Obsessive-compulsive Personality and the Personality Continuum with Dr. Shedler

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In today's episode of the podcast, we are joined by Dr. Jonathan Shedler to discuss obsessive-compulsive personality and the continuum on which personalities operate.

Introduction

For over a century, psychoanalytic psychology has recognized certain types of personality configurations that we see repeatedly. A clinician who understands these familiar patterns has a map of the patient's interior terrain to help navigate in treatment.

Choosing to remove the word "disorder" from the term is intentional because personality patterns are not inherently pathological. Personality is not about what disorder someone *has*, but rather who they *are* as a person. The starting point for discussing personality is recognizing that every human in the world has a personality and a personality style.

There is no clear divide between what we call a personality style and a disorder. The word "disorder" is really one of clinical convenience. When clinicians use the term personality disorder, what they are really saying is there's something about the personality style that is so rigid, extreme, or limiting that it causes dysfunction or suffering. Appending the term "disorder" to a personality style is superimposing a medical term on something that every human possesses and that inherently falls along a continuum.

DSM and Personality Disorders

The way DSM describes personality disorders has really convoluted the clinician's, as well as the public's, understanding of personality. The authors of DSM took personality styles discussed in the psychoanalytic literature and described them all in extreme and pathological form, sometimes to the point of caricature, and appended the term "disorder." As a result, the concept of personality became disconnected from clinical understanding and artificially recast in terms of disorders. Consequently, many clinicians now operate as if personality can be ignored entirely unless the person has a diagnosable personality disorder. This is actually a *de*volution as opposed to an evolution in the understanding of personality.

By reducing personality to a one-dimensional list of diagnostic criteria, DSM does not consider the underlying psychology involved. The result is that a DSM personality diagnosis is of little practical, clinical value; it tells us nothing about how to conduct effective treatment.

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Personality styles are really about the psychological themes that underlie our patterns of thinking and feeling: how we experience ourselves and others, how we attach to other people or fail to attach, habitual and characteristic ways of defending and coping, core motivations, and unconscious concerns and preoccupations. The person's internal experience is crucial; it is not just about observable behavior. DSM focuses on observable behavior and leaves out the internal experiences and processes that are actually at the core of the personality styles. Once inner experience is excluded, there is no relevant treatment information left.

Obsessive-compulsive Personality

Obsessive-compulsive personality is defined by high conscientiousness, meticulousness, and being highly regimented and cerebral with low emotional awareness. However, these are all the external signs and do not consider internal life.

When asked how they feel about something, someone with OCP will instead tell you what they *think*. The overuse and overvaluation of thinking, reasoning and logic is a defense against emotional life.

Some regard a logic-ruled mind as an ideal to aspire to, but a person governed completely by logic and disconnected from emotional life is a very incomplete, limited human being. We cannot selectively put a lid on certain emotions and not others. When we squelch "undesirable" emotions, all feelings get squelched. Squelching anger also squelches spontaneity and joy. Reason alone is not meant to be our master. That is not how we are built as human beings.

The whole goal of meaningful psychotherapy is the integration of head and heart, helping the patient to find balance and harmony and become more whole.

Preoccupations of OCP

Everyone's personality style, despite the DSM portrayal, is defined by certain predominant psychological themes and preoccupations. It's not about healthy vs. pathological, it's about the recurring themes and patterns in our lives.

In OCP, the predominant unconscious theme is around being in control versus being controlled. They are caught in an internal conflict around submitting to others' expectations and demands versus defying them. On one side of the conflict is submission to someone else's control, following the rules, deferring to authority. This leads to feelings of humiliation and rage. On the other side of the conflict is defiance, experienced unconsciously as destructive aggression. This

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leads to fear of retaliation and punishment and accompanying anxiety and guilt. Both sets of feelings are frightening and unacceptable.

As a result, their personalities are organized around constricting and avoiding emotion, which is when the observable features come into play. Their emphasis on logic and reason is less a conscious choice than a psychological defense against something that feels intolerable. This is why when you ask how they feel, they will instead tell you what they think—often with a detailed logical analysis. This is why one theorist referred to people with obsessive-compulsive personalities as “living machines.”

The Role of Psychotherapy in OCP

The goal of psychotherapy is not to change who someone is as a person, but to help them become a more mature, flexible, freer version of themselves. When someone is so occupied with what “makes sense” that they lose access to their needs, wants, and desires, that is not healthy. A psychologically freer person has the capacity to set aside their feelings and desires *as a matter of choice*, in the service of something of greater importance. When choice disappears and setting aside feelings is obligatory, freedom and flexibility are limited. The goal is to loosen defenses and create greater freedom.

In therapy, people on the OCP continuum may appear to be taking the therapist's observations and comments to heart. However, they are often treating the therapist’s observations only as abstract, academic theories to ponder, not connecting it to their personal experience or recognizing it as true for them personally. For example, they may say, “That makes sense,” which sounds like insight, but is very different from saying, “Yes, I recognize that in myself. I feel it.” A skilled therapist will call attention to the difference, helping the patient recognize how “that makes sense” serves to keep things at a safe, intellectualized distance.

Therapists may be tempted to try techniques to get past defenses and resistance and get to the real underlying feelings. But defenses generally operate automatically, outside awareness. Instead of trying to bypass them, it is more useful to help the patient become aware of them and become curious about them. If a patient is building a wall, our best strategy is not to try to climb over or under or around it, or try to bash it down, but to get curious about the wall itself. Why is there a wall just here? Why in this particular spot? How is it constructed? What purpose does it serve? We want to bring the wall-building into the patient’s awareness and enlist their curiosity about it.

For example, a therapist may be tempted to discuss the importance of attuning to bodily sensations and ask them where they feel something in their bodies. That is skipping a step; it’s

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trying to solve a problem before the patient experiences it as a problem. Instead, if the patient describes something and leaves out their feelings about it, we might comment on the omission. For example, the therapist might comment, "I'm getting a good sense of the facts and events, but not what they meant to you." If this doesn't stimulate the patient's curiosity, we might go on to comment, "Perhaps there's a reason you omitted that." We want to bring the pattern into awareness and help the patient to become curious about it.

The Psychiatrist Effect

Many psychiatrists don't practice psychotherapy—they practice medication management. But the meaning of a pill to a patient is not just a pill. Transference is still present. The pill takes on meanings, reflecting how the patient is experiencing the relationship. It will mean different things to different patients. Even if a psychiatrist is practicing only psychopharmacology, they are going to be a lot more effective if they recognize this.

There is a study that highlights the "psychiatrist effect," testing the effectiveness of imipramine vs. a placebo (McKay, 2006). The study showed that the most effective psychiatrists got better results prescribing a placebo than the least effective psychiatrists got prescribing the active medication. In other words, the benefits a patient does or does not get from the medication have a lot to do with how they feel about the doctor—and what about the doctor they are symbolically taking in along with the pill. The psychiatrist effect was actually bigger than the difference between the placebo and the imipramine.

The fallacy at the heart of manualized and evidenced-based therapies is that the effect of specific interventions can somehow be isolated from their relational context.

Transference in OCP

Psychotherapy that leads to meaningful and lasting change ultimately focuses on personality processes, not signs and symptoms in a vacuum. Intellectualization, emotional constriction, lack of spontaneity, inhibitions, anxiety, rumination, power struggles—the features we associate with OCP— cannot be separated from personality. These are things that are woven into the fabric of their personalities and their lives.

Every human's life and mind is organized around certain recurring patterns. Our relational patterns are formed through our earliest attachments and we repeat these patterns in various ways, for better or worse, for the rest of our lives. If the patterns allow joy and meaning, all is well. If they limit us or cause suffering, all is not well. Psychotherapy is also a relationship, and

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patients necessarily bring their relational patterns into the therapy relationship and begin to repeat them. They shape how the patient experiences and responds to the therapist. This is what we call transference.

When a patient attributes motives, intentions, thoughts and feelings to the therapist, they reflect the lenses they bring with them. We count on the patient to bring in these patterns. We want them in the therapy relationship because that's where it is possible to recognize them in a lived, experiential way (in vivo) and understand them. The hope is to find ways to rework them so the patient is not doomed to keep repeating self-limiting or painful patterns for the rest of their lives.

Countertransference in OCP

There is great variability in the way core psychological themes and conflicts manifest themselves in the therapy relationship. One patient may be very submissive and deferential to the therapist, expressing one side of the conflict around control vs. submission; another may be oppositional and argumentative, expressing the other side of the conflict. The same patient may express different sides of the conflict on different occasions.

Countertransference could look like the therapist becoming frustrated and irritated if the patient is overtly oppositional or one-upping them. If the patient is submissive, the therapist may initially fail to notice that the patient is not expressing their own will and agency. Or they may be pleased with the patient’s insights and apparent “progress,” only to realize over time that the insights do not result in any meaningful changes in the patient’s life. Then they may become frustrated with the patient and the treatment.

Harnessing Countertransference

While the instinct may be to ignore countertransferences, this closes down what is possibly the most important channel of communication in the therapy. The three channels of communication are what the patient tells us in words, what they communicate nonverbally, and the countertransference they elicit. We are least trained to pay attention to countertransference (likely to our peril).

In one way or another, the therapist is going to be a part of the conflict around control. The most common reaction from therapists treating patients with OCP is feeling like they are involved in a chess match or a power struggle. The therapy can begin to feel like a standoff. Instead of trying to set that aside and simply offering interventions, a therapist who knows how to think about and use countertransference constructively has other options. One is to make explicit (conscious) that there is something in the relationship that has the quality of a power struggle or standoff—to

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bring it front and center—and invite the patient as a collaborator to think together about why and how this is happening.

It's important for the therapist to attend to what is coming up in the countertransference and consider what is fueling it. In what ways are the therapist's own psychology and relational patterns coming into play? What is the patient's contribution? What are they doing, specifically? What repetitive interactions are getting played between therapist and patient? Then the therapist begins to call attention to repetitive patterns, and invites the patient to reflect on their side of the experience. This opens the door to understanding and insight—and change.

Every personality style has its preoccupations and will illicit countertransferences in the therapists. They are the gateway to understanding what is going on.

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