Helping People With Personality Disorders on a Crisis Line
Part 2

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MHTTC Mental Health Technology Transfer Center Network

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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.

Agenda

- Quick review: Personality disorders
- Histrionic personality
- Calls waiting: some examples of call interactions with callers who have personality disorders
- Bringing the interminable call to a close
- Finding closure and saying goodbye

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.

Note

- The process of seeking relief from a specific type of interpersonal interaction is an unconscious one for people with personality disorders. I use the term “agenda” for want of a better word, but as one listener pointed out, the word “agenda” usually implies an intentional plan. For a personality disordered individual, this process is unconscious and habitual. We need to be careful not to blame anybody for their behavior. That accomplishes nothing and demeans the caregiver.

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

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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.

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Histrionic Personality Disorder

History of Histrionic Personality Disorder

- 1892, Freud and Breuer: free association - a new treatment for “hysteria,” (now described as either Histrionic Personality Disorder, Functional Neurological Syndrome Disorder, or Somatic Symptom Disorder)
- DSM II (1968): Hysterical Personality
- DSM III (1980): Histrionic Personality and Somatoform Disorders
- DSM IV (1994) DMS-5 (2013): increased focus on flirtatious type as opposed to somatic type. There is substantial overlap between the two, but the association is puzzling. DSM-5-TR (2022) focuses on the flirtatious version which is more similar to borderline personality than to Freud’s original conception.

Demographics and Natural History

- Prevalence estimated .09% of general population, no geographic distinctions
- Women > Men? May reflect predominance of women in the population who seek healthcare.
- Socio-cultural factors are very important. Sex role stereotypes (southern belles, macho posturing males) mimic the disorder. Distress or impairment must be present for the diagnosis. Also be careful making this diagnosis in contexts where there are strong socialization pressures in competitive groups, e.g., teenagers.

Demographics and Natural History

- Impairment is lower in histrionic personality than in any other personality disorder. Any impairment seems to be interpersonal in nature, especially in romantic relationships. Individuals with this disorder are more likely to get divorced or never marry (DSM-R-TR.) However, the diagnosis is not associated with any disability (Grant B et al. 2004.)
- Little is known about long-term outcome.

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Comorbidity

- Comorbidity with histrionic personality include high rates of somatic symptom disorder, functional neurological symptom disorder, depression, borderline, antisocial, and dependent personality disorders.
- There can be frequent and dramatic suicidal gestures. It is not known whether there is a higher rate of suicide death.

Description

- Dramatic and superficial emotionality
  - These individuals may be initially impressive with their ease of expression.
- Need to be the center of attention
  - When they are being entertaining, they don’t limit their performance to appropriate situations and will do something dramatic to get attention if they feel ignored.
- Sexual provocation
  - They may be charming and flirtatious, a tease.
- Impressionistic and vague cognitive style
  - They have little interest in details.
  - Emotions appear superficial and inauthentic.

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 with long-term relationships. They do not delay gratification very well.

DSM-5-TR Definition Focus

- A pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts.

Interpersonal Agenda of Histrionic Personality

- The histrionic personality wants to be noticed 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.
- When feeling lonely or depressed or uncomfortable, the histrionic personality disordered individual will display this recurrent pattern of behavior in interpersonal relationships.

Differential Diagnosis

- Borderline personalities can be attention seeking, manipulative, and overly emotional, but they also exhibit self-destructiveness, angry disruptions of close relationships, and chronic feelings of emptiness, unlike the histrionic personality. They are not usually theatrical.
- Antisocial personalities are superficial, excitement seeking, reckless, seductive, and manipulative, but do not exaggerate emotionality. Histrionics do not usually engage in criminal activity.

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Differential Diagnosis

- Narcissists crave attention, but also want to be seen as superior. Histrionics are willing to be viewed as fragile or dependent if it gets them nurturance and caring.
- Dependent personalities need others for praise and guidance but are not flamboyant like histrionics.

Individual Psychotherapy

- Histrionic personality disordered 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.
- The therapist needs to constantly keep in mind that the style of this individual needs to be addressed in therapy, not simply enjoyed. The over-emotionality needs to be addressed gently but firmly. The goals of self-reliance and emotional modulation are always kept in the forefront (Benjamin L 2003a.)

Treatment

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

Suggested Movies

- Gone With the Wind
  - Scarlett O'Hara (Vivien Leigh)

Calls Waiting!

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Examples

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

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Call Scenario

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

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Your Response

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

Caller Response 1

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

Notes on Caller 1

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

Caller Response 2

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

Notes on Caller #2

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

Caller Response 3

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

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Notes on Caller #3

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

Caller Response 4

- Your suggestions are met with escalation - more desperation, more descriptions of how terrible everything is, how hopeless and unbearable. They suggest that you have not grasped how bad things are and try to illuminate you. They wonder if they need hospitalization in order to stabilize. Can you arrange that? Every time you try to bring the call to a reasonable end with some confidence that the plan is a good one and that they can get the help they need from your referrals, they insist that their situation is not the typical crisis line problem and they need something more. They can't imagine how they can go on without help.

Notes on Caller #4

- The escalation is sudden and dramatic. You didn’t see it coming and can’t seem to calm it down. All of a sudden, no plan will be accepted but an emergency room visit or hospitalization. The person is certain that you have never worked with someone who had it this bad.
- This is histrionic personality.

Long Calls

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

The Process

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

Finding Closure

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

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Saying Goodbye

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