Helping People With Personality Disorders on a Crisis Line

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Disclosure

- Dr. Mays is not on any drug advisory boards, paid for doing drug research, or otherwise employed, funded, or consciously influenced by the pharmaceutical industry or any other corporate entity.
- No off-label uses of medications will be discussed unless mentioned in the handout and by the presenter.
- No funny business.

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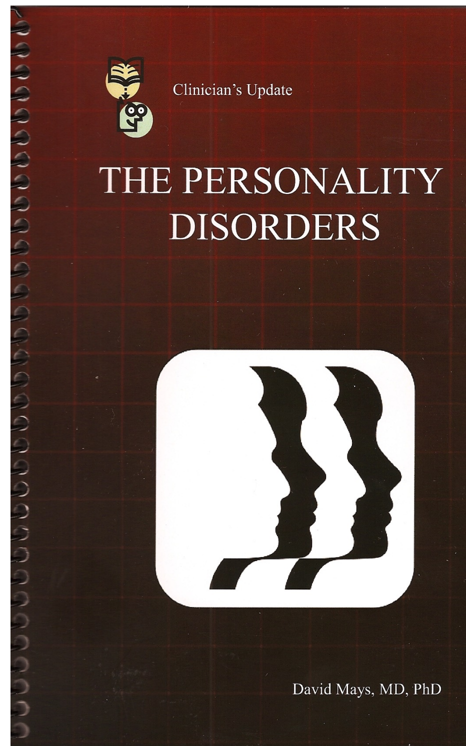
Personality Disorders e-Book: The Personality Disorders



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Agenda

- What is the difference between a personality disorder and other mental disorders? How is this a problem for crisis intervention?
- Borderline personality disorder
- Dependent personality disorder
- Histrionic personality disorder
- Issues related to gender and sexual identity
- Persistent suicidal behavior versus acute suicidal behavior
- Some modest goals

Pre-emptive Apology

- Everybody is different. Every illness is different.
- Everything is a matter of degree.
- Most people have mixes of different personality traits.
- No one approach works for everyone.
- There are different points of view regarding personality disorders.
- You were trained by somebody who said something different.
- I'm sorry. I didn't mean to.
- I don't know everything.

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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 are. A mental disorder is an illness you have acquired.

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Definition of Personality Disorder

- A personality disorder is an enduring pattern of inner experience and behavior that
- 1) deviates markedly from the expectations of the individual's culture
- 2) is pervasive and inflexible
- 3) has an onset in adolescence or early adulthood
- 4) is stable over time
- 5) leads to distress or impairment

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Personality Disorders: Relationship Disorders

- People with personality disorders usually do not believe there is anything wrong with them. If they have difficulties in life, it is because of other people. 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. I call this their “agenda.” 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 agenda that they use to relieve stress.

The Personality Disorder Agendas

- 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 Agendas

- 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 a mental disorder calls into a crisis line, it is usually because they believe their condition needs treatment and they want help. Or there may be circumstances in the person's life that are exacerbating the symptoms of their illness and they want help with those. Consequently, they are often eager for a referral to an agency or another professional where they can get help.
- If someone with a personality disorder calls into a crisis line, they are interested in finding a relationship where they can act out their agenda to help relieve their distress. You are that relationship. They will be less interested in getting a referral and more interested in talking to you. They may show "help negation" and other behaviors to divert the conversation from what you are suggesting to what they want.

Borderline Personality Disorder

Description of the Disorder

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

Behavioral Description

- Interpersonal problems
  - Turbulence, fear of abandonment, self-esteem dependent on important others
- Affective instability
  - Reactivity, intense negative emotions, pervasive dysphoria
- Behavioral difficulties
  - Impulsive, self-destructive, addictions, recklessness
- Cognitive problems
  - Lack of stable sense of self, psychosis and dissociation
- Comorbidity
  - Substance abuse, impulse control disorders, mood disorders, eating disorders, anxiety disorders, PTSD, ADHD

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Natural History

- The 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 get a life worth living, find a place in the world, and stop wanting to die.
- 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 Agenda of the Borderline Personality

- The person’s primary concern is to find someone who can understand them perfectly enough so that their sense of isolation will abate and their misery will stop. 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.

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Borderline Depression vs. Major Depression

- Borderline Personality Disorder depression is usually seen in the context of interpersonal relationship.
- It involves affects and behaviors that include emptiness, loneliness, fears of abandonment, self-condemnation in interpersonal situations leading to impulsive and self-destructive behaviors. The mood often shifts, hour to hour, depending on interactions and stressors.
- Antidepressants do not ameliorate these feelings. Patients with major depression and borderline personality may improve in their vegetative symptoms of depression with treatment, but continue to have dysphoria, emptiness, and loneliness. Depression scales will continue to identify them as depressed.

Bipolar Disorder and Borderline Personality Disorder Mood Swings

- Borderline personality differs from bipolar II in that euphoria is rare, and the shift in mood is usually from depression to anger.
- Mood shifts in bipolar disorder are relatively insensitive to the environment and are internally driven. By contrast, mood shifts in borderline personality are highly sensitive to environmental cues and interpersonal stressors.
- Mood stabilizers treat bipolar disorder, but at best, reduce aggression and calm affect in borderline personality – a non-specific effect.

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Some Reasons for Self-Injurious Behavior

- Affect regulation
  - Reconnection with the body
  - Calming the body during periods of arousal
  - Validating inner pain
  - Avoiding suicide
- Communication
  - Express things which cannot be said out loud
- Control/punishment
  - Trauma re-enactment
  - Bargaining and magical thinking
  - Self-control/manipulation

Self-Injurious Behavior in Borderline Personality

- SIB is reported by 43-78% of clients with borderline personality.
- The act of self-injury usually includes little overt suicidal ideation, but the probability of suicide is increased 2x in the future in a person who self-injures.
- Clinicians and family members see self-harm as manipulative (about us), but borderline personality clients see the acts as an attempt to control their inner experience (about them.)

Suicide and Borderline Personality

- BPD is the only DSM disorder that includes recurrent suicidal behavior as a criteria of the disorder.
- 75% of these clients will attempt suicide with an average of 3 attempts per person. 6% will die of suicide.
- Most attempts occur early in the 20's, but most deaths will happen later in the illness (mean age of 37).

Treatment Traps of Borderline Personality

(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 the relationship.
- When criticism, separation, and disagreement inevitably occur in a relationship, they 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.

Treatment Traps of Borderline Personality

- 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

- Clients will consciously and unconsciously manipulate to get what they think they need. The sense of entitlement can lead caregivers to grant favors and cross boundaries that they normally would not.
- Impulsivity may precipitate caregivers having to act immediately with phone calls, extended sessions, etc.
- The traumatic history may bring out rescue fantasies fed by the borderline client's idealizing transference.

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. Resist the temptation to believe that you are the only person who can help this caller because you are the only person who has truly listened to them.

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Common Ingredients of Successful Therapies (Paris 2008)

- Emphasize getting a life in the present – a job, going to school, having a relationship, etc
- Manage emotional dysregulation – learn and label feelings, then modify them through mindfulness, distress tolerance, problem solving
- Deal with impulsivity – use behavioral analysis, teaching patients to slow down before reacting
- Manage bad interpersonal relationships – get patients to broaden their sources of satisfaction and support

Hospitalization

- Borderline personality disorder is the predominant personality disorder on inpatient services. Hospitalization is useful for clients who are acutely suicidal or destabilized, but hospitalization should rarely be used for self-injurious behavior and does not decrease the risk for future suicide attempts in chronically suicidal people.
- Hospitalization usually results in regression in borderline clients (e.g., renewed and intransigent focus on their internal life and misery.)

"Just to be on the safe side, I'm putting both of us in the hospital."

Dependent Personality Disorder

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Description of Dependent Personality

- DSM-5-TR: 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

- 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 available to the individual before a diagnosis of dependent personality is made.)
- Pessimism and self-doubt: They tend to belittle their 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.

Description of Dependent Personality Disorder

- One of the problems with diagnosis is the threshold for clinical significance. For traits to become diagnosed as a disorder there must be significant impairment or distress. People can make choices to subordinate themselves without pathology.
- Also, in dependent personality disorder, the lack of confidence is not the significant feature, but the pathological use of relationships to deal with the deficiency.

Interpersonal Agenda of the Dependent Personality

- The dependent personality believes that they must be taken care of by a powerful person because they are unable to take care of themselves.

Transference and Boundary Issues

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Transference and Boundary Issues

- Dependent personalities will be friendly and compliant. They will see the caregiver as powerful and will be quite content to rely on the them to make everything better. Their submissiveness can give the false appearance of a treatment alliance.
- If the caregiver 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

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.

Histrionic Personality Disorder

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Description

- Dramatic and superficial emotionality
  - Initially impressive with their ease of expression
- Need to be the center of attention
  - While they are entertaining, they don't limit their performance to appropriate situations and will do something dramatic to get attention if they feel ignored
- Sexual provocation
  - Charming and flirtatious, a tease
- Impressionistic and vague cognitive style
  - Little interest in details
  - Emotions may appear superficial and inauthentic
- Lack of meaningful relationships

Description

- Lack of meaningful relationships
  - The histrionic personality usually fails in having sustained relationships. Their relationships are characterized by social dominance: “warm” dominance (attention seeking, exhibitionistic) or “cold” dominance (arrogant, haughty.)
- Depression and boredom
  - Depression and anger may result when the individual is not getting the attention that they want. They also may crave novelty and get bored with their usual routine or long-term relationships. They do not delay gratification well.

Interpersonal Agenda of Histrionic Personality

- The histrionic personality needs to be noticed and catered to and believes that if he/she is seen as attractive, or entertaining, or sickly enough, that need will be met. There is a strong fear of being ignored.

Treatment

CRISIS CENTER

CHENEY

Individual Psychotherapy

- Histrionic personality clients are relationship seeking and respond to warmth, so they are easy to engage. However, they have an unfocused, vague cognitive style which makes cognitive work difficult.

Treatment

- Group therapy is useful if the client is not too dramatic.
- There is no evidence for the efficacy of any medication.

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Gender and Sexual Identity

- Transgender and nonbinary (TNB) youths are disproportionately burdened by poor mental health outcomes owing to decreased social support and increased stigma and discrimination. (JAMA Network Open, 2/25/22.) More than half of transgender students who are "out" (publicly open about their transgender status) in K-12 school experience verbal harassment. One in 4 experience a physical attack, and more than 1 in 10 are sexually assaulted.
- As a result of these painful and traumatic experiences, 39% of trans individuals report experiencing severe psychological distress. By comparison, only 5% of the general U.S. population report this type of distress.

More Personality Disorders in Transgender Individuals? *Int J Env Res Pub Health* 17(5) March 2020

- In one study of 87 people in a clinic to undergo gender affirming treatment, 50% met the criteria for at least one personality disorder, with borderline personality being the most frequent diagnosis. However, this result depended on the kind of personality assessment used. In addition, it is noted that maladaptive personality traits may evolve as a way of coping with the stresses of gender dysphoria, e.g. using social isolation, self-injury, grandiose fantasies.

- But keep in mind that in someone with personality identity issues (e.g. borderline personality), difficulty with sexual identity would probably also be present. So it's complicated…

Acute vs. Ongoing Suicidality

- Suicide may be a behavior that emerges from a life crisis and mental condition (depression), or it can be an adaptation to life in general - a kind of lifestyle. In this case, the suicidal behavior is persistent, resistant, and self-defeating. This is usually what we see in personality disorders.
- Mental health interventions for these two patterns are very different, in the same way that interventions for pneumonia (acute) and diabetes (ongoing) are different.

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Repetitive Suicidal Behavior

- Frequent attempters' profile
  - Female>male
  - Younger (<44 years old)
  - No racial distinctions
  - Impulsive
  - Personality disordered

Repetitive Suicidal Behavior

- The more suicidal precautions one introduces, the more these individuals tend to regress – i.e. show more dependent, maladaptive, manipulative behavior.
- Since repetitively suicidal individuals show suicidal behavior in response to a wide array of stresses, the job of the caregiver is to broaden the range of choices available to them. ("You are so focused on suicide that you have forgotten about other choices. Let's talk about why suicide seems so appealing when you knew at one time there were better choices available.")
- A crisis service is not an appropriate way to manage persistent suicidality. Implementing a treatment plan usually requires a team approach, including clinicians, ER doctors, and law enforcement to prevent emergency detentions.

Repetitive Suicidal Behavior

- The client will often resist being part of a plan, so the caregiver needs to be flexible, patient, and persuasive, which is difficult when the patient is driving the treatment through fear.
- Nonetheless, these clients may be at risk for eventual death by suicide and the clinician needs to guard against burnout, numbness, anger at feeling manipulated – by using consultation and a team approach.

A Few Modest Goals

- The primary purpose of this training is to suggest that some people who call into crisis phone lines 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 (their agenda). Many of these callers have personality disorders.
- Since these callers are unlikely to be satisfied with your usual repertoire of ideas for crisis situations, you are likely to feel frustrated by the 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, regardless of the personality characteristics of the caller. In short, look at your process (what you do) rather than the outcome (how happy the caller is with you), which is something we have little control over.
- For people with personality disorders, your goal is not treatment but rather some anxiety relief and reassurance. Do not let yourself be dragged into endless hours of interaction because the caller wants more from you. There is often no end point for a caller 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 crisis 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.