CLINICAL SUPERVISION OVER COMPLEX CASES OF PERSONALITY DISORDERS ACCORDING TO METACOGNITIVE INTERPERSONAL THERAPY

SUPERVISIÓN CLÍNICA DE CASOS COMPLEJOS DE TRASTORNOS DE LA PERSONALIDAD SEGÚN LA TERAPIA INTERPERSONAL METACOGNITIVA

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Abstract

Treating patients with Personality Disorders (PDs) means dealing with what are often referred to as complex cases. The complexity of cases stems from several variables and in particular: the high percentage of diagnostic co-occurrences, patients' difficulty in reflecting on their own and others' mental states (i.e., metacognitive impairments), and the strong emotional pressure experienced by therapists. All this results in difficulties in building the therapeutic alliance and high drop-out rates. For these reasons, therapists often need supervision, with a more experienced therapist or even among peers. This article proposes the structured supervision model according to Metacognitive Interpersonal Therapy (MIT), which is an evidence-based treatment model for PDs.

Keywords: *supervision, personality disorders, Metacognitive Interpersonal Therapy, complex cases, metacognition*

Resumen

Tratar con pacientes con Trastornos de la Personalidad (TP) significa enfrentarse a lo que a menudo se denominan casos complejos. La complejidad de los casos deriva de diversas variables y en particular: el alto porcentaje de co-ocurrencias diagnósticas, la dificultad de los pacientes para reflexionar sobre sus propios estados mentales y los de los demás (es decir, dificultades metacognitivas) y la fuerte presión emocional que experimentan los terapeutas. Todo ello provoca dificultades en la construcción de la alianza terapéutica y altas tasas de abandono. Por estas razones, los terapeutas suelen necesitar supervisión, con un terapeuta más experimentado o incluso entre pares. Este artículo propone un modelo de supervisión estructurada según la Terapia Metacognitiva Interpersonal (TMI), que es un modelo de tratamiento para la TP basado en la evidencia.

Palabras clave: *supervisión, trastornos de la personalidad, terapia metacognitiva interpersonal, casos complejos, metacognición*

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Alberto is a novice psychotherapist, 32 years old, he is treating a young patient 28 years old suffering from Narcissistic Personality Disorder (NPD); he asks for a supervision because "I can't tolerate him anymore, he always makes me feel under examination!". Serena is a psychotherapist 42 years old; during supervision she refers her difficulty while she is working with a young girl, 31 years old, suffering from Dependent PD: "Oh my God, she really makes me feel so tender, I would do anything to make her feel good". Giovanni don't tolerate anymore the patient suffering from Histrionic PD he is treating with psychotherapy: "He constantly harasses me with phone calls and I spend hours talking on the phone, it would be better if someone else would treat him". Stefania is very confused about how to diagnose and treat a patient 44 years old: "He seems to suffering from all the DSM 5: sometimes he's anxious, sometimes very arrogant and sometimes so tender… once he is depressed and, in another session, he is excited and hyperactive".

These are just a few examples of what drive therapists dealing with patients suffering from personality disorders (PDs) to ask help with their work by asking for a supervision. And such a situation is not at all uncommon, since it is widely agreed that patients with PDs elicit in the therapist very strong feelings, often not easy to manage, leading to interventions that fail to help the patient, but are even anti-therapeutic. In fact, it is not surprising that this kind of patients are often defined as *severe* (Semerari, 2002) - to referring to the worse prognosis compared to patients with symptomatic disorders, *difficult* (Perris, 1993) - referring to the extreme difficulty in creating and maintaining a solid and stable therapeutic alliance or *complex* (Carcione et al., 2021) - emphasizing the difficulty of treatment related to the high percentage of diagnostic overlaps (Clark, 2007; Zimmerman et al., 2005). These difficulties are mainly related to two main aspects: 1) patients have difficulty reflecting on their own and others' mental states, i.e., they have difficulties in mentalization (Bateman & Fonagy, 2004) or metacognition (Carcione et al., 2010)[1]. 2) Therapists perceive a strong emotional pressure that often activates interventions that, by provoking them to engage in interventions that will result as anti-therapeutic, contributing to ruptures in the alliance. On the basis of this considerations, do not come as a surprise if drop-out rates are particularly high (Gamache et al., 2018).

Based precisely on these considerations, a treatment, named Metacognitive Interpersonal Therapy (MIT) (Carcione et al., 2021; Dimaggio et al., 2007), that focuses on treating general personality pathology rather than a specific PD, has been developed at the Third Center for Cognitive Psychotherapy in Rome. MIT has recently received evidence of its efficacy through the RCT CLIMAMITHE that collocates it among the evidence-based treatments for PDs (Rossi et al., 2023).

In this paper we will describe the central aspects to focus on during the supervision of therapists treating PD patients. Competency-based fundamentals in the practice of supervision will be explained, with the purpose especially of managing the therapeutic relationship and adhering to the MIT treatment manual. We will answer to some critical questions according to us useful to the development

of evidence-based competency-oriented approaches to clinical supervision: how do MIT supervisors facilitate reflective practice and encourage their supervisees to manage relational difficulties? How can supervision develop clinical skills in treating patients with PDs?

Providing treatments under clinical supervision has generally been viewed as a necessary and essential part of psychotherapy training but there is surprisingly little empirical support for this standpoint. Very few studies have investigated the effects of providing clinical supervision for psychotherapy and the evidence for the causal mechanism between supervision and treatment quality is limited. Since there is a lack of empirically based guidelines, psychotherapy supervision has instead often been structured based on models from psychotherapy practice (Alfonsson et al., 2017).

We will therefore provide some suggestions regarding the central nodes on which to center supervision following MIT for PDs.

As well as specific training in personality disorders is considered one of the principal variables for successful psychotherapy with patients suffering from PDs (Fernández-Álvarez et al., 2005), we believe that supervision by clinicians specifically trained and experienced in the treatment of personality disorders is essential to make supervision more effective than by a supervisor, also experienced, but with more generalist expertise. Conducting supervision according to specific theoretical frameworks has the consequence that some skills become the focus of attention and others are put on the secondary side. Of course, the characteristics of the individual supervisee will also need to be taken into account. Having a specific structured treatment referral allows supervision to be similarly structured, according to the guidelines of the treatment manual. In this way, the organizational structures of supervision will sensitize the supervisor and supervisee to certain classes of variables within the therapeutic relationship and, more generally, in the strategy and tactics to be followed in the course of treatment with that specific patient. In this way, supervisees will learn, through direct experiences within the supervisory relationship, how to deal with similar dynamics in treatment and thus acquire specific treatment skills (see also, Falender & Shafranske, 2010).

Metacognitive Interpersonal Therapy (MIT)

Metacognitive interpersonal therapy (MIT) is a cognitive behavioral oriented psychotherapy designed to promote metacognitive abilities and improve interpersonal relationships (Carcione et al., 2021; Dimaggio et al., 2007). It is designed to treat personality pathology rather than a specific PD. On the other hand, ICD-11 (World Health Organization, 2019) and Criterion A of the Alternative Model for Personality Disorders (AMPD; American Psychiatric Association, 2013) base the diagnosis on an assessment of general personality functioning, rather than on a categorical approach In addition, DSM 5-Section III emphasizes the key role of reflective skills in considering the assessment of an individual's level of personality

functioning through his or her ability to (a) self-reflect, thus promoting a stable sense of self and self-directedness and (b) understand the minds of others in order to establish and maintain empathic and good relationships (American Psychiatric Association, 2013). The MIT manual does not provide session-by-session instructions, but consists of a step-by-step procedure that starts with a multidimensional assessment of metacognition and other variables to construct a case formulation. MIT considers a pretreatment phase that begins with the assessment and ends with the contract by which patient and therapist plan treatment and setting rules to foster alliance (Bordin, 1979). The contract is based on a case formulation that includes some precise psychopathological variables: symptoms, mental states, metacognitive functioning, relational patterns and interpersonal problems (identifying markers of potential dysfunctional interpersonal cycles; Safran & Segal, 1990), emotion regulation, impulsivity and choice regulation.

Supervision is often a key time to manage the difficulties therapists face in treating complex patients: it plays a fundamental role in training to become MIT therapist and it has essentially 4 purposes: 1) to train the therapist in the treatment of PDs according to MIT; 2) to help the therapist in the assessment and, consequently, to construct the contract, treatment plan, and to establish the hierarchy of interventions; 3) to help the therapist in building and maintaining the therapeutic relationship and 4) to reduce therapist's stress and burn-out.

It should be premised at the outset that we do not present data on the effect of supervision on outcome or benefit to therapists in this paper, which will be the topic for future research.

Supervision and Case-Formulation

An adequate case conceptualization is fundamental to plan a good-treatment (Ruggiero et al., 2021), whereby first of all, the supervisor must help the therapist to have a clear case-formulation. According to MIT, this means answering to a series of questions regarding the main variables to be investigated in the assessment phase, in addition to the actual diagnostic formulation according to DSM 5-TR (American Psychiatric Association, 2023) or ICD-11 (World Health Organization, 2019):

1. has the therapist a clear idea about patient's problematic mental states, or the pattern of thoughts and emotions that are the sources of subjective distress and maladaptation?
2. Has the therapist a clear profile of patient's ability to understand and reflect on his own and others' mental states, including empathy and capacity for decentration (i.e. metacognitive functioning?
3. Has the therapist accurately investigates patient's ability to regulate emotions and impulses, and preferred variables driving choices regulation?
4. Has the therapist a clear idea about the patient's intersubjective world though reconstructing the dominant representations of patient's relationships with significant others and the reactions of others that tend to be elicited by

patient's behavior, starting with reactions induced in therapist him/herself?

The call for help through supervision may arise from this very stage. Indeed, the metacognitive difficulties that characterize PD patients and the co-occurrence of many problematic aspects in the same psychopathological picture presented by the patient can make it complicated for therapists to easily reconstruct these variables. Often this situation causes therapists a great deal of confusion that can lead to brooding about their competence or ability to help the patient, hindering therapeutic reflection. The supervisor can help focus on the clear variables, and highlight the missing ones, so as to build the correct picture of the puzzle.

Once this has been done, the next steps are aimed at sharing with the patient the case-formulation in such a way as to ascertain whether a clear agreement has been formulated on the aims and tasks of therapy, which are fundamental requirements for the therapeutic alliance (Bordin, 1979) and, above all, whether the patient has taken a reflective attitude, acquiring a clear awareness of the terms of the therapeutic contract.

Supervision on Therapeutic Relationship and the Coping of the Dysfunctional Interpersonal Cycles

A primary goal of supervision, for any theoretical orientation, is to focus on the therapist's ability to foster the building and maintenance of a good therapeutic alliance by thoroughly monitoring the progress of the therapeutic relationship. The importance of alliance for good therapy outcomes is well known (Horvath, 2001; Norcross & Lambert, 2006) and some authors also obviously emphasize the importance of a good relationship in clinical supervision (Bordin, 1983; Falender & Shafranske, 2010), even if some authors consider it having different characteristics (learning alliance) (Watkins, 2015); but this last aspect will not an issue of this paper.

Poor metacognition makes it difficult for the patient to understand the therapist's mind and for the therapist to understand the patient's mind. It reduces the strategies for negotiating and solving relational problems or autonomous emotional regulation. As a result, interpersonal relationships are problematic, including therapeutic relationships. The therapist may fail to find a way and time to appropriately intervene with the patient's needs at that precise moment. Recent data (Tanzilli et al., 2023) suggest an association between metacognitive functioning and therapist responsiveness (Stiles et al., 1998).

Supervisors must help the supervisees to became aware of their own feelings during therapeutic session. Therapists' emotions take on a very important meaning with regard to the therapist-patient relationship because they serve as indicators and inform the therapist's participation and construction in the process of interacting with the patient through his or her own appraisal systems (Gaetano et al., 2022; Semerari et al., 2021).

Through awareness of one's own mental states in session and accurate assessment of the patient's metacognitive functioning, it is possible to use what is

happening in the therapeutic relationship in a way that is beneficial to therapy, to move out of dysfunctional interpersonal cycles, and to master moments of alliance flexing or rupture.

Patients with PD have difficult interpersonal relationships. Influenced by negative expectations, i.e., pathogenic interpersonal schemas, they tend to be too aloof or too preoccupied, thus seeking too much closeness with requests for help and reassurance, or they keep away from any possible contact with emotions by manifesting coldness, contempt or simply disinterest. This will also happen in the therapeutic relationship, leading to major problems for therapists who often respond in ways that maintain problematic schemas (i.e., problematic interpersonal cycles; Safran & Segal, 1990; Safran & Muran, 2000; Carcione & Semerari 2019; Carcione et al., 2021). Supervision is a key time to help therapists remove obstacles to therapy and avoid iatrogenic risks.

This does not always occur only with overt events, such as when the therapist reports to the supervisor that he/she feels attacked or that he/she feels that the patient is taking a hostile closing attitude or is being over-pressured with requests for help. Many times, the modality is more subtle, stimulated by the patient's non-verbal attitudes, facial expressions, and voice tone, which may be sufficient to trigger strongly negative counter-transference reactions in the therapist (moving the appointment of sessions, forgetting the appointment, taking a cold or over-pressuring attitude, etc.). These are often the situations in which supervision is most needed.

How to help supervisees notice that they are involved in an interpersonal cycle? It is precisely noticing that the therapist is making an effort not to act in an anti-therapeutic manner that offers the crucial information that he is within an interpersonal cycle.

Once supervisees have become aware of their distress, the supervisor must help them focus on their own internal state and achieve awareness regarding the thoughts, affects, and impulses they feel toward the patient. Since these representations are an integral part of the patient's pathology, it follows that the nature of this pathology will largely influence the therapist's countertransference responses (Colli et al., 2014). Although the therapist's personal characteristics have an influence on the relationship, it is also true that as the severity of psychopathology increases, individual differences tend to diminish (Clarkin et al., 1999). One consequence of this is that typical interpersonal cycles are activated in DP psychotherapies that can be recognized by any therapist engaged in the treatment of these patients. (Dimaggio et al., 2007; Carcione et al, 2021). This assertion can be considered as general rule, that means that psychopathology tends to cancel the individual characteristics of the patient and the therapist and to induce problematic cycles that are always the same but characteristic for types of disorders.

Supervisees often present recurrent and recognizable problems during session. If we consider the patient's metacognitive impairments, difficulties in monitoring tend to evoke in the therapist a sense of opacity, as to walk through the fog; diffi-

culties in differentiation or decentration evoke the feeling of walking on eggs, that one's words are taken literally, and sometimes a struggle even in the therapist to distinguish between fantasy and reality; integration difficulties are associated with a sense of extreme confusion, chaos, and a tendency to lose the thread of the conversation and to constantly change the hierarchy of treatment goals. Therefore, the fact that the onset of problematic cycles is deeply linked to the interpersonal pathology of DP means that the same type of cycle tends to repeat itself when a certain type of pathology is present, independent of the therapist's personal characteristics. In other words, similar patients tend to create similar cycles and this makes it possible to attempt a partial classification of the cycles and above all a learning to recognize and manage them.

Recognizing in the context of supervision that one is involved in a typical interpersonal cycle has the advantage of being able to understand the difficulties in treatment and, more importantly, what the interaction partners of the patient we are treating feel, so then, with appropriate sharing techniques (i.e. universal we, self-disclosure, etc.; Carcione et al., 2021; Dimaggio et al., 2007) communicate with empathic understanding the experience of their management and facilitating their mastery outside of therapy.

So, identifying in supervision a problematic interpersonal cycle is certainly an important moment in therapy, because paradoxically it allows supervisees to recognize that they feel something very similar to the patient thus combining intellectual understanding with empathic understanding, precisely from the moments when they feel least empathic with the patient.

Semerari (Carcione & Semerari, 2019; Semerari et al., 2021) divides he interpersonal cycles that are activated in the therapeutic relationship into ***acute*** and ***chronic.***

Acute cycles are characterized by the intensity of the emotions, by the power of the thrust to action and by the relatively short duration that, when it does not lead to the breaking of the relationship, rarely exceeds two sessions.

Chronic cycles, instead, are characterized by feelings of lower intensity, by pushes to action more easily contained, but by a duration that, especially at the beginning of the therapy, tends to extend for several sessions.

Supervisor must help the therapist to recognize to be involved in an acute cycle to reach in therapy session the ability to:

a) Tolerate relational distress.
b) Avoid acting in a way that is harmful to therapy.
c) Use his/her own inner experience to understand the patient's.
d) Exploring the patient's mental state during the cycle.

Once the cycle has been overcome the therapist will be able to explore the patient's mental state, so that he/she through a process of integration, recognizes that it plays a key role in his/her relationships, being a recurring factor in them.

In chronic cycles, on the other hand, the goals are as follows:

a) Tolerate relational discomfort.
b) Use relational discomfort to understand the patient
c) Consolidate the alliance through direct exploration of the patient's mental state in the relationship with him or her.

At a more advanced stage, the therapist can take advantage of the cycles to make the patient understand his own role in the genesis of his interpersonal processes.

Through this attention to the therapeutic relationship, supervision can foster the construction and maintenance of a cooperative attitude in therapy, which is essential for treatment effectiveness (Monticelli et al., 2018).

The Metacognitive Functioning

The metacognitive profile of the patient, influence the personal style that therapist must have during therapy and change the aim that therapist, and also supervisor, must fix during treatment. Therapists, especially those less experienced in treating PDs, may find it difficult to follow the steps provided by MIT, following a specific order in pursuing the improvement of specific metacognitive skills. The supervisor, therefore, in accordance with the MIT manual (Carcione et al., 2021), must ensure that the therapist has worked on metacognitive functions in the following strategic order: 1) monitoring, 2) integration, 3) differentiation, and 4) decentration. Only during the fourth stage, working on decentration, can the therapist set himself the goal of explicitly agreeing with the patient to work on dysfunctional interpersonal cycles, clearly highlighting his role in generating and maintaining his relational difficulties. As we have seen in the previous section, therefore, although it is sometimes necessary to intervene on acute cycles that occur in therapy, in order to maintain the alliance, in interpersonal problems it must take place at this late stage of therapy, when sufficient reflective skills and an alliance strong enough not to make the patient feel judged or accused of being exclusively responsible for his or her own problems are present.

The Problem of Diagnostic Co-Occurrences and the Problem of the Timing of Intervention

PD patients have complex diagnostic frameworks and different psychopathological problems to treat and overlapping of different diagnoses is almost the rule (Carcione et al., 2021; Dimaggio & Norcross, 2008). Sometimes during supervision, therapists express great confusion related to the complexity of the clinical picture resulting in difficulty in treatment planning. At other times they express frustration believing that they followed the correct treatment procedures or made correct technical interventions, but despite this they failed. During supervision it may emerge that the therapist actually made correct interventions but at the wrong times, or correct interventions but at separate times that made them ineffective. For example, a therapist who wants to help the patient avoid repeating a problematic interpersonal cycle might immediately emphasize the patient's impact in generating

the unwanted response from others, without first making an intervention to validate or share the patient's wants and needs; or he might express in one session all understanding and empathy regarding the patient's suffering from frustrated needs and in a later session, taking for (wrongly) assumed memory of the previous session, emphasize the dysfunctionality of his relational pattern. Do the right thing at the right time is the essence of therapist responsiveness (Stiles et al., 1998), difficult to achieve with PD patients.

Therefore, one of the most common questions supervisees ask the supervisor is: where to begin?

Supervisor, following MIT manual, can lead the supervisee indicating some useful guide questions to structure an order in intervention planning, according to reasoning that includes a clear distinction between strategic, tactical, and technical interventions. In MIT, strategic interventions are those aimed at enhancing metacognition, tactical interventions are related to managing the therapeutic relationship and maintaining the alliance, and technical interventions are aimed at change and vary according to the therapist's skills, in line with the specific goals one aims to pursue (e.g., suggesting midfullness or ACT interventions if the aim is to foster acceptance, E-RP for anxiety symptomatology, etc.). The supervisor can help the supervisee monitor the timing of their interventions by following the order suggested in the following questions:

1. Which psychopathological factor is the biggest threat to the patient's health and integrity?
2. Which psychopathological factor is an obstacle to the therapeutic alliance and the therapy?
3. Which psychopathological factor contributes most to maintaining the disorder?
4. Which psychopathological factor is the greatest source of subjective distress and/or maladaptation?

Check List for Supervision and Treatment Adherence

MIT therapists were supervised throughout the duration of treatments, weekly or biweekly one-to-one sessions and weekly team consultation meetings. Useful in conducting supervision to promote MIT adherence, fill out a checklist on MIT strategies and techniques in order to monitor fidelity. The checklist consists of a list of questions specific to the different phases of therapy (assessment, definition of objectives, pretreatment, sessions) assessing whether the therapist addressed key elements of MIT therapy (i.e., Did the therapist investigate mental states? Did the therapist focus patient's attention on automatic thoughts and emotion? Did the therapist assigned homework?) (Carcione et al., 2021).

Clinical supervision of individual cases is the primary vehicle for training in the fidelity and competent delivery of treatments (Falender et al., 2004). In a study by Anderson et al. (2012) aimed to identify the effectiveness of psychotherapy su-

pervision on therapists' immediate (next session) and long-term (1 year) adherence to time-limited dynamic psychotherapy, the findings provide support for the immediate effects of supervision in shaping therapist techniques as well as highlighting the challenges of altering common relational processes through technical training.

Stiles et al. (1998) suggested that therapists who are learning interventions from a therapy manual may initially apply techniques more frequently, but without discretion and in a wider variety of contexts than needed. In supervision, therapists tend to focus on how they adhered to techniques from the previous session, whereas supervisors' comments about specific techniques predicted how the therapist would adhere to techniques in the *next* therapy session.

Conclusion and Limitation

In this paper, we focused on the guidelines that a supervisor should follow to help supervisees in treating PD patients according to MIT. Several limitations are present. First, the problem of regulating the relationship that is created between supervisor and supervisee has not been addressed. Again, there could be difficult management, varying from dyad to dyad, related to the metacognitive functioning and personal characteristics of both participants. These factors could lead to attitudes that may be judgmental by the supervisor or simply perceived as such by the supervisee, or sometimes the therapist's reflective difficulties may complicate supervision itself. Although these and other factors are undoubtedly relevant, we have decided to focus this article on supervision guidelines in order to facilitate correct treatment provision. Another important limitation concerns the absence of data on the effectiveness of this procedure, supervisee perceived satisfaction, and reduction of stress and burn-out. However, data suggest that effective supervision increase supervisee self-efficacy, decrease supervisee anxiety, improve skill acquisition, increase supervisee autonomy and openness, and reduce confusion about professional roles (see Whipple et al., 2020).

A careful study of these variables can certainly help break out of the *terra incognita*, as MacDonald and Ellis (2012) defined supervision in psychiatry, of the role of supervision in improving psychotherapy outcomes. Increase the use of video recording psychotherapy sessions in clinical supervision that appear the most reliable method compared to first-person report, by providing more effective feedback to supervisees, and more effective outcomes to the patients with whom they work (Haggerty & Hilsenroth, 2011).

In conclusion, while emphasizing how essential we believe it is to use well-structured treatments and also to guide with supervision in the proper implementation of them, we must always consider, in agreement with Hoffmann and Weinberger (2007) that psychotherapy is an applied discipline, a practice that blends principles of art and science. However, as Fernández-Álvarez et al. (2015) have argued, a good link between theory, research and practice, between models and therapeutic skills, is probably the best approach to optimize our interventions. Practice is more likely

to be effective if it is based on a theoretical and conceptual framework, although specific factors, related to the individual therapist's aptitudes, must always be considered (*science and art*!).

Supervisor must help therapist in applying procedures that help improve the patient's quality of life and must be able to build a good therapeutic alliance, resolve critical episodes, and manage emergencies. At the same time, however, clinical practice must rest on a solid and reliable foundation when it does not rely solely on the skill of the therapist.

Supervision is certainly an excellent tool for increasing therapists' training on at least two fronts: 1) increasing skills and 2) reducing stress in managing patients. An obvious question is how much supervision improves outcomes, but on this aspect, data are not yet conclusive (Schofield & Grant, 2013; Wheeler & Richards, 2007), sometimes even skeptical (Watkins, 2019). The fact that a few quality studies have been published during the last years is a promising sign but there is still a continued need for more rigorous studies on the effects of clinical supervision (Alfonsson et al., 2017).

Future direction can be directed to study the impact of MIT supervision on psychotherapy outcome and on welfare of therapist.

Notes

1. In this paper we will use for more familiarity of the authors the term metacognition

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APPENDIX

Checklist for Assessing Adherence to the Treatment Procedure

To help the therapist implement the techniques and procedures of MIT and, at the same time, to verify the adherence to the treatment model, this check-list is a guide for therapists, supervisors and researchers.

ASSESSMENT AND PRE-TREATAMENT	YES	NO
• Was a careful assessment done?		
If **Yes**, the therapist must have a clear idea of the following points: - the symptoms, including assessment of their severity and effect on general functioning;		
- patient's subjective experience, especially problematic mental states, or the pattern of thoughts and emotions that are the sources of subjective distress and maladaptation;		
- dominant representations of patient's relationships with significant others and the reactions of others that tend to be elicited by patient's behavior, starting with reactions induced in therapists, so as to form an idea of the patient's intersubjective world;		
- metacognitive functions, or patient's capacity to understand and reflect on his own and others' mental states, including empathy and capacity for decentration;		
- regulatory functioning, including capacity to regulate emotions and impulses, and patient's ways of regulating choices.		
• Did the therapist offer the patient a schematic summary of patient's disorder, expressed clearly and carefully, using the patient's own terminology and concentrating on the patient's subjective distress?		
• Did the therapist correct the schema based on the patient's observations?		
• Did the therapist construct with the patient a shared case formulation?		
• Does the therapist have a clear understanding of the maintenance mechanisms of the patient's disorder?		
• Did the therapist illustrate the treatment goals?		
• Did the therapist reach agreement with the patient on the treatment goals, their reciprocal responsibilities, and the rules of the therapeutic setting and relationship?		
• Did the therapist explain the rationale and treatment principles of cognitive therapy?		
• Did the therapist ensure that the patient understood the explanation?		
• Did the therapist formulate the therapeutic contract?		
THERAPEUTIC RELATIONSHIP	**YES**	**NO**
• Does the therapist maintain a climate of interpersonal cooperation?		
• Does the therapist use the *universal we*?		

• Is the therapist transparent in communicating the underlying intention of all interventions? (continually offer brief explanations of the reasons why certain questions are asked or why specific requests are made of the patient)		
INTERPERSONAL CYCLES	**YES**	**NO**
• Are there interpersonal cycles in the relationship? What are they?		
• Is the interpersonal cycle in an acute phase?		
If **Yes**		
• Is the therapist conscious of therapist's own discomfort?		
• Is the therapist tolerating the relational discomfort?		
• Is the therapist avoiding acting in ways that are damaging for the therapy?		
• Is the therapist conscious of the thoughts, affects, and impulses that the therapist directs toward the patient in that moment?		
• Is the therapist using therapist's own internal experience to understand the patient's internal experience?		
• Is the therapist focusing on the patient's mental state, by asking "to what extent is what I feel similar or complementary to what the patient feels?"		
• Is the therapist exploring the patient's mental state during the cycle?		
• Has the therapist achieved an empathetic understanding of the patient?		
• Is the therapist regulating his communication so as to modulate the emotional tone of the relationship?		
PRINCIPLES FOR CONDUCTING SESSIONS	**YES**	**NO**
• Was the session useful for the patient?		
• Does the patient have a metacognitive attitude?		
• Are the patient's attention and reflection focused on mental processes and contents?		
• Are there obstacles to a metacognitive attitude?		
If **Yes**, what are they?		
• Does the patient have metacognitive difficulties?		
• Is the patient in a condition of disorientation and confusion regarding his own internal states?		
• Is there a relational problem with the therapist?		
• Is emotive activation too intense to allow the patient to reflect on his own mental states?		
• Is the therapist regulating the emotional tone of the sessions?		
• Is the therapist respecting the principles of therapist authenticity?		
• Is the therapist authentic in expressing what he feels with his nonverbal conduct?		
• Has the therapist regulated the emotive tone of the session? □ now it is possible to explore the patient's problematic mental state		

PROBLEMATIC MENTAL STATE	YES	NO
• Does the therapist have a clear understanding of the criteria for choosing the problematic state to explore?		
- are there problematic states tied to risky behavior that may threaten the health or life of the patient?		
- are there mental states that contribute more than others to the patient's subjective distress and to the creation of interpersonal problems?		
- are there problematic mental states active during sessions?		
The therapist can now focus on **MONITORING** the selected problematic mental state		
• Has the therapist asked the patient to recount a specific episode where patient's distress was manifested?		
• Having identified such an episode, did the therapist focus on the emotions and (where present) the sensations felt during the episode?		
• Has the therapist asked the patient to describe the thoughts and images that precede, accompany, and follow those emotions?		
• Having identified the thoughts and emotions, has the therapist helped the patient to create an integrative metarepresentation of their connections? Or rather:		
• Has the therapist summarized the elements of the problematic state?		
• Has the therapist asked the patient to recall other episodes in which those kinds of thoughts and emotions were part of the experience?		
• Has the therapist asked the patient to give a name to the mental state?		
• Is the patient's primary state clear to the therapist?		
• Has the therapist helped the patient to recognize the problematic mental state as a recurring pattern?		
• Are the underlying intentions and objectives of the patient's behavior clear?		
• Has the patient understood the purposeful nature of patient's actions?		
• Has the therapist discussed with the patient alternative strategies for mastering maladaptive problematic mental states?		
• Has the therapist fostered the implementation of alternative strategies?		
• Does the therapist have a clear idea of how the patient makes use of the sessions?		
• Does the therapist try to stimulate a metacognitive attitude outside of the sessions?		
• Does the therapist make use of extra-session communications, homework, and reminders?		

INTEGRATION	YES	NO
• Did the therapist repeat the procedure for the various problematic mental states?		
• Is the patient aware of the recurrent patterns of internal experience?		
• Are the activating factors of a mental state clear?		
• Are processes for getting out of a problematic state clear?		
• Are the transition processes clear?		
• Was an exploration done of how the action and its consequences have an effect on a change of mental state?		
• Does the therapist help the patient reflect on the short and long-term consequences of patient's actions? Also in terms of variation of patient's internal state?		
• Did the therapist reformulate in diagrammatic form the patient's mental states?		
MANAGING SUICIDE RISK	**YES**	**NO**
• There is suicide risk?		
• Is it a chronic or acute risk (if acute□ hospitalization)?		
• Has the therapist explored the degree of suicide risk?		
• Is it a suicide risk secondary to a diagnosed mood disorder? (if **Yes** □ hospitalization)		
• Is it a suicide risk associated with weak sense of self and weak integrative capacity? (□ enhancement of metacognitive functions)		
• Do therapist and patient communicate openly and explicitly about suicidal ideation?		
• Have therapist and patient agreed on each one's responsibilities for managing the risk?		
• Has the therapist investigated whether the ideation is constant, and if it brings relief and is actively sought for this purpose?		
• Has the therapist investigated whether the patient is actively and concretely planning suicide?		
• Has the therapist investigated whether the patient openly declares an intention to commit suicide?		
• Has the therapist investigated whether the patient still hopes to improve patient's own condition?		
• Does the patient have a history of serious suicide attempts?		
• Does the patient have a family history of suicides?		
• Does the patient have a history of childhood sexual abuse?		
• Does the patient have a high degree of impulsivity?		
• Are there protective factors with regard to suicide (worry about the consequences for loved ones and/or moral or religious factors)?		
• Has the therapist understood the different objectives underlying the suicidal behavior?		

• Has the therapist explored with the patient his problematic mental state?		
• Has the therapist examined the primary emotion and the representations associated with it?		
• Has the therapist focused on the intentionality of the suicidal act, underlining its character as an attempt to master distress?		
• Has the therapist discussed with the patient possible alternative behaviors that could alleviate the distress?		
• Has the therapist written a reminder note that summarizes the characteristics of the problematic state and reminds the patient of the alternatives discussed?		
• Has the therapist invited the patient to call if the discussed alternatives prove to be ineffective?		
• Has the therapist delivered the reminder note to the patient, urging patient to read it when he feels the primary emotion?		
• Is the suicide risk linked to mental states of dissociative detachment? - If **Yes,** has the therapist composed the reminder note?		
• Has the therapist done everything possible in order to see the patient on the same day of the telephone call?		
MANAGING IMPULSIVE BEHAVIORS	**YES**	**NO**
• Is the therapist working on monitoring the mental states underlying the impulsive behavior?		
• Does the session focus on the emotions, thoughts, and images that make up the mental state?		
• Has the therapist helped the patient to distinguish between primary and secondary emotions?		
• Has the therapist helped the patient to recognize the intention driving the impulsive action?		
• Has the therapist asked the patient to concentrate on his primary lived emotion and to recall life situations and episodes where that same emotion was experienced?		
• Does the patient recognize the mental state as a recurring pattern of internal experience?		
• Are the primary emotions underlying impulsive behaviors clear?		
• Is it clear to the patient that the goal of impulsive actions is to manage negative emotional conditions?		
• Does the therapist help the patient to compare the concrete consequences of patient's actions to the active goals of his mental state?		
• Does the therapist have the patient acknowledge the paradoxical consequences of his conduct?		
• Does the therapist foster motivation for change?		
• Does the therapist discuss with the patient alternative mastery strategies?		
DIFFERENTIATION	**YES**	**NO**

• Does the patient have difficulty differentiating?		
- Does patient treat thoughts as concrete objects?		
- Does patient try to influence external reality with thoughts?		
- Is patient able to distinguish between imagination and reality?		
- Does patientexperience fantasies as though they were actually happening?		
- Does patient experience reality as though it were an invention of the mind?		
- Does patient have difficulty distinguishing between opinion and knowledge?		
- Does patient have rigid, absolute beliefs that are applied pervasively and assumed to be matters of fact?		
- Does patient have a radical distrust in their own capacity for judgment?		
• Is the patient able to assume critical distance from their representations?		
• Has the therapist helped the patient: - to develop the capacity to shift his attention from the external to the internal world and vice versa?		
- to acquire awareness that there exist different points of view concerning the same issue?		
- to acquire awareness that mental states are transitory even regardless of what happens in reality?		
• Has the therapist reassured the patient that there is nothing pathological in generating different and conflicting representations of the same issue?		
• Is the patient aware that all mental states, even negative ones, eventually come to an end spontaneously?		
• Is the therapist encouraging the patient to observe those states and accept them as part of themselves?		
• Has the therapist helped the patient to develop the capacity to treat a mental state as something purely “mental”?		
• Does the therapist have clear criteria for saying that a schema, a belief, or a set of beliefs is pathogenic or dysfunctional and that it is necessary to develop critical distance from it? (common sense psychology – bizarre character – harmful to emotional life and/or adaptation)		
• Has the therapist evaluated the possibility that such beliefs are well-founded or compensatory?		
DECENTRATION	**YES**	**NO**
• Does the patient have a decentering impairment?		
- Does patient have a distorted way of attributing intentionality to others?		
- Does patient have a tendency to stereotype in evaluating others?		
- Does patient lack empathy?		

- Does patient have mental states characterized by themes of threat, estrangement/exclusion, competition/comparison?		
• Has the therapist helped the patient to consider people as individuals different from one another by posing questions that stimulate appreciation of differences?		
• Does the therapist favor explanations based on the observation of differences in character and psychological attitudes?		
• When speaking of other people, does the therapist assume and invite the patient to assume an accepting attitude aimed at understanding rather than judging?		
• Does the therapist help the patient assume an attitude of non-judgmental curiosity?		
• Does the therapist encourage the patient to observe the emotions and affects of others, recognizing, at the same time, that the reasons underlying these affects remain hypothetical unless the other person expresses them directly?		
• Does the therapist encourage the patient to pay attention to the interests of others by observing what they like to talk about, what animates them in conversation, and what attracts their attention?		
• Does the therapist help the patient to take account of the context in trying to understand the relational significance of the behavior of others?		
• Does the therapist help the patient to accept the limits of the openness and empathy of others?		
• Does the therapist help the patient to reflect on his need for total acceptance and to manage the difficulties that derive from it?		
• Does the therapist help the patient to recognize and understand their own role in the creation of interpersonal problems and conflicts?		