Hope, perspective, action: a pantheoretical perspective on three common ingredients for effective psychotherapy for people with serious interpersonal problems

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TREATING people with serious interpersonal problems is both possible and challenging. Evidence testifies that these persons gain benefit from different psychotherapies but many still suffer from residual, at times serious, levels of symptoms and interpersonal problems by treatment termination. There exists therefore the need for common ground knowledge in order to better understand what is needed to treat them with more effectiveness, no matter what one's preferred orientation might be.

In this paper I will consider three ingredients of change that clinicians need to focus on in order to increase the likelihood that patients stay in treatment and derive benefit from it. I am not assuming these ingredients do the job on their own, there are many others I am not discussing mostly for reasons of space, but I will offer the position that any clinician needs to consider them. The idea is that psychotherapy with these persons, commonly diagnosed as having personality disorders, can be effective if clinicians are able to help patients: a) change their perspective; b) have some hope that they can improve and live a less painful and more fulfilling life; c) commit to action aimed at changing maladaptive patterns and strive towards goals they feel are deeply owned.

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Suffering and problems in personality type disorders stem from predictions

Interpersonal problems stem mostly from predictions arising from earlier formative relational experience. For example, neglect during childhood leads us to predict that others will neglect us when we have emotional needs. Patients expect that some of their innermost wishes will remain unmet by the others. This is an idea at the core of the large majority of psychotherapeutic orientations. Just as an example, Cognitive Analytic Therapy (CAT, Ryle & Kerr, 2020), Schema Therapy (Young et al., 2003), Transference Focused Therapy (Clarkin et al., 1999) and my own model, Metacognitive Interpersonal Therapy (MIT, Dimaggio et al., 2015; 2020) share this view.

Such wishes are relevant as they have been evolutionarily selected, and failing to meet them meant to our ancestors risking starvation, physical integrity, failing to mate and, ultimately death (Liotti & Gilbert, 2011). Examples of those wishes are: the need to be cared for when in pain, i.e. attachment (Bowlby, 1969/1982); social rank, which grants order of access to limited resources (Gilbert & Irons, 2005); exploration and autonomy, which are activated when the individuals need to find new resources such as food, lands, and refuges when necessary; caregiving, aimed at protecting the breed; sexuality, in its more complex form which is more than mere mating, and refers to forming stable bonds filled with intimacy; and group belonging, which increases the odds of being protected from predators and outgroups and to reach shared goals the individual would be unable to meet if left alone.

Due to a mixture of temperament, developmental history and cultural influences, individuals develop predictions of how others will react when they try to fulfil their wishes. A couple of examples may help. In the domain of attachment the individual can predict that 'If I ask for care the other will be unavailable'. As a consequence, she forms a core self-concept such as 'I am unlovable'. In the domain of social rank the prediction can sound like: 'If I seek appreciation the other will scorn me and ridicule me', which leads the individual to harbour the idea that 'I am inferior and unworthy'. In the domain of exploration a typical negative prediction sounds like: 'If I try to learn something, I will need resources that the other will not provide me with', which leaves the individual with a core concept of 'I am powerless and stuck'.

Due to those predictions, individuals tend to experience suffering and act in order to protect themselves from the psychological pain arising from both the negative view of themselves they endorse and the reactions from the others they fear. A person with a core self-concept such as 'I am unworthy' will be more prone to experience shame and sadness and as a consequence to become perfectionistic, to avoid social exposure and will be keen to adopt maladaptive coping strategies such as alcohol or drug abuse in order to soothe a pain he is unable to soothe in other ways.

What is the target of psychotherapy in the light of such ideas? I maintain here that three ingredients are necessary:

1) *changing perspective*. If individuals suffer from their predictions, they need to try and view themselves and the world from a different angle. Psychotherapy therefore is about helping individuals to form or bring to light alternative predictions about the fate of their own wishes.

2) in order to change perspective *hope* is needed. It does not mean thinking unrealistically that others will be always there for us, praise us and sustain our efforts. It is about having an underlying, albeit minimal, idea that we are not doomed to fail and that others will respond as we wish.

3) in order to change perspective and sustain hope, *committed action* is necessary. There is no point thinking that personality disorder-type problems will change only because we have developed a new and more adaptive set of ideas. They will not truly change the way they see themselves, the others and the world only by talking with their therapist if, once home, they sit on the sofa, ruminate about past relational problems, worry about the future or dwell on their anger about having been mistreated. Change comes to life out of sustained behavioural efforts to alter one's set of ideas held for a lifetime, and discover how alternative views are possible.

I will now describe how clinicians can implement these elements with a (fictionalised) case history, so to give a sense of their pragmatic application.

Changing perspective

In order to see the world from a different angle and discover different landscapes, clinicians need first to help patients realise that their interpersonal problems have two components. The first is reality based,

but that is not the focus of psychotherapy. Human relationships hurt – that is life and we are equipped to cope with problems. The second is that suffering stems from their predictions that their wishes will remain unmet by others. Put it simply: patients enter therapy saying 'I suffer because he neglects me'. The goal is to help them pass to this kind of understanding: 'He neglects me and that hurts. But I am aware now that I think that I am unlovable so when he neglects me, I agree with him, that makes me so clinging and depressed'. Clinicians validate the first aspect of suffering as human, reality based, but then try and agree with the patients that the work will be focused on the second element.

Charlotte is a 41 year old architect. She has been married for three years to a yoga teacher whom now she describes as bizarre. 'I loved him because he sounded original, kind of a mystic. But I realise now that he is more of a freak. He has 5 clients overall and he pretends he works and he doesn't realise I pay the bills. He is also a conspiracy theorist and, well, it's so annoying. How can I talk him into assuming more responsibilities?" Charlotte was unable to confront him out of fear of being insulted and attacked. Consequently, she was submissive and pleasing, which then reinforced her dissatisfaction. In this stage she portrayed her interpersonal condition as reality based and that made her feel stuck and powerless. I asked her where these ideas of being insulted and attacked came from and episodes of violence at home emerged. She was often belittled and at times beaten by her mother. Her father was aware of the physical punishments but agreed with her mother that that was okay and neglected Charlotte. She learnt to be the 'good girl' to avoid punishment. She also developed the idea that she was inferior and could only match with people she did not value. 'If I meet a clever man, how would he ever like me?'

At this point we realise that her suffering in her marriage mostly comes from her prediction that if she were able to express her wishes and opinions, she would have been both humiliated and in danger. This was the first step toward healing. But in order to change perspective she needed to have hope that a different view is possible. That was the second therapy step I had to help her to take.

Restoring hope

Where does hope come from? It is about giving room to more benevolent ideas of self and others such as 'worthy' in face of a 'praising and supporting' other. With such a concept of self and other, individuals can be motivated to act differently and have more chances to fulfil their own wishes in the real world. Of note, well-being is not strictly connected to real life fulfilment of the wishes. Put simply, healing does not mean finding the persons who love us forever or the job we dreamt of. If this happens, that is better, by the way. Well-being stems from the idea that we have a chance to be loved, to find the work we love, to explore the environment as far as it is possible. Against this background, when persons face setbacks, their core concept remains mostly unaffected: 'Okay, I failed, I was not cared for, not appreciated or not supported, but that's life, it's not necessarily on me, it makes sense trying again'.

When Charlotte realised her current marital struggles were so painful both because she did not like her husband any more and because of her learned experiences, she had moments of deep sadness and anxiety. She did not see any alternatives. How to restore hope when it is absent? The clinician needs to be aware that, with the exception of the most severe cases, patients do have some positive views of self and others. It is just that they seldom ever retrieve them – when they access them they do not take them as true, and they do not let them guide their actions. Mostly these ideas appear but they quickly vanish from their stream of consciousness (Dimaggio et al., 2020).

At this point, I asked Charlotte to focus on moments where she felt self-confident. In the first moment she cried and said she never was. I helped her recall many moments in which she described herself as competent at work and others in which she had evidence she is attractive. I also remembered a moment where she confronted me about something I said, and let her note she was quite clear in expressing disagreement and in having faith that she was right. She recognised that in all these moments she felt better and had good self-esteem.

Hope needs to last and guide action in order to ignite change. To do so, I used a combination of role-play and body-oriented work. We agreed to role-play a moment when her mother had insulted her. I played the mother. During the first rehearsals she surrendered, cried and could not retort. We repeated the scene many times and I invited her to talk back. She came to answer: 'You humiliate me and I don't deserve it'. She felt scared when saying so. I then invited her to repeat the same sentence while changing her posture and voice. I invited her to open her arms, raise her chin and speak louder. Then I monitored how she felt, and she realised that with this new stance she felt more self-confident. I then

spoke with a harsher voice and said she was disrespecting me. Again she felt bad and tended to surrender. We noted how she was again the prey of her mechanisms and I invited her to retort again, even yell if she felt like it. After repeated attempts she could tell her mother she did not want to be treated that way anymore.

At the end of this intense experience she realised that she felt more confident, she knew now that she could react even under stressful conditions. 'I don't feel powerless anymore, it's hard, but maybe I can try'. At this point of the therapy Charlotte has regained hope. Is that enough for a sustained change? No, change in the interpersonal domain needs to be supported by new behaviours, it is pointless changing ideas if old actions are repeated over and over again.

Committed action

There are some orientations, e.g. relational psychoanalysis (Aaron, 2013) and humanistic orientations inspired by Carl Rogers, who think that change mostly come from a safe and supportive relationship. Actually relational factors only explain a very tiny part of therapy outcome (Flückiger et al., 2018). Treating serious interpersonal problems requires that the client decide to act differently in their everyday life. They need to break old habits where they were driven by tendencies to surrender, attack, avoid, be perfectionistic and stern and so on. Only with the intentional enactment of new behaviours can new aspects of the self be consolidated and increase the chances of one's innermost wishes being fulfilled. This is a core tenet of many orientations, mostly cognitive-behavioural and third wave, such as for example Dialectical Behaviour Therapy, Acceptance and Commitment Therapy and MIT.

At this stage a core ingredient of change is anchoring the client to her wishes, focussing on the now re-instilled hope, and planning behavioural experiments. This is what I aimed to do with Charlotte. We planned to express disagreement with her husband on many occasions. We planned to face her fear of being alone so as not to cling desperately to him even when she was seriously unhappy with him. That was not easy at the beginning because she feared both humiliation and violence, even if she knew the last fear was completely unwarranted. Repeated attempts made her feel more and more safe and self-confident. She eventually realised she did not love him anymore and she deserved a man she appreciated. After a few months of therapy, she asked for divorce. She had to face conflicts but those were manageable.

Conclusions

Treating people with serious interpersonal problems, often diagnosed with personality disorders, requires many therapeutic activities. I have suggested here that at least three elements should be taken into account by clinicians, no matter their preferred orientation. First, they have to help the patients be aware that reality matters but only to a certain extent, and that their suffering is chronic because of their predictions that their goals in the relational domain will remain unmet. When patients reach this awareness clinicians need to monitor if patients have hope that they can change. This cannot be taken for granted and, if hope is missing, work must not be focused on behavioural change. Clinicians need to help patients contact their healthy aspects, made of self-confidence, a sense of safety, being lovable and having power over their mind.

Once clients have hope that a different destiny is possible, psychotherapy is about committed action. Therapist and patients need to agree goals and draft a new contract where it is clear that changes can be achieved by doing something different under a volitional effort. Change is built in the therapy room, but it is made solid and sustained thanks to something patients purposefully do between sessions for a prolonged period, until new habits become part of a new sense of self. ☐

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Mapping sexual diversity using Cognitive Analytic Therapy: a qualitative, cooperative enquiry with the LGBTQ+ community

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Abstract: Cognitive Analytic Therapy (CAT) is concerned with intrapersonal and interpersonal patterns and procedures, formed through early interactions with others and the world around us. CAT does not pathologise distress and does not lean on a diagnostic framework, instead it lends itself to understanding the complex subjectivity within identity formation, and how sexuality may interact with our Self, others and society. This paper utilises CAT theory and practice research to understand sexuality and introduce a CAT map of sexuality. This map was developed with members of the LGBTQ+ community (n=8) and encompasses commonalities observed in relational patterns and procedures, despite intersectionality and unique context. The CAT map of sexuality is not an attempt to generalise and suggest that all LGBTQ+ individuals will internalise these unhelpful patterns and procedures due to negative external influences, it is instead an attempt to understand sexuality and the complexity of self-other and self-society relationships as an LGBTQ individual. Clinical recommendations include affirmative practices, acknowledging societal snags and influences, and creating a safe and accepting space which invites individuals to bring their connected self into the room.

Keywords: cognitive analytic therapy; sexuality; LGBTQ; authentic Self; internalised homophobia

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