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CASE REPORT

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Exploring the processes of connection and disconnection in imagery work in a patient with depression and dependent personality disorder

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Abstract

Imagery work is a useful therapeutic tool in the treatment of depression. It is central in different therapeutic approaches, such as cognitive behavioral therapy and compassion-focused therapy. The clinical case of Cynthia is presented. Cynthia started therapy for severe depression associated with social anxiety and dependent personality disorder. At different key moments in the therapy, the proposed change strategies led to ruptures in the therapeutic alliance. For example, difficulties in accepting depression, fears of being judged by the therapist, guided imagery of compassion and work on the termination of therapy were both triggers of ruptures and spaces for working on the issues linked to the therapeutic relationship. The interactions between different factors of the therapeutic relationship from the perspectives of both the patient and therapist and the implementation of imagery practices in session are presented.

KEYWORDS

compassion-focused therapy, imagery, psychotherapy, therapeutic alliance

1 | INTRODUCTION

Imagery work is a key therapeutic strategy in cognitive behavioral therapy (CBT), as well as in other approaches, such as compassion-focused therapy (CFT). The way it is used can be defined according to diagnostic criteria, based on the processes targeted or both. Working on mental imagery is now an empirically supported practice (Holmes & Mathews, 2010; Holmes et al., 2016). It may also solicit the creativity of both the patient and the therapist. It can either bring out issues related to the therapeutic relationship or be a practice that then facilitates the adoption of other therapeutic tools, such as behavioral experiments. In this article, we first discuss how imagery work is relevant in psychotherapy, with a focus on CBT and CFT.

Using mental imagery work with clients with resistant depression highlights challenges linked to acceptance and self-criticism. For patients starting therapy, one first step in moving out of depression may be to accept that they are not feeling well. If therapists and clients move forward in the therapeutic process having skipped this first step, the therapeutic work may evolve with resistance, and the question of the acceptance of suffering will return, possibly in the context of a relapse.

One of the fundamental reasons for the need to acknowledge suffering is the nature of suffering itself. Indeed, as Choden & Gilbert (P. C. Gilbert, 2013) explain, suffering is not only emotional pain, such as stress, anxiety, or sadness, but also the refusal to feel that emotional pain. In depression, suffering itself is stigmatized. The patient may be ashamed of being depressed, feel devalued for being sick, or be ashamed of being off work or simply not well. Accepting that one is suffering is to free oneself from the inner stigma of depression and to reconnect with the shared humanity of this experience. Not all people will experience severe depression, and people are affected differently by depression; however, suffering is a human experience, and it is nothing to be ashamed of.

Therapists may accompany their patients in accepting suffering. This process of psychoeducation allows patients to reanchor themselves through compassion, which is a sensitivity to suffering that is associated with a motivation to release this suffering (P. Gilbert, 2014) toward themselves as well as to reopen themselves to receiving compassion, help and warmth from others and from their loved ones.

Depression is very often associated with relational closure and the reduction of positive emotions. Social joy, the joy of being in relationships, no longer facilitates interactions, and others may be perceived negatively (Beck et al., 1979). Self-criticism adds a level of complexity and reduces positive interactions both in real life and in therapy (P. Gilbert et al., 2006). When depression is associated with high levels of self-criticism, patients project negative thoughts onto the therapist. They solicit or create fewer positive interactions. The difficulty in receiving compassion resonates with self-criticism to create thoughts such as "I do not deserve to be helped and to be well." These thoughts hinder not only the therapeutic relationship but also the therapeutic process related to social interactions outside of therapy.

Social anxiety is frequently comorbid with depression. It is characterized by an extreme and persistent fear of embarrassment and humiliation that leads to the avoidance of social situations that may activate this type of anxiety. All humans avoid feeling ashamed of themselves. But people with social anxiety imagine that other people's thoughts, including their therapist's, are like their own self-criticism. Therefore, therapeutic disclosure is anxiously anticipated. The therapeutic interview can consequently be a form of exposure for patients with social anxiety. The therapist may not be aware of the level of anxiety experienced by the patient during the session. Strategies to inhibit nonverbal anxiety behaviors are used to protect the patient's image from anticipated social judgment. To avoid being perceived as anxious, patients will show a neutral face when they are in distress. The therapist may inadvertently expose the patient to high levels of anxiety, with no way to reassure them, potentially leading to a breakdown in the therapeutic alliance and, at worst, trauma for the patient.

Establishing a therapeutic alliance in the context of social anxiety requires vigilance in assessing the patient's problem and identifying micro avoidance behaviors, such as looking away. A dissonance between the content and the emotion expressed can help identify emotional inhibition or dissociative states. Perceiving and verbalizing these signals allow for a dialog to be opened around the difficulty of being in a session. A simple question such as "How do

you feel to meet a therapist" or "at the end of this session?" or "Is it easy for you to talk about this topic?," or "Do you feel embarrassed to talk about this?" will allow both the therapist and client to take a meta position in the interview and monitor the patient's emotional experience.

Chair work can be useful if the patient imagines the therapist's thoughts as his or her own self-critical thoughts. Chair work is a psychotherapeutic method that creates space to express self-multiplicity and internal relationships (Bell et al., 2021), as in the following excerpt. It can also be used to work on the therapeutic relationship.

Patient: "I'm not comfortable. You must find me boring."

Therapist: "Thank you for sharing how you feel. Have my behaviors led you to believe that I am judging you?"

Patient: "No, but I'm afraid you would think so."

Therapist: "Let's imagine that in the chair across from you sits the therapist who thinks you're boring."

There is a chance that simple role-play such as in the former example may be the first step in working through the therapeutic relationship. It may reduce the patient's tendencies to construe the therapist is a negative light. Moreover, it may create an opportunity to clarify not only what the critical thought is, in terms of content but also its prosody and function by asking questions such as the following:

> Is it the representation of a critical part? What tone of voice is this therapist using? What is the motivation of this judging therapist? Who does he or she look like?

It is also possible to confront the patient regarding the real effect of his or her critical thoughts and the possibility of his or her unmet needs:

> How does it feel to be in front of a therapist like that? Is it helpful?
>
> What would be really helpful for you in this situation?

This process may allow the patient to be active in the therapeutic relationship. The patient may reinvent a form of therapeutic interaction that is closer to what he or she would need. This type of exercise allows the use of the therapeutic relationship as a support for the work around the self-critical part of the client. It offers a new perspective on the difficult feelings the patient may experience in the therapeutic relationship. The clinical case presented will illustrate the relevance of this practice.

Guided imagery offers access to nonverbal and perceptual experience in the absence of external sensory stimulation (Holmes & Mathews, 2010). At first, we think of the verbal content of a person, but the expression and definition of the problem encountered are achieved through sensory mental images in addition to words. Sensory images are the grounding on which metaphors are built. They are useful in the interview in a conversational mode as well as during guided visualization exercises. The evaluation and use of the patient's mental images requires empathetic listening on the part of the therapist. The therapist must be open to perceptual modalities that may be different from her or his own as well as be able to prioritize the patient's perspective, which requires a complex mental elaboration and flexibility on the part of the therapist. Enrichment with images will deepen the content of the discourse with the patient. This process requires active participation on the part of the patient, who may be encouraged and supported by the therapist.

Depression is associated with an increase in negative mental images, a reduction in positive mental images, and biases in the interpretation of mental images (Holmes et al., 2016). This can evoke different types of emotions, such as sadness, fear, anger, and guilt (Reynolds & Brewin, 1999). Half of people with depression have distressing intrusive mental images of memories or imagined events (Patel et al., 2007), such as scenes of physical or sexual abuse in childhood and images of humiliation (such as school bullying), failure (such as losing a job), or overwhelming sadness (such as losing a loved one).

Hackmann et al. (2000) showed that people with social phobia have more negative mental images of themselves in social interactions. They also tend to interpret social information more negatively; for example, a smile will tend to be perceived more often as a sign of social dominance. Mental imagery and interpretation biases interact and participate in the maintenance of social anxiety, creating a vicious cycle whereby a biased interpretation elicits mental images of others criticizing the person, which in turn fuels tendencies to focus on critical faces (Leboeuf et al., 2022) and make negative attributions.

Both the type of information and the direction of attention are important. Social anxiety is associated with attention focused on the self in a social context rather than on the relationship, which hampers the beneficial effect of "tend and befriend" types of coping (turning to social comforting to regulate emotions). Stress is perceived more negatively by people suffering from social anxiety, for whom the resilience linked to the search for social support in a stressful situation is slowed. Negative images are therefore not positively updated when the environment is welcoming.

Imagery work begins by considering the mental imagery of depressed or anxious patients to better understand its significance in relation to their suffering and the way in which imagery and interpretation biases participate in the maintenance of the disorder. Once a functional analysis has been carried out, it is important to clarify the prioritized processes in the guided imagery work, whether in the interview or during the guided exercises.

For social anxiety, the uncovering of negative images related to socially traumatic (embarrassing/humiliating) events (Hackmann et al., 2000) is important. Mental imagery rescripting is a cognitive and behavioral therapy technique for both social anxiety and depression, with results superior to those of exposure protocols (Clark et al., 2006). The first phase involves cognitive restructuring, whereby the meaning of the early event and its implications for the present are challenged. The aim of this first phase is to prepare for the emotional exposure of the second phase, when the patient is asked to recall a traumatic social situation from the perspective of the inner child who experienced it. He or she is then invited to broaden the perspective from the current point of view. In the third phase, the patient is invited to offer adult support to the child who has experienced the trauma. The work done in the clinical case presented allows the illustration of this technique in an imaginary recalled traumatic situation. Rescripting was used at several points in therapy in the presented case, including at the end of therapy to work through nightmares about the threat of sexual assault.

The CFT approach, developed by P. Gilbert (2009), integrates some CBT techniques. What makes it unique is its focus on cognitive restructuring for the validation of the function of emotions. Within the first phase of cognitive restructuring, compassion is offered to the patient's emotional side by validating the patient's emotional reaction as adapted to his or her context, history, and biological needs rather than looking for an alternative thought. The reconnection between the adult and the child is based on compassionate motivation. There are 3 flows of compassion: compassion for others, received compassion and self-compassion (Matos & Steindl, 2020). Possible blockages in receiving compassion from others or from oneself (self-compassion) can hinder access to this type of guided imagery exercise.

Fear may not come from the idea of being free from suffering (the definition of compassion), but compassion occurs in a relational setting and may be associated with relational struggles such as a fear of being judged. For example, someone who has been harmed by a person who previously offered compassion may avoid receiving compassion. A person may have been abandoned, sexually abused, or humiliated by a person who also offered compassion separately (a partner, a teacher, a physician, or a parent). Compassion may then be perceived as dangerous, and the idea of being at the receiving end of compassion may trigger a historically rooted experience of vulnerability.

The experience of having received compassion alongside something unwanted, such as submission, unwanted sexuality, or humiliation, may condition compassion to be associated with a dangerous context and a sense of vulnerability. Clients who have that type of memory will likely experience fear and avoid compassion. They may also feel as if they do not deserve to receive compassion.

The case study presented here will illustrate that this preparation time that involves working on the fears, blockages and resistances to the different flows of compassion is important and that specific work may be required to enable the patient to receive compassion and to activate self-compassion in imagery work.

Beck et al. (1979) considered mental images to be central to understanding depression, but mental imagery techniques have only recently been studied experimentally. These techniques include exposure to problematic images (Kandris & Moulds, 2008), rescripting (Brewin et al., 2009; Patel et al., 2007; Wheatley et al., 2007) and positive mental image reinforcement (Dunn, 2012; Macleod & Moore, 2000). The latter technique, called cognitive bias modification (CBM), aims to train depressed patients' attention toward positive information to help reduce their biases toward negative information. Depressive patients (Holmes et al., 2016) may be asked to create concrete, positive mental images from blurry situations from everyday life. This technique reinforces positive emotions, which are often deficient in patients with depression, and creates a positive bias that competes with negative interpretation bias, a factor that maintains depression. Each of these techniques can be adapted to a conversational format, especially when narrating autobiographical events. This technique was used in the first part of the therapy in a conversational mode. Compassion-focused imagery (CFI) has the advantage of reinforcing a positive self-relationship, which increases positive self-images and counteracts the negative effects of self-criticism in depression.

Introducing CFI in therapy may be difficult for both therapists and clients. Depressed patients often have high levels of self-criticism. They may approach CFI by setting unattainable goals for the exercise and blame themselves if they do not reach those goals. For example, they may add an instruction such as "I must be perfectly relaxed" or "I have to stop thinking," which will create a struggle against the emotions that emerge during the exercise. The patient may lose interest in the other instructions and activate negative thoughts about themselves, which will increase tension and lead the patient away from the goal of relaxation that was part of the exercise. Adding flexibility in the instructions at the beginning of CFI may be helpful, for example, by validating the emergence of emotions as part of the exercise or by relativizing an instruction by indicating that "it doesn't matter." This may guide the patient to let go of the struggle to succeed perfectly. If the patient experiences blockages, no images may appear. Resistance will potentially lead to avoiding the exercise. The patient will say "yes, but…" and find excuses to do the exercise another day. This may be a sign of a rupture in the therapeutic relationship. Such a rupture may be recognized by noticing cognitive, emotional, or physical withdrawal on the part of the patient or the same patterns of avoidance on the part of the therapist. It can also be recognized by aggressive reactions, such as emotions of annoyance or movement toward conflict, in either the therapist or the client.

From an interpersonal perspective, the therapist may feel uncomfortable if there is an imbalance in the therapeutic relationship. If the therapist is in a higher position, positive emotions can emerge, such as a sense of competence. However, this imbalance will lead to a rupture if the client actively maintains a lower position through submissive behaviors. The therapist may start feeling uncomfortable.

If the client simply lacks self-esteem, direct or indirect validation may be sufficient to work toward a more balanced relationship. For clients with dependent personality disorder (DPD), who have an extreme need to be taken care of, a higher relational stake may block the relationship (Disney, 2013). If patients with DPD feel valued, feel that therapy is in progress or feel that the therapist could start initiating the end of therapy, a fear of abandonment emerges. Revalorization is avoided; self-criticism may increase, or any strategy of change may be blocked to remain in a situation of needing the therapist and thus maintain the therapeutic link. This type of interaction may be representative of interpersonal patterns in the patient's other relationships. The rupture that may emerge in the therapeutic relationship is an opportunity to help the client question these relational patterns.

It can be difficult for the therapist to welcome the feelings linked to being in a higher position in the relationship, which may or may not be comfortable. Being in such a position may activate subtle avoidance behaviors and may lead the therapist to be less active in the therapy and move from a compassionate motivation toward a motivation to avoid the client's suffering, which is referred to as nonsuffering motivation. A compassionate motivation aims at relieving compassion and often leads to moving toward suffering, but a nonsuffering motivation may lead to the avoidance of suffering by the client as well as the therapist.

CFI is a great opportunity for both patients and clients to create a space to explore this interpersonal dynamic. It can help to explore how the patient will receive compassion and therefore welcome fears, blockages, and resistance as part of the process. The therapist's resistance to use imagery is a subtle sign of a therapeutic rupture that should be explored. Understanding and accompanying the patient through these blockages are a large part of the therapy work presented here. These processes underlie depression, social anxiety, and DPD in different ways.

Patients suffering from chronic or severe depression are among the most "difficult" patients for therapists because of their demanding attitude and their self-destructive and addictive behaviors (Koekkoek et al., 2011). Indeed, having to deal with such a patient is among the most stressful factors for therapists, as depressed patients are likely to activate a wide variety of responses in them, ranging from compassion and sympathy to anger and hatred. A therapist meeting a depressed and dependent client may be tempted to save the client to avoid the feeling of frustration and despair he or she may experience from the empathy for the powerlessness or inaction of the client.

In the clinical case presented, the focus is on different types of ruptures that were triggered by the proposition of therapeutic strategies. These strategies for change were used to work on the ruptures and the relationship patterns that they revealed. These ruptures were used as opportunities for changes in the relational dynamic and allowed a negotiation between acceptance and change. Five situations created ruptures without breaking the therapeutic relationship: the nonacceptance of depression by the client, the nonacceptance of therapeutic strategies for depression, the feeling of being unworthy of receiving compassion from the therapist, the expectation of receiving compassion from a mother unable to offer it and the preparation of therapy termination. The different therapeutic strategies, such as diagnoses, strategies for depression, guided imagery, or work on termination of therapy, initiated the ruptures but were also used to work on the therapeutic relationship. The presentation of this clinical case is an attempt to illustrate this interplay.

2 | CASE ILLUSTRATION

2.1 | Presentation of the problem and description of the client

Cynthia is a young woman in her twenties who has been a high-achieving student. She is passionate about an ancient culture that has disappeared, which has provided her with a rich symbolic mental imagery. However, she was not able to achieve the doctorate she dreamed of pursuing, which is difficult for her to accept. She is curious to discover what the lost knowledge from the aforementioned ancient culture could bring today in terms of health. During the therapeutic work, she gradually invests in this project through difficult and courageous choices.

She experienced a break-up several years ago, a few days after an act of commitment, which was a shock. She is very ambivalent about the idea of opening herself up to a new encounter. A mixture of melancholy and fear holds her back from moving toward this possibility. The idea that someone will come and save her from her difficulties helped her in her childhood to accept a feeling of helplessness. This narrative is still present at the beginning of therapy. It soothes her but turns her to the past and prevents her from being fully responsible for her well-being in the present. The expectation of being rescued reinforces a sense of abandonment with the idea that someone should have been there for her.

Her sense of self-efficacy is low, even though she succeeds at everything she does. She blames herself for her imperfections with the feeling of "not being enough."

2.2 | Case formulation

Cynthia suffers from major depressive disorder (with a score of 35 on the Beck Depression Inventory—BDI), which is very difficult for her to accept. She does not want to "be like her mother" and repeat the family pattern.

The symptoms have been intermittently present since childhood. The idea of being depressed triggers suicidal cognitions with no intention of acting on them. She thinks she will get better when she falls in love. At the same time, she tells herself that she cannot be loved.

Her depression is related to DPD. Cynthia tends to let others make decisions and follow their advice to avoid relationship tension. The opinions of others weigh heavily in her decisions. Her last partner left her, complaining that he had to carry her negative emotions. She invests heavily in her friendships and is concerned about being alone after a friendship breakup.

She suffers from social anxiety. She has a great fear of being judged negatively and feels shame very easily. She has not been directly stigmatized, but her mother, who immigrated to France with her father during her childhood, has experienced many social stigmas. Her mother was married very young and quickly divorced, which was judged negatively in her home country. Cynthia's mother had a second marriage but was not able to remarry in church, which her father blamed her mother for. Cynthia's first language is not French, although she speaks it perfectly. Reflections on small differences in her accent or on a turn of phrase have led to a sense of judgment. On the other hand, she feels like "the only French person in the family" and feels culturally out of step with her family because of her cultural adaptation.

She suffers from slight alopecia, which is an additional difficulty for her self-esteem. She has a nontraditional spirituality, strongly inspired by the ancient culture she studies. At the beginning of therapy, she shared a feeling that those beliefs "cannot be evoked." They are associated with a form of embarrassment.

Her mother, having suffered a great deal, also has exhibited humiliating behaviors (such as expressing criticism with contempt) and violent tantrums (such as getting in a fight with a stranger in the street with a baby in a stroller). Cynthia would react by trying to sooth her mother and try to avoid situations of conflict. Her mother suffers from chronic depression and has made several suicide attempts. Cynthia has been involved in helping her mother with her depression. Her involvement in helping her mother in traumatic settings has conditioned her anxiety. Being confronted with her mother's suffering triggers feelings of distress.

Cynthia is very empathetic, but her empathy is rooted in coping with her mother's challenging behaviors. Therefore, it is associated with a sense of insecurity.

Her departure from home as an adult was violent. Her mother asked her to leave the family house overnight. Her parents' divorce and the departure of her father, who suffers from alcoholism, also created a particularly painful experience of abandonment. Both her father and mother are portrayed as heroes who survived difficult things before falling apart.

Cynthia did not experience sexual abuse as a child but has had painful experiences related to sexuality (such as being awakened by sexual intercourse, which she was only able to identify as abuse during her first therapy work). She has anxieties about sexual assault.

Her functional analysis, based on CFT is presented in Figure 1.

This functional analysis shows links between the patient's developmental history and her interpersonal behaviors and explains the therapeutic rationale. The relation to self creates loops of reinforcement, maintaining emotional insecurity and safety strategies.

3 | COURSE OF TREATMENT

The therapeutic plan is based on working on four processes: exposure to emotions both negative (fear of rejection of shame, anger) and positive (pride, sexual arousal); exposure to two different flows of compassion, that is, receiving compassion from others with compassionate assertiveness (expressing one's own needs, making decisions for one-self) and being open to receiving compassion and self-compassion (talking to oneself as to a dear friend, validating one's emotions, and practicing self-kindness, warmth of inner talk, shared humanity); and the reduction of self-criticism.

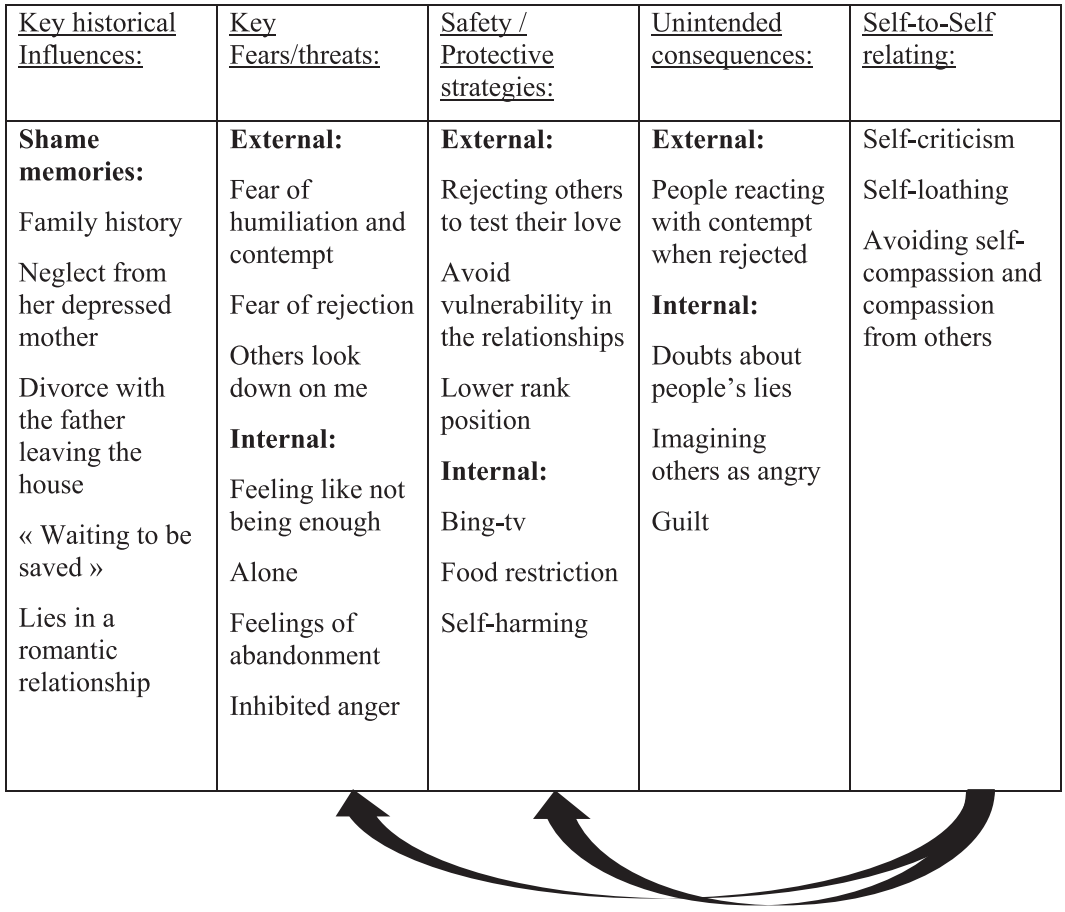

FIGURE 1 Compassion formulation (Dale-Hewitt & Irons, 2015)

The patient's request for therapy is to feel heard and validated in her emotions. This is congruent with the therapeutic plan. She says she wants to break her pattern of "not being enough."

The first rupture emerges at the beginning of therapy when depression is evoked. Cynthia does not "want to be that person." She is overwhelmed by negative emotions and closes herself off. The therapist, who has experienced several episodes of depression, is sensitive to the stigma associated with this illness and uses self-disclosure to activate a sens of shared humanity. Cynthia's reaction strongly activates the therapist's compassion. Psychoeducation based on CFT (P. Gilbert, 2009) is used to help with the acceptance of depression.

DPD is defined for Cynthia as securing herself in a low defensive position. In her past, Cynthia learned that to avoid challenging the family dynamic, she had to value others and their needs in a pattern of abnegation. Her empathy facilitates the anticipation of conflict situations that might challenge family relations, especially with her mother. Autonomy was linked to situations of conflict and was not encouraged. The generalization of this avoidance to all her relationships has not allowed her to realize that some people around her are open to her needs and want her to assert herself in who she is.

The fear of rejection is validated as a fundamental fear. Humans need to be part of a social group to survive, and the fear of rejection is avoiding exclusion. It is a protective mechanism for our survival.

Work on exposure to social situations is carried out. Different situations are identified as activating social anxiety, and Cynthia is invited to move toward these situations. Cynthia's mental imagery is used in the formulation

of the exposure. She is asked to imagine the feeling of shining. The sun is a strong symbol for Cynthia, and the symbolism of life as an inherent essence of value echoes her spiritual beliefs and the ancient culture, she holds dear. This symbol is used to identify situations in which she can take a stronger position in a relationship. It also represents the direction of attention in the social situation. She is invited to focus on external stimuli such as visual information and nonverbal information rather than observing herself through the eyes of the other person. Behavioral activation is proposed with an exploration of positive emotions, activities that give meaning to her life. Behavioral activation is worked on in connection with exposure to social situations.

One session is dedicated to working on Cynthia's self-criticism, which is very high, to reveal its function. Cynthia's mental imagery is used to represent the critical part of herself as a red imp with a contemptuous tone. The red imp character stems from imagery related to Catholicism, which stigmatized her mother due to her first divorce. In the Judeo-Christian tradition, "evil" and "good" are not equal: the fallen angels were creatures of God who were not created evil but fell because they wanted to be equal to God, whom they rejected. The opposition between an angel and a red imp is based on rejection and is often linked to internal struggle. The thoughts linked to the red imp are often rejected and become obsessive. The red imp expresses desires and wants but is also perceived as dangerous and needs to be controlled and rejected.

The therapist validates the function of this critical part that seeks to protect Cynthia from the judgment of others to protect her anxious part by anticipating the judgment she might encounter. The therapist also validates Cynthia by explaining that while trying to help, the critical part reinforces her depression by rejecting the bright side of her. Her self-criticism represents an internalization of her mother's violence, which resulted in a small scar that Cynthia still has on her face. Her self-criticism also drives dietary restrictions that are experienced as punishment.

When Cynthia is confronted with the idea of getting better, she expresses her ambivalence toward hope through imagery. She explains that hope is a rat gnawing at her stomach. It is locked in and seeks to free itself. She feels like every time she dares to hope, she is disappointed. Her hope only makes her feel powerless. Time, symbolized by a watch, looks at her with contempt as her dreams fade away with the passing of time. She uses this imagery to express her dreams of falling in love and starting a family dwindling with the passing of time.

The second rupture emerges as the imagery of an ideal compassionate other is proposed. Cynthia expresses that she does not deserve to receive compassion. She is annoyed about receiving compassion, and tensions emerge in the patient-therapist relationship. She seems to enjoy these tensions, and the therapist experiences similar emotions. The resistance is explored, and Cynthia explains that she is not worthy enough to receive compassion. The therapist explores what would be needed for Cynthia to feel worthy enough to deserve compassion. Cynthia explains that to feel like she deserves it, Cynthia would need to feel positive regard. It is possible for her to receive compassion from the therapist in this context of positive regard, but to imagine receiving compassion from another person seems too difficult to reach at that point in therapy. Cynthia's first therapy follow-up ended when she felt judged by her therapist. Receiving compassion is directly connected to both her therapeutic goal of changing the pattern of "not being enough" and to the blockages that create therapeutic ruptures.

At this point in the therapy, after 1 year and 15 sessions, a change in the dynamics of the relationship occurs. It is as if the acceptance phase has lasted a year. This first phase is not without its changes, but they come in small steps. During the first months, Cynthia refuses the proposed exercises of guided imagery. Then, she spontaneously decides to explore the guided exercises offered online by the therapist, without direct interaction, probably as a strategy of partial avoidance.

She begins with an exercise that suggests representing emotions as totem animals, that is, as animals that look after one's protection and well-being. This exercise was created to facilitate compassion for emotions, as compassion toward animals is easier than compassion toward humans. In this guided imagery exercise, difficult emotions are represented as animals. Cynthia's fear appears as a lost deer, and her critical part appears as a coyote. The choice of animals shows that her critical part threatens her anxious part. The therapist asks her what her doe needs. She explains that in her visualization, her compassion is represented by the moon that would guide the doe.

However, Cynthia refuses this help and pushes back against receiving compassion. This time, therapeutic rupture was represented in the imagery itself.

The beginning of her last relationship was associated with a moment of meditation where she opened herself to receive the light of the moon, her symbol of compassion. That relationship is now over, and she no longer wants the moon's help. These symbols help the therapist validate her resistance to receive compassion. In Cynthia's past, allowing herself to receive compassion was associated with opening to love. That love ended, and she felt abandoned. Thus, this feeling of compassion makes Cynthia feel too vulnerable to accept it.

Therapeutic ruptures are warning signs for the therapist. They indicate that something is stuck in the relationship (Eubanks et al., 2021). The tensions that emerge in the relationship activate unpleasant emotions, and the therapist can easily react in a rigid way by persevering to do more of the same. However, if there is enough awareness of these emotional reactions, the therapist can use them as a sign that it is time for a change in the therapeutic posture and move between strategies of change and acceptance or find a path that works for the patient. With Cynthia, to create a space of acceptance and avoid reinforcing the resistance to receiving compassion, the therapist proposes focusing the work on self-compassion imagery in the following sessions. Indeed, the three flows of compassion (self-compassion, received compassion and compassion for others) have specific fears, blockages and resistances associated with them (P. Gilbert, 2009).

Cynthia identifies her compassionate self as a goddess from the ancient culture she is studying who is mothering and magical, yet able to be angry. Self-compassion seems easier to access, while receiving compassion from others activates a sense of abandonment.

Several sessions are then devoted to emotional dependence and the rewriting of the story in which she must be saved. A new chapter is opened in which she can become the heroine of her own life.

After that work on the patterns of DPD, imagery work is proposed again. Cynthia can then visualize compassion as a dragonfly. She rejects the possibility of receiving compassion, but this time she makes it clear that she would have needed this compassion to come from her mother and a new form of rupture emerges. Cynthia expresses the cognitions she imagines the therapist is having: “You must think that what I'm feeling is ridiculous, that it's not that bad.” In that situation, chair work is proposed as a repair strategy (Eubanks et al., 2021). After questioning Cynthia to verify that none of the therapist's behaviors could have made her think that, it is suggested that she imagine in an empty chair a therapist who would say exactly what she imagines.

The empty chair is helpful for both clients and therapists. It allows the exploration of the patient-therapist relationship from a new perspective. The patient and therapist can stand up and look at the chair they were sitting in and have compassion for the person who experienced being in front of a judging therapist. They can also conclude that there are different ways to interact in the relationship. The therapists may also distance themselves from the difficult feeling of being in an abusive role. Otherwise, there may be a great frustration due to not being able to value the client.

The chair space facilitates the exploration of this imagined judgmental therapist and provides an opportunity to talk about it.

Cynthia's first reaction is to become angry: “This is not normal; she is mean.” Then, the therapist asks her who this person looks like. It is her mother who appears in Cynthia's mind. In addition, as she thinks about her mother, her cognitions change completely: “She must love me; I must be the problem.” This cognition is deeply rooted in Cynthia's childhood. When facing the “mean” behaviors of her mother, the only way to preserve her faith in her mother's love is to turn the criticism toward herself. Thinking of herself as the problem fulfills the need to be loved by her mother, even with her disorganized actions.

The therapist then asks Cynthia to stand up and to notice her two different reactions. This distancing helps her realize that she has compensated for her mother's lack of care by questioning herself. She is still looking for her mother's compassion but is unable to find it. This disappointment leads to an inability to listen to or validate her inner child and to shame herself as being “the problem.”

A new exercise is proposed, and Cynthia can then visualize her inner child, vulnerable, alone, locked in a dungeon with her feet in the water. The child refuses to look at her. Cynthia is not able to show compassion to this inner child. The therapist suggests that she offers her presence to simply stay in touch with her inner child. Offering a shared presence is a strategy that activates a feeling of connection and regulates the fear of compassion (Leboeuf, 2021). It activates a core process of compassion with a decrease in physiological arousal. It reconditions a coregulation in the relation as part of receiving compassion. In a second step, she can bring the child out of the water, putting her in a dry place.

This session highlights the function of Cynthia's resistance to receive compassion from someone other than her mother. A work of mourning of the lack of compassion from her mother is initiated.

4 | EVOLUTION DURING THERAPY

In the sessions that follow this awareness of unresolved grief, there is a marked improvement in Cynthia's mood (with a score of 22 on the BDI, or a reduction of 35%). Cynthia is able to expose herself professionally. She chooses to change her job to give herself the chance to invest in the professional project that is close to her heart. She reaches out more to others, exposes herself to situations associated with feelings of shame and is gradually able to open up to others about her feelings. She asks to space out the sessions. The times when she feels overwhelmed by her emotions are less frequent. She accepts the antidepressant and the work stoppage that her physician had proposed several months before. Antidepressants bring a significant reduction in rumination. The psychotherapy work helps to accept the physician's help or compassion and brings about compliance with the proposed treatment.

Cynthia is now able to accept her depression, which had previously seemed impossible. It is known that acceptance in conjunction with the emergence of psychological flexibility (the ability to invest in meaningful actions despite depression) are resilience factors (Levin et al., 2012). Before therapy, Cynthia experienced her depression as a signature of failure, which prevented her from enjoying her progress.

Cynthia reaffirms her need to understand her emotions. She brings to the sessions new issues related to obstacles in love, sexuality, and anger. She expresses the need to love herself, and it is proposed that she discriminate between appreciation and love. Appreciation is based on the positive and refers to self-esteem. Self-love is redefined as integrating negative emotions. It is through self-compassion that we, humans, can come to love ourselves in a form of self-inclusiveness that creates a sense of being whole or being fully connected to ourselves.

Anger that was previously internalized can begin to be expressed. Cynthia describes herself as having a “bad temper.” Expressing anger feels unacceptable, and this emotion is associated with a strong stigma. She tends to turn her aggressivity toward herself and self-harm. With the work of grieving her mother's compassion and accepting her depression, Cynthia begins to express annoyance and possible disagreement. She is surprised and unsettled by this. At first, she thinks it is a side effect of the antidepressant, but her physician clarifies that antidepressants do not cause anger.

The expression of anger is associated with a fear of conflict and rejection, and this sudden change in her behaviors makes her feel insecure. She expresses that it is impossible for her to have compassion for her anger, as that evokes her mother's abusive behaviors, and she refuses to do a compassionate imagery exercise for her anger. “Who am I to be assertive?” she asks. She expresses that having compassion for her anger can lead to sadness and that she no longer wants to be a sad, empathetic, listening, and compassionate person who is sensitive to others. She realizes as she begins to free herself from her depression that over time, her sadness has become like an “identity,” and she had become attached to it. She no longer wants to be depressed or sad.

Through imagery work, she can have compassion for someone in the same situation as her and can indirectly validate that her own anger is expressing suffering. The image of her mother appears in the exercise, and she can validate the suffering of her mother. Her anger, if it is sometimes expressed in a violent or inappropriate way, expresses a real suffering. This exercise helps to destigmatize anger by reconnecting the message of wisdom it

carries about suffering. This exercise also allows aggressiveness to be differentiated from assertiveness and offers concrete benchmarks for evaluating the aggressiveness of the message formulated independently of the reception of the message as being unpleasant. The expression of needs in a direct and clear way can be difficult to hear without the message being aggressive. At the end of this session, Cynthia talks about dreams she has about her father, where she repeatedly calls him a "jerk" for abandoning an animal. In her dream, she is the only one in the family to say something. The other family members stay silent. She expresses that this abandonment is symbolic of the abandonment she has experienced regarding her father's absence. Her anger expresses that this abandonment is unacceptable.

5 | OUTCOME AND PROGNOSIS

Cynthia is now able to express what she wants, for example, to her friends about their shared vacations. She no longer wants to be subjected to her friends' choices if they do not suit her. She has decided to enjoy a vacation in which she will be able to "go to her own encounter and encounter nature, hiking, facing the wind and the elements." Toward the end of therapy, she starts to use imagery work to connect her inner child. She can let her inner child go out of the dungeon into the world. It is still scary, but she feels like she can be the one to watch over the little girl. The symptoms of depression have decreased substantially. She is now able to face her mother's intense emotions without taking the responsibility to regulate her mother's emotions and to set boundaries. She has more self-compassion and is able to forgive herself. A phase of relapse prevention is proposed. The sessions continued to be spaced out. Work on the acceptance of emotions and the maintenance of the strategies that were shown to be effective is performed.

Initiating the termination of therapy causes the last type of rupture. Cynthia refuses to fill out the final questionnaires; she expresses that her therapy should last a very long time, that there is something wrong with her, and that she could never get better. At that point, Cynthia takes a confrontational attitude. Some anger is present, but she turns it against herself as if to avoid the conflict. The therapist is then confronted with two feelings: a feeling of wanting to support Cynthia and to encourage her to regain her confidence and a feeling of sadness and that the therapy has failed. The therapist then chooses to let the latter feeling express itself fully and rephrases that the therapy may be a failure. The therapist notes that it is not Cynthia's fault if the therapy was not able to help her and that it is okay to question the therapist. This forms a parallel with her past, when she often had to avoid questioning the people who were supposed to support her, such as her parents, because they did not have the psychological space for questioning themselves. She is thanked for doing so and strengthened.

At this point, for the first time in therapy, Cynthia and the therapist experience common humanity. The suffering is shared, and a different kind of connection emerges, one that is full of sadness but also tenderness and serenity.

Cynthia verbalizes that she is afraid that the therapy will end because she will feel rejected by the therapist. The dependency pattern is made conscious by the patient. She can put into words that she has associated autonomy and improved psychological well-being with rejection in the relationship (she had to become autonomous in the context of family conflict). The therapist then asks how the therapy could end without her feeling abandoned. She responds that she needs to define for herself when the therapy will end. The therapist also suggests separating the therapeutic relationship and the end of therapy. An agreement is reached that Cynthia can take an appointment if she wishes after the end of therapy.

The termination of the therapy and the rupture in the therapeutic alliance that emerges allowed Cynthia to replay the empowerment differently in relation to a partial remothering bond. The work of termination makes it possible to put into words the issue related to the relationship and to accompany her in the definition of her needs.

Cynthia has learned to expose herself to her negative as well as positive emotions, and she is now able to take the risk of a new love relationship. Her mood fluctuates greatly depending on her levels of loneliness. When an

event triggers an attitude of withdrawal or isolation, she more quickly returns to others, and her sadness passes after only a few days. There is still significant dysthymia but given that Cynthia has suffered from depression for several years, being more flexible with her mood is a significant improvement. Self-criticism is still present in moments of isolation, but it decreases after a few hours, and she is now able to engage in self-compassionate inner talk. Cynthia is more vocal about her needs and has been able to say no to proposals from important people based on her perception of the situation rather than on the relationship issue.

6 | CLINICAL PRACTICES AND SUMMARY

The imagery exercises were used in this therapeutic work to support work on the relationship and to bring out the issues related to the different flows of compassion. Cynthia's depression was linked to a strong compassion for others that, having become identity-based, prevented her from receiving compassion from others and from having compassion for herself. Doing an exercise in a therapy session at first evoked resistance because this compassion "should have come from her mother." The chair work helped to distance the fear of being judged by the therapist and clarify that the idea of not deserving compassion was a coping strategy to make sense of a lack of care she faced as a child. Cynthia's thought that it was not her mother who was mean but that it was she who did not deserve her care was maintaining her feeling of shame. This belief preserved the relationship with her mother but also prevented her from receiving compassion from others.

The therapy work helped to break down this blockage and allowed Cynthia to be open to taking medication. An anger that had been inhibited until then was able to be expressed in connection with her father, allowing her to free herself from the expectation of being saved. She was then able to take her own inner child outside of the dungeon and to become a little bit more the heroine of her own story every day.

The end of the therapy is neither a success nor a failure. In the clinical case presented, the processes that Cynthia and the therapist worked on evolved positively. Even if the symptoms of depression are reduced and well managed at the end of therapy, they are still present and sometimes difficult to accept.

It is central to work with effective therapeutic strategies. However, this clinical case attempts to demonstrate that if therapists are rigidly focused on the success of the therapy in terms of reducing emotional pain, they may miss out on questioning the therapeutic relationship. For clients with DPD, improvement in their well-being is linked to autonomy and may trigger a fear of rejection.

Therapy is not only about changes for patients but also about acceptance of their suffering. Allowing therapy to fail and allowing the therapist to feel the sadness and grief of letting go of the success of the therapeutic work, even just for a moment, allows the therapist to not only model emotional flexibility but also show an unconditional acceptance of patients as they are.

CONFLICT OF INTEREST

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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