micro-formulation: she had developmental experiences where she learned that whenever she tried to something she felt was her own, she faced others who criticized her or put barriers between her and her goals. These were experiences where her reaction became to adopt a position of inferiority and passivity. Affectively, Valentina reacted with shame, bitterness and anxiety. In the following imagery exercise she became aware of these emotions only after the therapist noted her expression and posture, and invited her to reflect on these. Through discussion it became apparent that the image of her constantly worried mother appeared in her mind. Valentina recalled a memory of when she was 8. She was in the woods during a holiday in the mountains. There was a picket fence along the shores of a small icy lake, where other children were playing or skating. Her mother yelled at her not to cross the fence. At this point the therapist invited Valentina to relive the episode via guided imagery, first and foremost for assessment purposes, with the goal to promote greater awareness of her inner states in that moment.

T: “What do you see?”

M: “The park. It’s sunny, the children are skating”.

T: “Where?”

M: “Beyond the fence, they run after each other along the shore, others are playing with a ball, a few are skating”.

T: “How does it feel looking at them?”

M: “Good. I like it”.

T: “Would you like going there?”

M: “mhm... Yes, it feels fine”.

T: “Have a look around, what do you see?”.

M: "My mother and my aunt, sitting on the green".

T: "How does your mother look?"

M: "She's not reacting, because I'm close by".

T: "Do you feel like approaching the lake?"

M: "Yes".

Valentina imaging trying walking near the lake, but suddenly her expression changes.

T: "What is happening now?"

M: "I hear my mum's voice calling me".

T: "How is that voice?"

M: "As usual. Angry, no point in arguing. Kind of: 'Where do you think are going?'"

T: "Can you sense her anger?"

M: "Maybe... not just that... worried as well... heck... I did not notice it before! Maybe she was thinking I would hurt myself".

T: "How do you feel now?"

M: "Anxious, but not about hurting myself, I fear that when I go to the lake she will yell at me".

T: "Where do you feel anxiety in your body?"

M: "Chest... short of breath".

During this stage, Valentina was mostly afraid of mother's anger. Importantly, during imagery, the therapist helped her to regain contact with the motive for social play – connected to exploration: she longed to be with the other children. The therapist, after using a mindful breathing exercise to reduce anxiety, asked Valentina to again contact with positive emotions linked with playfulness. During imagery work she smiled, at which point the therapist again suggested that Valentina approach the lake's shores.

T: "Now look again at the kids. Can you see them?"

V: "I do".

T: "What does the picture look like?"

V: "Pleasant again".

T: "Can you try approaching the fence?"

V: "Yes. I'm there now, I see the children play... they run, jump, yell. The skaters are the ones having the most fun".

T: "Would you mind trying to climb the fence?"

V: "My anxiety is increasing!"

T: "Good, that's normal. Can we agree that we try to persist until the anxiety gets too much. Just tell me when it's hard to manage".

V: "Ok".

T: "Where are you now?"

V: "I'm climbing. Good. Now I'm on top with legs astride. Wow, the view is amazing".

T: "Excellent, stay in touch with this feeling for as long as you want to".

After half a minute Valentina asks what can she do next.

T: "Would you like to go down, by the other side, the lakeside?"

V: "No. It's too much".

T: "How do you feel?"

V: "Anxious. My mother will surely yell at me in a short while".

T: "Ok. So try to stay on top of the fence a bit longer, do you feel you can do that?"

V: "Hmmm... yes, let's try".

T: "Breathe deeply ... now focus on the lake, the children playing... how do you feel now?"

V: "A bit calmer but not completely relaxed".

T: "Shall we go down the other side or better we stop here?"

V: "I prefer stopping here".

After this pause in the imagery rescripting, the therapist and Valentina started the reflection phase.

Valentina said rescripting was very important, because she discovered something she had forgotten: she has things she desires, thus there is a meaning to her overcoming her fears.

In this therapeutic moment Valentina was beginning to distance herself from her maladaptive patterns. She had reduced avoidance, helped by between-session behavioral experiments. She was not yet aware she had made changes to accomplish her goals, although her pessimism had lessened.

In the following sessions Valentina reported other memories in which her mother criticized and limited her autonomy. For example during a weekend, Valentina wanted to have a walk by the mountains with a group of girlfriends. During breakfast she told her mother about the plan, but her mother reacted by doubting this was a good idea. Valentina noted how her mother did not have any interest in her idea, rather she was just critical and worried. Valentina tried to respond but her mother replied that Sunday was better spent staying home in the family, studying and not doing “dangerous things”. Valentina switched into a position of *I-as shut off, awkward and causing suffering to others*.

As with the therapeutic tasks, Valentina tried to persist instead of giving up. She went the mountain walk and enjoyed it to a certain extent, but hyper-arousal and somatic anxiety remained. She described this as “background noise”, in particular a sense of heaviness in the chest, which we interpret as a sign of persisting maladaptive patterns at a somatic/procedural level.

The therapist then invited Valentina into a new guided imagery and rescripting exercise in order to soothe unpleasant schema-related arousal. During the first part of the imagery new aspects of her inner landscape surfaced, which we inferred marked her increasing capacity for metacognitive self-reflection

(Semerari et al., 2003)

T: “We are in the kitchen, with your mother. What do you see? What is happening?”

V: “We are having coffee. She is edgy, nervous. Rather angry I’d say. I tell her: ‘I’m going in a short while, trekking with my girlfriends’”.

T: “How do you feel now?”

V: “Anxious... embarrassed. Telling her about the walk makes me agitated. She looks nervous and I am afraid it is about me. But I now can see she felt that way before I spoke. She answers: “Ah. Now you go away? These friends of yours don’t have a home? A family? They are reckless and wild and do these dangerous things in the woods. I don’t understand you!””.

T: “How do you feel now, Valentina?”.

V: “As usual. Down. Inferior. Better to stay home, I can’t make it, I’ll stay home reading novels”.

T: “Good. These are your usual reactions, we know them pretty well. Focus a bit more on your mother’s face. What can you read in her expression?”

V: (*hesitating... her expression becomes gloomy*): “Well, kind of like a hand is crunching my stomach... anxiety for sure...also... she looks sad. We all leave her alone. My father doesn’t care, my father’s even worse. It’s Sunday, she feels sad. And I am leaving her even more alone... and worried”

T: “And tell me about you. What do you feel right now? What do you think about yourself?”

V: “I am a hyena! The most ungrateful daughter ever (*starts crying*)”

T: “How do you feel now? Let’s start from your bodily sensations”

V: “A weight on my shoulders. Like someone is sitting on me, crushing me down. I feel impotent, blocked, stuck. My shoulders are weak, always that vice in my stomach”.

T: “Let’s give an emotion label to these sensations”.

V: “I feel guilty... but also angry... I feel oppressed”.

At this point the therapist paused the guided imagery and asked Valentina to reflect on her experience. Valentina realized that she was again falling into the trap of her persistent, usual ideas about relationships - ending up with her believing she did not have the right to pursue her innermost wishes. She reported that imagery was a powerful experience and she was starting to realize that she couldn’t keep on sacrificing herself. Valentina then said that she wanted to learn how to ignore her mother’s complaints. Having realized that her mother was sad and worried before Valentina expressed the wish to go for a trekking, made Valentina more aware that she was not responsible for her mother’s depression.

Valentina and the therapist formed a detailed formulation of her interpersonal functioning. When Valentina was driven by a wish for autonomy and exploration she positioned herself as both *unworthy*, *inferior* and *bad because she made others suffer and worry*. She then positions the other as both *critical* and *fragile*. As a reaction the wish for autonomy is then turned off and correspondingly Valentina becomes shut down and paralyzed. In this formulation healthy self-positions are almost absent, so the

goal of rescripting becomes to help Valentina contacting them. At this point, imagery rescripting is enriched with sensorimotor work (Dimaggio et al., in press).

The therapist then asked her to enter imagery work again, focusing on the weight on her shoulders.

T: "What drive do you feel? If you could initiate an action, a movement, what would that be?"

V: "I would punch that fat stupid monkey on my back!"

T: "Do you feel like trying? I will put some pressure over your shoulders and you try to free yourself. Of course you won't punch me!" (*both laugh*).

The therapist put two pillows over the patient's shoulders and she puts some pressure on them.

T: "Is this pressure akin to the sensation you described?"

V: "Very much so".

T: "Well, try to get rid of it".

Valentina tries to shake her shoulders, but with little energy. The therapist easily keeps the pillows steady over Valentina's back.

T: "How do you feel?"

V: I am afraid I'm gonna hurt you"

T: "Very good. So you are caring about me, which is typical of you. But I remain here, putting pressure over your shoulder and won't stop. Focus on your wish to be free".

Valentina remains still for a few seconds, then tries to wriggle the pillows off with more energy. She manages to push them away a bit.

T: "How do you feel?"

V: "Relaxed. It's strange".

T: "What do you feel in your body?"

V: "I feel free, stronger. It feels good".

T: "Now let's try to voice these feelings. What would you say to your mother from this position of strength and freedom? Try standing up, adopting one of the power poses we practiced previously."

Valentina adopts a posture which makes her feel empowered, broadens her shoulders and then says: “Mum! You should try to doing something else that you like instead of whining and clinging onto others!!! You’ll see - it’s beautiful. I am starting to feeling better and want to keep this going!”

Valentina tells the therapist that she feels more energy in her muscles when speaking this way. She increasingly realizes how she was guided by problematic I-positions and notices that she now embodies different positions, and feels positive about them. Valentina feels a sense of power and agency. She realizes that she has control over her mental states and actions - an experience she barely knew in the past. When the exercise ends she feels lighter.

In the next sessions, the therapist tried to help Valentina gain greater access to I-positions characterized by agency and curiosity. For example, the therapist asked her to picture in her mind something that she desired and imagine it is on the opposite wall of the therapy room. She then asked Valentina to walk towards the image. Valentina reported that she desired a night with friends watching their favourite TV series. She visualized her friends on the sofa, and walked towards them, feeling joyful. While moving to this first step Valentina reported the intrusive image of her mother’s suffering face. The therapist asked her to focus for a few moments on it, then to focus on the positive image and try to let the guilt recede. Valentina succeeded in this exercise with minimal effort. She performed similar exercises in the next session until she was driven by the I-position of *active, motivated and energetic*.

Therapy Outcome

Active therapy continued for 2 ½ years and Valentina remains in follow-up. She no longer meets caseness for Avoidant personality disorder, social phobia or generalized anxiety. She reports that she sometimes feels inferior, awkward, guilty and paralyzed, but she can quickly recognize that these are ideas and feelings rooted in her personal history. As a result she is quickly able to regulate them. In dialogical terms, when she is driven by wishes for autonomy and exploration she embodies an I-position of *I as worthy and effective* whilst still positioning the other as *vulnerable and worried*. The shift here is that in the presence of a suffering and needy other she no longer assumes the position of the *Self-sacrificial caregiver*. Valentina now provides care in a more modulated and context-

appropriate way, such as lending a hand to a friend. She has completed her university degree and now has a part-time job in her chosen profession, which she greatly enjoys. During follow-up she still feels bound to her family, due to financial pressures. However, she is actively searching for a higher-paid job, in order to be able to live on her own.

Conclusions

Therapeutic change, when seen through the lense of Dialogical Self Theory, means changing the way individuals position themselves in relation to others. In therapy, individuals are helped to adopt a more flexible position repertoire, discard problematic positions that cause distress and maladaptive coping. Instead they work to adopt healthier I-positions capable of granting agency, connection with others and the possibility to fulfill core wishes and needs. We suggest that these positions are more than conversational styles or thought processes, instead constituting embodied, affect-laden forms of knowledge about human relationships. In this light, change requires therapists to influence the embodied processes underpinning these representations of self and others. Imagery and body work offer unique opportunities to accelerate change or offer an alternative where other techniques have been ineffectual. Guiding patients to re-experience problematic episodes offers new possibilities to explore neglected, occluded aspects of inner experience. Through imagery and somatic rewriting, individuals may learn new forms of embodied positioning, realizing that they can let themselves be guided by these rather than their old routines. We acknowledge that we have illustrated this via a single, successful case example, with no formally assessed outcomes. Future studies may focus on replication, assessing therapeutic outcomes and understanding mechanisms of change for individuals with different presentations.

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