

Personality Disorder and Crisis Stabilization

A plain-English guide for you and your family

WHAT IS HAPPENING

A healthy brain has circuits that steady your feelings, keep your sense of who you are stable, and let you trust that people won't abandon you over small things. The prefrontal cortex (the front part of the brain) acts like brakes on big emotions, and the amygdala (the brain's alarm center) sizes up threats. When a child grows up in an environment that ignores, dismisses, or punishes her feelings—or worse, exposes her to abuse or chaos—those circuits never wire up correctly. The brake part stays weak, and the alarm center stays on high alert. Now, as an adult, when stress hits, her emotions flood without a dimmer switch: intense anger, emptiness, or fear that people will leave. She can't hold a stable picture of herself or others, so she swings between seeing someone as perfect and then all bad. She may hurt herself to control unbearable feelings or make suicidal gestures when the pain peaks. Under extreme stress, she may feel unreal or disconnected from her body because her brain shuts down the 'this is me' circuit to protect itself. None of this is a choice—it's the brain trying to survive with broken regulation tools. The danger is real: five to ten out of every hundred people with borderline personality disorder will die by suicide over their lifetime. Treatment focuses on building new emotion skills through therapy (dialectical behavior therapy is the gold standard) and sometimes medication to calm specific symptoms. Recovery is possible, but it takes time, validation, and learning the regulation skills her brain never got a chance to build.

What you might feel

- Frantic efforts to avoid real or imagined abandonment
- Unstable, intense relationships that swing between 'you're perfect' and 'you're the worst'
- Unstable sense of self—who I am, what I want, and what I believe change often
- Impulsive behavior in at least two areas that can cause harm (spending, sex, substance use, reckless driving, binge eating)
- Recurrent suicidal behavior, gestures, threats, or self-harm (cutting, burning)
- Mood swings—irritability, anxiety, or sadness lasting hours to a few days

- Chronic feelings of emptiness
- Intense, hard-to-control anger or physical fights
- Stress-related paranoia or feeling detached from your body or reality (dissociation)

Call the doctor right away if...

- Active suicidal plan or recent attempt—always means immediate safety evaluation and often psychiatric admission
- Severe dissociation or psychotic symptoms (hearing voices, paranoia that others are plotting against you)—can mean the person is in crisis and at high risk for self-harm
- Escalating self-harm (deeper cuts, more dangerous methods like ligatures or overdoses)—signals worsening distress and rising suicide risk
- Substance intoxication during a crisis—sharply raises impulsivity and the chance of lethal action
- Stating they feel like a burden or have no reason to live—strong predictors of suicide attempt in the near future

What the care team will do

- Assess suicide risk every shift using a structured tool (ask about plan, means, intent, and recent self-harm), and remove dangerous items (belts, cords, sharp objects, pills) from the room if risk is present.
- Set clear, consistent limits on behavior (visit times, phone calls, staff check-ins) and communicate the same plan across all shifts so every nurse responds the same way.
- Teach and practice one grounding skill each shift (hold ice, name five things you see, deep breathing for six counts in and six out) and coach the patient to use it when distress starts, before it peaks.
- Respond calmly and matter-of-factly to emotional outbursts or threats, without extra attention or anger, and return to normal interaction as soon as the patient is calm.
- Validate feelings (say 'I hear that you're in a lot of pain right now') while redirecting harmful behavior (add 'and I can't let you hurt yourself; let's try the ice instead').
- Administer prescribed medications (SSRI like sertraline, mood stabilizer like valproate, or short-term benzodiazepine like lorazepam 0.5 to 1 mg as needed) on time, and watch for sedation or worsening suicidal thoughts in the first two weeks of an SSRI.
- Collaborate with the treatment team to create a written safety plan that lists the patient's warning signs, coping skills, people to call, and reasons to stay safe, and review it with the patient daily.

- Document objective observations (exact words, actions, times) rather than judgments ('patient is manipulative'), and share patterns with the psychiatrist to guide Dialectical Behavior Therapy referral or medication changes.

Medicines you may be given — and why

Dialectical Behavior Therapy (DBT)

DBT is a type of talk therapy built for people who feel emotions very intensely and have trouble riding them out without doing something they regret. It teaches four main skills. First, mindfulness: paying attention to right now without judging yourself. Second, distress tolerance: getting through a crisis without making it worse—like holding ice instead of cutting, or using paced breathing when you want to scream. Third, emotion regulation: learning to name what you feel, understand why it showed up, and cool it down before it takes over. Fourth, interpersonal effectiveness: asking for what you need and saying no without burning bridges or exploding. The therapist listens and says your pain is real (that is validation), but also coaches you to try new ways to cope. Standard DBT runs once a week for at least a year, with a skills group, plus phone coaching between sessions when a crisis hits. Over time, this repeated practice teaches your brain to pause between feeling and acting, so emotions feel less like tsunamis and more like waves you can ride.

Mentalization-Based Therapy (MBT)

MBT helps you step back and think about what is going on in your own mind and in other people's minds. When feelings run high, people with personality disorders often lose this ability—you might assume everyone else is attacking you, or you cannot figure out why you feel so desperate. MBT, done weekly for 12 to 18 months, teaches you to pause and wonder: What am I feeling right now? Why might I be feeling this? What might the other person be thinking or feeling? Then you test those guesses before reacting. This slows the jump from emotion to action and makes relationships less explosive. You learn to hold two ideas at once—like 'I feel hurt' and 'Maybe they did not mean to hurt me'—without spiraling into rage or despair.

Selective Serotonin Reuptake Inhibitor (SSRI) — e.g. fluoxetine (Prozac), sertraline (Zoloft)

SSRIs are used when a personality disorder comes with major depression or severe anxiety that therapy alone has not lifted. They block the pump that vacuums serotonin (a brain messenger that steadies mood, sleep, and impulse control) back into the nerve cell after it delivers its message. When you block that pump, more serotonin stays in the gap between cells and keeps the calming, mood-lifting signal going. This helps you feel less hopeless, less irritable, and a bit more able to use the therapy skills you are learning. SSRIs do NOT treat the

core personality pattern—they only cushion the depression or anxiety layered on top, so therapy can work better.

Mood stabilizer — e.g. lamotrigine (Lamictal), valproate (Depakote)

Mood stabilizers are prescribed when you swing between rage and despair several times a day, or when impulsive behavior—like spending sprees, dangerous driving, binge drinking, or drug use—keeps wrecking your therapy progress. These drugs were designed to prevent seizures (the electrical storms in the brain that cause convulsions), but they also calm overactive electrical firing in the limbic system (your brain's emotion center). Lamotrigine works by slowing the release of glutamate (the brain's main 'go' signal), which dampens emotional surges. Valproate boosts GABA (the brain's main 'stop' signal) and also blocks the sodium channels that let nerve cells fire too fast. Either way, your brain's emotional thermostat steadies, so feelings do not spike as wildly or as often.

Low-dose atypical antipsychotic — e.g. olanzapine (Zyprexa), quetiapine (Seroquel), aripiprazole (Abilify)

In a personality crisis, some people briefly lose touch with reality. You might see or hear things that are not there, believe everyone is plotting to hurt you, or feel completely disconnected from your own body (like you are watching yourself from outside). A low dose of an atypical antipsychotic can quiet these episodes. These drugs mainly block dopamine D2 receptors. Dopamine is a brain messenger tied to reward, motivation, and—when it floods certain brain circuits—delusions (false beliefs) and hallucinations (seeing or hearing things that are not real). Blocking D2 receptors dials down the false signals. Some of these drugs also block serotonin 5-HT_{2A} receptors, which helps with mood and impulsivity. The goal is SHORT-TERM use—days to a few weeks—just long enough to restore your grip on reality, then taper off and rely on therapy. These are not meant to be taken every day for months unless you have a separate psychotic disorder like schizophrenia.

Avoid polypharmacy

People in personality crises often end up on four, five, or more psychiatric medications at once because every new symptom gets a new pill added. This is called polypharmacy, and it rarely helps. The pills interact with each other, side effects pile up (tiredness, weight gain, confusion), and it becomes impossible to tell which drug is doing what. Current guidelines say: pick ONE target symptom—like depression, impulsivity, or a brief psychotic break—and use ONE medication for it. Give it a fair trial (usually 6 to 8 weeks) at the right dose. If it does not work, stop it. Add a second drug only if a completely separate symptom needs treatment (for example, an SSRI for crushing depression PLUS a short-term antipsychotic for a psychotic episode that is layered on top). Never add a drug just to 'try something' or because you feel pressured. Keep the medication list short and the reason for each pill crystal clear.

Brief psychiatric hospitalization

If you are acutely suicidal (planning to end your life right now), have just made a serious suicide attempt, or are so psychotic or dissociated that you cannot keep yourself safe, a short hospital stay—typically 3 to 7 days—can break the immediate danger. The hospital removes access to means of harm (pills, sharps, belts, cords), provides 24-hour monitoring so you are never alone, rapidly adjusts medications if needed, and connects you to outpatient therapy and social supports before you leave. The goal is stabilization, NOT long-term residence. Longer stays often make personality crises worse—being locked up can deepen feelings of helplessness, trigger more self-harm to get attention or relief, and delay you learning to cope in the real world with real supports.

Validate feelings, not behaviors

People with personality disorders often feel that no one understands how much pain they are in. When a doctor, nurse, or therapist dismisses your feelings—saying 'You are overreacting,' 'Calm down,' or 'It is not that bad'—you either shut down and stop talking, or you escalate (yell, threaten, self-harm) to prove how bad it really is. Validation means the clinician says out loud that your feeling makes sense given what you have been through, even if the behavior that followed is not okay. For example: 'It makes total sense that you felt abandoned and crushed when your friend canceled plans at the last minute. That would hurt anyone who has been left before. And also, cutting yourself to cope is not safe, and we need to find another way together.' This calms the emotional storm just enough that you can hear feedback about the behavior. It is a core piece of DBT and should guide every single clinical conversation.

Address social determinants of health (housing, substance treatment, therapy access, food, transportation)

Personality crises almost never happen in a vacuum. You might be homeless, not know where your next meal is coming from, actively using alcohol or drugs to numb the pain, stuck in an abusive relationship, or sleeping three hours a night because your apartment is loud, cold, and unsafe. No amount of medication or therapy will stabilize you if you do not have a safe place to sleep, regular meals, and access to the supports you need to survive day to day. Every treatment plan must include a checklist: Are you housed, or are you sleeping on a friend's couch or in a shelter? Do you have Medicaid or insurance to pay for therapy and medications? If you are using opioids, alcohol, or methamphetamine, are you offered medication for addiction treatment (like buprenorphine for opioids or naltrexone for alcohol) at the same visit, not told to 'get clean first'? Is your sleep environment safe and quiet? Do you have food? Can you get to appointments, or do you need bus tokens or rides? Addressing these social determinants is not optional or extra—it is the foundation on which all psychiatric treatment rests. Without it, nothing else works.

Where this information comes from

- American Psychiatric Association DSM-5-TR (2022)
- NICE Borderline Personality Disorder Guideline (2023)
- Cochrane Review: Psychological Therapies for BPD (2020)
- Journal of Clinical Psychiatry: Neurobiological Basis of BPD (2023)

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