THE PSYCHOTERAPY FOR INTEGRATED REGULATION OF EMOTIONS AND PSYCHOSOMATICS (PIREP): A New Integrated Model

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Why Integration Today?

- Over the last decades psychotherapy has multiplied into many models
- This richness has also created **fragmentation** and competing languages
- Trauma shows us its complexity: it is written in the **body**, shaped in **relationships**, and told through **narratives**
- No single framework can capture this reality
- **Integration is not optional – it is a clinical necessity**

"In the last decades psychotherapy has grown enormously, producing a wide variety of models and techniques.
This richness, however, has also generated fragmentation—different languages, competing frameworks, sometimes disconnected from one another.
Yet, when we work with trauma, we quickly realize that no single approach is enough: trauma lives in the body, it is shaped by relationships, and it is carried in the narratives we tell about ourselves.
That is why integration is not simply desirable—it has become a true clinical necessity."

The SEPI Spirit

- SEPI's mission: **exploration across traditions**
- Dialogue instead of boundaries between schools
- Integration means **bridging, not eclecticism**
- PIREP is born within this spirit:
  - A clinical model
  - Grounded in research
  - Open to dialogue with other approaches

"SEPI has always encouraged dialogue beyond theoretical boundaries.
Instead of separating schools, it invites us to explore what connects them.
Integration here does not mean an eclectic mix of techniques—it means building real bridges between neuroscience, psychoanalysis, cognitive-behavioral models, and embodied approaches.

The PIREP model was born exactly in this spirit: it is a clinical model, grounded in research, and always open to dialogue with other perspectives."

PIREP

THE PSYCHOTERAPY FOR INTEGRATED REGULATION OF EMOTIONS AND PSYCHOSOMATICS . AN INTEGRATIVE THEORETICAL AND CLINICAL MODEL

The Psychotherapy for Integrated Regulation of Emotions and Psychosomatics (*PIREP*) is a clinical model of integrative psychotherapy with a developmental and relational approach, based on the idea of an intervention that aims at the patient's emotion and bodily regulation (*Self- and autonomic-regulation*), as well as at their psychosomatic wellbeing, both when they are alone and in their interpersonal and intimate relationships (*intimacy regulation*).

PIREP

THE PSYCHOTERAPY FOR INTEGRATED REGULATION OF EMOTIONS AND PSYCHOSOMATICS .
AN INTEGRATIVE THEORETICAL AND CLINICAL MODEL

PIREP is a bio-psycho-social intervention, open to the progressively arising innovations coming from advances in clinical psychology, clinical psychiatry, affective neuroscience and psychosomatic medicine, which continuously find new possibilities of integration between the dynamic clinical model and the cognitive-behavioural model by means of the theories of attachment, developmental trauma and complex trauma.

Top-down & Bottom-up Integration

- **Top-down**: DMN, Theory of Mind, narratives
- **Bottom-up**: Polyvagal Theory, autonomic states, body regulation
- Mind-Body-Relationship as **one regulatory system**

"In psychotherapy we often privilege either the mind, the body or the interpersonal functioning.
But recent neuroscience shows us that mental processes and physiological states anf the relational dynamics are inseparable.
On the one hand, the top-down dimension: the Default Mode Network, Theory of Mind (ToM), the capacity to build narratives and mentalize.
On the other hand, the bottom-up dimension: Polyvagal regulation, autonomic states, embodied safety or danger.
PIREP integrates these two perspectives, treating mind – body - relationship as one regulatory system, constantly interacting in both directions."

Polyvagal Theory

- **Neuroception**: implicit detection of safety vs. danger
- **Ventral vagal system** → social engagement, co-regulation
- **Sympathetic system** → fight–flight
- **Dorsal vagal system** → shutdown, collapse

"One of the central frameworks in PIREP is Stephen Porges' Polyvagal Theory.
It teaches us that our nervous system is constantly scanning the environment for cues of safety or danger—what Porges calls neuroception.
When we feel safe, the ventral vagal system allows us to connect, engage, and co-regulate with others.
When danger is detected, the sympathetic system prepares us to fight or flee.
And when the threat feels overwhelming, the dorsal vagal system can trigger immobilization, collapse or dissociation.
Understanding these autonomic states is crucial in therapy, because they shape not only emotions but also our capacity for relationship and meaning-making."

Object Relations & Internal Saboteur

- **Fairbairn**: Anti-libidinal ego → persecutory voices
- **Internal Saboteur**: self-critical, ruminative, persecutory
- **Bromberg**: "Standing in the spaces" → holding dissociated parts
- **ToM/DMN**: dysfunctional, ruminative → fuels the Saboteur

"Another foundation of PIREP comes from Object Relations theory.
Fairbairn described the *anti-libidinal ego*, an internal persecutory presence that attacks the self.
In clinical terms, this emerges as what we call the *Internal Saboteur*: the self-critical, ruminative, persecutory voice inside the patient's mind.
Bromberg has shown us how dissociated self-states need to be held in the therapeutic space—what he calls *standing in the spaces*.
From a neuroscientific perspective, we can connect this phenomenon to the Default Mode Network and Theory of Mind (ToM).
When they become dysregulated, they generate ruminative, persecutory thoughts that reinforce the Saboteur, keeping the patient trapped in cycles of self-attack and isolation."

THE AMBIVALENT OBJECT AND THE RAISE OF INTERNAL SABOTEUR AS ANTILIBIDINAL SELF, AS ANTI BONDER

ANTILIBIDINAL SELF

INTERNAL SABOTEUR
Anti Bonder

FALSE SELF

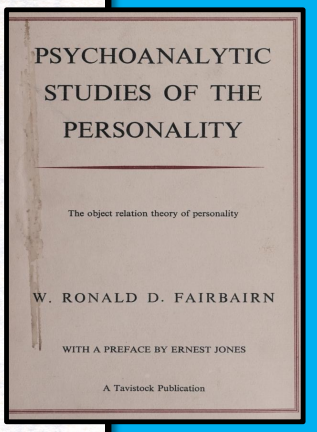
UNSAFETY
IN RELATIONSHIP

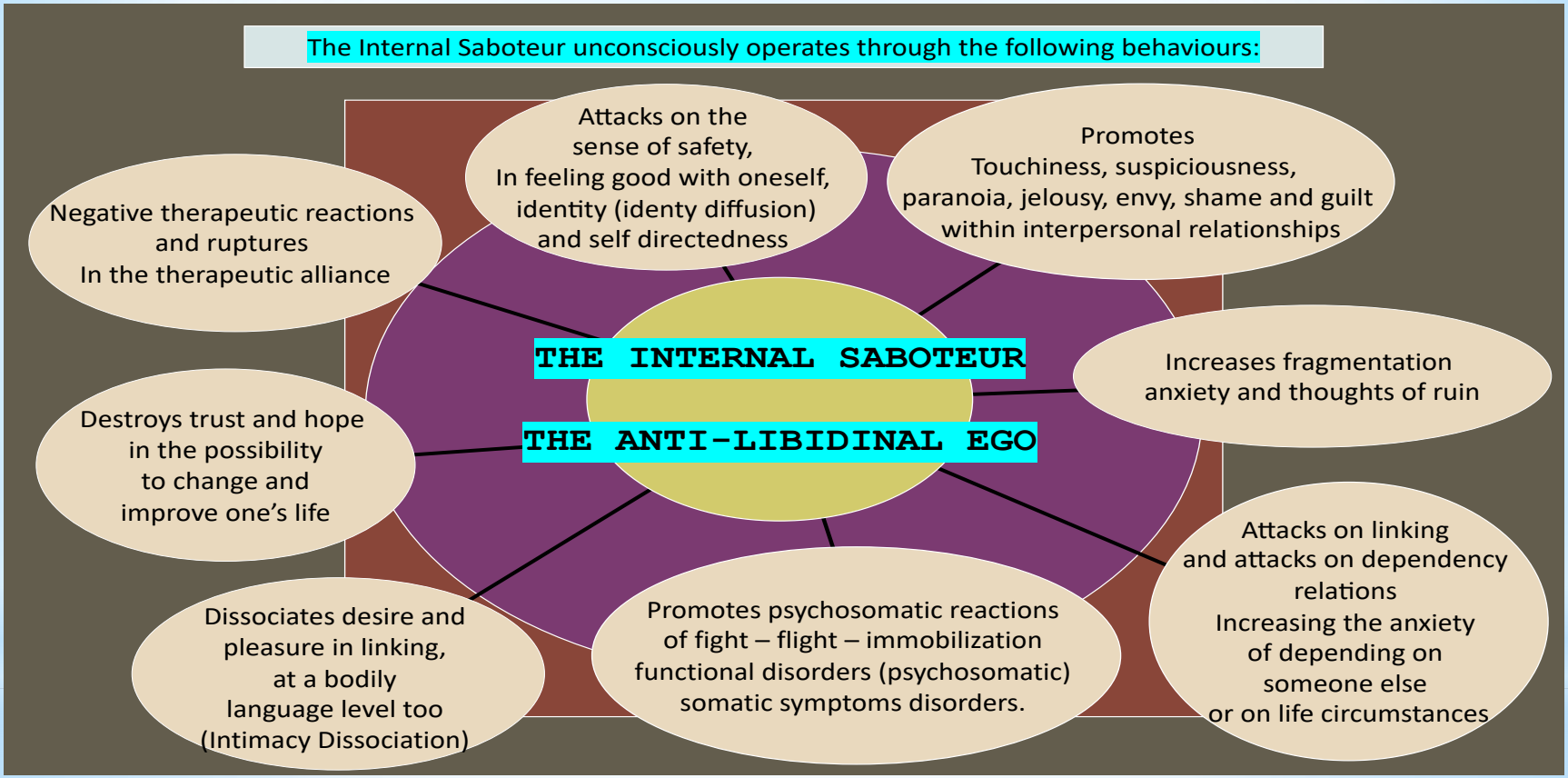
CENTRAL SELF

DISCONNECTION

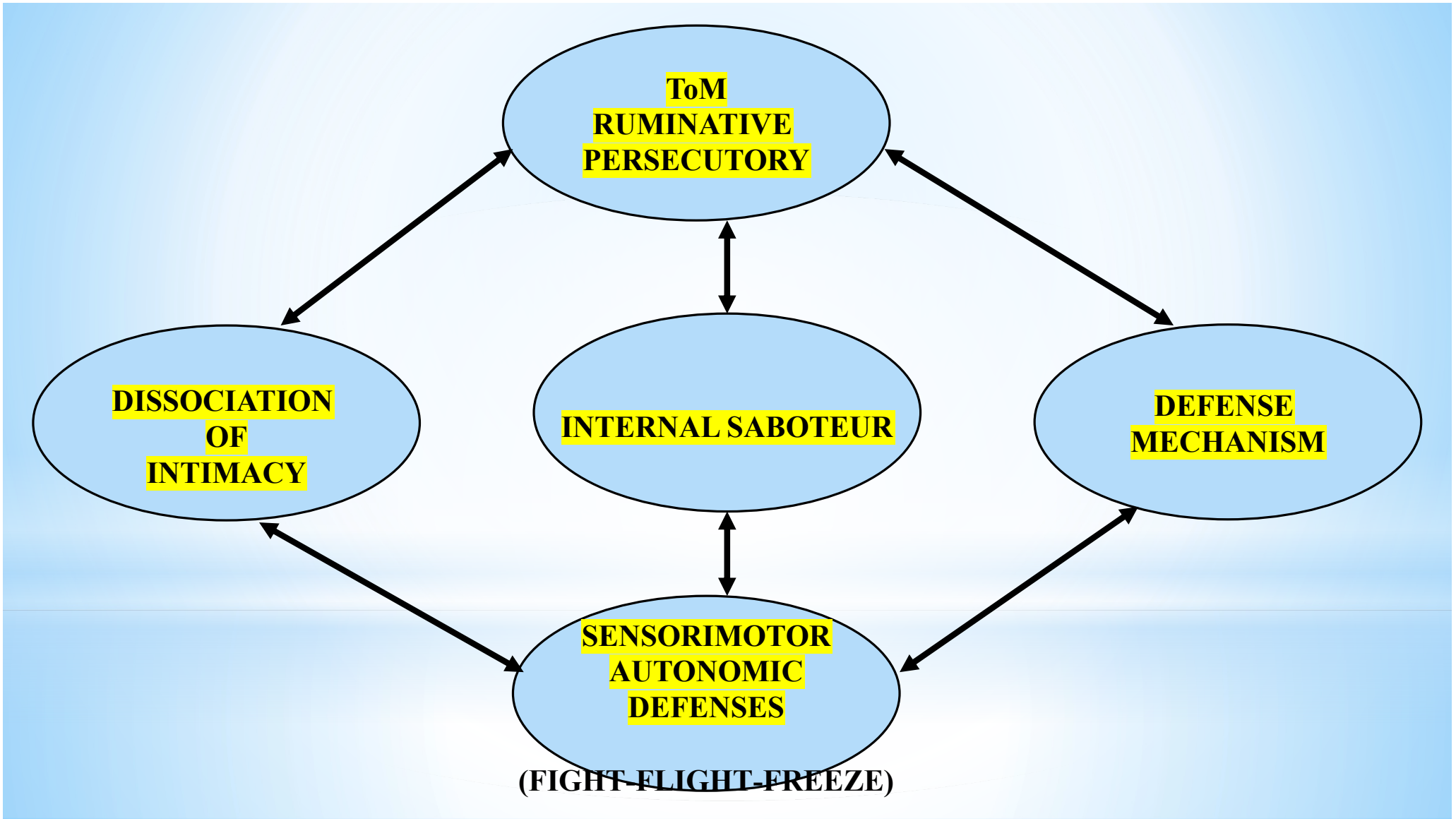
SYMPATHETIC/DORSOVAGAL
DYSREGULATION

ra 2.1 Le strutture endopsichiche (tratto da Fairbairn, 1952, p. 135).





Fairbairn demonstrated that developmental trauma arises within an environment where the primary object is ambivalent—simultaneously exciting and frustrating. In this context, the child redirects the anger originally aimed at the object toward the self. This dynamic gives rise to the *Internal Saboteur* or *anti-libidinal ego* (anti-bonder), which manifests both i n self-devaluation and in the dissociation of intimacy.


ToM
RUMINATIVE
PERSECUTORY
DISSOCIATION
OF
INTIMACY
INTERNAL SABOTEUR
DEFENSE
MECHANISM
SENSORIMOTOR
AUTONOMIC
DEFENSES
(FIGHT-FLIGHT-FREEZE)

THE ETERNAL RETURN OF THE INTERNAL SABOTEUR/ANTI BONDER

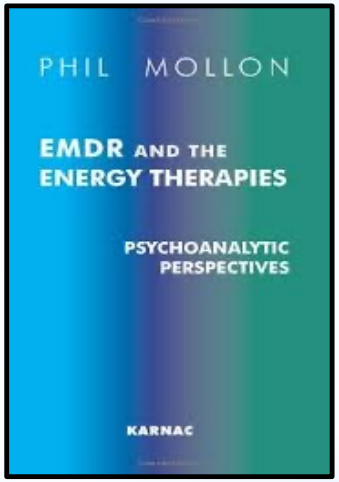
.....IN PSYCHOTHERAPY

nivano uccise e sostituite con copie identiche che, però, si comportavano secondo i desideri dei loro mariti (Mollon, 2002b). Se il bambino interioriz-za l'ambiente psichicamente omicida, da allora in p
tinuerà a essere perpetrato l'assassinio del sé auten
so verrà particolarmente attivato ogniqualvolta inco
timità emotiva e attaccamento genuini. Il mantenim
chicamente omicida viene suscitato dall'angoscia di disintegrazione.

Nel quadro espositivo fin qui delineato, ho descritto come lo stadio del sé frammentato e la minaccia della regressione vengano neutralizzati dall'assimilazione di strutture estranee erroneamente percepite come 'sé'. Se gli viene offerto un ambiente terapeutico, il paziente può cercare inconsciamente di tornare ai bisogni dell'oggetto-sé non soddisfatti nelle prime fasi della vita, scartando le strutture del falso sé, ma rischiando al tempo stesso di precipitare in una frammentazione irreversibile. Prima di effettuare il lavoro analitico, il paziente non conosce né se stesso né l'altro. È solo togliendo di mezzo i simulacri del transfert,[2] in modo da percepire in termini di immagini imposte i due che si trovano nello studio analitico (il sé e l'altro), che il sé veramente spontaneo ed essenzialmente sconosciuto può cominciare a emergere. Questo momento di crescita e di cambiamento reca con sé il terrore della disintegrazione, in quanto comporta l'abbandono di strutture note.

IMPLICAZIONI DEL LAVORO CON L'EMDR

Poiché l'EMDR e gli approcci energetici tendono a produrre molto in fretta l'elaborazione, è naturale che l'angoscia di disintegrazione venga alla ribalta. Un rapido cambiamento, anche se positivo, può essere allarmante, specialmente quando l'Io, o l'organizzazione psicologica della persona, è rigido o fragile, come può avvenire se il bambino ha dovuto instaurare un'indipendenza e un autocontrollo precoci poiché l'ambiente in cui è stato allevato era inadeguato, violento o imprevedibile. L'EMDR allora si troverà a fronteggiare una forte resistenza, suscitata dall'angoscia di disintegrazione. Ciò potrebbe costituire la base di una reazione terapeutica negativa, o di quel fenomeno che gli psicologi energetici chiamano 'rovesciamento psico-



During psychotherapy, when the Internal Saboteur starts again to devalue or attacks bonds and connections, the following experience can occur in the patient:
THREAT OF FRAGMENTATION
NEGATIVE THERAPEUTIC REACTIONS,
RECURRENCE OF SYMPTOMS DURING TREATMENT.

Attachment Theory & Self Psychology

- **Bowlby**: *Fear of intimacy* as a defensive strategy
- **Kohut**: Selfobject → regulation of self-cohesion
- Intimacy as a **relational regulator of affect**
- Failures of intimacy → disconnection/dysregulation

"Attachment theory also contributes to the foundations of PIREP.
Bowlby emphasized how early experiences of neglect or rejection generate a persistent *fear of intimacy*, which later becomes a central defensive strategy.
Kohut, from the perspective of self psychology, showed us that the self needs others as *selfobjects* to regulate its cohesion and vitality.
When intimacy is safe and attuned, it regulates affect and supports development.
But when intimacy fails—when it is inconsistent, intrusive, or absent—it becomes a source of fragmentation, disconnection, dysregulation.
This is why intimacy plays such a crucial role in emotional and psychosomatic health."

THE PSYCHOSOMATIC EXPRESSION OF AUTONOMIC DYSREGULATION

"Sorrow which has no vent in tears, makes other organs weep"

Henry Maudsley (1872)

Ilnesses eluding the soul devour the body (Ippocrate di Kos, IV B.C.)

Psychosomatic Perspective

- The body as an **archive of unmentalized trauma**
- **Somatoform dissociation** → body “speaks” when words fail
- **Psychosomatic dysregulation**: stress, arousal, symptoms
- Embodiment is both **symptom and pathway to healing**

"In PIREP we look at the body not only as a biological system, but as an archive of lived experience.
Trauma that has never been symbolized or shared is often stored in the body as tension, pain, or dysregulated arousal.
This is what we call *somatoform dissociation*: when the body speaks instead of words, carrying the burden of unprocessed memories.
Psychosomatic dysregulation emerges when stress and autonomic imbalance translate directly into physical symptoms.
But the body is not only the site of the symptom—it also becomes the pathway to healing.
By working with embodiment, we can transform these implicit traces into regulated and integrated experiences."

What is PIREP?

- PSYCHOTERAPY FOR INTEGRATED REGULATION OF EMOTIONS AND PSYCHOSOMATICS

- An **integrated model** for trauma, psychosomatics, and personality disorders

- Combines:
  - **Top-down** (DMN, ToM, narrative)
  - **Bottom-up** (Polyvagal regulation, embodiment)
- Focus: **emotional regulation, psychosomatic health, and co-regulation**

"PIREP stands for PSYCHOTERAPY FOR INTEGRATED REGULATION OF EMOTIONS AND PSYCHOSOMATICS
It is a new integrated model designed to address trauma, psychosomatic conditions, and personality disorders.
What makes PIREP distinctive is the way it brings together two levels of functioning.
On the one hand, the *top-down* dimension: the Default Mode Network, Theory of Mind, and the ability to create narratives and mentalize.
On the other hand, the *bottom-up* dimension: Polyvagal regulation, autonomic states, and embodied processes.
The central aim of PIREP is to promote emotional regulation, psychosomatic health, and co-regulation within the therapeutic relationship."

Three Pillars

PIREP is built on three regulatory pillars:

1. **Therapist's regulation** – the clinician's ability to monitor and regulate arousal

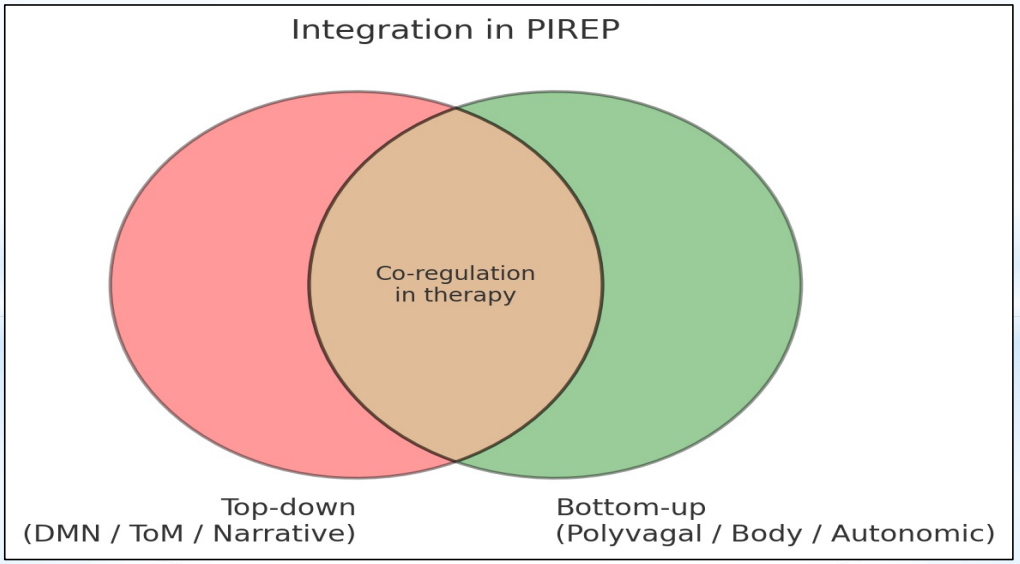
2. **Patient's regulation** – emotional and psychosomatic self-regulation

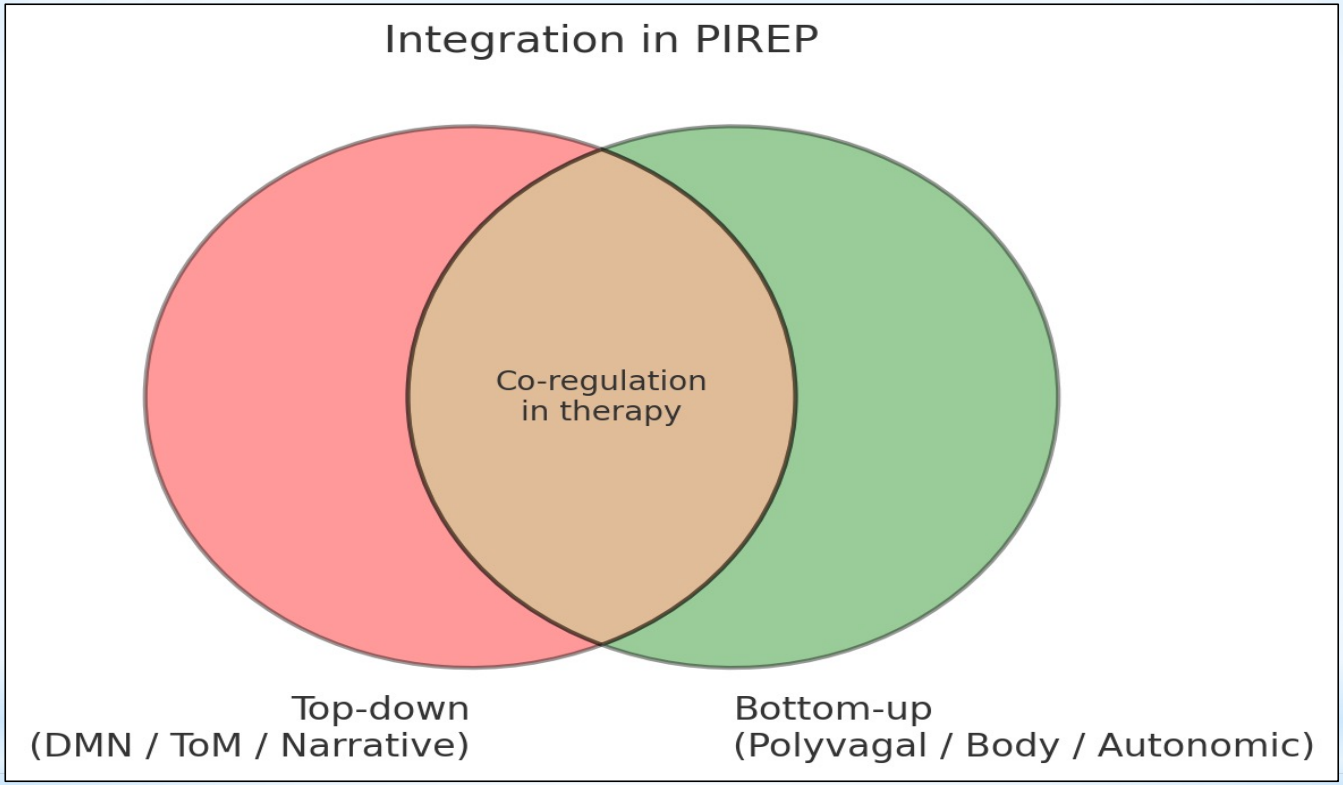
3. **Co-regulation** – therapeutic alliance as a *shared regulatory space*

"PIREP rests on three pillars, which correspond to three levels of regulation.
First, the therapist's own regulation: the ability to stay grounded, to monitor arousal, and to use one's presence as a stabilizing force.
Second, the patient's regulation: both emotional and psychosomatic. Here we are concerned not only with managing feelings, but also with regulating the body, arousal, and embodiment.
And third, co-regulation: the therapeutic alliance becomes a shared regulatory space where both partners influence each other.
This triangular foundation makes PIREP a living system of mutual regulation."

Diagram of Integration

- **Top-down**: DMN, Theory of Mind, narratives
- **Bottom-up**: Polyvagal regulation, autonomic states, embodiment
- Continuous **feedback loop** mind ↔ body
- **Therapeutic relationship** as a *regulatory bridge*





"This diagram captures the core logic of PIREP.
On one side, we have the top-down dimension: the Default Mode Network, Theory of Mind, and narrative processes.
On the other side, the bottom-up dimension: Polyvagal regulation, autonomic states, and embodiment.
These two systems are in constant feedback with one another—our thoughts and narratives shape our physiological states, and our bodily states deeply influence what and how we think.
At the intersection lies the therapeutic relationship, which serves as a bridge of co-regulation.
It is precisely here—in this shared space—that integration and transformation can occur."

Core Constructs

- **Internal Saboteur**
  - Persecutory, ruminative self-voice
  - Linked to dysfunctional ToM/DMN
- **Dissociation of Intimacy**
  - Fear–desire split in closeness
  - Rooted in attachment trauma
- **Psychosomatic Dysregulation**
  - Breakdown of body–mind regulation
  - Somatoform dissociation, stress symptoms

"The PIREP model revolves around three central constructs.
First, the *Internal Saboteur*: the inner persecutory voice that relentlessly criticizes and devalues the self. Clinically, we can link it to dysfunctional Theory of Mind processes and ruminative activity of the Default Mode Network.
Second, the *Dissociation of Intimacy*: a profound split between the desire for closeness and the fear of being hurt, abandoned, or engulfed. This pattern often emerges from early attachment trauma.
And third, *Psychosomatic Dysregulation*: the breakdown of body–mind integration. Here we see somatoform dissociation and stress symptoms, where the body itself becomes the stage of unresolved trauma.
Together, these three constructs form the backbone of the PIREP approach."

Clinical Tools

PIREP provides open-access assessment tools:

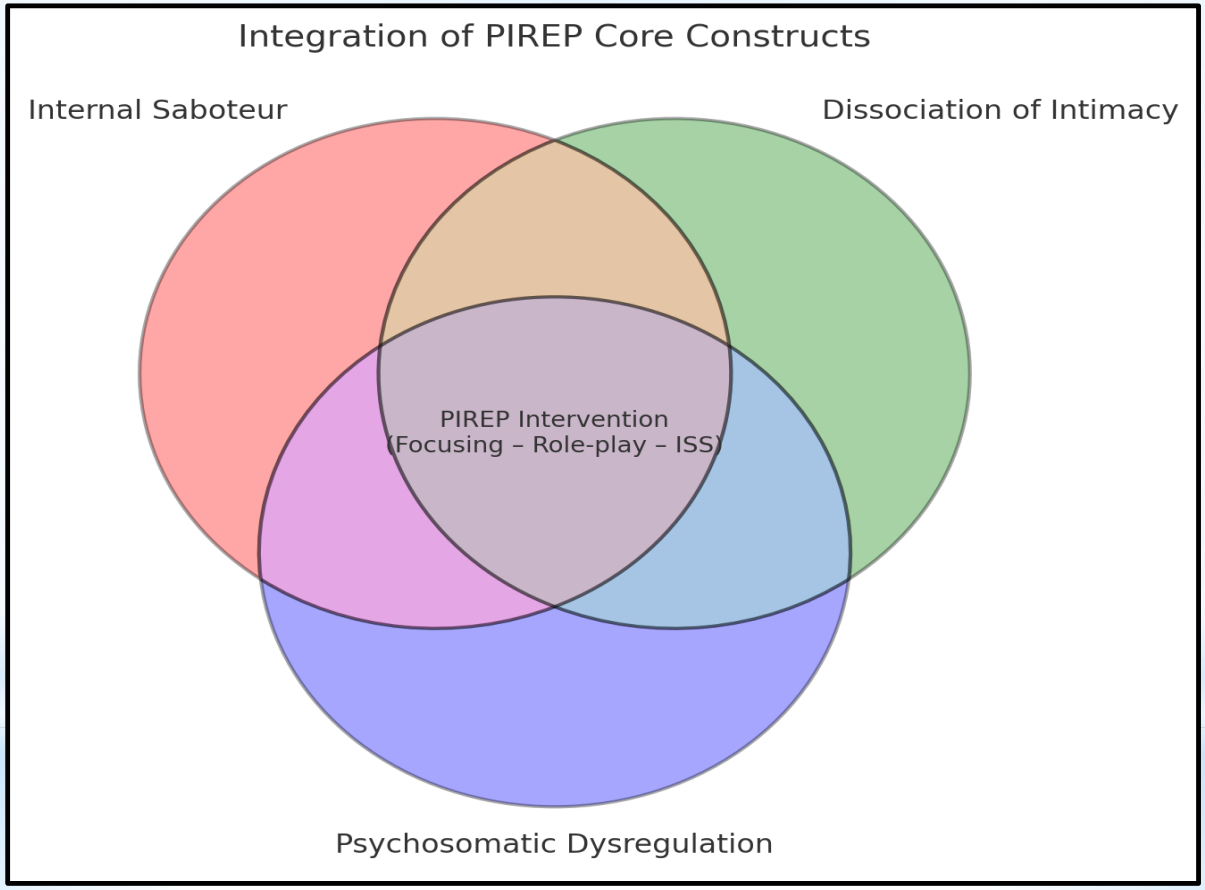
- **ISS – Internal Saboteur Scale**
  - Maps persecutory, ruminative voices
- **DIQ – Dissociation of Intimacy Questionnaire**
  - Assesses intimacy avoidance, ambivalence, fear
- **PDI – Psychosomatic Dysregulation Inventory**
  - Measures embodiment and psychosomatic health

(All validated and freely available for clinical and research use)

"To support clinical practice, PIREP includes three open-access instruments.
The first is the Internal Saboteur Scale, or ISS, which allows us to identify and map persecutory and ruminative voices inside the patient's mind.
The second is the Dissociation of Intimacy Questionnaire, or DIQ, which evaluates intimacy—specifically avoidance, fear, and ambivalence in close relationships.
And the third is the Psychosomatic Dysregulation Inventory, or PDI, which measures the degree of embodiment and the link between emotional stress and physical health.
All three tools are validated and freely available, making them accessible to both clinicians and researchers."

Integrated Case: Saboteur, Intimacy, Psychosomatics

- **Patient**: young woman, 32, presenting with panic attacks, chest tightness, relational avoidance
- **Psychosomatic Dysregulation**: body symptoms with no medical cause → panic, somatic tension
- **Dissociation of Intimacy**: oscillation between longing for closeness and fear of rejection
- **Internal Saboteur**: ruminative persecutory voice → *"I am weak, I will disappoint everyone"*
- **Intervention**:
  - Focusing for grounding and ventro-vagal co-regulation
  - Role-playing to give voice to dissociated parts in intimacy
  - ISS to externalize persecutory voices and transform them


Integration of PIREP Core Constructs
Internal Saboteur
Dissociation of Intimacy
PIREP Intervention
(Focusing – Role-play – ISS)
Psychosomatic Dysregulation

"Let me now present an integrated case where all three core constructs of PIREP come together.
The patient is a 32-year-old woman who came to therapy because of recurrent panic attacks and episodes of chest
tightness. Medical tests excluded any organic cause.
At the psychosomatic level, her body was carrying a dysregulated arousal that produced panic symptoms.
At the relational level, she lived in a constant dissociation of intimacy: desiring closeness, but withdrawing whenever she feared rejection or engulfment.
And inside her mind, the Internal Saboteur was always present—an inner voice repeating,
'I am weak, I will disappoint everyone.'
The therapeutic work integrated several techniques.
We used focusing and ventro-vagal grounding to regulate her body and create safety.
Role-playing allowed her to give voice to the two dissociated parts of her intimacy—the one that longs f or closeness and the one that fears it.
And with the ISS, we externalized her persecutory inner voice, transforming it into an object of dialogue rather than an unquestionable truth.
This case shows how the three constructs—psychosomatic dysregulation, dissociation of intimacy, and the internal saboteur—are not separate phenomena, but parts of the same dysregulated system, and how PIREP provides a framework to integrate them in the therapeutic process."

Focusing Technique

- **Embodied awareness** of the “felt sense”
- Guides patient from **arousal → regulation**
- Therapist presence = ventro-vagal co-regulation
- Creates link: **body sensation ↔ emotional meaning**

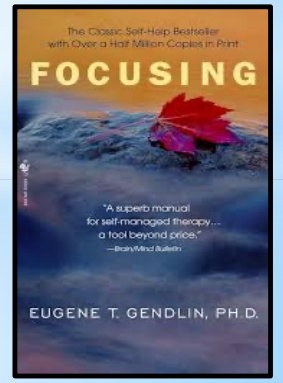
"One of the core bottom-up techniques in PIREP is *focusing*.
This method invites the patient to pay attention to the ‘felt sense’—the subtle bodily sensations that carry emotional meaning.
Through focusing, patients learn to move from a state of arousal toward a state of regulation, using the body itself as a guide.
The therapist’s presence here is crucial: by offering calm and attuned attention, the therapist provides ventro-vagal co-regulation.
Focusing builds a bridge between bodily sensations and emotional meaning, transforming what was once overwhelming into something that can be named, shared, and integrated."

FOCUSING IN POLYVAGAL INFORMED PSYCHOTHERAPY

*In psychotherapy, Focusing is a guided meditation technique consisting of **6 steps**. Throughout these steps, the patient is invited to focus on the sensations he felt in their body (***Felt-Sense***) related to a specific problem that has already emerged in the session and is troubling them.

*The purpose of Focusing as neural exercise is to first mentalize the Felt-Sense in the body, and then the range of emotions, images, memories and words that emerged in the patient's inner experience throughout the 6 steps.

*Focusing allows the patient to **MENTALIZE NEUROCEPTION THROUGH THE FELT-SENSE** and the experience of **chronic THREAT**, to regulate emotions and arousal, in order **to develop a greater sense of SAEFETY**, self-mastery and self-acceptance.....of not always feeling in danger, even when there is no danger.....and searching **connection**.....



*The 6 steps of focusing take 1 minute each: the patient is invited to close their eyes and follow the regular flow of breath throughout the guided meditation.

The 6 steps of Focusing

1. **Creating a space**: in this step, the therapist invites the patient to create a state of relaxation by focusing on their breath.

"Let's now close our eyes and get comfortable, relax and begin to follow our breath, coming in and out of our nostrils; let's follow our breath and stay focused and relaxed within ourselves, in silence, for one minute".

2. **The Felt sense**: in this step, the therapist invites the patient to focus on the sensation felt in the body in relation to the problem previously shared.

"While still following the flow of our breath, let's now focus on the problem, in order to fully feel the sensation in the body. Let's ask ourselves: what is the sensation I am feeling in my body in relation to the problem? Where in the body do I feel this sensation? What parts of the body are involved? Stay focused on the sensation and keep breathing slowly for one minute".

3. **Finding a symbol**: in this step, the therapist invites the patient to find a word that best matches the sensation felt in the body

"Now, keep breathing and stay focused on the sensation in the body, to answer the question: What is the word that best describes the sensation that I'm feeling in the body? Now find within yourself the word that best describes the sensation you are feeling, a word that matches as closely as possible your felt sense and keep breathing slowly for one minute".

4. **Resonance**: in this step, the therapist invites the patient to let the felt-sense in their body, along with the corresponding images and words, resonate inside of them.

"Now, keep breathing slowly and stay in the experience in order to fully feel it inside of you. Let it resonate within you, let it vibrate within you and surrender to what you feel, continuing to breath for one minute".

5. **Asking questions**: in this step, the therapist encourages the patient to ask questions on what they are experiencing.

"Now, while staying focused on the experience you are feeling, ask yourself: where does all of this come from? What is its origin? And then, continuing to breath slowly, let's ask ourselves: what are the possible solutions to this? How could I get better? Continuing to breath slowly for one minute".

6. **Acceptance**: in this step, the therapist invites the patient to experience a benevolent, calm and profound self-acceptance.

"Now, still following your breathing coming in and out of your nostrils, fully accept the experience you are feeling and welcome it inside of you; embrace it as it is, with benevolence and tenderness, accept yourself for who you are, continuing to breath normally for one minute".

At the end of this minute of Focusing, the therapist will guide the patient to end the exercise and return to the ordinary conscious experience, concluding the meditation as it follows:

"Continuing to breath normally, let's now slowly open your eyes again and gradually return to being who we are".

At the end of Focusing, the patient verbalizes with the therapist their bodily sensations, images, thoughts, words and memories experienced while focusing on the felt sensation, in order to process them together to support the patient's neuroception and safety..

Focusing is a bottom-up/top-down intervention as it starts from felt-sensations in the body and, through the 6 steps, aims to the mentalization of new strategies for a greater safety in both agency and intimacy.

In the PIREP Focusing allows:
not only to discover new things about themselves (mentalization), but also to experience the affective value of the clinical relationship and the Therapeutic Alliance as a form of "interpersonal game" with the aim of increasing Safety.

Role-Playing Technique

- **Two-chair dialogues** with dissociated self-parts
- Gives voice to **conflicting inner states**
- Uses **ventro-vagal safety** to reduce fear and collapse
- Promotes **integration through co-regulation**

"Role-playing is another powerful intervention in PIREP.
Through two-chair dialogues, patients can give voice to their dissociated parts and conflicting inner states.
The technique is not only cognitive or expressive—it is embodied.
Following Porges' Polyvagal Theory, the therapist uses ventro-vagal safety cues—tone of voice, facial expression, and presence—to help the patient regulate arousal while entering into dialogue with painful self-states.
In this way, role-playing becomes a process of co-regulation: the patient experiences that even in the presence of inner conflict, safety and connection can be maintained.
This opens the way for genuine integration."

AUTONOMY

SOCIAL ENGAMENT

SELF-REGULATION

CO-REGULATION

3 SAFETY IN CONNECTION

BEING SAFE IN THE PRESENT MOMENT

INCREASED WINDOW OF TOLERANCE OF AVERSIVE STIMULI IN CONNECTION

2 AROUSAL REGULATION

NEUROCEPTION

1 INTEROCEPTION

GOALS OF PIREP

Therapeutic Alliance & Repair in PIREP

- **Alliance = regulatory space**
  - Safety, trust, co-regulation
- **Ruptures**: inevitable in trauma & personality disorders
  - Withdrawal, mistrust, anger, somatic shutdown
- **Repair process in PIREP**
  - Therapist's **ventro-vagal regulation**
  - Naming and validating rupture
  - Using **focusing & role-playing** to integrate dissociated states

- **Outcome**: alliance becomes **stronger, more resilient**

"In PIREP, the therapeutic alliance is not only a working relationship—it is conceived as a *regulatory space*.
It provides safety, trust, and co-regulation, where patient and therapist share the task of regulating arousal and emotions.
But ruptures are inevitable, especially with trauma and personality disorders: withdrawal, mistrust, anger, or even somatic shutdowns often disrupt the connection.
In the PIREP model, repair follows three steps.
First, the therapist relies on their own ventro-vagal regulation: staying calm, grounded, and attuned.
Second, the rupture is named and validated, so that it becomes explicit rather than hidden.
And third, techniques like focusing and role-playing help to give voice to dissociated self-states that usually fuel the rupture.
The paradox is that successful repair does not weaken the alliance—it makes it stronger, more resilient, and a direct source of healing."*

Dreamwork as Embodied Simulation

- Dreams as **threat simulation** (Revonsuo)
- In PIREP: dreams as **embodied rehearsal** of trauma & intimacy
- Link: **body states ↔ dream imagery**
- Intervention: therapist as **co-regulator of dream experience**

"In PIREP, dreamwork is not only about symbolic interpretation—it is about embodiment.
Neuroscientist Antti Revonsuo proposed that dreams function as a form of *threat simulation*, allowing us to rehearse survival scenarios.
In our perspective, dreams are also *embodied rehearsals*: they carry bodily states into symbolic imagery, often replaying unresolved trauma and conflicts around intimacy.
For example, a patient's dream of being rejected can be seen not just as a story, but as a reactivation of the body's dysregulated arousal during sleep.
The therapeutic task is to re-enter the dream in a state of ventro-vagal safety, with the therapist acting as a co-regulator.
This allows the dream experience to shift from fear and fragmentation toward integration and meaning."

Countertransference through Polyvagal Lens

- Therapist's **arousal regulation** is central
- Countertransference = **autonomic response** as well as emotional reaction
- **Ventro-vagal state** enables attunement and repair
- From rupture → **co-regulation & integration**

"In PIREP we also revisit countertransference through the lens of the Polyvagal Theory.
Countertransference is not only an emotional reaction—it is also an autonomic response of the therapist's body.
When the therapist shifts into sympathetic fight–flight or dorsal vagal shutdown, attunement is compromised.
But when the therapist remains anchored in the ventro-vagal system, a state of calm presence and safety becomes available.
This regulation allows the therapist to recognize ruptures in the alliance, to tolerate them, and to transform them into opportunities for repair.
In this way, countertransference becomes not a disturbance, but a diagnostic and regulatory tool for co-creating integration."

Clinical Tools

PIREP provides open-access assessment tools:

- **ISS – Internal Saboteur Scale**
  - Maps persecutory, ruminative voices
- **DIQ – Dissociation of Intimacy Questionnaire**
  - Assesses intimacy avoidance, ambivalence, fear
- **PDI – Psychosomatic Dysregulation Inventory**
  - Measures embodiment and psychosomatic health

(All validated and freely available for clinical and research use)

"To support clinical practice, PIREP includes three open-access instruments.
The first is the Internal Saboteur Scale, or ISS, which allows us to identify and map persecutory and ruminative voices inside the patient's mind.
The second is the Dissociation of Intimacy Questionnaire, or DIQ, which evaluates intimacy—specifically avoidance, fear, and ambivalence in close relationships.
And the third is the Psychosomatic Dysregulation Inventory, or PDI, which measures the degree of embodiment and the link between emotional stress and physical health.
All three tools are validated and freely available, making them accessible to both clinicians and researchers."

Internal Saboteur Scale (ISS)

- **Purpose**: measure persecutory, ruminative inner voices
- Example item: *"A voice inside tells me I will always disappoint others"*
- **Clinical value**:
  - Externalizes self-critical voices
  - Maps intensity & frequency of rumination
- **Link**: dysfunctional **ToM / DMN** activity

"One of the tools developed within PIREP is the Internal Saboteur Scale, or ISS.
Its purpose is to measure persecutory and ruminative inner voices—the harsh, self-critical dialogues that patients often carry inside.
For example, a typical item is: *'A voice inside tells me I will always disappoint others.'*
The clinical value of the scale is twofold.
First, it allows us to externalize these voices, to turn them into something observable and discussable.
Second, it maps their intensity and frequency, giving us a sense of how much the patient is trapped in cycles of rumination.
From a neuroscientific perspective, these voices are linked to dysfunctional Theory of Mind and Default Mode Network activity—when self-reflection becomes hijacked by persecution rather than understanding."

Internal Saboteur Scale (ISS)

The following statements describe recurrent thoughts, inner voices, and modes of inner dialogue that anyone may experience in relation to themselves and their relationships. The focus is not on external behaviors, but on what happens within the mind, in the form of ideas, comments, judgments, or ruminations that may spontaneously emerge in everyday life. We ask you to indicate how often such thoughts or inner voices have occurred over the past four weeks, choosing the response that best represents your experience.

Please use the following response scale:

0 = Never · 1 = Sometimes · 2 = Often · 3 = Always

1. My mind returns to the thought that others may judge me for my weaknesses or flaws.

2. An inner voice keeps telling me that I am not good enough in social relationships.

3. I ruminate that my body and my sexuality are a source of disappointment for the other person.

4. I find myself feeling guilty for how I behave.

5. When I think back to my past intimate or sexual experiences, I judge myself negatively.

Item	**0**	**1**	**2**	**3**
1. My mind returns to the thought that others may judge me for my weaknesses or flaws.				
2. An inner voice keeps telling me that I am not good enough in social relationships.				
3. I ruminate that my body and my sexuality are a source of disappointment for the other person.				
4. I find myself feeling guilty for how I behave.				
5. When I think back to my past intimate or sexual experiences, I judge myself negatively.				
6. I feel angry imagining that others might hurt me or treat me unfairly.				
7. A part of me insists that I should take revenge for how others treat me.				
8. I keep thinking that if I follow my desires or personal needs, I will end up regretting it.				
9. I am convinced that in friendships, I will end up being excluded or replaced by others.				
10. When I look inside myself, I feel discomfort about aspects of me that I consider unacceptable.				
11. My mind returns to the thought that others might envy me and therefore harm me or distance themselves from me.				
12. I mentally relive my past mistakes as if they were still present.				
13. I am tormented by the idea that the people I care about may think badly of me.				
14. In my imagination I compare myself with the bodies of others and feel inadequate.				
15. It is as if an inner voice keeps repeating that if I bond with someone, sooner or later I will be betrayed.				

16. An inner voice insists that I must not trust anyone.				
17. I cannot help but think that I am not capable of dealing with tasks that concern me.				
18. In my imagination I am convinced that if someone really knows me, they will lose interest or judge me negatively.				
19. When I look inside myself, critical and devaluing thoughts about my body emerge.				
20. I sometimes imagine that the people I care about might abandon me.				
21. Inside me returns the idea of always being a second choice compared to others who are more capable or deserving.				
22. I ruminate about being neglected by the people I am emotionally attached to.				
23. In my head conflicting thoughts pile up and make me feel insecure.				
24. When I receive comments or criticism, inside me the sensation of being offended is immediately triggered.				
25. I sometimes imagine scenarios in which I am criticized for my behavior.				
26. An inner voice tells me that if I show my vulnerabilities, the other person will use them against me.				
27. When I think of my partner, I ruminate that they may turn their attention or sexual desire to others.				

28. The thought of situations in which I embarrassed myself returns to me.				
29. In my imagination I suspect that others want to harm me or take advantage of me.				
30. Inside me a voice insists that any project I make is destined to fail, so I end up not carrying it out.				
31. In my thoughts I constantly judge people for who they are or for their behavior.				
32. When I look inside myself, I feel envy comparing my shortcomings with the successes of others.				
33. I ruminate on the frustration of not being able to get what I want.				
34. An inner voice repeats to me that in social relationships, sooner or later I will be rejected.				
35. In my fantasies I feel discomfort when I imagine expressing my sexuality freely.				
36. The thought returns that I do not deserve affection or consideration from others.				
37. I think that others are angry with me, even without clear evidence.				
38. I find myself thinking back to what I would like to say to others, but then I cannot express it.				
39. Even when I am in good health, I always think I have some illness.				
40. When I am interested in someone, an inner voice tells me that they will eventually disappoint me.				

41. In my fantasies I imagine that my life will definitely fall apart.				
42. When I think of myself, I feel anger toward my mistakes or current flaws.				
43. I find myself reliving situations in which I was victimized by someone in the past.				
44. My mind keeps returning to the decisions I have to make, always fearing I will make the wrong choice.				
45. An inner voice tells me that I will never change, no matter how hard I try.				
46. I keep thinking that every time I take a step forward, I will end up ruining everything.				
47. Inside me resonates the idea that I am worth nothing compared to others.				
48. I ruminate on the conviction that no one will ever really understand me.				
49. I find myself repeating that if I show my emotions, I will end up being ridiculed.				
50. Inside me I feel that I am a burden to others.				
51. My mind returns to the idea that I do not deserve to be happy.				
52. I ruminate on the idea that I will eventually remain poor and without resources.				
53. A part of me keeps repeating that if I express my needs, I will end up being rejected.				

54. A voice tells me that if I get too emotionally involved with someone, I will end up losing my freedom.				
55. My head is full of thoughts telling me that whatever I do will be useless.				
56. I ruminate on the idea that I will disappoint everyone's expectations.				
57. My mind returns to the fantasy of being mocked or made fun of by others.				
58. I tell myself that if I express my anger, I will end up destroying my relationships.				
59. In my thoughts, every time I try to defend myself, I imagine I will end up looking bad or aggressive.				
60. Even when a relationship is going well, I think it is better to break it off for fear of suffering.				
61. When I receive a compliment, inside me I do not really feel I deserve it.				
62. I sometimes feel easily offended by how others behave toward me.				
63. A voice tells me that in the end I will remain alone.				

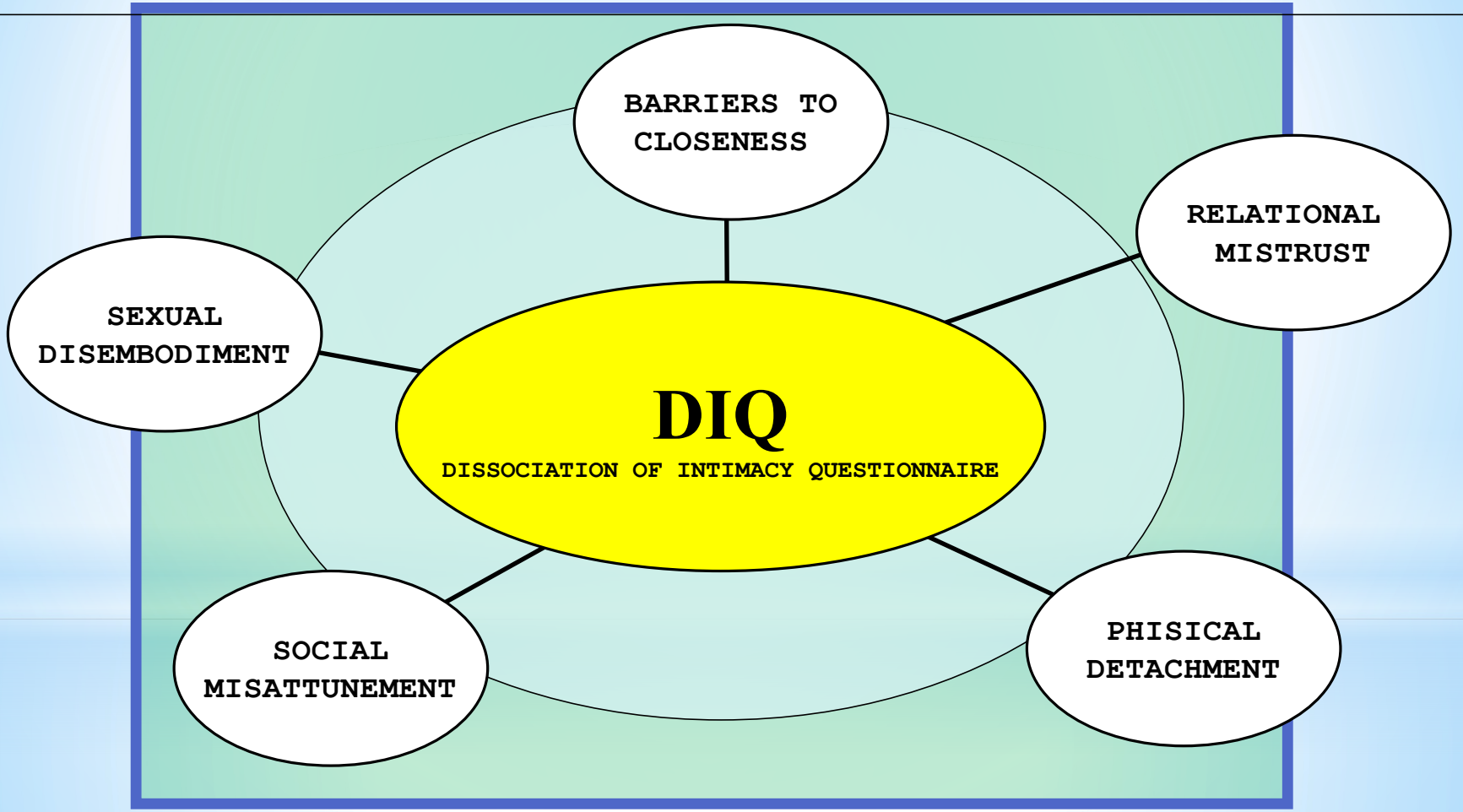
Dissociation of Intimacy Questionnaire (DIQ)

- **Based on DSM-5 AMPD** "Intimacy" domain
- Assesses dissociative dynamics across emotional, cognitive, somatic, and sexual domains

- **Five validated factors**:
  1. **Barriers to Closeness** – fear of vulnerability, avoidance of intimacy
  2. **Relational Mistrust** – suspicion, fear of betrayal, fragile alliance
  3. **Physical Detachment** – somatic disconnection, numbing in intimacy
  4. **Social Misattunement** – sense of disconnection, not being attuned
  5. **Sexual Disembodiment** – split between desire, body, and affection

"The Dissociation of Intimacy Questionnaire, or DIQ, was developed within the DSM-5 Alternative Model for Personality Disorders, focusing on the intimacy domain.
It assesses the dissociative and defensive dynamics that undermine closeness—across emotional, cognitive, somatic, and sexual levels.
Our validation study confirmed a five-factor structure.
The first factor is *Barriers to Closeness*, which reflects fear of vulnerability and avoidance of intimacy.
The second is *Relational Mistrust*, characterized by suspicion, fear of betrayal, and fragile trust in the other.
The third is *Physical Detachment*, where the body becomes numb or disconnected during intimacy.
The fourth is *Social Misattunement*, the subjective sense of not being in tune with others, of being relationally out of sync.
And the fifth is *Sexual Disembodiment*, the split between desire, the body, and emotional connection in sexuality.
This multidimensional structure makes the DIQ a precise tool for understanding how intimacy is disrupted, and for guiding clinical interventions aimed at restoring relational safety."

Pentagonal model of the Dissociation of Intimacy Questionnaire (DIQ)



Dissociation of Intimacy Questionnaire (DIQ)

Below are highlighted some ways of relating and being with people. Specifically, these statements refer to how individuals perceive themselves and others in their close or intimate relationships.

In the first part, you may describe how you usually behave with others. In the second part, you may describe how others usually behave, or have behaved, with you (you may consider the last four weeks as a reference period).

Please respond to all statements by ticking your preference, choosing among:

1. Not at all 2. A little 3. Moderately 4. Quite a lot 5. Very much

We kindly ask you to fully complete both parts.

	a) **Myself with others**			b) **Others with me**	
1a	In situations of intimacy, I find it difficult to talk about my feelings.	1 2 3 4 5	1b	In situations of intimacy, I have the impression that others find it difficult to talk about their feelings with me.	1 2 3 4 5
2a	I avoid getting involved in romantic relationships.	1 2 3 4 5	2b	Others avoid getting involved in romantic relationships with me.	1 2 3 4 5
3a	I find it difficult to share with others what I feel.	1 2 3 4 5	3b	Others find it difficult to share what they feel with me.	1 2 3 4 5
4a	I find it difficult to trust others.	1 2 3 4 5	4b	Others find it difficult to trust me.	1 2 3 4 5
5a	I am always suspicious, even with people I have known for a long time.	1 2 3 4 5	5b	Others are always suspicious of me, even those who have known me for a long time.	1 2 3 4 5
6a	When I am in love, I am afraid of being abandoned.	1 2 3 4 5	6b	When someone is in love with me, they are afraid of being abandoned.	1 2 3 4 5
7a	In situations of intimacy, I find it difficult to make physical contact with the other person.	1 2 3 4 5	7b	In situations of intimacy, others find it difficult to make physical contact with me.	1 2 3 4 5
8a	In situations of physical intimacy, I tend not to be fully present.	1 2 3 4 5	8b	In situations of physical intimacy with me, I perceive others as not fully present.	1 2 3 4 5
9a	In contexts where physical proximity is involved, I feel as if I were detached.	1 2 3 4 5	9b	In contexts where physical proximity is involved, I feel as if others were detached.	1 2 3 4 5
10a	In general, I feel bored when others are having fun.	1 2 3 4 5	10b	In general, I have the impression that others feel bored when I am having fun.	1 2 3 4 5
11a	When I am with others, I feel like an external spectator of what is happening.	1 2 3 4 5	11b	When others are with me, I feel like they are external spectators of what is happening.	1 2 3 4 5
12a	When I am with others, I can't wait to leave.	1 2 3 4 5	12b	When others are with me, I feel like they can't wait to leave.	1 2 3 4 5
13a	In sexual intimacy, I sometimes do not feel my bodily sensations.	1 2 3 4 5	13b	In situations of sexual intimacy with me, I perceive others as if they were unable to feel their bodily sensations.	1 2 3 4 5
14a	In moments of sexual intimacy, I feel like that experience is not entirely real.	1 2 3 4 5	14b	In moments of sexual intimacy with me, I perceive others as if they are experiencing it as not entirely real.	1 2 3 4 5
15a	In sexual intimacy, at times I feel as if I were an external spectator.	1 2 3 4 5	15b	In situations of sexual intimacy with me, I sometimes perceive others as if they were external spectators.	1 2 3 4 5

INTIMACY DISSOCIATION

The Dissociation of Intimacy consists in deactivating the social attachment system and dissociating the pleasure of feeling safe with others and in intimate relationships, since these are all felt as a source of Threat.

Intimacy Dissociation therefore compromises the ability to love, cooperate and develop a mature experience of dependence and bonding, as well as to have relationships based on mutual trust and support, all key elements for a mature and safe dependence.

Intimacy Dissociation will be considered,
in this dynamic polyvagal model,
as an expression of the *Internal Saboteur or Anti Bonder*,
distorting and destroying the patient's self-image and
interpersonal relations, of social behavior
and intimacy, until the complete deactivation of
the attachment system and a dissociation of a sense of
authentic safety, trust, autonomy and pleasure in being with
oneself and with others.

*The Internal Saboteur can be described as a internal judgmental voice, an internal voice, (sometime as PATHOGENIC BELIF) that emerges within the internal dialogue during self-evaluation or when we are facing decision, challenges or situations related to self-esteem and one's and other people's social perception.

*Such internal judgmental voice gives rise to negative thoughts, doubts and fears, 'pathogenic beliefs' preventing the development of personal trust, fostering self-criticism and pathological perfectionism and negatively influencing behavior, diverting it from a sense of safety in connection..

*In Intimacy Dissociation, the Internal Saboteur or the Anti Bonder arises in the form of fantasies, cognitive processes, decision making and behaviors that interfere with the development of self-esteem and with the creation and maintenance of intimate connections with bonds.

Psychosomatic Dysregulation Inventory (PDI)

- **Purpose**: assess embodiment & psychosomatic health
- **Core domains**:
  - Stress reactivity
  - Body awareness & regulation
  - Somatoform dissociation
- **Clinical value**:
  - Tracks psychosomatic change during therapy
  - Links emotional dysregulation ↔ physical symptoms
- **Open-access** tool, aligned with PIREP framework

"The third instrument developed within the PIREP model is the Psychosomatic Dysregulation Inventory, or PDI.
Its goal is to assess the degree of embodiment and the balance between emotional regulation and physical health.
The PDI explores three core domains: stress reactivity, the person's awareness and regulation of the body, and manifestations of somatoform dissociation—when the body expresses what the mind cannot put into words.
Clinically, it is useful not only for diagnosis but also for monitoring therapeutic progress, showing whether the patient is moving from dysregulation to embodied regulation.
It highlights the intimate link between emotional suffering and physical symptoms.
And, like the other tools of the PIREP, it is fully open-access, which makes it available for clinicians and researchers worldwide."

PDI
Caretti V., Baldoni F., Porcelli P., Schimmenti A.

Please, fill in the following information

Name:_____

Gender: _____ Age: _____

Marital Status: _____ Occupation: _____

Now mark with an X the answer that best suits your experience. In the last 6 months I have had the following problems:

		Never	Sometimes	Often	Very often/Always
1	Headache				
2	Stomach ache (for women, except period pain)				
3	Nausea				
4	Vomiting				
5	Stomach bloating				
6	Belly Rumble (noise coming from the belly)				
7	Heartburn				
8	Binge eating				
9	Urgent need to defecate				
10	Diarrhea				
11	Constipation				
12	Loss of appetite				
13	Disgust towards several foods				
14	Gastric acid				
15	Difficulty digesting				
16	Repeated hiccups				
17	Feeling the need to eat more than usual				
18	Food intolerance (besides allergies)				
19	Belching				
20	Flatulence				
21	Back pain				

PDI (*PSYCHOSOMATIC DYSREGULATION INVENTORY*)

My research group built a self-report questionnaire (**PDI**) to verify the presence and extent of physical symptoms without an organic cause, but above all to increase the patient's mentalization of autonomic dysregulation in his somatic symptoms.

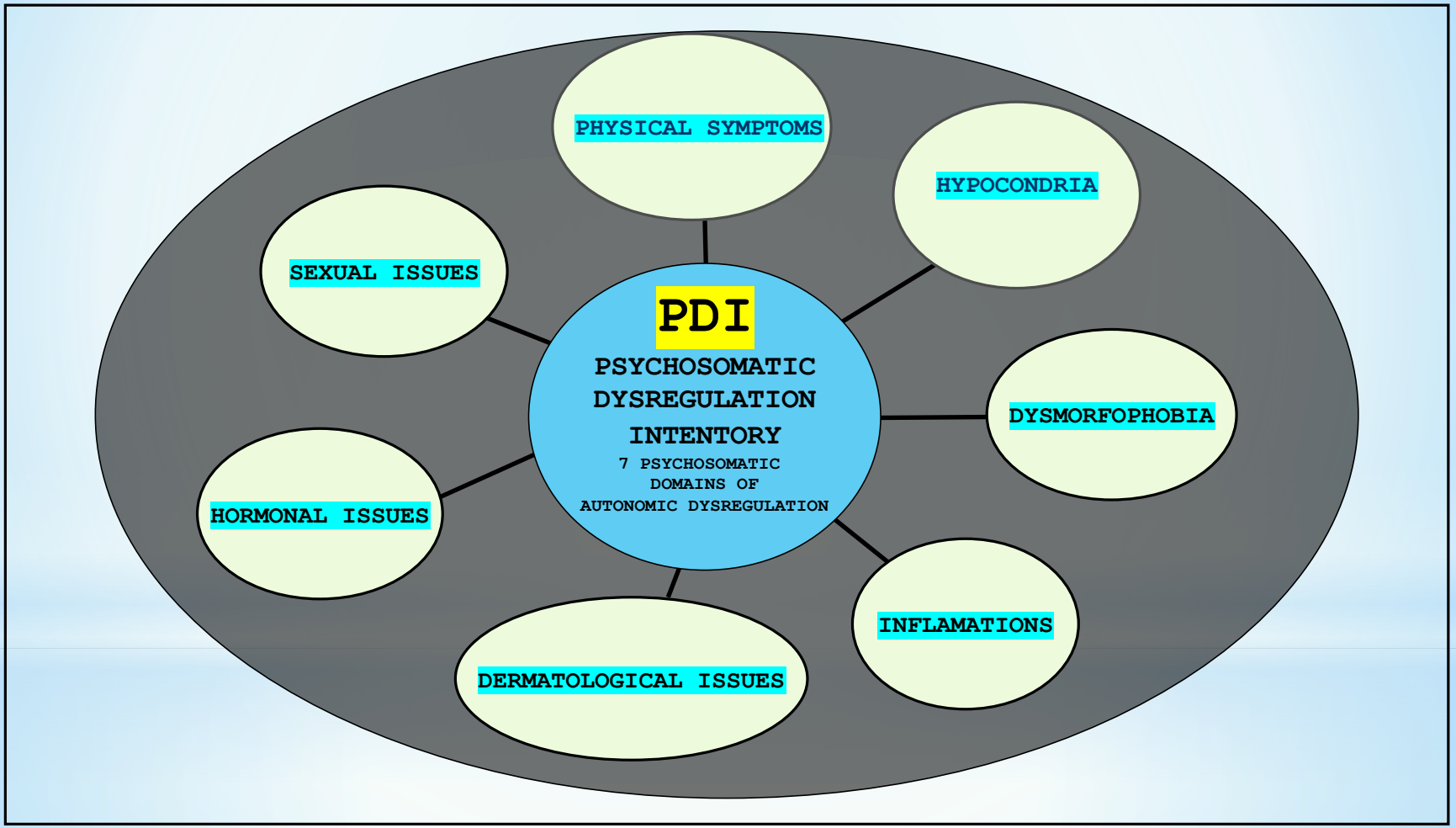
PDI is a screening test to detect physical problems without organic causes resulting from a dysregulation of neuroception, such as psychosomatic disorders, alterations in body image, hypochondria and discomfort in intimacy.

It is used clinically, commenting with the patient only the items (there are 98 plus 3 for male and 3 for female in all) to which the subject has assigned a reply of **often** or **always**.

These items are explanatory of chronic states of tension and postural rigidity resulting from a condition of neuroception dysregulation, malaise to be in one's body (disembodiment) and in relations with others.

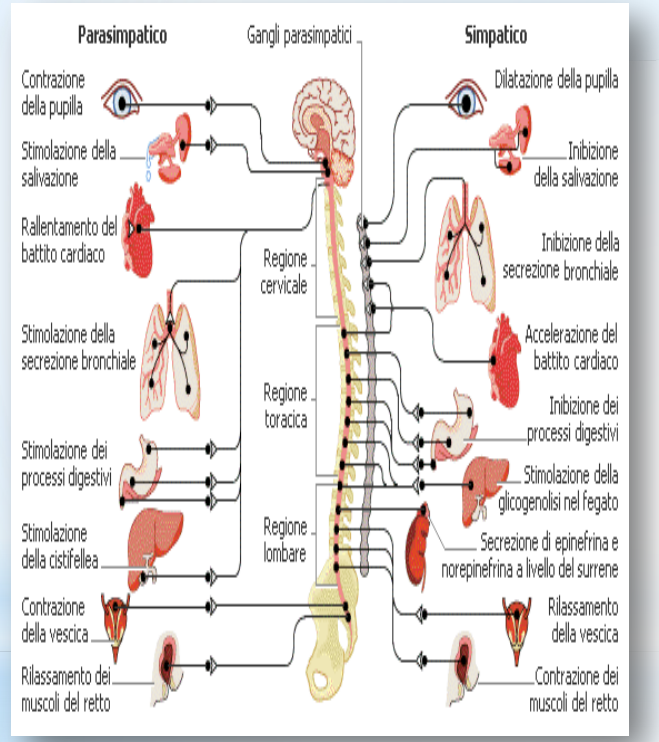
The purpose of **PDI** is to encourage the patient's body-mind insight and increase the **arousal regulation**, **neuroception** towards greater **psycho/somatic safety**

7 PSYCHOSOMATIC DOMAINS OF NEUROCEPTION DYSREGULATION



Caretti V, Baldoni F, Porcelli P, Schimmenti A, 2019

Psychosomatic Dysregulation Inventory (**PDI**)



PDI
Caretti V., Baldoni F., Porcelli P., Schimmenti A.

Please, fill in the following information

Name: Diane

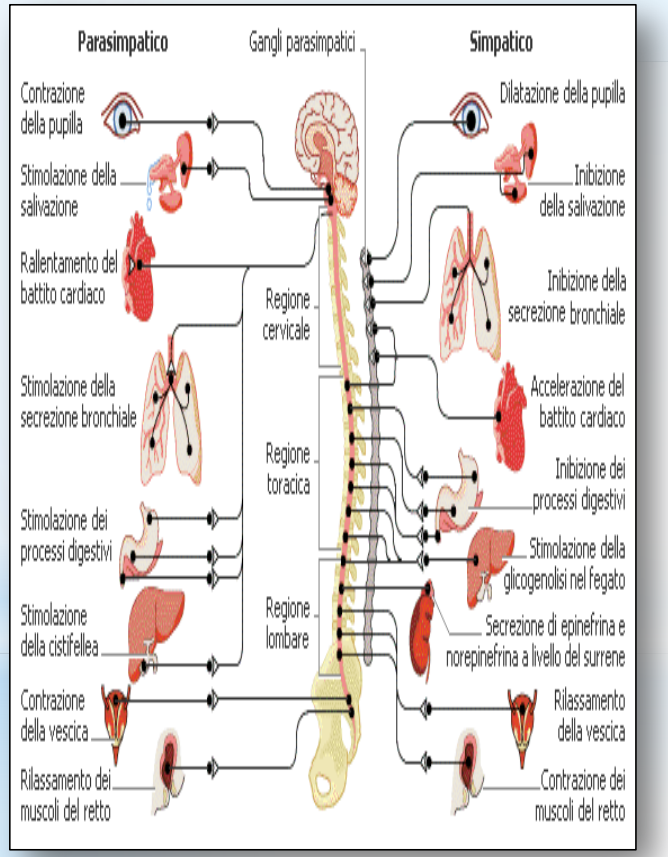
Gender: F Age: 24

Marital Status: unmarried Occupation: student

		Never	Sometimes	Often	Very often/Always
1	Headache			X	
2	Stomach ache (for women, except period pain)			X	
3	Nausea		X		
4	Vomiting		X		
5	Stomach bloating				X
6	Belly Rumble (noise coming from the belly)			X	
7	Heartburn			X	
8	Binge eating		X		
9	Urgent need to defecate		X		
10	Diarrhea		X		
11	Constipation	X			
12	Loss of appetite			X	
13	Disgust towards several foods	X			
14	Gastric acid			X	
15	Difficulty digesting			X	
16	Repeated hiccups		X		
17	Feeling the need to eat more than usual			X	
18	Food intolerance (besides allergies)	X			
19	Belching		X		
20	Flatulence		X		
21	Back pain				X
22	Muscular pain (legs, thighs, arms, hands, feet)				X
23	Joint pain				X

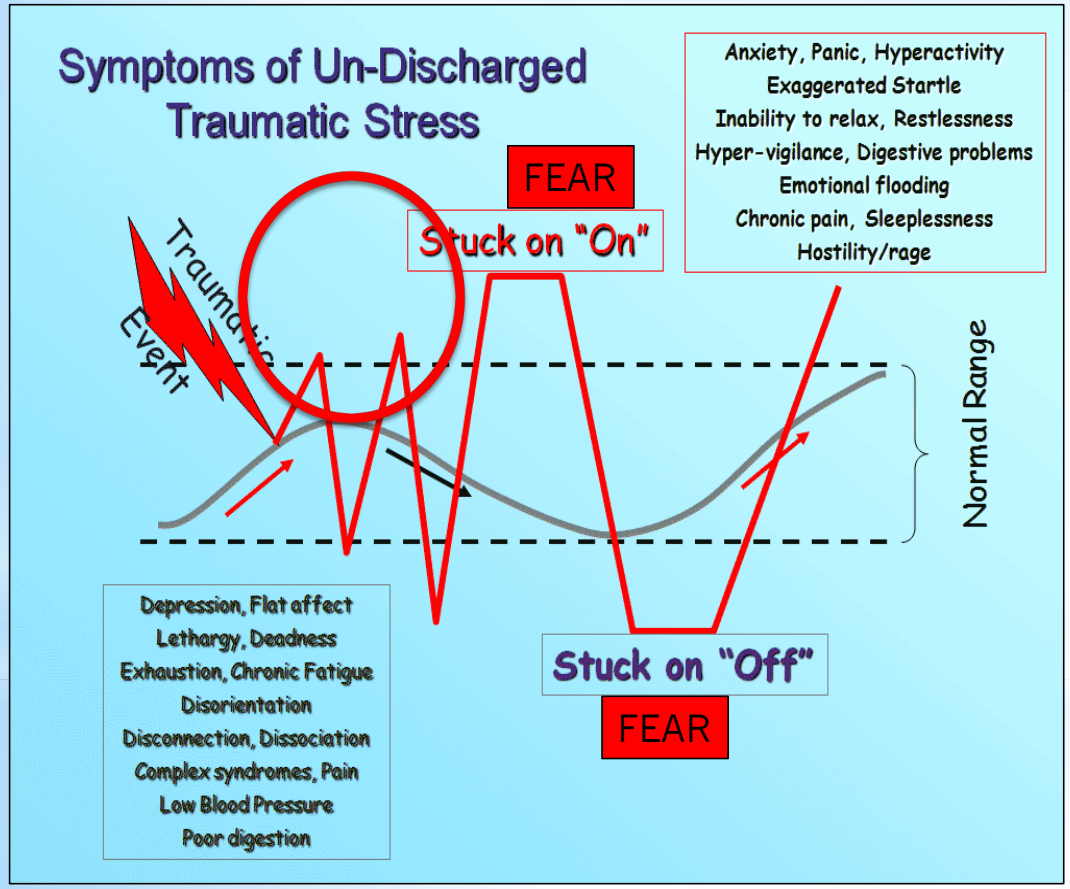
The screening of psychosomatic autonomic dysregulation with **PDI**

Psychosomatic Dysregulation Inventory (**PDI**)



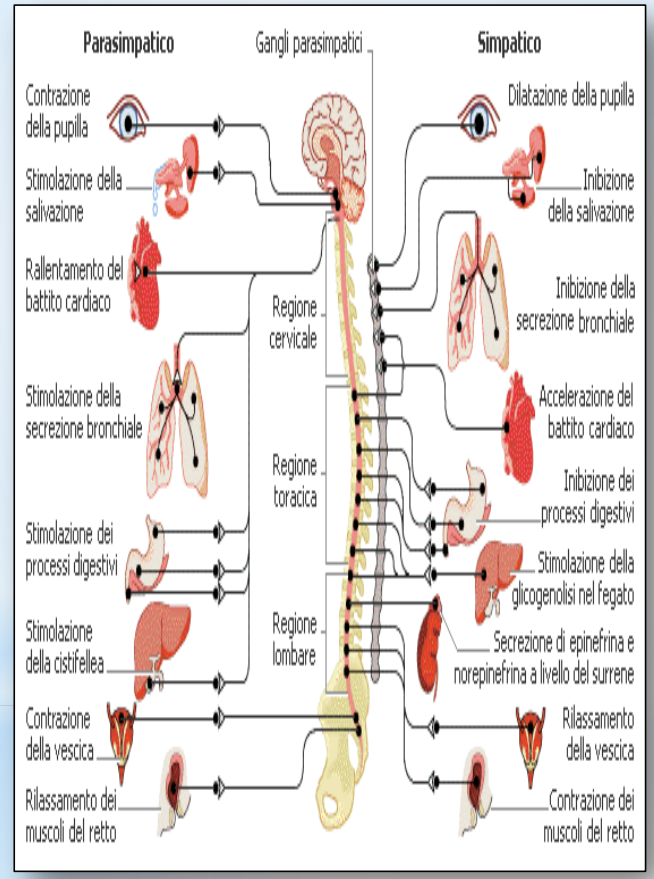
24	Genital pain (excluding during sexual intercourse)	X			
25	Cramps		X		
26	Tension in the head, shoulder or neck				X
27	Difficulty urinating	X			
28	Pain while urinating	X			
29	Urgent need to urinate		X		
30	Short breath, feeling like I cannot breathe (not while doing sport)				X
31	Feeling like I cannot coordinate breathing with talking				X
32	Feeling like I am suffocating				X
33	Palpitations (feeling like my heart is beating fast and hard)			X	
34	Fatigue (weakness/loss of energy)				X
35	Chest pain or chest pressure			X	
36	Dizziness		X		
37	Difficulty swallowing		X		
38	Dry, red or swollen eyes				X
39	Goosebumps (in absence of cold)		X		
40	Voice loss, as if I was unable to speak			X	
41	Need to cough or clear my voice (in absence of a cold)			X	
42	Hearing difficulties (I cannot hear or I hear confused noises, as if I was deaf)	X			
43	Hearing close sounds as if they came from further away			X	

Psychosomatic Dysregulation Inventory (**PDI**)



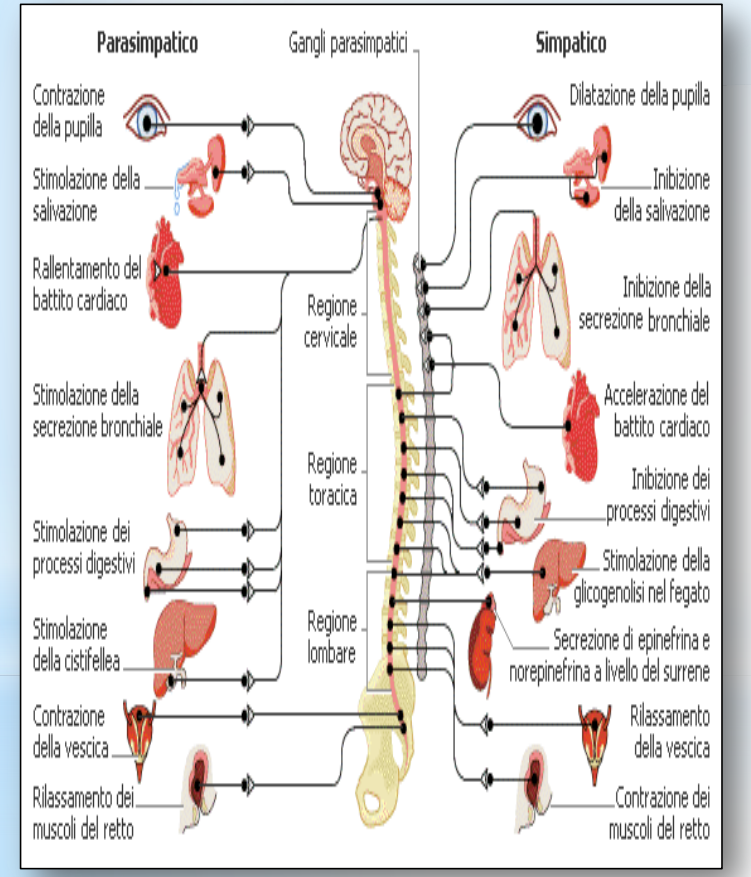
44	Trembling hands, arms, legs or other body parts			X	
45	Continuous sounds, whistles, buzzes or noises in my ear				X
46	Blurred or split vision		X		
47	Seeing things and people as if they were bigger than normal	X			
48	Severe temporary drop in vision	X			
49	Seeing things as if they were different from usual (as if I am watching inside a tunnel or as I am seeing just to a part of what I'm looking at	X			
50	Sense of fainting or loss of consciousness		X		
51	Memory loss (as if I cannot remember things)				X
52	Seizures		X		
53	Difficulty walking or keeping balance		X		
54	Sense of weakness to arms and legs				X
55	Feeling like I'm moving in slow motion			X	
56	Feeling numb in my body				X
57	Feeling paralyzed in my body		X		
58	Feeling dizzy and foggy-headed				X
59	Loss of sexual drive			X	
60	Pain during sexual intercourse	X			
61	Sense of rigidity in my body				X
62	Feeling like I have a lump in my throat				X

Psychosomatic Dysregulation Inventory (**PDI**)



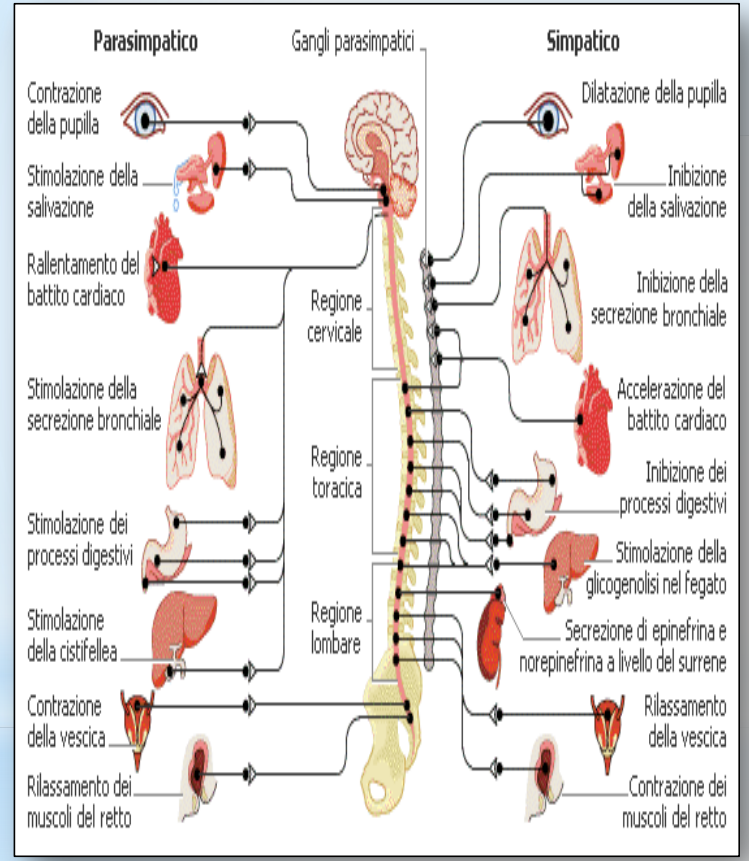
63	Feeling like I have something in my throat, like a small ball				X
64	Suffering from several different symptoms				X
65	Babbling or stuttering when stressed				X
66	Feelings of anxiety and fear during normal sexual intercourse			X	
67	Difficulty in reaching orgasm			X	
68	Feeling like my body is insensitive to pain		X		
69	Insomnia and/or difficulty falling asleep			X	
70	Restlessness and difficulty keeping still				X
71	Lethargy and feeling the need to sleep more than usual				X
72	Waking up at night and being unable to fall asleep again		X		
73	Waking up in the morning more tired than when I fell asleep				X
74	Nightmares		X		
75	Unpleasant feelings when I smell something I usually like	X			
76	Tingling in some body parts				X
77	Itching that makes me continuously scratch		X		
78	Heat waves or cold shivers, in absence of a fever			X	
79	Excessive sweating		X		

Psychosomatic Dysregulation Inventory (**PDI**)



80	Excessive and continuous salivation		X		
81	Excessive worry about my health		X		
82	Excessive worry I have a serious illness		X		
83	Excessive thinking about my death		X		
84	Fear that my physical aspect will suddenly change				X
85	Excessive thinking about my physical flaws				X
86	Dry mouth		X		
87	Comparing my physical aspect to other peoples'	X			
88	Face contractions or tremors (e.g. mouth or eyelids)			X	
89	Looking in the mirror and feeling a sense of uneasiness or unfamiliarity			X	
90	Feeling pleasure in physical contact with other people				X
91	Gritting teeth during sleep	X			
92	Clenching teeth during sleep	X			
93	Feeling like my body does not belong to me				X
94	Feeling ashamed of my body		X		
95	Physical symptoms that rapidly appear and disappear			X	
96	Inflammation (cystitis, gingivitis, sinusitis, bursitis, bronchitis, etc.)		X		
97	Dermatological problems		X		
98	Hormonal problems (e.g. thyroid		X		

Psychosomatic Dysregulation Inventory (**PDI**)



	disorders or diabetes)				

For men:

		Never	Sometimes	Often	Very often/always
1	Impotence				
2	Premature Ejaculation				
3	Delayed Ejaculation				

For women

		Never	Sometimes	Often	Very often/always
1	Menstrual problems (irregularities, intense pain, mood swings, excessive blood loss during menstrual cycle)				X
2	Vaginal dryness during sexual intercourse		X		
3	Vaginal pain at penetration	X			

The screening of psychosomatic autonomic dysregulation with **PDI**

🔷 Comparative Table: ISS – DIQ – PDI in the PIREP Model

Instrument	Domain Assessed	Clinical Focus	PIREP Interventions
ISS – Internal Saboteur Scale	Inner dialogue, persecutory voices, ruminative ToM	Identifies the devaluing and persecutory voices of the Internal Saboteur, which fuel rumination and self-devaluation.	- **Top-down**: narrative restructuring, two-chair dialogue, psychoanalytic interpretation. - **Bottom-up**: emotional grounding when voices emerge.
DIQ – Dissociation of Intimacy Questionnaire	Emotional, physical, social, and sexual intimacy	Maps the "micro-fractures" of intimacy: barriers, mistrust, bodily detachment, social misattunement, sexual disembodiment.	- **Top-down**: mentalization, role playing, narrative re-elaboration. - **Bottom-up**: focusing, breathing, sexual embodiment, attunement exercises.
PDI – Psychosomatic Dysregulation Inventory	Psychosomatic and autonomic regulation	Assesses levels of physiological and somatoform dysregulation linked to stress, trauma, and wounded intimacy.	- **Bottom-up**: autonomic regulation techniques (breathing, grounding, ventro-vagal co-regulation). - **Top-down**: psychoeducation on stress, mentalization of body and symptoms.

PIREP-AI Platform

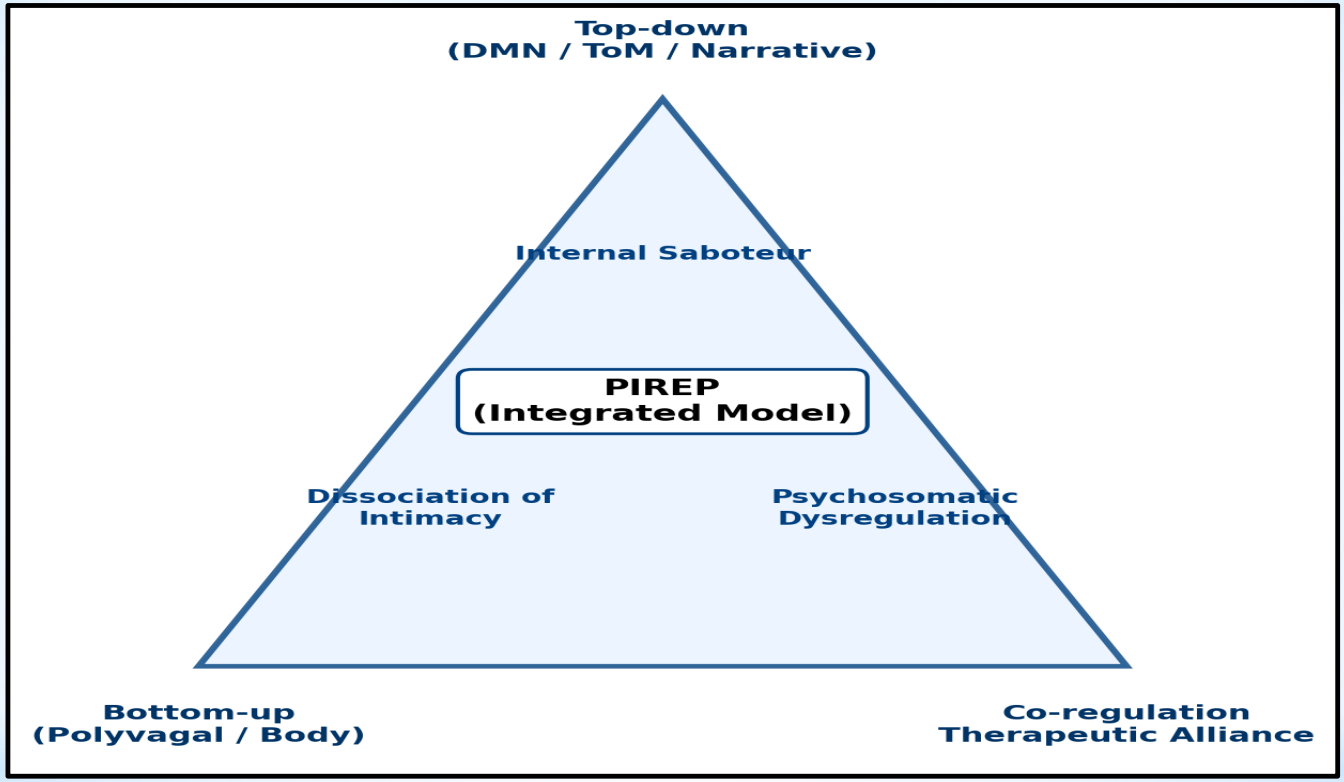
- **Work in progress**: developing a digital platform
- Integration of **ISS, DIQ, PDI**
- Functions:
  - **Clinical assessment & supervision**
  - **Training modules** for therapists
- **AI-assisted**: case formulation, monitoring, feedback
- Aim: create a **bridge between research and practice**

"We are currently working on the development of the PIREP-AI platform.
This is not yet a finished product, but an ongoing project that aims to digitally integrate our three instruments—the ISS, the DIQ, and the PDI.
The platform is designed to support clinical assessment and supervision, and to provide training modules for therapists.
Through AI-assisted functions, it will help with case formulation, longitudinal monitoring, and structured feedback for supervision.
The ambition is to create a bridge between research and clinical practice, making the PIREP framework and its open-access tools directly accessible to clinicians in their everyday work.
So, this is a platform in progress—an evolving part of the PIREP ecosystem."

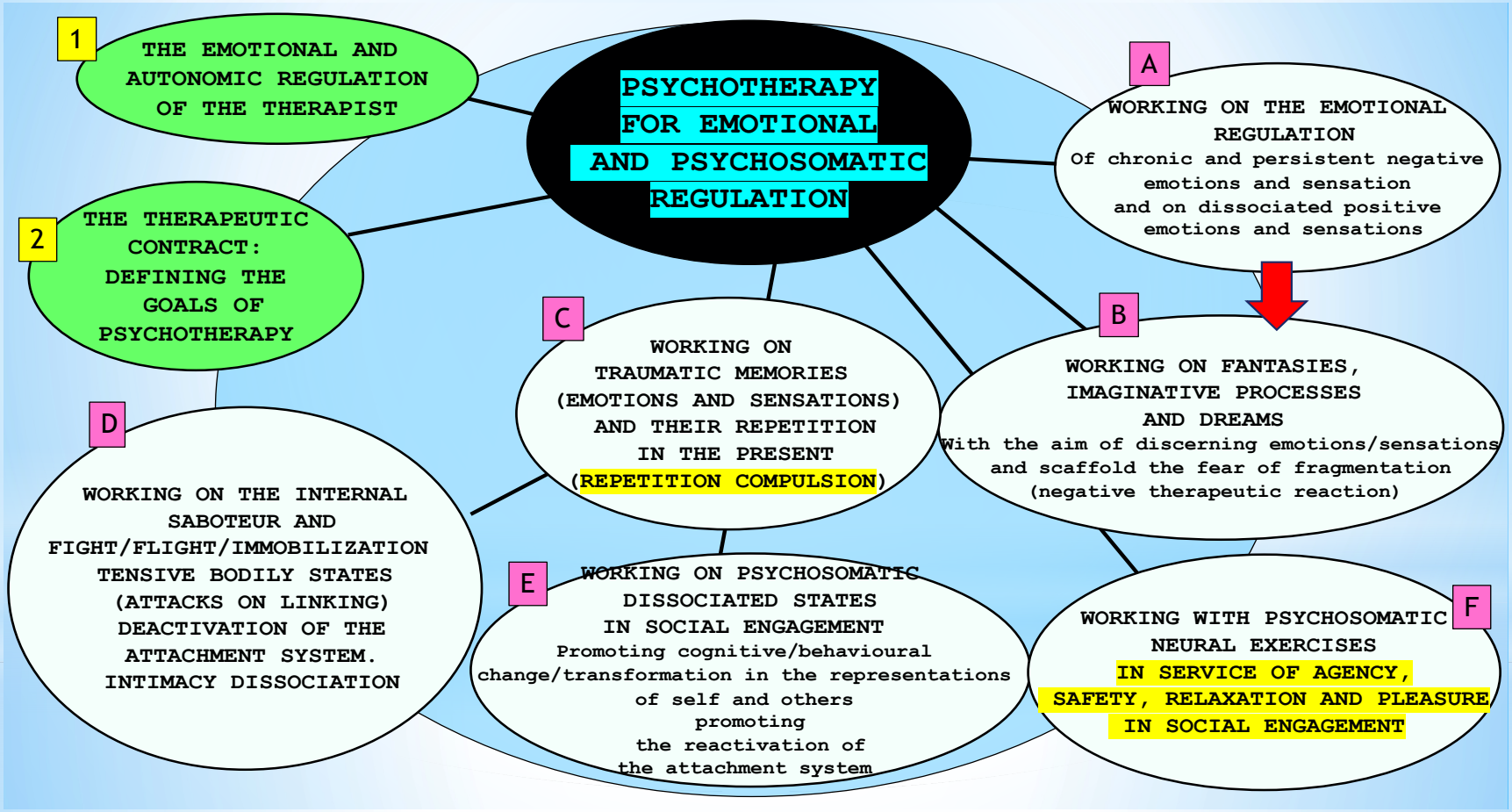
Summary Diagram

PIREP as a bridge between:

- **Top-down** → DMN, ToM, narratives
- **Bottom-up** → Polyvagal regulation, embodiment
- **Co-regulation** → therapeutic alliance as shared space
- Integration of:
  - **Internal Saboteur**
  - **Dissociation of Intimacy**
  - **Psychosomatic Dysregulation**



"This diagram summarizes the essence of the PIREP model.
At one corner, we have the *top-down* dimension: the Default Mode Network, Theory of Mind, and narrative processes.
At another, the *bottom-up* dimension: Polyvagal regulation, autonomic states, and embodied experience.
And connecting these, we have *co-regulation*, the therapeutic alliance as a shared space of safety.
Within this integrative framework, we address three core constructs: the Internal Saboteur, the Dissociation of Intimacy, and Psychosomatic Dysregulation.
Together, they form the clinical backbone of PIREP, showing how mind, body, and relationship are not separate domains, but parts of a single regulatory system.
In this way, PIREP acts as a bridge—between top-down and bottom-up, between patient and therapist, and ultimately between fragmentation and integration."


PSYCHOTHERAPY FOR EMOTIONAL AND PSYCHOSOMATIC REGULATION
1
THE EMOTIONAL AND AUTONOMIC REGULATION OF THE THERAPIST
2
THE THERAPEUTIC CONTRACT: DEFINING THE GOALS OF PSYCHOTHERAPY
A
WORKING ON THE EMOTIONAL REGULATION
Of chronic and persistent negative emotions and sensation and on dissociated positive emotions and sensations
B
WORKING ON FANTASIES, IMAGINATIVE PROCESSES AND DREAMS
With the aim of discerning emotions/sensations and scaffold the fear of fragmentation (negative therapeutic reaction)
C
WORKING ON TRAUMATIC MEMORIES (EMOTIONS AND SENSATIONS) AND THEIR REPETITION IN THE PRESENT (REPETITION COMPULSION)
D
WORKING ON THE INTERNAL SABOTEUR AND FIGHT/FLIGHT/IMMOBILIZATION TENSIVE BODILY STATES (ATTACKS ON LINKING) DEACTIVATION OF THE ATTACHMENT SYSTEM. INTIMACY DISSOCIATION
E
WORKING ON PSYCHOSOMATIC DISSOCIATED STATES IN SOCIAL ENGAGEMENT
Promoting cognitive/behavioural change/transformation in the representations of self and others promoting the reactivation of the attachment system
F
WORKING WITH PSYCHOSOMATIC NEURAL EXERCISES IN SERVICE OF AGENCY, SAFETY, RELAXATION AND PLEASURE IN SOCIAL ENGAGEMENT

Clinical Implications

- **Applications of PIREP**:
  - Trauma and complex PTSD
  - Personality disorders (borderline, narcissistic, avoidant)
  - Psychosomatic conditions
- **Therapeutic impact**:
  - Enhances **emotional regulation**
  - Restores **embodiment & psychosomatic health**
  - Repairs **intimacy & relational trust**
- **Integration**: from fragmented approaches → coherent clinical model

"What are the clinical implications of PIREP?
First, its applications extend across a wide spectrum: trauma and complex PTSD, personality disorders such as borderline, narcissistic, and avoidant structures, and psychosomatic conditions.
In terms of therapeutic impact, PIREP provides tools to enhance emotional regulation, to restore embodiment and psychosomatic health, and to repair intimacy and relational trust.
Perhaps most importantly, it allows us to move from fragmented and partial approaches toward a coherent and integrative clinical model—one that unites mind, body, and relationship in the therapeutic process."

Future Research

- **Validation studies** of ISS, DIQ, PDI in clinical populations
- **Neurobiological markers**: linking DMN, Polyvagal states, embodiment
- **Longitudinal research**: tracking regulation and intimacy over therapy
- **Digital innovation**: development of PIREP-AI platform
- Goal: strengthen the **bridge between research & clinical practice**

"Looking ahead, the next steps for PIREP involve research and innovation.
We are conducting validation studies of our three instruments—the ISS, the DIQ, and the PDI—particularly in clinical populations.
We also aim to explore neurobiological markers, linking Default Mode Network activity, Polyvagal states, and embodied processes.
Another crucial direction is longitudinal research: following patients over time to see how regulation and intimacy change during therapy.
And finally, we are developing the PIREP-AI platform, a digital tool to integrate research, clinical assessment, and training.
The overarching goal is to strengthen the bridge between research and clinical practice, making integration not just a theory, but a living reality in psychotherapy."

Closing Quote

“The body keeps the score,
but therapy restores the rhythm of connection. “

"I would like to end with a simple idea:
The body keeps the score—our wounds and our traumas are inscribed in the body.
But therapy, when it integrates mind, body, and relationship, has the power to restore the rhythm of life.
This is the spirit of PIREP: to transform fragmentation into integration, and suffering into connection."

THANKS!

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