# Transcript: Crisis Line Response: Helping People with Personality Disorders (Part 2)

**Presenter: David Mays, MD, PhD**

JEN WINSLOW: Good morning, everyone. We're just going to let folks get into the room, and then we will start in just a moment.

Well, welcome again, everyone, to today's webinar-- Crisis Line Response-- Helping People With Personality Disorders, Part 2. This webinar is co-sponsored 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're having any technical issues, please individually message me, Jen Winslow, or Rebecca Buller 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 those in the Q&A section on your Zoom toolbar, rather than the chat section, as that can move quickly.

If captions or live transcript would be helpful, please use your Zoom toolbar by going in the More section. Select Captions, Show Captions. And at the end of the 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 session in full. This can take up to two weeks. The recording and presentation materials will be available on the Great Lakes MHTTC website within the next week.

Our presenter today is Dr. David Mays. Dr. 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 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.

Welcome the outstanding Dr. David Mays.

DAVID MAYS: I know. When will it stop? When will the accolades finally quiet down? I actually, I haven't gotten any awards for any of that stuff for a long time. But I did get a little trophy, because I take piano lessons. And you take piano lessons. And one of the things you have to do is, you play at a recital. Your teacher has a recital. And so there are some-- my teacher has some other adult students. But mostly, it's kids, from six years old through high school. But mostly, it's in that middle range, before the kids quit and don't want to do it anymore. And so none of the other adults play in the recital, just me. So it's always little kids and me. And I got a little trophy for participating in the recital this December. So that's my latest award. I should probably include that so we get something more recent.

Anyway, hello to all of you. It's a pleasure to be back. And I'm going to share my screen with you now, and you will be able to see our plan for the day, which is basically my PowerPoint. You will be getting a copy of this PowerPoint soon after or almost immediately after the presentation, and you will also get a copy of my booklet, which is sent-- will be sent to you electronically. So everything that you could possibly want to refer to related to this presentation and this topic, you're going to get.

So ho ho ho. Merry Christmas. It never stops, and you're going to continue to get your gifts. My disclosure is, I don't have any conflicts of interest that are worth reporting. I don't have any conflicts of interest, period, let alone any that are worth reporting. And here's the booklet, in a real life booklet. But you will get an electronic copy, same material.

And here's what we're going to do today. I looked over your comments and questions and the evaluations. And what I'll do is, I'll start with the quick review of personality disorders. Because really, who can remember what we talked about back in whenever it was, November, December? So I'll do that briefly.

And then several people mentioned that I shortchanged histrionic personality when I was going over the four main personality disorders that you may have some contact with. That's because I did it in about 20 seconds. So I'm going to go over that again to make sure that I say the things that I want to say.

Then we're going to do some examples of calls, some examples of call interactions with callers who have personality disorders, where their personality disorder becomes the primary focus of the call, rather than their chief complaint, rather than the thing that they first said.

We'll talk about how to bring an interminable call to a close. That is, a call that's not getting anywhere and is not accomplishing anything, that really is exhausting, both to the caller and the person answering the phone. And talk about ways of finding closure and saying goodbye at the end of those calls.

So that's the topic for today. And with any luck, I will have time for some questions toward the end, if you're interested. And with no further ado, let's get started.

Now the perspective that I give you in this particular two-hour presentation that we've had-- this is the second hour. Don't panic. This is not two hours today. But is to look at how a personality disorders are relationship disorders, and how they express themselves in the relationship.

There are lots of different ways of looking at personality disorders. You can look at it biologically. You can look at it in terms of phenomenology. That is, how are people feeling? What does it feel like to them? You can come up with speculations regarding etiology, and you can interpret personality disorders in using a framework of any of the different ways of looking at people's behavior, from cognitive behavior to psychoanalytic and all that.

But what I want to focus on when I talk about personality disorders is the interaction, the real time interaction that you have with people, where their personality disorder expresses itself. And people with personality disorders tend to seek solutions to their problems or ways of dealing with their stress through their relationships with others in regularly recurring, unconscious patterns.

Now I call this their agenda, what they work at, what they keep bringing up in relationships. For instance, if a person with narcissistic personality is feeling depressed, they'll try to find relief in a relationship. That is, for the narcissistic personality, someone who will adore him or her or make them feel special. And each personality disorder has a typical interpersonal agenda that they use to relieve stress. So that's the assumption, the framework, the model that I'm using in this talk.

Now it the word agenda-- I don't-- I'm looking for a better word. So you can suggest a better word to me. Agenda implies that it is a conscious, manipulative, intentional kind of behavior for some people. And I don't mean it that way. I mean that it is a process that's unconscious and habitual, but it’s sort of the goal of their interaction with you is to act on what they think they need.

This doesn't-- I'm not saying that that's conscious or that it is, I guess, to use that word, the word manipulative again. It isn't that they're trying to get you to do this, and they're aware of it. It's just, this is kind of what they do. And it's what they do because it's what they've learned and what they believe will bring them relief. And you can think about that in your own life.

You have relationships with people. And when you're feeling down, many of us turn to a significant other or a loved one. And we want reassurance, or we want affirmation, or we want to be told we're right.

We complain about things at work, or we're whining about something. We want someone-- we don't want-- there are times when we don't want to be confronted about that. We want someone to agree with it. We don't necessarily-- we're not aware of this. But we all have these sort of things that we want from people in times of stress. And that's what I'm talking about.

So we need to be careful not to blame anyone for their behavior or to hold them responsible in some immediate way. And that just accomplishes nothing. And it demeans you as the caregiver, and it discounts the person. So that's not what I mean. It's just a way to point at certain recurrent behaviors that people use in order to get to feel better.

And personality disorders do that, and we all do that. But the thing about personality disorders is, they tend to do the same things over and over and over again, and they're not very adaptive. That is, they're not very effective and working most of the time. So that's what we talk about.

And to review the personality disorder agendas, the antisocial wants to control or avoid being controlled. The borderline personality disordered individual wants to be understood enough that the emptiness and pain will end. The narcissist wants to be adored. The histrionic wants to get attention, be the center of attention, either by being attractive and entertaining or by being ill. The obsessive compulsive wants to follow the rules and avoid blame. The avoidant personality she wants to avoid being hurt. It's very much like social phobia. The dependent personality wants to assure love and protection, at any personal costs.

The paranoid wants to stay safe in a dangerous world. Schizotypal and schizoid are sort of outliers for this particular approach, because neither one of them care about other people. And so for schizotypal, it's a little bit more like a mild psychotic disorder, ambulatory schizophrenia. And for the schizoid, it's more like a kind of mild autism. So

other people aren't really involved in their life. But you aren't going to have anyone with schizotypal personality or schizoid call you in crisis anyway. So it isn't anything we need to worry about.

Now why does this matter? It matters because if someone with a mental disorder calls into a crisis line, they will present to you situations that they believe are leading to a crisis, and they're asking you for help. Or it may be that there are circumstances in that person's life that are creating symptoms of an illness, and they want help with those if they already have a pre-existing illness.

And so consequently, they will be open to working with you and listening to your ideas, and will consider and accept referral to other agencies or other professionals who can help them in a more ongoing basis. But if someone with a personality disorder calls a crisis line, they're interested in acting out their agenda or using these unconscious processes to get relief from their distress. That is, they don't really want someone else to help with the problem.

You will do just fine, thank you, if you will simply give them what they need. And what they need depends on what personality disorder they have. So they're less interested in getting a referral, more interested in talking to you. And they may show the behaviors that will divert the conversation from what you're suggesting, that sounds like a reasonable solution to their problems, and instead to getting the kind of interaction and that they want.

So I raced over histrionic personality disorder last time. And let me do that a little bit more mindfully now so that you feel like you've got a better grasp of what that is.

Now histrionic personality disorder was originally hysteria, back in the 1900s-- I'm sorry, the 1800s, the 19th century. And hysteria was the puzzling neurologic illness where people would lose the function of an arm or a leg, or they couldn't speak. And there was no physical cause for that.

And so Freud and Breuer, who were neurologists during that time, tried to come up with ways of treating this disorder. And out of this puzzle came the notion of free association,

where people would talk about what was going on or how they were feeling, and then gradually be able to unencumbered themselves from whatever psychological processes were inhibiting their behaviors. And this becomes psychoanalysis.

Hysteria, in the old days, is now described as either histrionic personality disorder or functional neurologic syndrome disorder. Functional means you've got a disorder, but there's no physical cause other than your mind. Or somatic symptom disorder, which is a focus on physical symptoms.

This evolves through the different DSMs. And right now, in DSM-5, we have an increased focus on the flirtatious type as opposed to somatic type. So cultures change. And as our culture changes, so do the ways that we express ourselves.

So it used to be that people would faint, or they would lose the use of their hands, or something like that. That was somatic. But now, the flirtatious type, the putting on a show type, is more prominent, especially with social media and other kinds of ways people have of getting attention in public.

And the DSM-5-TR, the latest version, focuses on the flirtatious histrionic personality, which is much more similar to borderline personality disorder than Freud's original conception was. So that's kind of where we are with histrionic personality. It's about 0.09% of the general population. No geographic distinctions. Men are diagnosed more--women are diagnosed more than men. But this probably reflects cultural issues more than it does actual incidence of the condition.

And sociocultural factors are very important. Sexual stereotypes, the southern belle, the emotional kind of presentation that you might get with someone who's more emotional, Southern Mediterranean presentation.

So this may be more we may see this more in women in certain cultures. Macho posturing males is the equivalent of that, and we'll see that more in men. But these sexual stereotypes are going to mimic the disorder. But they aren't the disorder. Rather, they're cultural expressions that are appropriate in the certain culture.

Distress or impairment has to be present for the diagnosis for all personality disorders. You don't do it just because you don't like the way someone's behaving. You don't call them, label them with a personality disorder. They have to be suffering or causing distress.

And also, be careful making the diagnosis in contexts where there's strong socialization pressures. In competitive groups like teenagers, teenagers may behave in certain ways in certain hysterical, overemotional ways with friends, because that's what their friends do, and they kind of want to be part of that group. So you'll see that there.

Very low impairment with histrionic personality disorder. It's primarily interpersonal impairment, usually in romantic relationships, where things just become unmanageable for the partner with these overt hysterical displays of emotion.

The diagnosis itself is not associated with any kind of disability, and we don't know much about long term outcome. There's a lot of somatic symptom disorder, functional neurologic symptom disorder. Because these are all related somehow in the expression and feeling of emotion. Remember, this goes back to Freud's hysteria. And this is how hysteria kind of ends up falling into different categories in the 20th century.

So of course, we'll see comorbidity with that. Because we don't really know. We don't have any biological measurements. We can't do a blood test or a brain scan and say, oh yeah. This is more functional neurologic symptom disorder. This is more histrionic personality disorder. We can't do that. So we just have to make guesses.

There's also a comorbidity with depression, with borderline antisocial and dependent personality disorders as well. There can be frequent dramatic suicidal gestures, as you can imagine. But we don't know if there's actually a higher rate of suicide death. So it would seem to be the case that mostly, when histrionic personality disorders make suicide gestures, they are exactly that. It's a gesture for effect. It's a gesture for the drama of it, rather than an actual desire to die.

And so the description is going to be that we have dramatic and superficial emotionality. The person needs to be the center of attention. And there's a time and place to be

entertaining, of course. But they don't limit their performances to appropriate situations, and they'll often do something dramatic to get attention if they feel ignored, no matter what the setting.

They can be quite charming and flirtatious, a tease. They have an impressionistic and vague cognitive style, with little interest in details. The emotions appear superficial and inauthentic. They don't have meaningful relationships. Everybody's their best friend. Everybody, they love everybody. And depression and anger may result when they're not getting the attention that they want. So they may crave novelty. They get bored in routine or with long term relationships. They're not very good at delaying gratification.

So DSM-5-TR defines it primarily as a pervasive pattern of excessive emotionality and intention seeking. So that pretty much captures it. They want to be noticed. They believe if they're seen as attractive or entertaining that need will be met, and there's a strong fear of being ignored. So when they're feeling lonely or depressed or uncomfortable, they want to get attention and be the center of the room.

Differential diagnosis-- borderline personalities can also be attention seeking, manipulative, and overly emotional. But they show self-destructiveness, angry disruptions of relationships, and chronic feelings of emptiness. They are not usually theatrical.

Antisocial personalities are superficial, excitement seeking, reckless, and seductive. But they do not exaggerate emotionality. Histrionics also do not engage in criminal activity. So we can tell those apart.

Narcissists crave attention, but they also want to be seen as superior. Histrionics are willing to be viewed as fragile or dependent if it gets them nurturance and caring. So it's the narcissist who needs to be the best of the best. Histrionics don't need that. They just want to be the center of attention.

Dependent personalities need others for praise and guidance but are not flamboyant. So it's the combination of needing other people to notice you and having your over-

emotionality. So how do we treat it? Well, they're relationship seeking. They respond to warmth. So they're easy to engage. They're easy to develop rapport with.

But it's very difficult to have conversations with them about matters of their behavior or thought or any cognitive theories, because they just don't think that precisely about things. And the therapist needs to be careful that they don't get entranced by and entertained by the client. So the over-emotionality needs to be addressed, which is not always what we want to do when we're in a therapy session. Because it's more fun to be entertained by somebody.

Group therapy can be useful if they're not too dramatic. There's no evidence for the efficacy of any medication. Watch Gone with the Wind, and Scarlett O'Hara is a pretty good example of over-emotionality, which is used in order to get attention and get what she wants. So there you go. Who needs to go to school to learn this stuff? We can just watch movies. Okay, that takes us through histrionic personality disorder in a little bit more detail, with a little bit more time.

Now I want to talk about calls. And we're going to do some examples here of calls where different people present with the same problem, but are going to have different responses to you as the person answering the call. So 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're referring to. In other words, something's going wrong with the interaction. You've stopped getting anywhere, and you don't know why. So here's the scenario that I set up.

This is a person. You answered the phone, and they're calling in because they want to talk to someone about the extreme stress they've been under. The primary problem is that they've been experiencing a lot of anxiety and depression regarding finances, and problems with their children, and some medical problems related to pain.

So they have pain. It keeps them from going to work. They then need to get more money, because they're not on salary with a lot of sick time. And their kids are young and demanding, or maybe their kids are teenagers and demanding anyway. They don't

feel like they're getting any help with these problems, and they feel like they're at wit's end.

They've been having difficulties at work, because they're not sleeping well, and they've been using up their sick time. Their significant other's tired of hearing about it all and it's not helping out. Their doctor's prescribed a tranquilizer, which helps, but now says that the individual needs to see a mental health person if they're going to continue to need the prescription. The doctor says I'm uncomfortable continuing to prescribe Valium to you longer term. You need to take care of the problem. See a mental health person.

But then the caller says, they don't have the money or the time to do that. They don't know where else to turn. They admit, as you ask them how they're feeling and explore suicidal feelings, that they do feel suicidal and hopeless at times.

OK, so that's the scenario. It's someone with the range of regular problems that people have, who will call on a crisis line. And here's what you do.

You listen empathically-- good for you-- and you gather data. It's your impression that this person is overwhelmed by the situation described and needs, one, an ongoing relationship with some kind of advocate, a social worker or a case manager or someone in the community, through community support, who could help them with financial guidance. So are you really in a financial hole? There are people who can help with that. Well, we can hook you up with someone who can do that.

They need a referral for medication. So they've got to see either a nurse practitioner or some mental health provider who can help them get hooked up with someone who can prescribe the correct medicine, if they need medicine at all. And they could benefit from with some supportive therapy to help them deal with their family issues.

You think that their suicidal feelings, while are worth investigating, which you have done, are best dealt with by actively problem solving their concerns, rather than initiating big full fledged suicide prevention strategy and getting them seen in the ER and all that. You think it's-- in other words, they don't have a plan. They haven't really

thought about it. They aren't saying goodbye. They aren't doing all the things that would alarm you.

Rather, their suicidal feelings are primarily the result of feeling overwhelmed. And if you can help those feelings, the person is not going to have problems with suicidal stuff. They don't really want to die. They just don't know what to do.

So, good for you. Sounds like great analysis of what's going on, with a lot of problems. And you've really got it broken down into segments.

And you present the plan to the client and ask if they think this makes sense, saying if they agree with this, you've got some recommendations for them about where to go to get this kind of help. And here's caller number one, their response.

The caller responds with anger, saying this is exactly the sort of runaround 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. They don't need a referral to another quack for medications. They already know what medications work--tranquilizers, the Valium. They need a prescription without more pressure, until their anxiety improves. And then they'll stop taking it.

And, 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 color ends by asking if there's anyone else they can talk to, like a supervisor or someone with more experience.

Now, based on what we've talked about, I shouldn't say that. Because this is sort of a trick question. Because this is one we haven't talked about. But I want you to think for a second and see if you could come up with what kind of personality disorder profile this might match. And then, of course, I'll tell you the answer.

And the reason it's a trick question is because I didn't talk too much about this. But it's something that I think you're all familiar with. This is an angry caller, who's demeaning, who's controlling of you, who's saying you don't know anything, and wants to talk to someone who will help them.

It's focused on the medication. They want to make sure they have access to the Valium, and they want the person who's going to help them get what they want. They're not interested in problem solving or listening to your suggestions.

And this is antisocial personality. It's focused on power and getting what they want. They're not interested in collaboration. They know what they want. They're interested in getting it. And so this style of interaction, which is derailing your usual expectations for problem solving and how to work with people, would best fit with antisocial personality disorder. That is someone who's interested in controlling and avoid being controlled. So that's how I would diagnose that interaction. Let's do one that you've heard of, that I've talked about more.

So you do your response, and here's what caller 2 says. The caller is silent for a few moments, and then says, in a soft voice that the referrals won't be needed. But thank you for your time.

You are alarmed, because this is a sudden change in demeanor. By the way, in psychiatry, we don't like things that happen suddenly, and we often don't trust them. If you're an inpatient, taking care of someone, in inpatient for instance who comes into the hospital, because they're suicidal, and they come in for safety, and you see them the next day, and they say everything's fine, and they're very calm, and they deny any depressive symptoms whatsoever, we don't like that.

None of you would like that. Why don't we like it? Because change doesn't happen suddenly, usually. Change happens slowly. So when things happen all of a sudden, it raises alarm bells.

So person says, soft voice, I don't need your referral. Thanks for your time. You're alarmed. You 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.

Now you go into full suicide prevention mode, and the conversation continues. The caller becomes more responsive to you as you ask and talk more about how they're feeling, their despair, their emptiness, their hopelessness, their desire to die.

It seems like-- it feels to you that you're establishing good rapport. They're sharing with you. They seem to be honest with you, and so forth. But every time you feel like the caller is able to agree to a no self-harm contract and more specific follow-up regarding their suicidal feelings, something happens.

They'll make an ambiguous remark, just as you're ready to hang up the phone, like no matter what happens, I want you to know I appreciate what you tried to do for me. And all these things alarm you again. And you can't end the conversation, because it feels like things are up in the air, and things are not safe. In fact, it seems to be getting worse. And the call goes on and on.

So what do you think this interaction is indicative of? Someone who calls in, they talk to you with a certain level of urgency. You present the plan. You ask if it's OK. And all of a sudden, it's not OK. And it's not OK not in an angry way. It's not OK in a resigned, kind of hopeless way.

And then it becomes a call about suicidal feelings, and there doesn't seem to be any way to resolve this. Because every time resolution appears to be in your grasp, it disappears. And the person feels just as bad as ever, and you don't feel safe hanging up the phone.

Well, these calls are unnerving, and they're frightening for the person who is talking on the phone. The quiet voice evokes menace and a commitment to suicide. It arises and peaks always 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 that feels safe.

This is an example of borderline personality disorder. Fearful of ending the call when they do not feel better and having the thought of suicide always in the back of their mind, and this is quite the typical crisis mode thinking of someone with borderline personality disorder.

I don't want to leave a person who I think can help me, and there is constantly, there's always the fallback position of thinking, well, I can kill myself if-- I'm going to have to kill myself if I don't feel better. So that's what's happened to this call. And that's-- the interaction with you is trying to get you to give them what they need, which is helping the feeling of emptiness and loneliness inside. And the suicide feelings are always part of that.

Here's a third caller. The caller is enormously appreciative and says they have written down the recommendations you've 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 to them. They don't even feel like they need a referral for medication, if they just had someone to talk to who could listen like you do.

They know that you're busy, and they will let you go. But they want to know if they could call tomorrow, just to let you know how the referrals are working out. It could just be a brief call, and it would mean a lot to them to hear you again, and to just give you some feedback on how things were going with their life.

Note, you learn-- you tell them, no, you can't call me. We don't work like that. But you can call and talk to someone. And please let that person know. But it probably won't be me. It'll be someone else who hooks you up on the phone line.

You learn the next day that someone was calling on the crisis line, trying to find you, even though you explained to them it was not possible for you to have an ongoing relationship with them. So that didn't stop them from calling. And in fact, it feels a little bit, in your weak moments, like you're being stalked.

The call seemed to go well, and you're feeling pretty good about how you did with the call. You established great rapport. The person was very eager and working with you. But the caller is showing a little bit of clingy stubbornness that probably can easily be managed, probably.

This is dependent personality, the person who feels like they're very compliant with your recommendations. But in fact, they're not so much interested in your recommendations as they are in having you tell them what to do.

And there's always new things for you to tell them what to do. Every day is a new challenge. Every day there's new problems. They just want to be able to ask you how to handle it, just for a few minutes every day, or at least regularly, so they know how to count on that. So the call finally was not so much about their problems as it was finding someone who can tell them what to do about their problems.

And then finally, caller response number four-- you give you a response. You ask how that sounds to them, and your suggestions are met with escalation, more desperation, more descriptions of how terrible everything is, more hopelessness, and more expressions of how unbearable the situation is. They suggest that you have not grasped how bad things are, and they want to eliminate you.

They wonder if they need hospitalization in order to stabilize. They don't know how they can get through the afternoon. Can you arrange that? Can you get them to a hospital? Can you get them to see somebody who can really deal with this unmanageable problem?

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 even another second without getting some kind of help.

The escalation is sudden and dramatic. You didn't see it coming, and you 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've never worked with someone who had it this bad.

Well, this is histrionic personality. This is the person who cannot bear to have the attention focused elsewhere, who needs to be taken care of and will be as dramatic as necessary in order to keep your attention and get the attention. So histrionic personality, once again, that's the primary agenda of the caller, to get the attention.

So those are four examples of calls that seem to all of a sudden veer off course. Everything seemed to be clear to you. You had a good plan. But the person's reaction was unexpected-- either anger-- they want their medicine. They know what they want. They don't want to be told how to solve the problem.

They just want to get what they know that they want-- or the person who wants you to continue to reassure them and make them feel better and finally get to the issue that is really causing the call, which is their feelings of emptiness and loneliness. And they'll do whatever it takes to keep you on the line.

There's the person who simply wants somebody who will tell them what to do and be available to them whenever they need help with knowing the best course of action. And then finally a histrionic person, who isn't interested in the referrals, is interested in making sure that they are getting absolute, primary, full stop care for how bad they feel.

All of them have in common that they are responding in unexpected ways, and you are feeling stuck in the problem of the endless call. And that's what I want to talk about next, is what do we do about calls that seem to go on and on, and there isn't any good place to quit? And no one will-- you're not getting any help doing that.

There's a few principles that you should keep in mind when a phone call does not end when you think it should. That is, when you feel like, great. This is perfect. We have the problem. They have the solution. And it's time to say goodbye.

Number one, it's a well-known observation that the first complaint mentioned at a doctor's visit is usually not the thing that the patient is most concerned about. So people

go in, and they say, well, I want to talk to you. I have these headaches, and I want some help with headaches. And the doctor says, OK. Headaches, that's-- I'm used to dealing with that. Talk about stress relief. Talk about medications. Talk about when the headaches happen, and so forth.

But it isn't until 15 minutes later that the primary concern comes out. And that is that the person is worried that they have multiple sclerosis or a much worse illness. Maybe they have a brain tumor or whatever. But they don't say that at first. It takes a while for the patient to warm up to the doctor, to feel trust, and to finally develop the courage to talk about what they really have in mind. And that is so common. I do that. I've done that with my doctor, too. So it's not pathological behavior. Of course, if I do it, it's not pathological. It's normal. But you know what I mean. I mean, I think everybody has certainly had that impulse.

So we know that when you're working in primary care, that the person coming in, the first complaint that they mention, there may be something else that they're really more interested in. So that can be very true for someone calling on a phone line.

Two, different people have different abilities to articulate what's bothering them. So it may take people a lot longer to say, in clear terms, what it is that they need or what they want. So some people are very articulate. They get it all planned out. Maybe some people write it down. But other people. They need a lot of coaching and help before they can finally describe in some detail how they feel. So it takes longer to do that with some people than others.

Three, often, a skillful interviewer, which is all of you, can help people develop a new insight into what's wrong, and thus a new Avenue to explore. So by asking illuminating questions, by listening empathically and intelligently, you're able to guide people through offering some insights or thoughts about something, or other questions that may lead them to a new understanding.

And so, wow, I never thought about that. And as you discover something new, there's something new to talk about. So these phone calls can be longer than just I'm having financial problems at home, and my husband doesn't love me anymore. My wife's-- I

think she's having an affair. So these are things that you get to because you're doing a good interview.

And finally, talking to an empathic person is a pleasant and rare experience. And people don't want it to end. Most of our conversations with people are not that-- people aren't that good of a listener.

They're not that empathic. And when you get someone who really has got it-- they've got the ability to sit as though they have all the time in the world. They're listening to you. They're responding to what you say very accurately. It is an amazing experience.

And to the extent that you are very good listeners on the phone and are practiced doing this, that's a pretty nice feeling for people who are not used to feeling listened to. So that's another reason why people may want to linger on the phone with you.

So maybe people don't say what's really on their mind at first. Maybe people can't say what's really on their mind. Maybe you have helped them discover that there's something more to talk about. And maybe people just finally have found someone who will listen to them. So these are reasons why you may have long calls other than the person has a personality disorder, and they're trying to use their interpersonal contact as a way to try to get what they want, using their unconscious patterns.

For those calls that go on and on that don't fit any of the previous categories, the issue is usually the caller is seeking a solution to their problems other than the solutions that have been talked about. And this can be, they want an interaction that's going to meet their needs.

In general, their agendas, as I call them, or the unconscious interactions, are not going to be effective in dealing with their crisis. Why? Well, if they were effective, then they wouldn't have had to call you. That's the problem with personality disorders is that they've got these recurrent patterns of behavior. But they don't work very well. They're stuck in doing things that are not very effective for finding solutions.

And the caller just tries harder to make these patterns work. You've heard that before. You try something that fails. You just try it harder and harder, and the calls continue, as the caller continues to try to get what they want from the interaction.

At this point, you need to get off the line. Because nothing is being accomplished, and nothing is likely to be accomplished except exhaustion-- exhaustion in you, exhaustion in the caller, or both. And in fact, this is how most of these calls end, with exhaustion. And you just can't do this.

Primarily, you can't do this not because it's not useful, but because it's going to burn you out, and you aren't going to be able to continue doing this job. And we don't want to lose you. You're experienced, good crisis phone worker. We don't want you to get burnt out. We want you to be able to continue.

So the solution here is, you've got to find closure. You have to find closure for yourself, and not expect that the caller will accept your decision that it's time to stop the call in the circumstances that I've just described.

Now this is very hard for all of us. But it is not the caller's job to recognize that the call is not achieving anything. It's your job. They are not going to be responsible for ending the call. You are. And that means you have to do the hard thing.

So how do you know when to do that? Well, you have to have a sense of what your job is, and you have to have the ability to assess the step you've taken in every call. Have you been a good listener? Have you given the caller an opportunity to speak?

So they've had time to speak. You haven't cut them off, shortchanged them, jumped to conclusions. You've given them an opportunity to express how they really feel, and you've given them the words to help them do that.

Have you done a good risk assessment? So you've looked at suicide. You've looked at violence. And have you covered all those bases? You know how to do that. Have you done it? Is your plan that you've given them a reasonable one, and it's a plan that the caller can act on? I mean, it's no use coming up with the elaborate plans that no one

can do anything about, because they're too complicated or there aren't the resources. So is this a plan that addresses the issues, that's reasonable, that is doable, that the person can do?

And have you asked for and listen to feedback about how the caller feels about the interaction? Do you have a good sense of why it is that they feel that they're not done with the call?

And finally, have you taken a moment to consider what you may have missed? So you need to go through this for an interminable call. Have you listened? Well have you given them a chance to talk? Have you done a good risk assessment? Is your plan reasonable? And is it one that a person can follow?

The person you're talking to, can they follow this plan? Have you asked for and listened for feedback about how they feel? And have you taken a moment to consider what you've missed?

If you've done all those things and you're not getting anywhere, it's time to say goodbye. Now, you all have ways to soften the termination of a call. Here are some things that I have used.

Explain, you've reached the end of any useful help you can provide. Ask if they have any final questions. Let them know that you care about what happens to them. You believe they have the resilience to deal with these difficult feelings, and you thank them for reaching out and calling.

And so this is what you say. And finally, you hang up if you need to. So that's what I would say are the main topics involve when we're dealing with personality disorders and the calls go on and on and on, because they're not interested in the solutions that you can provide, and the caller simply cannot end the call. They're incapable of ending the call because of their personality style, and you need to do it. You check, and you see what you've done. And then you say goodbye.

Now one thing I didn't say that I should, and I will next time we do this, is documentation. You need to document the things that I mentioned here, which is part of what your finding closure is. You need to document how long the call was, the issues that you got, what you saw as the primary issues, what you saw as the risks, how you see the problems with the call, what you did to try to solve those, and how you decided to handle it, at what point you end the call.

It's just very nice to have that sort of documentation, so that in the event of a bad outcome-- and there are bad outcomes-- you can go back and remember what you did. Because often, bad outcomes don't happen for a length of time, and you have lots of calls. You can do that. And also, you've got documentation in the event that there's some sort of legal issues or quality control issues or so forth.

So that's what I would say, and that takes me to the end of what I want to talk about. And so I'm taking a look here at questions.

Question: What's the main difference between schizophrenia and schizoid and schizotypal personality disorder?

Answer: It's a matter of degree. With schizophrenia, you have a thought disorder that manifests itself with delusions, hallucinations, cognitive problems, and problems with affect. People often feel, they often appear flat. So sometimes, we call these negative symptoms of schizophrenia, and so forth. Now schizoid personality doesn't have any delusions or hallucinations, no cognitive problems, no psychotic symptoms. They rather are simply uninterested in interacting with anybody. So schizoid-- when I talk about this-- excuse me-- I'm talking too much. I have to go. Two more minutes.

I think of the Norwegian bachelor farmer here in Wisconsin. It's somebody who lives alone. They don't really have intimate, or even particularly friendship interactions with other people. They're just very, very distant. They're not depressed, but they look depressed. And so that's what schizoid personality disorder is. So it really isn't related to schizophrenia at all. It's an unfortunate name. Schizotypal, these are people who are odd. They have magical thinking often. They're a bit eccentric. But they don't have the delusions or hallucinations to the degree that someone with schizophrenia will have,

and they don't have the cognitive problems, and they don't have the flat affect, the problems with emotional expression, the secondary negative symptoms of schizophrenia. In fact, they may tend to be more angry and more emotional, more that sort of angry, impulsive interaction. So that's how those would be different.

Any other questions? If not, we're down to about a minute and 20 seconds. I can tell, because I have an atomic clock. I love atomic clocks. That's because I'm obsessive-compulsive personality. I know exactly what time it is.

So I'm going to turn this back over to Jen, who will do a kind of follow-up And I will tell you that you've got my email address. If any of you have questions, you can ask me that way. And I certainly wish you the best in your work. It's important work. It's hard work. Use your consultation with colleagues and friends.

JEN WINSLOW: Thank you, Dr. Mays, and thank you, everyone, for being here. That was fantastic. Just as a reminder, you will be automatically redirected to a very brief survey that we would greatly appreciate you taking. It we'll just take a quick moment, a few minutes to take.

Also, a reminder, you will be emailed the presentation materials and the booklet that Dr. Mays referred to. So you can expect that this week, as well as-- your certificate will be emailed to you in a separate email as well.

So thanks again, everyone. Please check out our website and our social media for more upcoming trainings, and we hope to see you again soon. Have a great day.