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Rapport with Personality Disorders

David Mays, MD PhD

Agenda

- The Problem
- What is the difference between a personality disorder and other mental disorders? How is this a problem with establishing rapport?
- A few personality disorders
- Some modest goals

The Problem

- From ABC News, Oct 10, 2023
- Since it’s launch, the use of the 988 Crisis Hotline has ballooned. As of September 2023, 5,000,000 individuals have used the service and the federal government has invested $1 billion. But in view of this growing demand, 988 services throughout the country are making difficult decisions about “repeat callers.” Restricting services is not ideal, but given the extent of the demand and the limits of staffing, there isn’t another choice.

What is personality?

- "Personality" is a relatively persistent pattern of psychological characteristics that expresses itself automatically in almost every facet of functioning. This pattern emerges from a mix of biological predisposition and experiential learning. Personality traits comprise our distinctive pattern of perceiving, feeling, thinking, and coping. They are "ego-syntonic" - they feel familiar and personal.
- Other mental disorders (anxiety, depression, etc.) are “ego-dystonic” – people feel that something is wrong with “them” and they want to get better.
- In short, a personality disorder is who you feel you are at the moment. A mental disorder is an illness you have acquired.

The Dimensions of Personality

- It is worth emphasizing that all personality traits exist on a continuum. Let's use narcissism as an example. People may be a little narcissistic. Some people may have a personality trait of narcissism. Some people may have a mild narcissistic personality disorder. And some people may have a severe narcissistic personality disorder. And everybody may be more narcissistic in some circumstances and less narcissistic in another.
- The bottom line for DSM-5-TR is that we only diagnose a personality disorder if these traits deviate markedly from the expectations of the culture and lead to distress or impairment.

Personality Disorders: Relationship Disorders

- Personality disorders manifest themselves primarily in relationships with other people. People with personality disorders will seek solutions to their problems through their relationships to others. For example, if a person with narcissistic personality is feeling depressed, that person will try to find relief in a relationship, e.g. find someone who will adore him.
- Each personality disorder has a typical interpersonal pattern that they use to relieve stress.

The Personality Disorder Patterns

- Antisocial: to control/avoid being controlled
- Borderline: to be understood perfectly enough that the emptiness and pain will end
- Narcissistic: to be adored
- Histrionic: to get attention by being attractive/entertaining or by being ill
- Obsessive Compulsive: to follow the rules and avoid blame

The Personality Disorder Patterns

- Avoidant: to avoid being hurt (think social phobia)
- Dependent: to assure love and protection at any personal costs
- Paranoid: to stay safe in a dangerous world
- Schizotypal: agenda is unclear – this is more of a thought disorder than personality disorder (like an “ambulatory schizophrenia”)
- Schizoid: clueless to the world of other people (like an “ambulatory autism”)

Why This Matters.

- If someone with depression calls into a crisis line or seeks help from a mental health professional, it is usually because they want help treating their depression. Or there may be circumstances in the person's life that are exacerbating the symptoms of their depression and they want help with those. Consequently, they are often eager for suggestions from the treater or a referral to agencies that can do something about their circumstances.

Why This Matters

- If someone with a personality disorder calls a crisis line or comes in seeking treatment, they are interested in finding a relationship where they can find help to relieve their distress. You are that relationship. They will be less interested in getting advice or a referral and more interested in talking to you. They may show ”help negation” and other behaviors to divert the conversation from what you believe led to the problem or your thoughts about what they can do to improve how they feel.

Some Examples

- Antisocial Personality Disorder
- Borderline Personality Disorder
- Dependent Personality

Examples

- Here are some scenarios of calls where the caller does not seem to be interested in working with you on problem solving the issues they refer to in their call.
- In other words, something has gone wrong with the interaction.

The Scenario

- This individual phones in to talk to someone about the extreme stress they have been under. The primary problem is that they have been experiencing a lot of anxiety and depression regarding finances, problems with children, and some medical problems related to pain.
- They have been having difficulties at work because they are not sleeping well and they have been using up their sick time.
- Their significant other is “tired of hearing about it all and is not helping out.”
- Their doctor has prescribed a tranquilizer, which helps, but now says that they need to see a mental health person if they are going to continue to need a prescription. They say they don’t have the money or the time to do that.
- They don’t know where else to turn. They admit to feeling suicidal and hopeless at times.

Your Response

- You listen empathically, gathering data. It is your impression that this person is overwhelmed by the situation described and needs
- 1) an ongoing relationship with an advocate that could help with financial guidance
- 2) referral for medication and
- 3) supportive therapy to deal with family issues.
- 4) You believe that the suicidal feelings are best dealt with by active problem solving and are not an emergency concern.
- You present this plan to the client and ask if they think that makes sense, saying you have some places to recommend for them to go for follow-up.

Response 1

- The caller responds with anger, saying this is exactly the sort of run-around that they expected from a crisis line. In an exasperated tone, they explain why none of those things are going to work. They don't need "financial guidance", they need more money. The don't need a referral to another "quack" for medications. They already know what medications work – tranquilizers. They need a prescription without more pressure until their anxiety improves. Finally, family issues are clear enough – they need their significant other to start being supportive instead of being so self-centered and do something for them for a change.
- The caller ends by asking if there is anyone else they can talk to, like a supervisor or someone with more experience.

Notes on Caller 1

- Angry, demeaning, controlling, focused on medication (tranquilizers) and finding the person who can help them get what they want.
- No interest in problem solving or listening to you.
- This is antisocial personality – focused on power and getting what they want.

Antisocial Personality Disorder

DSM-5-TR Definition

- DSM-5-TR describes the core characteristic as a disregard and violation of the rights of others since age 15, indicated by 3 or more of these:
  - Getting arrested
  - Lying
  - Conning
  - Impulsivity
  - Aggression
  - Reckless
  - Irresponsibility
  - No remorse.
- For adults who are simply criminal, we diagnose Adult Antisocial Behavior.

Primary Interpersonal Features

- Control: They are argumentative. They often insist on being right and rarely concede any issue.
- Aggression: Used both as a defense against perceived hostility, and as a means for control.
- Rebelliousness: Contempt toward authority.
- Predatory behaviors: They are quite keenly aware of the feelings of others, using others' weaknesses against them.
- Deceit: They are dishonest often for the sake of dishonesty itself.
- Externalization of blame: They have a strong propensity to blame the victim for being in the wrong place at the wrong time.

The Interpersonal Pattern of the Antisocial Personality

- When stressed, envious, bored, or otherwise uncomfortable, the antisocial personality will engage in an agenda focused on power and control - controlling the interaction, the relationship, and the therapy.
- To the bafflement of other people, they will give up personal comfort and security, money, even personal freedom for the sake of staying in control of whatever strikes them as important at the moment.

Transference and Boundaries

- Individuals with antisocial personality disorder will try to manipulate the therapist into advocating for them at work, in the legal system, etc.
- Problems often arise when a caregiver feels that the client needs special care and a nurturing relationship. As the therapist tries to rescue the client, boundary violations become more inevitable (Gutheil T 2005.)
- It is important to remember that antisocial clients are generally much better at manipulating than therapists are at detecting and managing manipulation. Treaters need to beware of feeling that their client has been treated unfairly and is not understood by other members of the treatment team, the legal system, or family members. Expecting manipulative behaviors and making them as ineffective as possible by communicating well with everyone is essential. It is also important that caregivers understand principles of violence risk assessment and management.

Treatment

- Results for all forms of treatment for antisocial personality disorder are generally dismal. Clients are usually uninterested in treatment. Their dishonesty, sensitivity to power issues, and constant manipulating make them poor candidates for therapy.
- There is little evidence for the efficacy of any medications.
- Other treatments such as milieu therapy, empathy training, self-esteem training, or anger management, are problematic or have not shown any consistent benefit.

Treatment

- There is a spectrum of antisocial clients, however, and some less damaged clients may be able to form a treatment alliance with a caregiver. There is a chance that they can come to feel remorse through developing empathy. They may desire to change their behavior.
- With more entrenched adult antisocial clients, who meet psychopathy criteria with fewer humanizing experiences and more neglectful and abusive histories, most research points to a grim prognosis. It is possible that youth with signs of psychopathy and antisocial tendencies may be better treatment candidates.
- Any worthwhile treatment must include strict limits and no opportunity for deception. Compassion and flexibility in the treater will usually be interpreted as weakness.

Caller Response 2

- The caller is silent for a few moments, and then says in a soft voice that the referrals won't be needed and thanks you for your time. You are alarmed and ask if everything is OK. It takes some prodding, but the caller eventually admits to having decided that there is no solution to the problem but suicide. You go into full suicide prevention mode and the conversation continues. The caller becomes more responsive to you as you ask about feelings. It seems that you are establishing good rapport. But every time you feel like the caller is able to agree to a no self-harm contract and follow-up, something happens – like an ambiguous remark just as you are ready to hang up the phone ("No matter what happens, I want you to know I appreciate what you tried to do for me…") You can't end the conversation like that, and the call goes on.

Notes on Caller #2

- Unnerving and frightening. The quiet voice evokes menace and a commitment to suicide. It arises right as the call is ending, making the phone worker feel manipulated and concerned at the same time. There doesn’t seem to be any way to end the interaction that feels finished or safe.
- This is borderline personality disorder – fearful of ending the call when they do not yet feel better and having the thought of suicide always in the back of their mind.

Borderline Personality Disorder

Clinical Consensus of the Disorder

- Severe emotion dysregulation
- Strong impulsivity
- Social-interpersonal dysfunction

Natural History

- Diagnosis is unstable, improvement over time is the norm (75%). Hospitalization is uncommon after the first few years of illness.
- Most individuals with borderline personality eventually lose the impulse to be self-destructive and suicidal.
- However, complete recovery (good social and vocational functioning, in addition to symptomatic improvement) is difficult to obtain. Engaging in meaningful work is an important part of recovery from borderline personality disorder. Being on disability and having poor health is associated with lack of recovery.

Interpersonal Pattern of the Borderline Personality

- When stressed or anxious or depressed, the person's primary concern is to find someone who can understand them well enough that their sense of misery and isolation will abate. It is a kind of "Golden Fantasy" – by finding the one person who can help them, all of their needs will be met.
- A strong fear of abandonment arises when something seems to disrupt the developing relationship. Abandonment fear is expressed with "rage" as a kind of hostile dependence.

Study Predicting Suicidal Behavior, 6+ years

- Most suicide attempts occurred in the first two years of the study (24.8%)
- The first 12 months: major depressive disorder. Outpatient treatment reduced attempts
- 4 years: illness severity (hospitalizations) predicted suicidal behavior
- 6 years: absence of outpatient treatment, low socioeconomic status predicted suicidal behavior
- All intervals: poor psychosocial and global functioning, family history of suicide predicted suicidal behavior.
- Symptomatic improvement did not prevent poor psychosocial outcomes.
- Borderline personality disorder symptoms did not have any predictive value for suicidal behavior over the long term.

Transference in the World

(Choi-Kane 2022)

- People with BPD appear steady, positive, and receptive to direction and collaboration when they feel connected to others. But they remain sensitive to rejection which makes them probe to try to find real or perceived threats to their relationships.
- When criticism, separation, and disagreement inevitably occur in a relationship, clients enter a more volatile state and express anger or self-injurious behavior. This alienates others and causes real abandonment. When truly alone, feeling worthless and hopeless, these individuals may become more seriously suicidal.

Transference in the World

- People will rally around and reconnect with the individual. Things stabilize. But in the long run this cycle reinforces helplessness and self-destructive behaviors.
- Fluctuating between dependency, hostility, and need for rescue begins to define the individual's interpersonal style.

Boundaries

- The best way to avoid transference and countertransference disasters with a client with borderline personality is to keep very firm boundaries, both physical and verbal.

Psychotherapy

- There is some evidence (low overall certainty) that psychotherapy can be helpful with people who have borderline personality (Stoffers-Winterling J et al.) Whenever a specialized treatment for borderline personality is compared to well-structured general psychiatric treatment, there is no significant difference in outcome. But unfocused and solely supportive treatment is inadequate (Fonagy P et al. 2017.)

Caller Response 3

- The caller is enormously appreciative and says they have written down the recommendations you have given and will work at implementing them immediately. They also express the observation that just talking with someone, namely you, has made a world of difference. They don’t even feel like they need a referral for medication if they just had someone to talk to who could listen like this. They know you are busy and will let you go. But they want to know if they could call tomorrow to let you know how the referrals are working out. It could just be a brief call and it would mean a lot. (Note: you learn that they called the next day trying to find you, even though you explained that it was not possible to have an ongoing relationship with them.)

Notes on Caller #3

- The call seemed to go well and the you are feeling pretty good about how you did. You established great rapport. But the caller is showing a little bit of clingy stubbornness that probably can be easily managed. Probably.
- This is dependent personality.

Dependent Personality Disorder

Demographics and Natural History

- Dependent personality is among the most frequent personality disorders encountered in mental health clinics.
- Incidence is 0.4% with women diagnosed more commonly than men.
- Age and cultural issues are very important in making a diagnosis. Some cultures value passivity and deferential attitudes that could appear “dependent” in a more competitive culture. Dependent personality requires a pervasive pattern of inability to make decisions or show initiative that is far in excess of the usual cultural norms.

Demographics and Natural History

- The course of the disorder is unknown but appears to be chronic. There is some evidence of deterioration over time, with increased isolation and withdrawal, along with increasing anxiety and depression.
- Men with pathological dependence may become extremely jealous and controlling, leading to abuse and even murder of the spouse or partner.
- People with intense dependency needs can function well if they have a supportive environment, good social skills, and are somewhat flexible.
- As with all personality disorders, no diagnosis is made unless the condition leads to clinically significant distress or impairment in important areas of functioning.

Description

- The focus of DSM-5-TR is an excessive need to be taken care of that leads to submissive and clinging behavior.
- Need for attachment: Dependent personalities tend to feel paralyzed when they are alone and need repeated assurances that they will not be abandoned. They need constant guidance and will search for a powerful figure to attach to. Without such a figure, they will appear clingy and helpless.
- Dependency on approval: They exhibit an overwhelming need for social approval and affection, and they are willing to adapt their behavior to please others. They have difficulty initiating projects or working independently. If they are assured that they are being supervised with someone's approval, they can function adequately.

Description of Dependent Personality Disorder

- Submissiveness and feelings of inadequacy: They quickly submit and comply with what others wish, even if the demands are unreasonable. They may tolerate abuse. They are ingratiating and are afraid of expressing disagreement. (There must be other viable options of expressing opinions available to the individual before a diagnosis of dependent personality is made.)
- Pessimism and self-doubt: They tend to belittle their own abilities and take criticism from others as evidence of their worthlessness.
- Dependence does not mean passivity. Dependent individuals may ingratiate themselves, exploit others' guilt, promote themselves, and even intimidate and control others to get their needs met.

Interpersonal Pattern of the Dependent Personality

- The dependent personality believes that they must find a powerful person to take care of them because they are unable to take care of themselves. When an individual with dependent personality disorder feels insecure, lonely, or otherwise distressed they will seek to find someone who will take control.

Transference and Boundary Issues

- Dependent personalities will be friendly and compliant. They will see the therapist as powerful and will be quite content to rely on the therapist to make everything better. Their submissiveness can give the false appearance of a treatment alliance.
- If the therapist assumes a dominant role, which the client desires, a very pathological co-dependency can develop.
- These clients are rejected for therapy more than any other disorders because of their transparent wish for unconditional, continuous care.

Treatment

- There is no research regarding medications, although an antidepressant could be tried if there are significant symptoms of depression.
- Clients are likely to stay in therapy since they place no value on independence or initiative.
- The task of giving up dependency is a long slow process. Self-esteem is built bit by bit.
- Clients need to learn to differentiate from others, which is an alien concept for them.
- Group therapy, with a mix of support and confrontation, may be useful.

Coda: The Endless Call

Long Calls

- There are a few principles to keep in mind when a phone call does not end when you think it should.
- 1) It is a well-known observation that the first complaint mentioned at a doctor’s visit is often not the thing that the patient is most concerned about.
- 2) Different people have different abilities to articulate what is bothering them.
- 3) Often a skillful interviewer (you!) can help people develop a new insight into what is wrong and thus a new avenue to explore
- 4) Talking to an empathic person is a pleasant and rare experience and people don’t want it to end.

The Process

- For those calls that go on and on and don’t fit any of the previous categories, the issue is usually that the caller is seeking a solution to their problems other than what has been talked about. This is often someone with a personality disorder seeking relief by acting on their unconscious patterns.
- In general, these patterns will not be effective in dealing with their crisis (or else they wouldn’t have called you.) The caller will try harder to make these patterns work. The call will continue.
- At this point, you will need to get off the line since nothing is being accomplished and nothing is likely to be accomplished except exhaustion in you, the caller, or both. This is how most of these calls end – with exhaustion. You can’t do this. You will get burned out.

Finding Closure

- You must find closure for yourself and not expect that the caller will accept your decision that it is time to stop the call. This is hard for all of us. But it is not the caller's job to recognize that the call is not achieving anything. It is your job.
- You must have a sense of what your job is and have the ability to assess the steps you have taken in every call.
  - Have you been a good listener?
  - Have you given the caller an opportunity to speak?
  - Have you done a good risk assessment?
  - Is your plan a reasonable one and one that the caller can follow?
  - Have you asked for and listened to feedback about how the caller feels about the interaction?
  - Have you taken a moment to consider what you may have missed?

Saying Goodbye

- If you have done all those things, it is time to say goodbye. Here are some ways to soften the termination of the call:
- 1) Explain that you have reached the end of any useful help that you can provide
- 2) Ask if the caller has any final questions.
- 3) Let them know that you care about what happens to them and you believe they have the resilience to deal with these very difficult feelings.
- 4) Thank them for reaching out and calling.

Documentation

- Yes.

A Few Modest Goals

- The primary purpose of this training is to suggest that some people who come in for help are not interested in your help in managing their problem. They are solely interested in their own solution, which involves a certain kind of interaction with you. Many of these callers have personality disorders.
- Since these individuals are unlikely to be satisfied with your usual repertoire of ideas for crisis situations, you are likely to feel frustrated by the visit or call since nothing is being accomplished and you don’t feel like you are getting anywhere.

A Few Modest Goals

- I recommend that you evaluate your performance on the quality of your assessment and your ability to be a compassionate listener. In short, look at your process (what you do) rather than the outcome (how happy the visitor is with you), which is something we have little control over.
- For people with personality disorders, your goal for them is personality restructuring, but rather some anxiety relief and reassurance. Do not let yourself be dragged into endless hours of interaction because the person wants more from you. There is often no end point for someone who is looking for a particular interaction with you as their treatment. Set limits. Explain that this service is by definition time-limited, and there are other options for them if they need a different kind of help than you can give, e.g. an emergency room.

A Few Modest Goals

- No one expects you to become a diagnostic genius. Understanding people with complex problems requires hours of in-person contact and a treatment contract that goes way beyond a crisis call. In addition, suicidal behavior is very anxiety producing for everyone and requires the implementation of a consistent protocol for risk management purposes.
- When personality issues cloud the interaction, it is always useful to have a basic understanding of what is happening. With patience, you can learn over time which responses from you are helpful and which are not.