Approaches to the therapeutic relationship in patients with personality disorders

AUTHORS: Andrew Skodol, MD, Donna Bender, PhD
SECTION EDITOR: Murray B Stein, MD, MPH
DEPUTY EDITOR: Michael Friedman, MD

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Literature review current through: **Oct 2023.**
This topic last updated: **Oct 28, 2022.**

INTRODUCTION

The relationship between a clinician and a patient in psychotherapy plays a central role in alleviating symptoms and fostering character change [1]. The treatment relationship can be a potentially powerful vehicle for patient improvement, as it can provide a supportive environment for exploration and because issues that come up in this context can be processed in a very immediate and instructive way.

The importance of establishing and maintaining a productive therapeutic relationship requires the clinician to consider the personality style and personality psychopathology of each patient. Personality fundamentally affects interpersonal relations, and personality pathology is always associated with significant interpersonal impairment in areas such as empathy and intimacy [2]. The therapeutic alliance, a measurable conceptualization of the therapist-patient relationship, is one of the most robust predictors of outcome in psychotherapy [3-7]. Personality difficulties can significantly affect the alliance, contributing to ruptures that must be attended to carefully [8].

This topic describes common treatment issues, problems, and opportunities in the clinician-patient therapeutic relationship for patients with personality pathology. Establishing and maintaining a therapeutic relationship in psychiatric practice are described separately. The epidemiology, clinical manifestations, diagnosis, and treatment of specific personality disorders are also discussed separately.

- (See "Overview of the therapeutic relationship in psychiatric practice".)
- (See "Overview of personality disorders".)
- (See "Antisocial personality disorder: Epidemiology, clinical manifestations, course, and diagnosis".)
- (See "Antisocial personality disorder: Treatment overview".)
- (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis".)
- (See "Borderline personality disorder: Psychotherapy".)

PERSONALITY DISORDERS AND TRAITS

Whether or not a patient meets full criteria for a specific American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR) personality disorder, knowledge of their personality traits and patterns of personality functioning are critical for building and maintaining a therapeutic relationship.

Studies have shown that the quality of a patient's interpersonal relationships in general significantly affects the building and nature of the therapeutic relationship [9-11]. We consider an individual's characteristic way of relating, in determining the appropriate interventions that can effectively retain and involve the patient in the treatment. Forming a relationship with a patient is often difficult, however, particularly in work with patients with severely narcissistic, borderline, or paranoid personality characteristics, because troubled interpersonal attitudes and behaviors will affect the patient's engagement with the therapist.

Across personality types and traits, clinicians can expect to have emotional reactions and thoughts that must be carefully monitored and understood to protect the alliance and choose interventions [12]. A systematic review of studies (comprising over 1100 patient participants total) investigated the relationship of patient personality and therapists' subjective experience. Patients with eccentric or odd presentations evoked therapist feelings of disconnection and distance; patients with emotional dysregulation evoked a feeling of anxiety or incompetence, and anxious and withdrawn patients tended to elicit sympathy and concern [13].

With more difficult patients, typical clinician feelings of being overwhelmed, disorganized, helpless, and frustrated can be mitigated if ongoing attention is given to understanding and managing experiences engendered by the treatment relationship [14]. It is essential to attend to one's "mentalizing" capacity, the ability to think about the mental states of yourself and others as patients with personality challenges may be impaired in this regard [15].

We attempt to determine which aspects of a patient's personality pathology are dominant at intake and reassess the patient's personality status at various points over the course of treatment. The nature of the relationship established early in the treatment is most powerfully predictive of outcome [16]. A meta-analysis of 153 studies of the relationship of the role of the therapist in determining treatment alliance and outcome demonstrated that clinicians' contributions to the quality of the alliance significantly predicted the level of patient improvement, including accounting for the presence of personality disorder. The authors cited work supporting such factors as: hope and positive expectations; warmth, acceptance, and understanding; empathy; and rupture-repair responsiveness as some of the most important therapist attributes [17]. Another study including 173 outpatients confirmed the importance of therapist attunement and attending to the quality of the alliance across the course of treatment, as fluctuations in the working alliance predict changes in level of psychological functioning [18].

Patients with complex needs are also more likely to drop out of treatment. In a study of long-term psychotherapy with a group of patients with borderline personality disorder, for example, therapist ratings of the therapeutic alliance six weeks into treatment predicted subsequent dropouts [19]. In a clinical trial of 180 subject with borderline personality disorder treated over one year with dialectical behavior therapy compared to general psychiatric management, poor therapeutic alliance was one of the strongest predictors of premature drop-out [20]. A table (table 1) summarizes tendencies of patients with each DSM-5-TR personality disorder that may challenge early alliance-building, as well as aspects of the personality type through which a clinician might engage the patient.

DSM-5-TR PERSONALITY CLUSTERS

Diagnostic clusters of DSM-5-TR personality disorders are useful in considering issues related to the therapeutic relationship [21]. However, increasing evidence suggests that the DSM categories and clusters do not adequately capture the complexity of character pathology traits and symptoms. Patients often meet criteria for two or more personality disorders, perhaps spanning different clusters, such as the co-occurrence of schizotypal personality disorder with borderline personality disorder or borderline personality disorder with avoidant personality disorder [22], or a patient may not meet full criteria for any one disorder, but has prominent features associated with one or several personality disorders. Personality and personality pathology are often viewed dimensionally.

Cluster A — Cluster A, the so-called odd-eccentric cluster, is comprised of schizotypal, schizoid, and paranoid personality disorders. Most relevant for building a therapeutic relationship is the

profound impairment in the capacity to form interpersonal relationships associated with these disorders. Because of pronounced mistrust or interpersonal discomfort or withdrawal, people with characteristics of these personality disorders often do not seek treatment unless dealing with acute problems such as a substance use disorder. For those who do seek treatment, there is evidence that these patients have great difficulty establishing a therapeutic relationship [23].

Schizotypal — Individuals with schizotypal personality disorder often have one or no significant others outside family members; thus, it is often assumed that they have no desire to become involved in relationships. However, in many cases, these patients may be excruciatingly uncomfortable around people rather than lacking interest in social connection. Social discomfort may not be readily apparent; establishing a relationship with such patients may require being attentive to unspoken issues. The therapist may be a participant in some elaborate fantasy that makes it difficult for the patient to find some minimum level of comfort.

A study assessed how 201 patients with different personality disorders reported thinking about their therapists, finding that patients with schizotypal personality disorder had the highest level of mental involvement with therapy outside the session [24]. Patients with schizotypal personality disorder scored highly on factors about missing their therapists and wishing for friendship, while simultaneously feeling aggressive or negative toward them. Some members of the schizotypal group described longing fantasies of having the therapist as a romantic partner. (See "Schizotypal personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, and diagnosis".)

Schizoid — Schizoid personality is consistently associated with a lack of desire for intimate human connection [25]. Some people with a schizoid character can appear to live very conventional lives on the surface, eg, having families and jobs. However, they keep other people at an emotional distance. A pronounced lack of feelings of conflict, with associated affective coldness or dullness may be present, such that a schizoid person is unlikely to become anxious or depressed and, thus, often lacks motivation to seek treatment. Underlying the apparent detachment may be intense neediness for others and the capability to respond interpersonally to a few carefully selected people [26]. Patients who have more awareness of their interpersonal needs have a greater likelihood of forming a relationship in therapy, if they choose to seek treatment. (See "Overview of personality disorders", section on 'Schizoid'.)

Paranoid — Individuals with paranoia personality disorder are incessantly alert for threats and see threats where others do not, ie, they are vigilant for perceived slights, finding offense in even the most benign remarks or circumstances. Challenges to building a therapeutic relationship are pronounced, since a therapist will inevitably say or do something that provokes such an interpersonally sensitive patient. However, paranoid individuals are often defending an

extremely fragile self-concept and may possibly be reached over time in treatment with an approach that includes unwavering affirmation and careful handling of the many possible ruptures [25]. (See "Overview of personality disorders", section on 'Paranoid'.)

Cluster B — The "dramatic" cluster includes borderline, narcissistic, histrionic, and antisocial personality disorders. Each of these character styles is associated in some way with testing and pushing the limits of the treatment relationship, and great care is needed by clinicians to avoid crossing appropriate boundaries in a quest to build a relationship. Many Cluster B patients present the most daunting challenges to maintaining a therapeutic relationship. The associated impulsivity, and emotional dysregulation and lability, have been shown to correlate with higher intensity alliance ruptures, such as pronounced confrontation or withdrawal behaviors [27]. The tendency to engage with others in a sadomasochistic manner (eg, power struggles, provocative behavior, self-harm gestures) is common with Cluster B type pathology and poses particular perils for the treatment relationship. Strains and ruptures in the therapeutic relationship are quite common in patients with these disorders, and must be handled with skill, tact, and empathy. If negotiated effectively by the therapist, these challenges to treatment can serve to strengthen the relationship and deepen patients' self-knowledge [28].

Moreover, patients with Cluster B personality pathology are sometimes treated in an inpatient setting, which involves several mental professionals who need to carefully collaborate to deliver appropriate care. A large study of 3406 patients with Cluster B personality disorders examined the relationship between the working alliance of the inpatient treatment team and effects on depressive symptoms. Traits associated with borderline personality disorder were significantly associated with lower working alliance scores. Improved team alliance across treatment predicted lower depression scores at discharge, with patients feeling heard, connected, and sharing goals with the team as important factors [29]. Similarly, patients with complex needs may end up using emergency resources. A meta-analysis demonstrated the crucial importance of training and supporting staff in these emergency departments to provide interventions that are collaborative between patients and caregivers, with clear communications, and an optimistic attitude [30]. (See "Collaboration between prescribing physicians and psychotherapists in mental health care".)

Borderline — Individuals with borderline personality disorder do not develop the ability to integrate the ubiquitous strengths and weakness of themselves and of others, but rather create "splits" in their mind to protect good images from bad [31]. Splitting leads to a poorly developed and integrated self-concept and identity problems. Building a therapeutic relationship can be difficult because patients frequently exhibit pronounced emotional upheaval, self-destructive acting-out, and views of the therapist that alternate between idealization and denigration.

Within relationships, borderline individuals are very needy and demanding, often straining the boundaries of the treatment relationship and exerting pressure on clinicians to behave in ways they normally would not.

Research has demonstrated that these pressures can impair the clinician's ability to reflect on their own mental states and those of the patient [32]. Clinicians who work with borderline patients must be able to tolerate and productively discuss anger and aggression directed at them. However, because borderline patients, in most cases, desperately seek interpersonal relationships, engagement in treatment is often possible.

In a study of patients with borderline personality disorder treated with psychodynamic psychotherapy, a strong alliance and good treatment outcome were linked to a solid commitment by the therapist to remain engaged in treatment until the patient had made significant gains. Additionally, special emphasis was placed on facilitating the patients' expression of aggression and rage without fear of retaliation [33-35]. (See "Borderline personality disorder: Epidemiology, pathogenesis, clinical features, course, assessment, and diagnosis" and "Borderline personality disorder: Psychotherapy".)

Narcissistic — Individuals with narcissistic personality disorder have a fundamental deficit in the ability to regulate self-esteem without resorting to strategies of overcompensation or over-reliance on admiration by others [36]. Narcissistically vulnerable individuals have difficulty maintaining a cohesive sense of self because of overwhelming shame, resulting from a sense that they fundamentally fall short of an internal ideal self. These patients may have hidden compensation strategies reflected in a private sense of entitlement to being seen as special. Constant reinforcement from others is sought to bolster fragile self-images. When this internal dynamic manifests as excessive self-effacement and social reticence, it is referred to alternatively as vulnerable, deflated, or covert narcissism. (See "Narcissistic personality disorder: Epidemiology, pathogenesis, clinical manifestations, course, assessment, and diagnosis".)

Alternatively, people who are behaving in obviously grandiose and entitled ways (those who might meet criteria for DSM-5-TR narcissistic personality disorder) are said to exhibit grandiose or overt narcissism. Greater emphasis may be placed on attempting to maintain self-esteem through omnipotent fantasies and by defeating others. Personal belief centers on the notion that they are perfect, and so love and admiration will be received from other "ideal people," and there is no need to associate with inferiors. In its most extreme form, this manifestation of character pathology is referred to as malignant narcissism [37].

Narcissistic personality traits pose significant challenges in building a therapeutic relationship. The patient will need to not allow the therapist to voice anything that represents an alternative

view to that of the patient's. For narcissistic patients, other people, including the therapist, do not exist as separate individuals, but merely to gratify their needs. The clinician must tolerate this degree of vulnerability and self-protection, sometimes for a lengthy period of time before trust develops [38].

Histrionic — A patient with a histrionic personality needs to be the center of attention and may behave in seductive ways in an attempt to keep the clinician entertained and engaged. Emotional expression is often shallow or greatly exaggerated. Individuals with histrionic personality disorder, assume a deep connection has been made with the therapist and dependence can develop very quickly. They have very little tolerance for frustration, resulting in demands for immediate gratification. Attention-seeking attributes can be helpful in establishing a preliminary therapeutic relationship. However, as with patients with borderline pathology, the clinician must be prepared to manage escalating demands and dramatic acting-out. (See "Overview of personality disorders", section on 'Histrionic'.)

Antisocial — Antisocial personality disorder is associated with ongoing violation of society's norms, manifested in such behaviors as theft, intimidation, violence, or making a living in an illegal fashion (eg, by fraud or selling drugs). People with antisocial personality disorder have little or no regard for the welfare of others. This personality disorder is found extensively among inmates within the prison system.

Gradations in the severity of the antisocial style are associated with different treatment outcomes [39]. Milder forms are more amenable to treatment; however, patients at the more severe end of the antisocial spectrum are not generally successful in treatment. These individuals are sadistic and manipulative, pathological liars, show no empathy, compassion, or remorse for hurting others, and take no responsibility for their actions. Those who are additionally violent are the most difficult to engage in treatment. (See "Antisocial personality disorder: Epidemiology, clinical manifestations, course, and diagnosis" and "Antisocial personality disorder: Treatment overview".)

Empirical evidence shows that some antisocial patients are capable of forming a treatment alliance resulting in positive outcomes [40]. However, there is a risk of developing a "pseudoalliance" with an antisocial patient. The patient may act as if a relationship existed to gain certain advantages, particularly within an institutional context (eg, in a hospital or prison) [41]. Individuals may profess disingenuously to have increased their self-understanding and pretend to move toward reform as an attempt to manipulate the therapist into recommending inappropriate dispensations or privileges. Therapists who work with these types of individuals must maintain vigilance, self-reflection and a healthy skepticism so as not to be charmed or

misled into thinking the patient has suddenly and miraculously changed, or into agreeing to inappropriate arrangements.

Sadomasochistic character — While sadomasochism is not a distinct personality disorder in DSM-5-TR, sadomasochistic tendencies are most dramatically overt in patients with borderline, narcissistic, and/or antisocial personalities, although this pattern can be found across the spectrum of personality disorder pathology. Sadomasochistic interpersonal patterns are characteristic ways of engaging others in a struggle in which one party is suffering at the hands of the other. Patients with a sadomasochistic approach to relationships often subtly sabotage treatment in an attempt to punish the therapist.

A patient may seem at times to agree with a therapist's observations, but actually experiences them as verbal assaults, while masochistically suffering in silence and showing no improvement in treatment. Behavior may be highly provocative, attempting to "bait" the therapist into saying negative things. Acting out in apparently punishing ways may be common, such as attempting suicide using a newly prescribed medication when it seemed as though the treatment was progressing.

Trauma in the form of a loss of a parent, loss of love as a result of abuse or neglect, or the experience of loss of the self due a severe childhood illness, may underlie sadomasochistic tendencies [42]. From this perspective, the cruel behavior of the sadist may be an attempt to punish the other person (in this case, a therapist) for threatened abandonment. The masochistic stance entails loving someone who treats them poorly, because suffering is seen as the only way of maintaining a connection [43]. Sadism and masochism always co-exist in individuals, and may alternate in ascendance or present simultaneously. As an example, someone may be submissive and long-suffering (masochistic), but at the same time use that passivity to control and undermine a significant other (sadism).

To maintain a relationship with a patient with a sadomasochistic interpersonal style, the therapist must constantly assess whether "attacks" represent a rupture in the therapeutic relationship that needs to be addressed or simply a need to give voice to tremendous anger. In the instances where the relationship appears to be in jeopardy, the therapist should discuss the patient's reaction to the therapist's interventions, acknowledging their distress and telling them that the therapist would reflect on what had led them to make the offending comments. The therapist must withstand being portrayed as bad or incompetent in the patient's mind without retaliating as though it were true.

Cluster C — The "anxious/fearful" cluster is comprised of dependent, avoidant, and obsessive-compulsive personality disorders. Patients with Cluster C disorders are emotionally inhibited

and averse to interpersonal conflict and are often considered to be the most treatable on the spectrum of personality disorders. These patients frequently feel very guilty and internalize blame for situations even when it is clear there is none. Building a therapeutic relationship is more easily facilitated because these patients are somewhat more capable and willing to take responsibility for their problems and more readily engage in a dialogue with the therapist to try to solve them, compared with patients with more severe Cluster A or B disorders [39]. The inhibited agency of some of these patients leads them to behave in a passive-aggressive manner rather than confront situations directly.

Dependent — Fearing abandonment, dependent patients tend to be passive, submissive, and in need of constant reassurance. They go to great lengths not to offend others, even at great emotional expense, agreeing with others' opinions when they really do not, or volunteering to do unsavory things to stay in someone's good graces. There is some empirical evidence, however, that these tendencies can contribute positively to alliance-building [44]. Indeed, in the context of treatment, dependent patients are easily engaged, at least superficially, but they may withhold a great deal of personal information for fear of alienating or offending the therapist in some way.

One difficulty in working in psychotherapy with such patients is the reinforcement gained by the patient's behavior. That is, because passivity and submissiveness usually result in being taken care of, dependent patients are loath to see the value in asserting independence. Patients with dependent personalities assume that they are actually incapable of functioning independently and that being assertive will be experienced by others as alienating aggressiveness. A therapist must be alert to the potential for the patient to withdraw emotionally and psychologically (such as withholding information) which is a typical manifestation of strain or rupture with this type of pathology. Additional challenges to the therapeutic relationship may occur when the therapist attempts to encourage more independence. (See "Overview of personality disorders", section on 'Dependent'.)

Avoidant — The avoidant individual is interpersonally sensitive, afraid of being criticized, and constantly concerned about saying or doing something foolish or humiliating. In spite of an intense desire to connect with others, an avoidant person does not let anyone get close unless absolutely sure of being liked. Because of this acute sensitivity, avoidant patients can be difficult to retain in treatment. A study of 38 patients receiving a short-term supportive-expressive psychotherapy found that patients with avoidant personality disorder were significantly more likely to drop out compared to patients with obsessive-compulsive personality disorder [45]. Clinicians who work with patients with avoidant personality disorder need to be constantly mindful of the potentially shaming effects of certain comments that are taken as criticisms, but

can also work with the patient's underlying desire for attachment to enlist them in building a relationship. The latter has been supported by a study demonstrating a positive correlation between alliance and an avoidant personality prototype [44]. (See "Overview of personality disorders", section on 'Avoidant'.)

At least some patients diagnosed with avoidant personality disorder are actually better characterized as vulnerable narcissists. These patients covertly crave admiration to bolster their fragile self-esteem and secretly or unconsciously feel entitled to it, rather than simply being afraid of not being liked or accepted [46]. This style has been referred to as hypervigilant narcissism, emphasizing extreme interpersonal sensitivity, other-directedness, and shame proneness [41]. Unrecognized narcissism in avoidant personality disorder has significant treatment implications, as described above in the treatment of narcissistic personality disorder. (See 'Narcissistic' above.)

Avoidant personality disorder is frequently seen as very similar to and/or co-occurring with social anxiety disorder. However, individuals with avoidant personality disorder are typically more broadly and severely impaired [47]. In avoidant personality disorder, the hypersensitivity to social evaluation is associated with a core belief that the self is inferior. It is important to understand underlying self, interpersonal and emotional schemas to optimize treatment alliance and effective interventions [48]. (See "Social anxiety disorder in adults: Epidemiology, clinical features, assessment, and diagnosis".)

Obsessive-compulsive — The obsessive-compulsive character is associated with more stable interpersonal relationships than some other personality styles, but individuals with this style are often unaware of their emotions, have very limited ways of functioning in the world, and deny interpersonal and psychological conflicts [49]. Self-willed and obstinate, with attention to rules and regulations, people with obsessive-compulsive attributes guard against meaningful consideration of their motives toward others.

Maintaining control over internal experience and the external world is a top priority, so rigidity is often a hallmark of this character type. Except in its most severe manifestations, obsessive-compulsive character pathology is less impairing than some of the others, and more readily ameliorated by treatment. Although stubborn and controlling and averse to considering emotional content, obsessive-compulsive individuals also generally try to be "good patients" and so can be engaged in a constructive therapeutic relationship that is less problematic compared with other types of personality disorder patients.

Obsessive-compulsive personality disorder (OCPD) is distinct from obsessive-compulsive disorder (OCD), an anxiety disorder [50]. In contrast to OCPD, described above, OCD is

manifested by the patient's experience of obsessive thoughts and compulsive behaviors. There is only modest co-occurrence between OCPD and OCD. (See "Obsessive-compulsive disorder in adults: Epidemiology, clinical features, and diagnosis".)

Passive-aggressive — The passive-aggressive (negativistic) personality disorder diagnosis was initially included in Cluster C [51], but shifted to disorders needing further study in DSM-IV [52], and deleted altogether in DSM-5. In our experience, we find this diagnosis to be clinically useful [53]. Like sadomasochism, passive-aggressive tendencies may be present across many personality disorder types.

Passive-aggressive traits include argumentativeness, scorning authority, resistance to carrying out social and occupational responsibilities, angry pessimism, alternating between defiance and contrition, envy, and exaggerated complaints about personal misfortune. These attributes pose challenges to the formation of an effective therapeutic relationship because these patients are likely to expect that the treatment holds no promise of helping, and they behave in ways that contribute to that outcome. It is important for the clinician to tolerate these difficult stances and help the patient to explore and understand why they may be engaging in such behaviors, whether it be because of discomfort with self-assertion due to fear of rejection or punishment, or perhaps as a means of trying to protect one's autonomy through thwarting others.

THERAPEUTIC ALLIANCE

Instruments for assessing the therapeutic alliance, initially developed for clinical research, can also be useful clinically. A commonly used valid instrument for assessing the therapeutic alliance is the Working Alliance Inventory (WAI), which consists of either 36 or 12 (short-form) self-report items measuring therapist and patient agreement on the goals for therapy (the "goals"), how to achieve those goals (the "tasks"), and quality of the therapist-patient relationship (the "bond") (table 2) [6,7].

SUMMARY AND RECOMMENDATIONS

- **Personality disorders and traits** – Patients entering psychotherapy should be assessed for personality style, pathology, or disorder. Individuals with personality disorders will manifest disturbed patterns of interpersonal relations that can have a deleterious effect on the therapeutic relationship if not skillfully and empathically addressed by the therapist. (See 'Personality disorders and traits' above.)

- **Cluster A** – Individuals with schizotypal, schizoid, and paranoid personality disorders (Cluster A) often do not readily seek treatment unless dealing with acute problems such as a substance use disorder. For those who do seek treatment, there is evidence that these patients have great difficulty establishing a therapeutic relationship, although some do desire connection. (See 'Cluster A' above.)

- **Cluster B** – Borderline, narcissistic, histrionic, and antisocial personality disorders (Cluster B) are each associated with testing and pushing the limits of the treatment relationship. Clinicians need to take great care to manage alliance ruptures and avoid crossing appropriate boundaries in a quest to build a relationship. Many patients with Cluster B disorders present the most daunting challenges to maintaining a therapeutic relationship, but also manifest relationship seeking that can aid in the clinical work. (See 'Cluster B' above and "Overview of the therapeutic relationship in psychiatric practice", section on 'Boundary crossings and violations'.)

- **Cluster C** – Building a therapeutic relationship with patients with dependent, avoidant, and obsessive-compulsive personality disorders (Cluster C) is facilitated because these patients are willing to take responsibility for their problems and more readily engage in a dialogue with the therapist to try to solve them in comparison to patients with more severe Cluster A or B disorders. (See 'Cluster C' above.)

Topic 16980 Version 17.0

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