

Achieving personality growth in psychotherapy

Personality is a combination of qualities that endure and yet slowly evolve. Psychotherapy can modify existing personality characteristics that cause social and occupational dysfunction as well as personal suffering. This process of modifying personality structure involves new learning experiences and can be supported by a deeper understanding of the patient’s relationships with the therapist and others, in addition to an appreciation of the self’s inherent complexity. The benefits of personality growth include a more coherent identity; increased capacity for richer, deeper, and more enduring relationships; and improved emotional control, including tolerance for negative feelings such as fear and sadness.

Psychotherapy can assist in personality growth when a therapist makes careful observations, formulates the multiple underlying causes of salient problems, and uses techniques that promote new learning opportunities. Each chapter in this book will begin with several observations, followed by their proposed formulations, and will conclude with an illustration of relevant techniques. This first chapter provides an overview of observations, formulations, and techniques utilizing a case example to illustrate each of these three elements, followed by a discussion of the general principles of technique.

Observation

Observations are made based on the patient’s report of conscious personal and interpersonal experiences including complaints and symptoms, signs that are observed during therapeutic sessions, and the therapist’s own emotional response to the patient. The therapist may observe deficiencies in certain general capacities, such as difficulty in thinking clearly or in separating fantasy from reality. Observations are also made regarding how a patient responds to the therapist’s interventions. If, for example, a patient rejects a comment the therapist offers, an observation might be made about the nature of the rejection.

Such an observation could then inform a formulation of the case. In considering the quality of the observation, the therapist might ask him/herself if the comment was rejected because it was not attuned to the patient in some way, in need of revision, or perhaps evocative of strong feelings that the patient wants to avoid. A variety of observations combine to contribute to the formulation of what is happening in the present therapy moment.

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Silver

The case of Silver will be used as an example of moving from observation to formulation and technique.

Silver was a 31-year-old unmarried man when he sought treatment for anxiety symptoms. He had periods in which his tense muscles, sweaty palms, sense of dread, and ruminative worry significantly interfered with his work. He also had difficulties with feeling inferior and maintaining intimate personal relationships, both of which caused him distress. He was diagnosed with Generalized Anxiety Disorder, but his problems seemed closely related to long-standing and personality challenges regarding identity and relationships. A differential diagnosis of Narcissistic Personality Disorder with compulsive and dysphoric features was considered.

Silver had worked for several years in lower management at a large corporation. About six months prior to his presentation for treatment, he had been promoted. His increasing responsibilities involved more frequent and important interactions with the people whom he supervised as well as with those who supervised him. In addition, as the scope of his work widened, he had to cooperate more and more with his peers. The interactions, though desirable, increased his tension and anxiety.

Silver hoped to develop cooperative partnerships with his workplace peers, yet he felt uneasy and suspicious that his colleagues might act in competitive ways that would interfere with his chances for advancement in the company. If others wanted to cooperate with him on a project, Silver felt edgy and would withdraw from them, feeling more anxious because he was unsure what the right or wrong behaviors would be. He would fluctuate back and forth, anxiously approaching coworkers, and then withdrawing from them for fear of embarrassment.

Silver had recently dated a woman for three months, during which time they had satisfying sexual experiences. When Silver asked her to move in with him, she ended their connection firmly but kindly, telling him that he was “not right for her.” He felt that she viewed herself as superior to him, and did not see him worthy of domestic partnership or marriage. Since this experience Silver had dated sporadically, but felt that the women he dated were inferior to what he expected for himself.

Silver desired both friendship and intimacy with a woman, but seldom achieved either. Whenever he sought to deepen a relationship, he ended up feeling rejected and unworthy. As a result, he tended to stay away from people. He felt very alert to possible signs of scorn, rejection, or exploitation by others.

In discussing an exploratory and possibly open-ended course of psychotherapy with him, his goals were clarified. He wanted to have more pride and confidence in the work he produced, and to be able to share more with his work peers. He also wanted more close friends and intimate relationships. He even desired to get married, but he was seldom able to feel relaxation and mutuality with women.

As a result of the limited relationships, both at his work and in his love life, Silver often felt lonely and sad. He loved to listen to music, and it helped him to

ease his distress. He drank alcohol in moderation, but wanted to reduce that, as it seemed to him like an escape that could lead to further trouble.

During the evaluation interviews, he seemed engaging, clear, and motivated to gain a better self-understanding. Therapy began as weekly sessions, sometimes twice a week. About a month into the psychotherapy, after the opening minutes of each session, he seemed to slump down and draw back. In this apathetic state, he might flip-flop in his attitude toward therapy, stating that he felt unsure about being there, and spent much time indecisively and abstractly deliberating on whether therapy could help him in any way.

After perhaps ten minutes in this state, he would usually rouse himself and try to come out of his shell. He would speak on topics concerning his work and relationships until he became more anxious, and then he would slump into what seemed like a restorative mood in which he was almost aloof to the therapist. He expressed feelings, yet also made efforts to suppress them. The feelings, flickering over his face, were often expressed only briefly and then masked. They appeared to be a mixture of self-disgust, sadness, and fear—a state of mind of mixed emotions in which he had difficulty connecting feelings to ideas.

Observations of Silver included his self-report of anxiety and problematic relationships socially and at work. He avoided people to reduce states of tension and sweaty palms, but the avoidance led to loneliness. During sessions the therapist observed that Silver exhibited tense facial muscles and avoidance of eye contact. These signs decreased in intensity and frequency after the first weeks. The therapist noted his own reactions during sessions. He became hyper-alert when Silver seemed to tense up, and bored when Silver seemed to drone on without communicating directly and honestly.

Formulation

Formulation in therapies for personality growth usually moves from a surface observation towards the delineation of repetitive and maladaptive interpersonal patterns. These patterns are rarely apparent during the first evaluation and early phases of therapy. As therapy progresses and more information is gathered, the therapist can begin to infer how and why patterns repeat themselves in spite of unfortunate consequences. Additionally, as time goes by, the therapist develops hypotheses as to what may be causing blunting of possibilities for self-actualization and satisfaction.

The macro-formulations of the whole case begin with mini-formulations of what is going on in the present moment. In going from surface observations and disclosures to deeper meaning structures, a therapist may utilize a framework called **configurational analysis** (Horowitz, 2005; Horowitz, Marmar et al., 1984; Horowitz, 1997, 2005; Horowitz and Ells, 1997, 2005). In this framework, the therapist begins by analyzing the states of mind in which the observable phenomena do and do not appear. The therapist then considers the emotions that may

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lead to changes in mental states, such as into defensive states or disorganized states of extreme distress. These are labeled “topics of concern.”

Then one examines whether the emotions and state changes can be grouped into “views of the self in relationship with others” and “self-criticisms.” These enduring and slowly changing attitudes will be called person schemas. The steps of such configurational analyses are: **states, topics of concern, and person schemas.**

States

After selecting certain phenomena for attention, the therapist and patient may consider the states in which they occur, as well as those states in which they do not occur. Silver’s sweaty palms occurred in a *tense* state of mind. This tense state then contrasted with his *apathetic* or aloof state of mind, which was achieved and stabilized when he was able to avoid others either by working alone in his office cubicle or by delving into solitary interests and hobbies.

Silver desired a state he termed *happiness*. Silver differentiated happiness from the state that he sometimes experienced when in great distress, which was a depressed state of feeling that “everything is worthless.” Over the course of therapy, states of shame and anger were eventually uncovered, neither of which were recognized at the time of first formulation. Although some states occur in therapy sessions, wider ranges are reported from self-observation in other contexts such as while at work or with family or friends.

Emotional regulation is central to this analytic step of conceptualizing states of mind as comprising a patient’s repertoire. Emotional regulation can range from under-control to over-modulation. For example, repetitive phenomena such as angry expressions can occur in well-modulated states, in explosive under-controlled states, or in blunted over-controlled states. The therapist’s attention should include not only the angry feelings, but also how the anger varies in intensity, associated ideas, and level of control.

On one occasion during Silver’s therapy, the therapist was surprised when Silver entered a state of under-modulated shame, cringing into the recesses of his chair, looking furtively and frightened at the therapist while blurting out something like “I am such a wreck.” Silver quickly recovered, but over the course of many sessions the state of searing shame recurred as he became more exploratory of his ideas and feelings. Triggers of this state were observed and became topics of attention.

In general, several questions may help the therapist formulate mental states, determine topics of concern, and develop person schemas. These questions are:

When and why do state transitions occur?

Do certain topics trigger the patient’s entry into distressing states?

Are there states of mind during which the patient seems to experience or present alternative identities?

Topics of concern

Transitions into under- or over-controlled states may occur with the emergence of certain topics that bring up emotions that are difficult for the patient, and perhaps even the therapist, to experience. A topic may return again and again because it is important, conflictual, and unresolved. It may be avoided for a while before it returns as a topic to be discussed.

Silver might, in therapy, be in a conversational, well-modulated state, but then shift to either an under- or over-controlled avoidant state when confronting the topic of feeling lonely. In a state of safety, Silver was able to discuss this topic and relate incidents of anticipated or actual rejections of friendly conversations at work, or of asking a woman to go on a date. Some stories involved his own ineptitude, which led to him entering an intense, degraded, and shame-filled state.

The therapist observed that Silver expected his overtures to lead to a response of rejection, and that this anticipation also contributed to the tension he experienced when he forced himself to approach others. Thus, while engaging others with as much charm as he could muster, Silver was also anxiously expecting their possible lack of interest.

His hypervigilance for rejection often superseded his desire for intimacy, prompting Silver to wall himself off from others and enter his calmer but unsatisfying state of apathy and aloofness. This helped Silver regulate both his experience of tension and his sense of degradation, but it also left him lonely. When that became a depressive state, Silver would once again venture to connect with others, but the cyclic pattern described would unfold once again despite Silver's dearly held hope for a different experience.¹

A therapist and a patient will likely recognize only certain aspects of salient topics before understanding all of the submerged meanings. A therapist's notation of these repetitive behaviors and themes may flesh out formulations.

Avoidances are important to observe. At times, the patient may veer away from a certain topic, perhaps inhibiting or distorting certain concepts. An important aim is to help the patient feel safer and more in control of what topics can be addressed, and what emotions can be more fully experienced. One way Silver avoided entry into the potentially under-modulated state of shame was to focus attention on the other person's shortcomings: he would deny any desire to make a deeper connection with such a person, and judge them as an unsatisfactory potential companion. If there had been an argument, Silver presented the incident implying that the other person was at fault.

¹ Wachtel (1993) points out the irony in these patterns, in which, "the situation that the patient ends up in is precisely the one he is trying to avoid. He does not *aim* for the consequences he encounters; he produces them despite—yet because of—his vigorous efforts to prevent them . . . The irony in what ensues lies in how, by the very act of carrying out that intention, the patient contributes to the outcome he is trying to avoid" (pp. 23–24).

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In addition to observations, the therapist may develop certain questions. Do certain topics feel stressful on recollection, or repeatedly lead to undermodulated states? Are certain topics dismissed or distorted by the use of defensive maneuvers to down-regulate emotion? Does the patient use a habitual emotional control style to avoid certain topics?

Person schemas

Person schemas operate unconsciously in order to organize the combination of internal knowledge and external sensations into thoughts and feelings. By the time it is possible to conceptualize this deep level of case formulation, the therapist and the patient, most likely together, will have noted particularly problematic states. As the therapist observes which topic shifts lead to that state, the therapist can look for various habitual *self-concepts and relationship attitudes* in each state. Eventually, the origins of these attitudes can be illuminated.

Person schemas are often dyadic; the self-other relationship models that inform thoughts about difficult topics are expressed through therapeutic dialogue. Such a model is illustrated by Silver's statement: "I am too weak, I just caved in when he said. . ." These kinds of statements reveal self-concepts and social attitudes.

For example, Silver might meet a new person and expect them to arrogantly disparage him because they are older, stronger, more expensively dressed, and/or in a bigger office. Silver's *transference* feelings about the therapist gave insight into his person schemas. For example, he expected the therapist to degrade him when he confessed to incompetent behaviors or could not clearly express his feelings. Through the therapeutic relationship, he came to learn that in reality the therapist might be kindly disposed, cooperative, and understanding of his experience, which undermined the automatic imposition of his unconscious relationship model that organized his thinking. By becoming aware of what was real rather than habitual, he gained new experiences in therapy and learned new role relationship models.

Once conceptualized, attitudes can be investigated in terms of how they formed and habitually repeated in the past. What was implicit and procedural can be elevated to verbal, declarative, and explicit statements. That can lead to a deeper understanding of how and why a certain maladaptive pattern in interpersonal relationships is repeated, and ultimately how to forge a new pattern. Habitual beliefs can be challenged with new cognitive processes that reflect a more positive outlook.

Technique

With Silver, the therapist promoted a shared experiencing of Silver's thoughts and feelings. He provided clear labels for Silver to use in identifying the feelings and attitudes that might trigger entry into a tense and anxious *state*. He did so by

repeating what Silver said with tentative words for expressing emotions more clearly in their conversations.

Labeling these *topical* triggers helped Silver stabilize more centered states and communicate his feelings to the therapist. This process helped the therapist attend to Silver's shifting states, as well as the beliefs about self and others that were expressed therein. Moments in which Silver sought to minimize his negative emotions were called to his attention. The therapist then used both clarification and interpretation to engage Silver in an exploration of the *core relationship patterns* that informed his shifting sense of self and his expectations of others.

Silver and the therapist discussed various ways to understand and handle rejection. They explored new ways of connecting with others that might be more socially effective. The therapist began to challenge the irrational components of Silver's self-concept of unworthiness. The therapist encouraged more rational views of himself and more development of skills. This helped Silver integrate existing positive beliefs about himself and his relationships, which led to the adoption of combinations of beliefs that reflected a more realistic, continuous sense of self-efficacy.

The case of Silver illustrated how, in the middle phase of therapy, maladaptive attitudes about identity and relationship can be clarified and challenged. Self-concepts and self-judgments are often found to be discordant or irrational in that they neither reflect a patient's current situation, nor do they accurately appraise personal potential. The process of change involves learning to re-focus attention and reappraise old beliefs. Then therapy conversations can create new plans and improve self-regulation.

General principles of technique

General principles include creating a sense of safety, tactfully redirected or deepening attention, observing for signs of progress or stagnation, and containing emotionality as deeper attitudes emerge.

Safety and emotional containment in a therapeutic alliance

Negative emotions often feel dangerous; they can lead to dreaded states of mind. Both the therapist and the patient will find that the therapy processes can proceed well when **safety** is established, full expression is encouraged, and hope is present. This means that the therapist seeks to understand the meanings beyond the patient's immediate words. Such readiness involves going beyond the patient's story into subtle meanings and stances. The right frame of mind for the therapist could be taking an equidistant position on various parts of the patient's conflict so that all parts can be expressed.

The idea of the therapist's neutrality has been revised in the years since Freud used a free association method to encourage awareness of repressed memories,

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fantasies, ideas, and feelings.² A more fruitful frame of mind is to listen for possibly conflicting concepts that arise in the patient and in the therapist's own reactive mind. The patient may be explicitly asked to explore emotions and meanings thoughtfully, instead of arriving at hasty judgments, which over time can move toward more holistic solutions.

Focusing attention on a topic

In a therapy environment, patient and therapist select a *topic as the focus for their joint attention*. The patient usually generates this topic in the opening period of the session. The therapist listens for a potentially useful theme to emerge and follows its thread through the patient's discourse. Eventually, the topic is refined as one that contains dilemmas or conflicts that are problematic for the patient.

As the patient tells stories about what has happened and caused them distress, the therapist aims to gradually help the patient establish reasonable *cause-and-effect sequences*. Sometimes it helps to compare and contrast different outcomes of a pertinent conflict, such as best-case, worst-case, and most likely scenarios. This contrast can help the patient think realistically and reduce exaggerations and minimizations.

Meanwhile, the therapist watches for defenses that serve as obstacles to understanding. These emotional control processes act to prevent anticipated dangers and in doing so often operate at the pre-conscious levels of information processing. This means that a patient may be unaware of the presence and function of these avoidance operations, in addition to the thoughts and feelings that are being suppressed. Interventions that help with fuller and safer emotional expression can lead to clarification of suppressed emotions, and perhaps also to the modification of maladaptive inhibitions, avoidance patterns, and unintentional "blind spots."

The process of expressing a richer narrative on a difficult topic will lead to feelings embedded in, and in part caused by, *repeated maladaptive attitudes*. As these attitudes are clarified, it may be helpful to trace the routes of their development. This may involve expressing childhood memories and fantasies. Past traumas can be addressed to develop new self-narratives.

Psychotherapy involves both learning and unlearning. However, it is important to understand that unlearning does not mean erasure: although models of past self-other configurations endure unconsciously, they can be rendered latent by activating and developing more adaptive views of self and other. This process can be fostered by new, mutually authentic attachments. The evolution of an effective and realistic *therapeutic alliance* is one such attachment. Modifying habitual

² For an emotion-focused take on neutrality, see Beuchler (2008). Beuchler has emphasized the utility, as well as the limits, of the therapist's cultivation of a state of curiosity. Beuchler suggests that this state often enables the therapist to help the patient maintain, or more accurately, regain the emotional equilibrium that is crucial to the therapeutic process. In this way, she follows Schafer's (1983) and Greenberg's (1986) positions that neutrality (in the sense of equidistance between parts of a conflict) involves a state of being that affects the interpersonal field, in addition to a set of behaviors that avoids harsh critical judgments (Horowitz, 2013).

defensive styles and automatic avoidances are often necessary in order to engage in the corrective experiences that can occur in therapy.

Evaluating progress in therapy

Part of the observation, formulation, and technique revision that the therapist utilizes in different phases of treatment involves continuous evaluations of how the therapy is progressing. Symptoms and problematic states can be considered in terms of intensity and frequency over time. Although distress may temporarily increase with fuller emotional expression, it should improve gradually over time and give rise to increased life satisfaction.

States of mind ideally become easier to modulate, leading to more confidence and spontaneity. *Topics* that have been too traumatic to contemplate should move towards completion and a sense of mastery. Concepts of self and other may become progressively more realistic, *person schemas* may be reconfigured, and social actions may become more effective.

The therapist may ask him- or herself the following questions to assess progress:

- Is the patient gaining a greater ability to reflect on his or her own mental processes in a way that connects cognition and affect as opposed to defensive intellectualization or emotional flooding? Silver gradually learned more language for labeling his feelings and his states of mind, indicating progress.
- Is the patient learning more about how to understand more accurately and deeply the motivations, intentions, and attitudes of others? For Silver, the therapist's questions about what he thought the other person deserved in a particular social situation led to new insights and more realistic expectations.
- Is the patient learning cause-and-effect reasoning to anticipate the potential consequences of their own actions? Although Silver had always worried about disapproval by supervisors when he had to show his work, he became able to focus more on favorable outcomes and how to amplify their probability. He was able to map out in advance how he would handle scheduled interviews with his supervisors.
- Is the person gaining a greater sense of realistic self-confidence? Silver gradually gained pride from an enhanced capacity to engage his friend when on dates rather than giving in to his fears and withdrawing.

By focusing on personal meaning systems and specific plans of how to approach situations that cause distress or impairment, a patient may begin to: (1) develop more rational views and patterns of action (*i.e.*, become more realistic); (2) modify defensive styles (*e.g.*, to express even distressing emotions more safely); and (3) learn to use new rational views and behavior patterns to either counteract or contain irrational views or impulsive patterns. Small changes in these areas accrue and lead to larger and more difficult changes. As a patient tests for safety and finds it, he or she is likely to progressively confront more and more emotionally complex topics.

Bringing maladaptive patterns and dysfunctional thoughts to the patient's conscious awareness amplifies his or her learning about coping and relating.

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At the level of conscious awareness, and in conversation with the therapist, the patient examines beliefs and goals that are usually intuited but not clearly verbalized or discussed with another person. The patient learns new conceptual skills to integrate discrepancies and contradictory views on the self and others.

Patients ideally develop new patterns of self-evaluation, as well as new ways to work with others, be productive, gain intimacy, improve caretaking functions, and regulate emotion. These capacities are planned and practiced to discover if they are more adaptive than past patterns. Focused attention and conscious thinking can be used to solve problems in life in general, as well as to address issues that have been dwelling within the patient as unconscious memories, fantasies, intentions, and expectations.

Conversations with a therapist help the patient advance in capacities for reflective *self-awareness*: reflecting on conscious thoughts expands a patient's awareness of possible choices in ways that lead towards better decisions. Long-standing dilemmas give way to solutions that are neither too ideal to realize, nor too catastrophic to contemplate.

As a sign of progress, Silver appeared to increase in his ability to use reflective thinking about himself during sessions. Many patients become more adept at integrating potentially conflicting threads of cognitive-affective experience by entertaining perspectives of the self and the other, while recognizing the limits of each perspective. By exercising mentalization, a patient can re-examine thoughts and feelings that occur in primary consciousness, and then clarify and modify them in a way that allows for greater tolerance of ambiguity, better affect regulation, and ultimately, a more stable and flexible sense of self in relation to others (Bateman & Fonagy, 2004; Fonagy, Gergely, Jurist, & Target, 2004; Fonagy & Target, 2006, 2000; Falkenstrom et al., 2007). In order for psychotherapy to achieve personality growth, patients must develop the ability to reflect on their own as well as others' mental states.

Containing emotional attitudes safely

The expectation within the *role-relationship model* of an adequate *therapeutic alliance* is that the therapist will help the patient safely contemplate fantasies, thoughts, and emotions the patient finds threatening. Additionally, the therapist will utilize professional expertise to maintain the therapeutic frame, even in the face of pressure from *transference* and *countertransference* feelings to do otherwise. This work facilitates the exploration of experiences that the patient may avoid outside of therapy, whether consciously or unconsciously, due to a fear of being overwhelmed by them.³ Under these circumstances, person

³ As I have described it here, the therapist's provision for the patient's expectations—which range from unconscious fantasies to explicitly articulated desires—encompasses both Bion's (1962, 1967) concept of the therapist's role as a container for the patient's unconscious projections of intolerable and unintegrated aspects of self and other, and Winnicott's (1972) concept of the therapeutic space as a holding environment.