Transcript: Crisis Line Response: Helping People with Personality Disorders

Presenter: David Mays, MD, PhD
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JEN WINSLOW: Good morning, everyone. We're just going to take a quick minute and let folks get into the room. And we'll be starting momentarily.

Well, again, welcome, everyone, to today's webinar, Crisis Line Response-- Helping People with Personality Disorders, with our presenter, David Mays.

JEN WINSLOW: This webinar is cosponsored by the Great Lakes MHTTC and SAMHSA. The Great Lakes ATTC, MHTTC, and PTTC are funded by SAMHSA under the following cooperative agreements.

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A few housekeeping items. If you are having any technical issues, please individually message me, Jen Winslow, or Alyssa Chwala in the chat section at the bottom of your screen, and we will be happy to assist you. If you have any questions for the speaker, please put them in the Q&A section on your Zoom toolbar.

If captions or live transcript would be helpful, please use your Zoom toolbar to enable them by going into the More section. Select Captions and Show Captions. At the end of this session, you will be automatically redirected to a very brief survey. Certificates of attendance will be sent out via email to all who attended the full session. This can take up to two weeks. The recording and presentation materials will be available on the Great Lakes MHTTC website within a week.

And I want to welcome our presenter, David Mays. Dr. David Mays is a licensed physician in the state of Wisconsin, where he is a clinical adjunct assistant professor in the University of Wisconsin Department of Psychiatry. He is board certified by the American Board of Psychiatry and Neurology and is a Distinguished Life Fellow of the American Psychiatric Association. He is also a member of the Wisconsin Psychiatric Association.

Dr. Mays has received the Distinguished Service Award from the Alliance on Mental Illness in Dane County, the Exemplary Psychiatrist Award from the National Alliance on Mental Illness, the Exceptional Performance Award from the Wisconsin Health and Family Services, the Outstanding Professional Award from the Wisconsin Association on Alcohol and Other Drug Abuse, and the Outstanding Mental Health Professional Award from the Wisconsin National Alliance on Mental Illness. Again, welcome everyone. And I'll turn it over to you.

DAVID MAYS: Hello. I'm pleased to be here. And I just was listening to those wonderful things about myself. And I wanted to let you know that whenever you hear a speaker and someone introduces them and they're reading wonderful things, it's because the speaker sent them that stuff.

So it's just me boasting about all this stuff that I did because Jen didn't know any of that stuff. She said, send me a bio. So I sent a bio, and that's what it sounds like. You should know that about every speaker, that the wonderful things that you're hearing about them is because that's what they wanted you to hear. And that's all I have to say. That's my mea culpa.

So what I want to do is get started right away because we don't have a lot of time. And I'm going to share my screen with you. And we're going to go and talk about personality disorders.

So let me get the picture of me off my screen so I don't have to see that. And here it is, personality disorders. And we're going to talk about how dealing with personality disorders on a crisis line is different than dealing with other kinds of callers that you may be more educated about.

Now, my disclosure. This is the opposite side of the introduction that you just heard. I'm not on any drug advisory boards. I don't have anything that I know of that is a conflict of interest. So no funny business here. It's all just straight brilliance. I'm kidding.

You will get a personality disorders e-book that I have compiled. It's really an evidence-based and evidence-structured look at personality disorders. And you can go through that in your leisure time if you want to know more about personality disorders.

Normally, when I teach a class on personality disorders, it's-- well, I just did one for the university that's going to be asynchronous learning. It's going to be online, and it's 10 hours. But we're going to truncate that a little bit for this one. You don't have to sit here for 10 hours, and neither do I.

But we're going to hit the highlights. And we'll start with what the difference is between a personality disorder and other mental disorders. And we'll talk about how this could be a problem if you're answering phones for a crisis intervention hotline.

And then we'll talk specifically about borderline, dependent, and histrionic personality disorders. We'll touch briefly on gender and sexual identity issues. And then we'll talk a little bit more about persistent suicidal behavior versus acute suicidal behavior. And then I'll offer you some modest goals.

This is a part of a two-part presentation. The second part will be determined in large degree by you because I want to gear that based on your questions and your concerns that don't get answered today. But first, I'll start with an apology.

Everyone is different. Every illness is different. Everything is a matter of degree. You can have a little bit of personality disorder. You can have a lot of it. And there's a wide range of different presentations. Most people have mixes of different personality traits. There is not one approach that works for everyone. There are different points of view regarding what personality disorders are. You were all trained by somebody who said something different than I said. And I'm sorry, and I didn't mean to. And I don't know everything. I think that probably covers all of my apologies for today.

Let's start with what personality disorder is. And as you have questions, please submit them in the Question and Answer, and I will get a look at those before we're done. Personality is a persistent pattern of psychological characteristics that expresses itself automatically. You don't think about your personality. You just are your personality. The way you ask questions, the way you think about things, the way you interact with other people, the way you respond to news events, your interests, how you feel when you wake up in the morning, and all that kind of stuff-- it's all personality. It expresses itself in almost every facet of functioning.

And it's a pattern that comes from a mix of your biological predispositions. It's what you inherit from your parents. And that then interacts with experiential learning, what happens to you.

So you get these things mixing together. And as a result, we have a group of personality traits. Personality traits are ego-syntonic. They feel familiar, and they feel personal. In short, it feels like you.

There are other mental disorders, like anxiety and depression, where it doesn't feel like you. You feel like something's wrong with you. You will go to a therapist or a doctor and say, I don't want to feel this way anymore. This isn't who I am. I want to get rid of it. I want to go back to the way I used to be.

So that's called ego-dystonic. It doesn't fit with how we think about ourselves. Personality disorders are ego-syntonic. It's us. And the other illnesses that happen, they're ego-dystonic. We want to get rid of them. In short, a personality disorder is who you are. And a mental disorder is an illness that you've acquired.

The definition in DSM of personality disorder is that it's an enduring pattern of inner experience that deviates markedly from the expectations of the culture. So when we talk about a personality being disordered, it's because it is-- this is strange behavior in our culture.

It's pervasive and inflexible. So people behave the same way, whether they're in court or whether they're having drinks with friends or whether they're interviewing for a job. These things come out. They're inflexible. It has an onset in adolescence or early adulthood. It's stable over time, and it leads to distress or impairment.

This definition is not a very good definition. I'll point out one thing that you can notice right away, is imagine that this definition was not a personality disorder but was instead of a chronic depression or a bipolar disorder or even schizophrenia. You would find that it was really-- the definition works.

So there's nothing particularly distinctive about this definition of any other mental disorder. And that's why DSM really made an effort to try to change it in the most recent version of the Diagnostic and Statistical Manual. But it was, of course, controversial. No one could agree. And so they end up not doing anything.

Now, what I would like to emphasize today-- and there's lots of different ways to talk about personality. You can talk about the biological roots. You can talk about what's going on with brain scans and all that. But what I want to talk about is the relationship focus. Personality disorders are really relationship disorders.

People with personality disorders usually do not think there's anything wrong with them. They think if they're having problems in their life, it's because of other people. And if other people would just change, their problems would go away.

Personality disorders manifest themselves primarily in relationships with other people, and people with personality disorders will then seek the solution to their problems through their relationships with others. See how that works? If I think that my problem is because of you and I'm going to try to fix you to solve my problems-- and this is going to all take place in the relationship space.

Now, I call this their agenda. You can call it their transference. You can call it whatever you want. But let's just call it agenda for our purposes today. For instance, if a person with narcissistic personality-- and you all know what that is-- if they're feeling depressed, what's the solution to the problem of their depression?

Well, if I'm feeling depressed in my day-to-day life and I don't have narcissistic personality, I'm going to look for different ways of fixing this. Maybe I need to exercise more. Maybe I need to find some interests. Maybe I need to see a doctor and get an antidepressant. I'm going to look for different solutions, and they'll often be very personal solutions.

If a person with narcissistic personality is feeling depressed, they will try to find relief in a relationship. They'll try to find specifically someone who will adore them, right? I'm depressed. What can I do to get somebody think I'm wonderful?

That's a personality disorder. And with all of the different personality disorders, their solution for feeling bad is to find something in a relationship with someone else that will make them feel better. Now, each personality disorder has a typical interpersonal agenda for dealing with their dysphoria. And here they are.

There's 10 personality disorders. I'm going to go through all 10 of them briefly, and then we'll focus on three in particular who are most likely to call crisis lines. The antisocial personality, to the extent that they feel dysphoric about something, is going to want to try to get in a relationship where they can be in control. They can manage it. And then they can try to get what they want from somebody.

Borderline personality. The borderline personality disorder client wants to be understood perfectly enough-- someone who really gets what they're saying. And when they find that person, then their feelings of emptiness and pain will go away.

The narcissist wants to be adored. The histrionic wants to get attention. It's very important for the histrionic to be the center of attention. And if the histrionic is feeling low or depressed or bored, they'll do something to become the center of attention again. The obsessive-compulsive. If I'm feeling distressed, I want to get everything in order. I want to follow the rules. I want to make sure I'm not in trouble with anybody else. Everybody thinks that I'm doing fine.

The avoidant wants to avoid being hurt. Now, this is a little bit harder to fit into the agenda of solving a problem through relationship. But that's because avoidant really has a very strong overlap with social phobia. And there's some disagreement as to whether or not these two might be variants of the same thing. Social phobia is an anxiety disorder.

Dependent. The dependent person wants to make sure that they're taken care of by somebody because they don't feel like they can take care of themselves. And when they're feeling nervous or anxious, they'll want to find somebody to tell them what to do. Paranoid wants to stay safe in a dangerous world, so make sure that the people around them are kept at a distance.

The schizotypal. The schizotypal personality disorder is a little bit of an outlier. It's more of a thought disorder than a personality disorder. You might think of it as kind of a preschizophrenia, an ambulatory schizophrenia that doesn't really move toward becoming schizophrenic. That's because schizotypal personalities have a lot of magical thinking and odd behaviors and so forth.

And schizoid. Schizoid basically are clueless to the world of other people. They don't see other people in the same way that we do. They don't have a sense of engagement with the world.

They're kind of spiritless. They don't seem to have much zest for living. It's kind of an ambulatory autism. But these are not going to call you on a crisis line, so we don't need to go into too much detail about them.

Now, why am I talking about this? If someone with a mental disorder calls into a crisis line, it's usually because they feel like they've got something that needs to be fixed, and they want help. They need treatment.

Or they've got a systems problem, and they wonder if you can fix it. Or they're feeling out of control. Maybe you can help me feel in control again, and they're looking for help. Or there may be circumstances in their life that are exacerbating the symptoms of their illness, and they want help with that.

So they may want help with themselves, fixing how they feel. Or they may want help with their circumstances to fix those circumstances, which will help how they feel. Consequently, they're often eager for a referral to an agency or another professional where they can find the help that they want.

If someone with a personality disorder calls into a crisis line, they're interested in finding that relationship. Remember, these are people who look to relationships to solve their problem. And they're going to want a relationship. And they're going to want to act out their agenda to help relieve their distress.

In other words, they're not calling for help with their depression. They're calling to talk to you. They're calling to have a relationship with someone answering the phone who, with any luck, they can get to do and say the things that they believe will help them feel better. That's their agenda.

You are that relationship. They are less interested in getting a referral and more interested in talking to you. How do you know that that's happening? Well, one of the things that you may see is help negation.

Everything that you suggest, they say, well, that's not going to work. Or that won't work. Or I tried that. Or yeah, that doesn't work for me. Antidepressants? No, they don't work. Go see a doctor. Ah, I've talked to these people before. They can't help me. Why don't you go for a walk? Ah, taking a walk. That never helps.

They're going to want to stay on the line with you and talk to you. And everything you suggest, basically, they're going to tell you why it doesn't work. They may also have other behaviors that divert the conversation from what you're suggesting and take it back to what they want, which is their agenda in the relationship.

Now, that's the intro. Let me talk about three different personality disorders in a little bit more depth. And we'll try to make this a little bit more relevant for you.

Just before I start on this, someone asked a question about the five-factor dimensional model for personality disorder. I mentioned before that the current definition of

personality disorder is not a very good definition. And some of the things that people have looked for in the new DSM is to try to change that definition.

And they've looked for different models of personality. The five-factor model is one model of personality. It's a model where we believe that we can create anybody's individual personality by mixes of different factors of degrees of openness or degrees of willingness to work with others and that kind of thing.

And there's a lot of good evidence that the five-factor model can capture a lot of personality. So in answer to the question, I think the five-factor or trait model of personality is a promising one. And we'll probably see more of that. But there isn't universal agreement that that's the way to do it. So yeah, so that's the answer to that question.

OK. I'll get this off of here. I can't get-- there we go. OK. So now I want to talk specifically about personality disorders. And we'll talk about borderline. Brief description of borderline personality disorder. This is a personality disorder of severe emotion dysregulation.

So people who have this disorder, one of their characteristics is that they're unable to contain their emotions. They can't self-comfort. They can't look ahead and recognize, oh, I've had this emotion before. I understand that this emotion will be fleeting, or I know where it comes from. Here's what I need to do to fix it.

The emotions are so overwhelming and out of control that the person tends to be swept away by them. Whether it's happiness or whether it's anger or whether it's rage or whether it's anxiety or whether it's self-disgust, whatever it is, imagine-- you've all had all of those feelings to some degree. But imagine that they're really overwhelming. They arrive suddenly, and you can't control them.

Strong impulsivity. So there is an inability to, in some circumstances, to control your desire to act. So you act now, think later. And as a result of emotion dysregulation and impulsivity, there's a lot of social interpersonal dysfunction, as you might imagine. So

basically, people with borderline personality disorder have a lot of trouble maintaining equilibrium in their life.

I want to point out, by the way, that this is-- we're not in the business of judging people with personality disorders. It's really easy to do that because, as I say, these are disorders about who people are. So we tend to blame people with personality disorders more for their behavior than we do someone with schizophrenia or someone with PTSD. And that's because we see it as more their character.

But what I want you to all stand back and understand is our character is not really something that we have designed and implemented and managed. I'm not sitting here as a person who gets all this credit for being the person that I am right now. There is a lot of reasons why I am the way I am. And there are lots of reasons why you are too.

And borderline personality disorder, for your information, has one of the strongest biological determinants of any personality disorder-- that is, it has a very strong degree of heritability. So people with borderline personality disorders aren't to be judged for that.

That doesn't mean that we roll over and let people with borderline personality disorders do whatever they want because it's not their fault. No, we don't do that. On the other hand, we don't judge them for what they're doing either because this is truly a very unpleasant disorder that people would not have if they had a choice. And it's unclear how much choice people have when we're talking about personality.

So what we have is interpersonal problems. Self-esteem depends on other people. Turbulence, fear of abandonment, affective instability. They're reactive. They have intense negative emotions, pervasive dysphoria. They just feel bad.

Behavioral difficulties. They're impulsive and self-destructive. They're prone to get addicted. They're reckless. They've got cognitive problems, lack of a stable sense of self. They can even appear psychotic under stress and dissociate.

And comorbidity. Lots of comorbidity with substance use, impulse control disorders, mood disorders, eating disorders, anxiety disorders, PTSD, ADHD. In short, if anything can go wrong, it will when you've got this degree of emotional instability.

What do we know about natural history? We know that the diagnosis itself is unstable. Now, what I mean by that is going by DSM criteria, which, as you're all familiar with DSM, it's a criteria-based diagnostic system that says if you've got five of these 10 behavioral characteristics, you've got the disorder, right? So that's how we diagnose with DSM.

It is not ideal. It's not even close to ideal, but that's what we've got because what we do in mental health is we go by diagnosing people by syndromes. It's what we can see. We don't have any blood tests or brain scans that we can use to diagnose people, so what we see. And if we see five of these 10 things, we're going to call it borderline personality disorder.

One of those things may go away over time. And now the person no longer meets the criteria for personality disorder. So the diagnosis is gone. But is that really what's happened? Well, not really. What's happened is one thing has changed.

So the research is based on meeting the criteria. And that means the diagnosis is unstable, which means that people no longer meet the diagnosis over a period of time. That's not a true reflection on how they're doing, but it does reflect that some improvement over time is the norm.

And hospitalization is uncommon in borderline personality disorder after the first few years. Most individuals eventually get a life worth living. And they stop wanting to die, and they find their place in the world. So this is not a hopeless diagnosis.

But it is a diagnosis that continues to provide lifelong difficulties, especially in maintaining vocational functioning and good social relationships. And engaging in meaningful work is an important part of the recovery from borderline personality disorder. Being on disability and having poor health is associated with lack of recovery.

So this is a whole topic in and of itself. And I don't want to go there. I'm just drawing a picture for the life of someone with borderline personality disorder and the natural history. There is some improvement over time. People do stop being quite so suicidal. They do learn to manage some of their feelings, but it is a long, hard road.

Now, their agenda is to find someone who will understand how bad they feel. It's a kind of golden fantasy that they find one person who can help them. All their needs will get met, and they will no longer feel miserable. And they will have a strong fear of abandonment when something seems to disrupt the relationship that they thought was going to save them.

And abandonment, then, is expressed as rage. And this is a hostile dependence. Normally, when people are dependent on us, they are nice to us because they don't want us to go away. If they're hostile, they want to avoid us.

But with hostile dependence, you have people who are hostile toward us. But they don't feel like they can lose us because they need us for something. And we have hostile dependence. Hostile dependence is a very characteristic relationship style for someone with borderline personality disorder.

They need you because you are their salvation, but you're not doing your job. How do they know you're not doing your job? Because they still feel bad. If you were doing your job, I wouldn't feel bad anymore. So they become angry at you. But by the same token, they won't leave you alone because they need you for help.

We see hostile dependence not just in borderline personality disorder but also for people in chronic pain. In pain clinics, they're not getting the relief they want. But they can't leave the clinic because they need something. And it develops this hostile dependence.

I want to point out two interesting diagnostic mistakes that people make with borderline personality disorder. The first one is to mistake major depression for borderline depression. Almost everybody with borderline personality disorder experiences

depression. Very seldom is it major depression of the type that we're familiar with in DSM.

Borderline depression is usually seen in the context of interpersonal relationships. A friend doesn't call. They wanted to get to know someone, and they felt rebuffed. They're trying to get their therapist to listen to them. The therapist doesn't. And all of these things then bring about a feeling of depression.

The depression of itself doesn't have a life of its own. It's more likely to be triggered by some sort of interpersonal thing. And it involves moods and behaviors that include emptiness and loneliness and fears of abandonment and self-condemnation in interpersonal situations. And they feel these things. And this often leads to impulsive and self-destructive behaviors.

Significantly, the mood often shifts hour to hour. So people will feel bad, but then an hour later, they'll feel better. Then they'll feel on top of the world. And then they'll be depressed again.

This is a very different picture than what we get with someone who has a major depression, who is depressed all the time. It doesn't matter what the interpersonal interactions are around them. And they don't get any relief from their depression and moods.

And they don't necessarily feel self-condemnation or fears of abandonment. Or they wouldn't necessarily describe feeling empty. They're more likely to describe pain. I feel in pain. This is a painful condition for me.

Now, why is this important? It's important largely for treaters because antidepressants do not treat borderline depression. They do treat major depression, where you've got a lot of vegetative symptoms, poor appetite, poor sleep, poor concentration, and so forth.

If you have a client who has borderline personality disorder and they also have a major depression, which is entirely possible, you can treat them with an antidepressant. Their

vegetative symptoms will get better. But they'll continue to describe themselves as depressed. That just doesn't respond to antidepressants.

So I want you to know that. And I also want you to know that although people with borderline personality disorder complain of mood swings, They do not have bipolar disorder.

Borderline personality disorder often gets confused with bipolar II. Now, bipolar I, you've got full-fledged manic episodes for periods of time. And that usually will be able to distinguish from borderline personality disorder. But bipolar II doesn't have the full-fledged mania.

And borderline personality disorder clients will often describe themselves as having mood swings. Remember, their depression will come and go, hour by hour. Well, that's a mood swing. Well, yes, but it's not what we mean by the mood swings in bipolar disorder.

The mood shifts in borderline personality disorder are usually from depression to anger, not euphoria to depression. And mood shifts in bipolar disorder are relatively insensitive to the environment. But mood shifts in borderline personality disorder, again, are usually related to environmental cues and interpersonal stressors. That's unlike bipolar disorder. This is important because mood stabilizers treat bipolar disorder, but they do not treat borderline personality disorder.

I want to talk briefly about self-injurious behavior. There are lots of reasons why people may hurt themselves. They may want to reconnect with the body or calm the body during periods of arousal. Maybe it's a way of validating inner pain. I've heard many clients say, I cut myself because now I know where it's hurting instead of just hurting vaguely inside.

And sometimes, it's bargaining to prevent suicide. And other times, it's a way of communicating. So look at what I did. I had a client with borderline personality disorder who would go into the restrooms in the clinic before she saw me. And she would wrap her arms in toilet paper and set them on fire.

And she'd come in with these fresh burns on her arm and say, look at this. Look at how I feel, is what she was saying. And it just drove me wild until I finally understood what was going on here. She was trying to let me know something.

Of course, she came in with a very angry affect, saying, you're not helping me. And I'm just going to keep doing this because you're such a terrible, horrible therapist. So it's communication sometimes.

And then it's also trauma re-enactment or magical thinking or self-control. There's lots of different reasons for this. So with borderline personality disorder, almost 3/4 in some studies show that they will engage in self-injurious behavior.

And often, they'll say it's not about killing myself, which is true statistically. But ultimately, the probability of suicide is increased when people self-injure. It's kind of practicing for self-injury, if you will.

Clients and family members see self-harm as manipulative. So you're doing this. You're trying to get me to feel sorry for you or trying to get me to do something for you. But borderline clients will see this as an attempt to control their inner experience. It's about them. So try to think of it that way when you're dealing with this on a crisis line rather than thinking it's manipulating you or manipulating people in their life. It might just be this is the best way they have of dealing with it.

Now, borderline personality disorder is the only DSM disorder that includes suicidal behavior in the criteria. So it is unusual for a person with borderline personality disorder to not try to kill themselves. And there's an average of about three attempts per person.

Some people will die of suicide with borderline personality disorder. So you can by no means discount suicide risk in someone simply because they're diagnosed with borderline personality disorder.

I will tell you that most attempts occur early on in the illness. But most deaths happen later in the illness. Here, the mean age is 37 years old, which is the age that Marilyn

Monroe died of suicide. Most people agree, who have studied her biographies, that she had some degree of borderline personality disorder.

And we see these people who die of suicide as being disconnected from treatment. They've had a long illness of many years, decades of misery, and so forth. So it's a little bit different than the illness of the people who call crisis lines in their teens and 20s.

Now, again, that doesn't mean that you can rely on this statistic to predict the behavior of your individual caller. But it does give you some background about what we know about the illness and suicidal behavior.

How do we treat it? Well, there's some traps that we can fall into that you should be aware of. People with borderline personality disorder appear steady, positive, and receptive to direction and collaboration when they feel connected to others. But they remain sensitive to rejection. And that means that they're always probing, trying to find if there's real or perceived threats to their relationship.

And when criticism or separation or disagreement occur, they enter a more volatile state. They express anger. They will self-injure. This alienates others, who end up really abandoning them. And then when truly alone, feeling worthless and hopeless. This is when the individuals become more seriously suicidal.

Now, here's the trap. At that point, people rally around and reconnect and things stabilize. But in the long run, this cycle of probing for weaknesses in the relationship, alienating people, becoming suicidal, and having people come around again reinforces helplessness and self-destructive behavior.

So we want to avoid this kind of cycling. Fluctuating between dependence, hostility, and need for rescue begins to define the individual's interpersonal style. And this is what the focus is of a lot of treatment of borderline personality.

Boundaries are very important in this relationship, as they all are. And we need to be careful that we don't fall into wanting to having our own rescue fantasies or that we find ourselves responding to a sense of entitlement for the caller, that they need special

care, they need more phone time, they need to know who we are so they can call us when we're working our shift, and so forth.

We need to keep firm and compassionate boundaries, physical and verbal. Resist the temptation to believe that you are the only person who can help this caller because you're the only person who's ever listened to them. And we've all heard that. And we all need to be careful and maintain our professional hat.

The common ingredients of successful therapy. We want to emphasize getting a life in the present for the person, managing the emotional dysregulation, dealing with impulsivity, and manage bad interpersonal relationships.

We try to avoid hospitalization because, in general, hospitalization results in regression-- that is, people do worse when they are hospitalized with borderline personality disorder because they focus on their internal life and misery rather than developing a life. So in the cartoon, "Just to be on the safe side, I'm putting both of us in the hospital." Why not?

OK, that's borderline personality disorder, the most complicated disorder I wanted to talk to today. Let me take a quick look at the questions. There's a thank you. And when-- let's see. "When you're going through the personality disorders, it seems that people can have numerous of these aspects without it being a disorder. When is it a disorder?"

When it reaches a certain threshold of distress. And that's the best answer I can get. It's a very subjective answer, but that's how DSM describes it. You are absolutely right. We've all got some of these traits. And some of us have more than others. But it's only when it really interferes with your life that we call it a disorder.

"There's a movement in psychotherapy to ignore the genetic predisposition, attribute everything to behavior." So this is about borderline personality disorder. Yes, we like to blame the environment. We used to blame mothers for borderline personality disorder, like we blame them for autism. There is a significant genetic component.

So we have to remember that. It is both. It's genetics, vulnerability, and their environmental stresses. And some of the environmental stresses in many of the early aspects of life with borderline personality disorder are extreme. But they are not the only thing. Many people have extreme environmental stresses and do not develop borderline personality disorder.

And so wondering if self-injurious behavior might cause the release of endorphins or oxytocin or so forth. It's possible. I will tell you that our treatments that we've designed to try to block the release of an inner painkiller high that you might get if you cut yourself as reinforcement don't particularly prevent the self-injurious behavior. So I don't think that's the entire picture, but it's probably the picture for some people.

Let me go ahead here and get to dependent personality. As you might imagine, with dependent personality disorder, we have an excessive need to be taken care of, a need for attachment. They tend to feel paralyzed when they're alone. They need repeated reassurance. They need constant guidance.

And they have an overwhelming need for social approval and affection, so much so that they're willing to adapt their behavior to please others. They have difficulty initiating projects or working independently. If they're assured that they're being supervised, they can function quite adequately.

There's submissiveness, feelings of inadequacy. They will quickly comply with what others wish. They may even tolerate abuse. They will be ingratiating, afraid of expressing disagreement. They have self-doubt.

And dependence, by the way, does not mean passivity. Dependent individuals can exploit other people's guilt. They can promote themselves. They can even intimidate and control others to get their needs met.

Now, one of the problems with the diagnosis here is the threshold of clinical significance because a lot of people have different degrees of dependence. And you can certainly make a choice to subordinate yourself without being pathological. The lack of

confidence is not the significant feature in looking at dependent personality. A lot of us lack confidence, especially in certain situations.

But it's the pathological use of relationships to deal with it. I may lack confidence in my ability to do public speaking, but I'm not going to seek out relationships to hold my hand and get me through it. That is more of a dependent stance rather than the problem being lack of confidence. So again, I want to bring this back. These are interpersonal disorders, and that's how they express themselves.

And so the dependent personality disorder wants to be taken care of. They will call a crisis line because they want you to tell them what to do. And that's going to be their primary goal. I need someone to help me find what to do. Oh, this is so good. Can I talk to you again?

They'll be friendly and compliant. And the submissiveness-- when they're taking all your suggestions on the phone, it's going to seem like you've really got a very good treatment alliance with them. But they're going to call back.

If you assume a dominant role with someone who's dependent, you're going to develop a very pathological codependency if you're seeing them for therapy. And the analog with phone services, someone can get dependent on a crisis line. I'm going to call up, and I will get a nice person who will listen to me. And they'll tell me what to do. So that would be the big hazard that we would have with dependent personality.

How do we treat this? Well, we don't really have any good evidence for medications. And it's no problem getting people to stay in therapy or to keep calling because that's what they do. But in fact, what they need to do is to learn to differentiate themselves from other people and develop some assertiveness, for want of a better word. Group therapies can often be useful. You get a mix of support and confrontation.

But for you, what you need to know is that there are some people who are going to call you, who are going to be very easy to talk to, who are going to be quite submissive and agreeable to your suggestions. But they're going to keep coming back because it isn't the suggestions that they want. It isn't autonomy they want.

They want some person or some system to tell them what to do. That is their goal of the call. It's the relationship, the relationship with the agency or the relationship with you, the person who answers.

And finally, histrionic personality disorder. I think you probably know this because you figured out it's related to hysterical. We have dramatic and superficial emotionality. The person needs to be the center of attention.

They don't limit their performance, though, to appropriate situations. They do something dramatic to get attention if they feel ignored. They might call you to get attention from you. And it will be some drama or there'll be something very charming or there will be something very entertaining.

There's little interest in details. People with this disorder often are impressionistic. They have a vague cognitive style. And they don't really tend to have very meaningful relationships in their life.

They usually fail at any sort of sustained relationship. Their relationships are characterized by social dominance-- their warm dominance, which can be attention seeking, or cold dominance, arrogant or haughty. But there's some sort of dominance involved here.

And depression and boredom. They may get depressed and bored when they're not in there getting the attention that they want. They aren't very good at delaying gratification.

The histrionic personality needs to be noticed. And they will do that either by being seen as attractive, if they're on YouTube or Twitter or TikTok, or entertaining or sickly enough. And then they're the center of attention, and that then deals with their fear of being ignored.

So here's the crisis center. This is a typical day-- Monday morning at the crisis center. Or what's today? Wednesday. Wednesday afternoon. This is what you see going on.

Histrionic personality disorders-- the clients are relationship seeking. They respond to warmth. However, they have an unfocused, vague cognitive style. It makes any sort of cognitive work difficult. Group therapy here, again, can be useful if they're not too dramatic. There's no evidence that any medication works.

So those are the three personality disorders, a brief overview of each of them. If you have more of an interest, I'll refer you to my booklet that will tell you more than you want to know about any of the personality disorders in a little bit more depth. But you can get the idea here that when people with these three disorders, for instance, call the crisis line, they're interested in acting out what they want with you rather than hearing any suggestions that you have that might make their life better.

I want to talk just briefly about gender and sexual identity issues. Transgender and nonbinary youths are disproportionately burdened by poor mental health outcomes. And there's lots of reasons for that, but decreased social support and increased stigma and discrimination is no small part of this.

More than half of transgender students who are out in K-12 school experience verbal harassment. And there's physical attacks and sexual assault. And a lot of these people have problems then with severe psychological distress-- 39% of trans individuals compared to 5% of the general US population.

What is the relationship between personality disorders in transgender individuals? This is a somewhat controversial topic because in a way, it feels like we are blaming the victim when we start labeling people with mental illnesses that are going along with the transgender circumstance. And in one study, 87% of people in a clinic to undergo gender-affirming treatment, 50% met the criteria for at least one personality disorder. Borderline personality disorder was the most frequent.

But it turns out that this result depended on the kind of personality disorder assessment that was used-- that is, did you do it by interview? Did you do it by questionnaire? And so forth. And in addition, the authors noted that there was maladaptive personality traits that could clearly have evolved as a way of coping. So you might use self-isolation or self-injury or grandiose fantasies to deal with the sorts of stress that you're dealing with.

So the authors' conclusion here was not that transgender individuals were more likely to have personality disorders because they had personality weaknesses. But rather, there were all sorts of reasons why we may see them. And they may end up labeled with personality disorders.

But we should also keep in mind that in someone with a personality identity issue, like borderline personality, it's not unreasonable to think that identity should also include sexual identity. So can we have transgender individuals or people with sexual identity concerns secondary to the borderline personality disorder, which is their primary diagnosis? Or can we have people who get a borderline diagnosis because they've got a primary gender dysphoria?

The answer is yes, both. And that's why it's complicated. It can go either way. So we probably don't need to get too mixed up in this. But I just want to say I think that the state of diagnosis in the field is it's complicated. How's that for a useful rule of thumb? It's complicated, says Dr. Mays.

A few words about acute versus ongoing suicidality. Suicide can be a behavior that emerges from a life crisis and mental condition, as with depression or a bad anxiety disorder or bad adjustment disorder. Or it can be an adaptation to life in general that is a kind of lifestyle. So whenever anything goes wrong, I'm going to kill myself.

In this case, the suicidal behavior is persistent, resistant, and self-defeating. And this is usually what we see in personality disorders, primarily borderline personality disorder. Suicidality arises at the drop of a hat with people who have developed this as a pattern and a habit.

The mental health interventions for a life-crisis suicide versus a lifestyle suicide are very different. And so I will treat that differently in the clinic in the same way I treat pneumonia, which is an acute illness, differently than I treat diabetes, which is an ongoing illness. And so with borderline personality disorder, the suicidality is an ongoing lifestyle issue that needs to be addressed as part of a treatment plan and dealt with over a period of months and years.

For repetitive suicidal behavior, the profile is different. With suicide deaths, males are preponderant gender over females, sex over females. But for repetitive attempts, it's females more than males.

It's younger. It's no racial distinctions, as opposed to white males being the most likely suicide victims. It's impulsive. And it's personality disordered. So it's a different illness.

For people who have repetitive suicidal behavior, the more precautions one introduces, the more they tend to regress-- that is, they become more dependent, more maladaptive, more manipulative. Since repetitively suicidal individuals show suicidal behavior in response to a wide array of stresses, my job as an ongoing caregiver is to broaden their range of choices.

A crisis service is not an appropriate way to manage persistent ongoing suicidality. Implementing a treatment plan usually requires a team of people on an outpatient basis, including law enforcement, ER doctors-- everything we do to try to prevent hospitalization.

Now, the clients are going to resist being part of the plan, which complicates it all. So the caregiver needs to be flexible and patient and persuasive, which is very difficult when the client is driving the treatment through fear. I'm going to kill myself if you don't do what I want. But you've got to guard against burnout here. And that's what we struggle with primarily in behavioral treatment.

So I'm going to leave you with a few modest goals, and then I'll take a look at some of the questions. And we'll try to get those answered in the next two minutes. The primary purpose of the training is to suggest that some people who call into crisis phone lines are not interested in managing their problem. They're interested in their own solution, which involves an interaction with you.

Since these callers are unlikely to be satisfied with your usual responses for crisis situation, you're likely to feel frustrated since nothing is being accomplished. And you don't feel like you're getting anywhere.

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. 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. But we do have control over getting better and better at what we do, answering these calls.

Your goal is not treatment for personality disorders but at least some anxiety relief and reassurance. Don't get dragged into endless hours of interaction because the caller always wants more from you. There's often no end point for a caller who's looking for a particular interaction with you as their treatment.

Set limits. Explain that the service is, by definition, time limited. And there are other options if they need a different kind of help than you can give, like going to an emergency room.

No one expects you to become a diagnostic genius. Understanding people with these complex problems takes a lot of training and a lot of contact. In addition, suicidal behavior is very anxiety producing for everyone. And you must implement your consistent protocol for risk management.

I do not want anyone to leave this training thinking, oh, borderline clients are not suicidal that I need to worry about. They won't do it. Yes, they will sometimes. So you still do your good suicide risk assessment. But I want you to understand what is happening in some of these interactions. And with patients, understand that you can learn over time which responses are going to be helpful and which are not.

So let me take a quick look at the crisis. How are we, on the crisis, supposed to deal with these people when they call? That's a issue. Do your process. Listen. But do not get dragged into endless conversations.

Have an end point. I think we've reached the end point of how I can help you on the phone. Here are some of your other options, and we'll need to stop now. I think maybe

that's an important kind of basic rule to follow. DBT is a very effective intervention for borderline personality disorder. Someone wants to make sure that they get the booklet.

OK, I have one more closing remark here. And that is that I will be doing a follow-up presentation. The presentation will be based on your feedback from this one. If you have more questions, if you want me to talk more about a certain thing, if you're confused about some of these issues, or there's something I didn't touch on, would you please send that to Jen?

She will send out an email and ask you. Tell me what you'd like to know next time, and we'll do another hour on this. And I'll be glad to be here again. So Jen, I'll turn it over to you. We're already a minute late.

JEN WINSLOW: Thank you so much, Dr. Mays. Just briefly, you will be automatically redirected to that very brief survey right as we close this session. So we appreciate you filling that out.

As David said, we are going to be doing another presentation with him. The registration and info is not open. But we will email you, letting you know when that is. In the meantime, you will receive an email from me that will include the recording, a PDF of the slides, and the booklet. So that will be coming, and more information on how to get me your questions and feedback for his next presentation.

So thank you so much for being here. We appreciate it. We put a link in the chat for a event on December 8 called Crisis Worker Interventions with a DBT Lens. So we hope to see you there. All right, thanks, everyone. Have a great day.