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Personality Traits and Readiness for Change in Psychotherapy: A Qualitative Study with Young Adult Women

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Abstract: This qualitative phenomenological study explored the relationship between personality traits and psychotherapeutic readiness in young adult women within the Indian context. Semi-structured interviews were conducted with ten participants (eight clients with recent psychotherapy experience and two practicing therapists). Data were analyzed using Reflexive Thematic Analysis, revealing that readiness is not a linear progression through discrete stages but a multidimensional, relational state shaped by personality architecture, family-of-origin dynamics, and the therapeutic alliance. Key findings include: (1) readiness is contingent on relational safety, with therapist warmth, self-disclosure, and humour facilitating engagement; (2) personality-specific barriers intellectualization, hyper-defensiveness, the freeze response, secondary gains, and the "self-aware trap"impede movement from contemplation to action; (3) the therapeutic alliance serves as both container and catalyst, with the 8-12 session mark emerging as a consistent turning point; (4) transformative moments arise from naming defenses, connecting developmental patterns, successful behavioral experiments, and recognizing loss inherent in change; and (5) family roles are directly re-enacted in therapy, with differentiation from enmeshed family systems emerging as necessary for sustained change. The study contributes novel concepts including the threshold model of readiness, the distinction between "won't change" and "can't change" clients, and the phenomenon of family as barrier post-change. Findings underscore the need for systemic awareness in individual treatment and have significant implications for clinical practice with young adult women.

Keywords: *Readiness, Psychotherapy, Personality Traits, Relational Safety, Self Aware Trap, Therapeutic Alliance, Family Roles*

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1. Introduction

1.1 *The Current Scenario of Mental Health in Young Adult Women*

Young adult women's mental health has emerged as a critical focus in global mental health discourse, drawing increasing attention from researchers, policymakers, and clinicians (Cuijpers et al., 2019). This heightened interest stems from the convergence of significant psychological challenges during "emerging adulthood" (18-29 years), a developmental period characterized by identity exploration, instability, and major life transitions (Arnett, 2000). University students and young adults consistently report elevated psychological distress, with anxiety, depression, interpersonal difficulties, and suicidal ideation among the most prevalent concerns (Auerbach et al., 2016; Eisenberg et al., 2013; Ibrahim et al., 2013).

Epidemiological evidence indicates that university students globally experience higher rates of anxiety and depression compared to the general population, with young adult women exhibiting particularly elevated prevalence of internalizing disorders (Auerbach et al., 2018; Liu et al., 2019). The etiology of this distress is multifaceted, stemming from the unique developmental challenges of emerging adulthood compounded by sociocultural pressures related to gender roles, family expectations, and career aspirations (Arnett, 2015; Nelson & Luster, 2015). University counseling services and community mental health resources have expanded to address these growing needs, with demonstrated effectiveness in reducing psychological distress and enhancing well-being (Biasi et al., 2017; Connell et al., 2008; Minami et al., 2009; Murray et al., 2016; Speranza et al., 2021). However, a critical gap persists in understanding the factors that predict successful engagement with and outcomes from therapeutic interventions (Bohart & Wade, 2013; Kazdin, 2007).

1.2 *The Concept of Psychotherapeutic Readiness*

Psychotherapeutic readiness represents a multidimensional and dynamic psychological state that fundamentally determines the trajectory of clinical intervention and the ultimate success of behavioral change in young adult women (Prochaska & DiClemente, 1982; Prochaska & Norcross, 2018). Readiness is not merely the absence of resistance or the presence of motivation; it constitutes a complex negotiation between an individual's stable personality dispositions and the fluid developmental demands of emerging adulthood (Arnett, 2000; Roberts & Mroczek, 2008). For young adult women specifically, this transition involves significant shifts in identity formation, autonomy, and social roles—all anchored in underlying personality architecture.

The clinical significance of readiness is underscored by consistently high dropout rates in outpatient mental health settings, averaging 35.5% across studies (Reinholt et al., 2021;

Swift & Greenberg, 2012). Premature termination—often stemming from insufficient readiness—carries consequences beyond wasted resources, including reinforced beliefs about the futility of help-seeking and heightened resistance to future intervention (Barrett et al., 2008; Zinbarg et al., 2008). Understanding how internal dispositions interact with motivation to seek and sustain therapy is therefore essential for improving clinical outcomes and reducing premature dropout in this vulnerable population.

1.3 *Theoretical Framework: Models of Change and Readiness*

The Transtheoretical Model (TTM), developed by Prochaska and DiClemente (1982), remains the most influential conceptualization of psychological change, identifying five distinct cognitive-behavioral stages: precontemplation, contemplation, preparation, action, and maintenance (DiClemente & Prochaska, 1982; Prochaska & Velicer, 1997). Each stage presents unique challenges requiring stage-matched interventions. The model's predictive validity is substantial—early applications correctly identified 93% of clients who would drop out due to stage-intervention mismatching (Prochaska et al., 1994).

Motivational Interviewing (MI), developed by Miller and Rollnick (1991), is a collaborative, person-centered communication approach designed to strengthen intrinsic motivation for change. Grounded in collaboration, evocation, and autonomy support, MI draws heavily from humanistic traditions (Rogers, 1959; Miller & Rollnick, 2013). Practitioners employ specific techniques—open questions, affirmations, reflections, and summaries—to elicit change talk and resolve ambivalence (Rollnick et al., 2008). Meta-analyses demonstrate MI's efficacy across diverse populations, equivalent or superior to other active treatments (Burke et al., 2003; Hettema et al., 2005; Lundahl et al., 2010).

Self-efficacy, central to Bandura's (1977) Social Cognitive Theory, refers to beliefs in one's capacity to execute behaviors required for specific goals (Bandura, 1997). Four sources of self-efficacy—enactive attainment, vicarious experience, verbal persuasion, and physiological states—are all implicated in therapeutic readiness (Bandura, 1977). Recent research demonstrates that MI-based interventions significantly enhance self-efficacy, predicting improved treatment engagement and outcomes (Wang et al., 2025).

1.4 *Theoretical Framework: Personality Theories*

Psychodynamic theory emphasizes that adult behavior and readiness for change are rooted in unconscious processes and early childhood conflict resolution (Freud, 1923). Defense mechanisms protect the ego from painful realities but can trap individuals in precontemplation (Cramer, 2015; Beutler et al., 2000). Contemporary perspectives identify reflective functioning

and epistemic trust as crucial for therapeutic readiness (Fonagy et al., 2016; Fonagy et al., 2019).

The Five-Factor Model (FFM)—openness, conscientiousness, extraversion, agreeableness, and neuroticism—provides the most widely accepted trait taxonomy (McCrae & Costa, 1987; Costa & McCrae, 1992). The DSM-5-TR Alternative Model for Personality Disorders (AMPD) aligns with the FFM, assessing maladaptive extremes (American Psychiatric Association, 2022; Krueger et al., 2012). Humanistic psychology emphasizes inherent human dignity and the drive toward self-actualization (Maslow, 1954; Rogers, 1951, 1961). Rogers (1957) posited that therapy creates conditions—unconditional positive regard, empathic understanding, congruence—under which authentic selfhood can emerge.

1.5 *Family Systems Theory and Personality Development*

Bowen's (1978) Family Systems Theory conceptualizes the individual as an emotional unit within a relational network (Kerr & Bowen, 1988). Core concepts include differentiation of self—the ability to maintain individuality while remaining emotionally connected. Well-differentiated individuals balance thinking and feeling; poorly differentiated individuals experience emotional fusion, impairing independent thought and action (Bowen, 1978; Skowron & Schmitt, 2003). Johnson et al. (2002) demonstrated that family and parent-child variables explain substantial variance in identity statuses among young adult women: 32% for achieved identity, 45% for foreclosed, 46% for moratorium, and 55% for diffused identity. Differentiation level significantly predicts young women's capacity to engage independently in the action stage of change (Han et al., 2023).

1.6 *Personality, Help-Seeking, and Therapeutic Outcomes*

Anglim et al. (2020) synthesized 48 studies examining personality and help-seeking, revealing dissociation between attitudes and behavior for neuroticism—negative attitudes but increased help-seeking behavior. Bucher et al. (2019) meta-analyzed 67 studies, finding that high conscientiousness and low neuroticism emerged as the most robust predictors of treatment adherence and action stage movement. Successful psychotherapy significantly reduced neuroticism, enhancing readiness to manage future stressors (Roberts et al., 2017).

Rodriguez-Seijas et al. (2019) found that premature treatment discontinuation correlated with higher scores across all PID-5-BF domains except antagonism, with disinhibition and psychoticism doubling early dropout likelihood. Molloy et al. (2018) demonstrated positive correlation between conscientiousness and treatment adherence. Agreeableness positively associated with therapeutic alliance (Bucher et al., 2019).

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1.7 *The Indian Context: Gender, Family, and Mental Health*

Young women in India experience distress within intersecting cultural forces: stigma, gender-based discrimination, patriarchal norms, and limited decision-making autonomy (Bansal et al., 2024; Sharma et al., 2019). Help-seeking is negotiated within families, with fear of being labeled difficult silencing many before they access care (Gupta & Sagar, 2021; Rao et al., 2021). Bansal et al. (2024) identified extraversion and conscientiousness as primary predictors of active coping readiness among Indian young adults. Clinical distress presentation often diverges from Western frameworks, manifesting as somatic complaints rather than verbalized sadness or anxiety (Raguram et al., 2017; Kohrt & Harper, 2021).

1.8 *Research Gaps and Rationale*

Despite extensive quantitative research on trait-readiness correlations (Bucher et al., 2019; Roberts et al., 2017), qualitative exploration of how young adult women subjectively experience psychotherapeutic readiness remains scarce (Gulliver et al., 2010). Personality traits are frequently studied in isolation from family context, neglecting how emotional fusion and differentiation of self-shape the dispositions women bring to therapy (Zinbarg et al., 2008; Levy et al., 2018). A critical gap exists in understanding experiences of young women entering therapy at the initiative of others (Gibson & Cartwright, 2013). Additionally, most studies fail to account for how Indian hierarchical family systems and gender norms influence young women's psychological health (Bansal et al., 2024; Mehrotra & Tripathi, 2021).

1.9 *Research Questions and Objectives*

The research questions examine: (1) how young adult women describe their subjective experience of readiness for change; (2) the perceived relationship between personality traits and movement through stages of change; (3) how childhood family experiences have influenced personality traits; and (4) primary facilitators supporting transition from pre-contemplation to active engagement.

Objectives include: exploring how young women with different personality traits experience readiness; identifying personality-specific internal barriers; examining transformative moments catalyzing readiness; exploring therapeutic alliance experiences; and investigating how childhood family experiences affect personality traits and subsequent readiness for therapeutic change.

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2. Methods

2.1 *Research Design*

This study adopts a phenomenological approach within the qualitative research paradigm, prioritizing the investigation of subjective, lived experiences of participants (Creswell & Poth, 2018; Denzin & Lincoln, 2011). The study draws primarily from the hermeneutical phenomenological tradition, which focuses on interpreting meaning within social and historical contexts (Heidegger, 1927/1962; Gadamer, 1960/1989), requiring the researcher to interpret participants' meaning-making while remaining conscious of their own professional lens through rigorous reflexivity (Berger, 2015; Finlay, 2009). This approach is ideally suited to explore how young women experience readiness, perceive the relationship between personality and therapeutic engagement, and understand how family experiences have shaped their therapeutic journey (Smith et al., 2009; Thapwong et al., 2024).

2.2 *Variables*

This study investigates two primary phenomena: personality traits (adaptive and maladaptive patterns of thinking, feeling, and behaving) and psychotherapeutic readiness (the multidimensional state of preparedness to engage in therapeutic change). These are explored through the intersecting lenses of family-of-origin experiences and the therapeutic alliance, examined as interconnected lived experiences rather than quantifiable variables (Creswell & Poth, 2018; Braun & Clarke, 2021).

2.3 *Sample*

The sample consisted of 12 participants, recruited from young adult women aged 18-29 in the Delhi NCR who have recently completed or have an ongoing course of psychotherapy. Therapists working with this demographic were also interviewed. This sample size is justified by phenomenological guidelines, where smaller samples are justified by depth of data (Morse, 2015; Sandelowski, 1995). Saturation often occurs within the first 12 interviews (Guest et al., 2006; Hennink & Kaiser, 2022). Purposive sampling was employed with inclusion criteria: (a) female gender identity, (b) age 18-29, (c) current or recent psychotherapy experience, and (d) willingness to reflect deeply. Participants were recruited through mental health clinics, university counseling centers, and online mental health communities.

2.4 *Tools*

Data were collected using a semi-structured interview schedule developed for this study based on the five research objectives, exploring psychotherapeutic readiness, personality characteristics, family-of-origin influences, the therapeutic alliance, and transformative

moments. The schedule underwent expert review by three qualitative research and psychotherapy experts to establish content validity.

2.5 *Procedure*

After initial screening, eligible participants were scheduled for in-person or video conferencing interviews lasting 45-90 minutes (average 65 minutes). All interviews were audio-recorded with consent. Prior to participation, informed consent was obtained. Audio recordings were transcribed verbatim, with identifying information removed. Thematic analysis was conducted manually.

2.6 *Thematic Analysis*

Thematic analysis followed the six-phase framework of Reflexive Thematic Analysis (Braun & Clarke, 2006, 2021): familiarization, generating initial codes, organizing codes into themes, reviewing themes, defining themes, and writing up. A reflexive journal documented analytical decisions. Rigor was maintained through ongoing reflexivity (Berger, 2015; Finlay, 2002). Following Lincoln and Guba's (1985) criteria, credibility was ensured through rich participant quotes, dependability through an audit trail, transferability through thick description, and confirmability through reflexive documentation (Braun & Clarke, 2021; Tracy, 2010).

3. Result and Interpretation

The thematic analysis of client and therapist interviews revealed five major themes concerning young adult women's experiences of personality and readiness in psychotherapy. First, safety within the therapeutic relationship emerged as the foundational condition for readiness, with participants describing the need for warmth, non-judgement, and freedom from pressure. As one client stated, "Support se... safe space hai. I feel like I'm back to me" (P10). Second, personality-specific barriers to change were prominently identified, including intellectualization as an outcome of high conscientiousness and openness, excessive self-awareness, perfectionism leading to inconsistency, and people-pleasing habits. Clients reported that these traits, while often adaptive in academic or professional contexts, became obstacles to emotional engagement: "I am a very self aware person. So my therapist usually has a problem with that only, that you're too self aware... the problem is how to change the behaviour" (P1). Third, family-of-origin experiences profoundly shaped both personality development and therapeutic dynamics, with clients describing re-enactment of familial roles within the therapeutic relationship. Fourth, therapeutic alliance functioned as a safety net for exploration, where validation, gentle pacing, and feeling deeply understood facilitated movement from

resistance to readiness. Fifth, turning points in therapy—including homework completion, recognition of defensive patterns, and genuine validation from the therapist—marked the shift where clients began to embrace rather than resist change.

These findings align with and extend existing theoretical frameworks on therapeutic change. The primacy of safety and trust in facilitating readiness corroborates the Transtheoretical Model (Prochaska & DiClemente, 1982), which positions a supportive relational environment as precursor to any stage of change. However, the present findings add nuance by demonstrating how personality traits—particularly high conscientiousness, openness, and self-awareness—can paradoxically function as barriers despite their generally adaptive value. This suggests that for young adult women, intellectualization and perfectionism may serve as culturally sanctioned defences against emotional vulnerability, requiring therapists to address these patterns directly. Furthermore, the re-enactment of family roles within therapy supports psychodynamic conceptualizations of transference while grounding these patterns in the specific sociocultural context of Delhi NCR, where familial expectations around gender, responsibility, and achievement are particularly pronounced. The finding that external accountability through the therapeutic alliance sustains readiness—given the mood-dependent inconsistency many clients reported—extends Self-Determination Theory (Ryan & Deci, 2000) by highlighting how autonomy-supportive yet structured therapeutic relationships can compensate for fluctuating intrinsic motivation. Collectively, these results position personality not as a static barrier but as a fluid, context-responsive phenomenon, and readiness as an emergent state co-constructed within a secure therapeutic alliance that acknowledges familial legacies and cultural pressures.

4. Discussion

The present study aimed to qualitatively explore the relationship between personality traits and psychotherapeutic readiness in young adult women within the Indian context. Findings from ten participants (eight clients and two therapists) reveal a complex, multidimensional portrait of readiness extending beyond linear stage models to encompass relational safety, identity-level barriers, family-of-origin dynamics, and transformative turning points.

4.1 *Readiness as Relational and Threshold-Based*

According to the Transtheoretical Model (TTM), individuals progress through five stages (Prochaska & DiClemente, 1982). However, this study found that readiness depends not merely on cognitive appraisal but on relational safety within the therapeutic dyad. Participants

needed therapists to be like a "friend" (P1), emphasizing horizontal, non-authoritarian connection—aligning with Rogers's (1961) assertion that warmth and unconditional positive regard create conditions for exploration. Therapist self-disclosure facilitated alliance formation (P1, P9), challenging traditional notions of therapeutic neutrality.

The distinction between internally and externally initiated readiness emerged, addressing Gibson and Cartwright's (2013) research gap. Some participants described self-determined agency (P2, P4, P8), while others entered therapy at family insistence (P7). Participant 8's experience of therapy as a "last resort" due to suicidal ideation illustrates Bandura's (1997) self-efficacy theory—suggesting readiness as depletion of self-efficacy, a threshold model emphasizing resource exhaustion rather than insight accumulation. Participants described cyclical engagement patterns, with consistency shattering after 4-5 months (P3, P7), aligning with Prochaska and Norcross's (2001) cyclical nature of change (Miller & Rollnick, 2013).

4.2 *Personality-Specific Barriers*

Extending Bucher et al. (2019), intellectualization emerged as a prominent barrier, with clients delivering emotionally heavy content without "sitting with" feelings (P2, P3, P5). This aligns with Freud's (1949) defence mechanisms. A variation emerged as the "self-aware trap" (P1, P2), where psychological insight created a sense of superiority blocking receptivity—extending Roberts et al.'s (2017) work, suggesting professional identity may complicate therapeutic receptivity. Hyper-defensiveness (P5, P9) coincided with Bowen's (1978) poor differentiation of self (Beutler et al., 2000; Mallia et al., 2024). The freeze response (P8) represents collapse of agency linked to high neuroticism (Bucher et al., 2019; Bandura, 1977; Rodriguez-Seijas et al., 2020). Participant 10 articulated secondary gains—"holding onto it because it helps keep me out of this spotlight"—illuminating avoidance as self-reinforcing (Freud, 1949; Klein, 1957). The implementation gap (P8) highlights the preparation-action juncture (Molloy et al., 2014).

4.3 *Therapeutic Alliance as Catalyst*

Participants emphasized that a deeply warm, secure space is necessary for exploration (P2, P4, P5, P10), aligning with Karver et al. (2018) and Flückiger et al. (2018). Participant 10's description of her therapist's "smile and face" illustrates internalization as secure base (Bowlby, 1988). Therapists emphasized patience with resistance (P9), echoing Miller and Rollnick's (2013) motivational interviewing. The 8-12 session turning point (P5) provides a practical clinical guideline. Paradoxically, fear of dependency emerged (P7), reflecting poor differentiation (Bowen, 1978)—a phenomenon under addressed in alliance literature.

Validation before analysis (P8) aligns with Greenberg's (2002) emotion-focused therapy. Feeling "unseen" illustrated alliance fragility (P1, P5; Beutler et al., 2000).

4.4 *Turning Points: Insight, Action, and Loss*

Insight-oriented turning points included naming defences (P2, P8; Freud, 1923; Steinert et al., 2017) and connecting developmental dots (P8, P10; Bowen, 1978; Perosa & Perosa, 2002). Behavioural experiments created turning points (P1; Bandura, 1977). Journaling as catharsis and grounding techniques (P7, P10) illustrated somatic interventions (Carvalho & Arruda, 2018). Most profound was loss embedded in change: "you lose some people along the way" (P4, P7)—a significant gap in TTM literature focused on benefits without addressing costs.

4.5 *Family Systems and Role Re-enactment*

Diverse family roles emerged—"lead role" (P1), "holding place" (P2), "valued adult with unmet inner child" (P3), "fixer" (P10)—representing differentiation manifestations (Bowen, 1978). Hyper-independence reflected emotional cutoff (P1; Bowen, 1978). Participant 3's split between valued adult and unmet inner child illustrated Winnicott's (1965) false self. Family roles were directly re-enacted in therapy: P1 became helper to therapists, P3 worried about therapist's tiredness, P4 listened more than expressed—representing transference and systemic patterning (Bowen, 1978). Therapists observed family as barrier post-change in collectivist contexts (P9; Bansal et al., 2024). Participant 10 recognized change requires "distancing yourself" to develop Bowen's "I-position."

4.6 *Novel Contributions*

This study offers several novel contributions: (1) a threshold model suggesting readiness may be triggered by resource depletion rather than insight accumulation; (2) the "self-aware trap" identifying how psychological knowledge paradoxically becomes a barrier; (3) the 8-12 session marker as a practical clinical guideline; (4) secondary gains maintaining "invisibility"; (5) the distinction between "won't change" and "can't change" clients; and (6) the need for distance as prerequisite for change, challenging assumptions about seamless integration of therapeutic change into existing family relationships.

4.7 *Limitations and Future Directions*

Limitations include: small sample from Delhi-NCR, most psychology students, limiting transferability; retrospective recall bias; exclusion of family perspectives; female-only sample; need for cross-cultural research on collectivist contexts; need for intervention research testing clinical implications; quantitative development of identified constructs (e.g., "self-aware trap," "implementation gap"); and investigation of the 8-12 session marker across modalities.

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5. Conclusion

This study reveals that readiness is not linear but multidimensional, relational, and dynamic—shaped by personality architecture, family-of-origin patterns, and therapeutic alliance quality. Personality-specific barriers represent protective strategies, not failings. Turning points emerge from naming patterns, connecting developmental dots, behavioural experiments, and mourning loss. The 8-12 session marker offers practical guidance. Family systems theory proves essential for understanding role re-enactment and post-change barriers. As Participant 7 stated, "It's a little bit scary because that you've known for a really long part of yourself... and then suddenly you realise that it's not serving you"—capturing the courage, grief, and hope sustaining therapeutic readiness.

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