The Journey to E.M.P.A.T.H.Y.
Care for Personality Disorders in the Elderly

Geriatric Education & Consultation Services
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Sometimes being a carer will catch up with you.
3 Diagnostic Types
Personality Disorder

- Cluster A
- Cluster B
- Cluster C
All three are hard to treat

“This is all you can do for my personality disorder?”
DSM-5

Personality Disorders: General Diagnostic Criteria

A) An enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual's culture. This pattern is manifested in two or more of the following areas:

1) cognition (ways of perceiving and interpreting self, other people, and events.)
2) affectivity (the range, intensity, lability, and appropriateness of emotional response)
3) interpersonal functioning
4) impulse control
B) The enduring pattern is inflexible and pervasive across a broad range of personal and social situations.

C) The enduring pattern leads to clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D) The pattern is stable and of long duration, and its onset can be traced back at least to adolescence or early adulthood.

E & F (are exclusionary data)
Personality Disorder
Cluster A

- Paranoid
- Schizoid
- Schizotypal

Display odd and eccentric behaviours. Seen as “weird” by their neighbours. Often are loners and tend to avoid society. Manage to function at a marginal level.
Personality Disorder
Cluster C

- Avoidant
- Dependent
- Obsessive – Compulsive

Are anxious and fearful. Are seen as “needy” by those who know them. Attract people who are the “fixer uppers”, those who need to be needed.
Personality Disorder: Cluster B

- Narcissistic
- Histrionic
- Borderline
- Antisocial

- Display dramatic, emotional and erratic behaviours
- People tend to avoid them
- Staff and family splitting is common
- Tend to see people and events as either good or bad
- Have a tendency to set themselves and their needs above the needs of others and have a sense of entitlement
Additional Cluster B Symptoms

- More prone to depression
- More suicidal than the average population
- Poor impulse control in many areas of life
- Tend to blame others for issues
- Live on the dangerous edge in many areas of life
- Difficulty setting personal and moral boundaries
- More addictions than the general public
Personality Disorder is not Dementia

- Dementia tends to lessen the symptoms of personality disorder

- Underlying principles for care planning:
  - Dementia: These individuals have been autonomous and expect to be treated that way. Care should providers try to maintain that autonomy and set boundaries only when absolutely necessary.
  - Cluster B Disorders: These individuals have always struggled with autonomy. They have a hard time setting their own behavioral boundaries. Care providers should help them set boundaries within the given social setting.
Behaviours of dementia start with brain deterioration generally in old age. These people respond better if staff let them establish their own boundaries for care. They have been fully autonomous and feel most comfortable with autonomy even in dementia.

Cluster B disorders start around adolescence and early adulthood. Part of the syndrome is difficulty with boundary setting. They frequently relied on others for this and now at the end of life stage will have a difficult time learning boundaries. Brain involvement is poorly understood at this time.
Personality Disorders and Age-Associated Stresses

- Older persons with personality disorders can become overwhelmed by age-associated losses and stresses, largely because they may lack:
  - Coping skills
  - Personal, social, or financial resources

- Admission to a hospital or long-term-care setting poses a unique stress on persons with personality disorders
Abused children more likely to develop Cluster B disorders. But… not all who are abused develop it nor is it true that everyone who has a Cluster B disorder has been abused.

Emotional maturation got stuck at an adolescent stage. Boundary setting becomes difficult.
“Which parent do you want to sign it: my natural father, my stepfather, my mother’s third husband, my real mother or my natural father’s fourth wife who lives with us?”
Principles for Treatment

1) Goal is to decrease the frequency and intensity of challenging behaviors, not cure the disorder

2) Same basic approaches as with younger patients, but consider impact of age-related stressors and comorbid disorders

3) Clarify the diagnosis, then identify recent stressors that may account for the current presentation
   - Guides the selection of realistic target symptoms and therapeutic approaches
   - Allows treatment team to anticipate future stressors

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Symptomatic Treatment

- Antidepressants if depressed
- Benzodiazepines for acute withdrawal of addicting substances
- Antipsychotics for severe behavioural symptoms
- Behavioural approach for ethical issues
Insight-oriented therapy has limited effect in personality disorders; however, supportive psychotherapy can help to alleviate anxiety and distress.

Regular scheduled sessions with clear limits help establish the therapeutic boundaries.
Unless there is a comorbid mental illness or dementia these persons are legally and socially responsible for decisions that produce serious life consequences.

Although inclined to dysfunctional or disruptive behavior, these persons are able to comprehend the consequences of their behavior.
Histrionic Personality Disorder

Pervasive pattern of excessive emotionality and attention seeking, beginning by early adulthood and present in a variety of contexts, as indicated by five or more of the following:

1) is uncomfortable in situations in which he or she is not the center of attention
2) interaction with others is often characterized by inappropriate sexually seductive or provocative behavior
3) displays rapidly shifting and shallow expression of emotions
4) consistently uses physical appearance to draw attention to self
5) has a style of speech that is excessively impressionist and lacking in detail
6) shows self-dramatization, theatricality, and exaggerated expression of emotion
7) is suggestible, i.e., easily influenced by others or circumstances
8) considers relationships to be more intimate than they actually are.

Diagnostic Criteria From DSM-5, American Psychiatric Association, 2013
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Borderline Personality Disorder

Pervasive pattern of instability of interpersonal relationships, self image, and affects, and marked impulsivity, beginning at early adulthood and present in a variety of contexts, as indicated by five or more of the following:

1) frantic efforts to avoid real or imagined abandonment

2) a pattern of unstable and intensive interpersonal relationships characterized by alternating between extremes of idealization and devaluation

3) identity disturbance: markedly and persistently unstable self-image or sense of self

4) impulsivity in at least two areas that are potentially self-damaging (e.g. spending, sex, substance abuse, reckless driving, binge eating)
5) recurrent suicidal behavior, gestures, or threats, or self mutilating behavior

6) affective instability due to a marked reactivity of mood (e.g. intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)

7) chronic feelings of emptiness

8) inappropriate intense anger or difficulty controlling anger

9) transient, stress related paranoid ideation or severe dissociative symptoms

Diagnostic Criteria From DSM-5, American Psychiatric Association, 2013
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Antisocial Personality Disorder

1) Called sociopathic and/or psychopathic disorder in the past.

2) Consists of a pervasive pattern of disregard for and violation of the rights of others.

3) These people frequently end up in the justice system and rarely live long enough to end up in the LTC system.
Narcissistic Personality Disorder

Pervasive pattern of grandiosity (in fantasy or behavior), need for admiration, and lack of empathy, beginning in early adulthood and present in a variety of contexts, as indicated by five or more of the following:

1) has a grandiose sense of self-importance (e.g. exaggerates achievements and talents, expects to be recognized as superior without commensurate achievements)

2) is preoccupied with fantasies with of unlimited success, power, brilliance, beauty, or ideal love

3) believes that he or she is “special” and unique and can only be understood by, or should associate with, other special or high-status people

4) requires excessive admiration
5) has a sense of entitlement, i.e. unreasonable expectations of especially favorable treatment or automatic compliance with his or her expectations

6) is interpersonally exploitative, i.e. takes advantage of others to achieve his or her own ends

7) lacks empathy: is unwilling to recognize or identify with the feelings and needs of others

8) is often envious of others or believes that others are envious of him or her

9) shows arrogant haughty behaviors or attitudes

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Treatment Ideas for the
Cluster B Disorders

1) Assess for and treat underlying mood lability, depression, anxiety, and substance abuse
2) Adopt a consistent, structured, and predictable approach with strict boundaries to contain challenging behaviors
3) Adopt a team approach with all involved clinicians to devise a common plan; avoid staff splits between “supporters” and “detractors” of the patient
4) Use behavioral contracts and authority figures when necessary to address recurrent challenging behaviors

5) Do not personalize difficult behaviors directed toward staff members; instead, provide opportunities for staff to ventilate frustration and negative thoughts and emotions with professional colleagues

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Mrs. Jones
Narcissistic Personality Disorder

- Staff complaints:
  - Demanding
  - Rude
  - Ridged
  - Manipulative
  - Intimidating
  - Self destructive
  - Splits us as staff
E.M.P.A.T.H.Y.

- E = Ethical care planning
  - Encourage autonomy within given boundaries
- M = Make them responsible
- P = Prevent splitting
- A = Absolute consistency
- T = Tough love (non-punitive, matter of fact)
- H = Hear what they are really saying
- Y = Your emotional checks and balances
Ethical Care Planning

- Bill of rights
  - Whose problem is this and who will benefit from the proposed care plan?
- Non-malfeasance
  - Duty to do no harm
- Beneficence
  - Duty to benefit
- Equity
  - Duty to treat fairly and with equity
- End the power struggles
Encourage Autonomy
Within Boundaries

- Frequently “pushing the envelope”
  - This pushing is seen as a desire to know where the actual boundaries are
  - Help them set boundaries within ethical parameters
    - Give them lots of choice and then they are responsible
  - Use bill of rights
  - Use ethical principles of non-malfeasance and equity
    - Plan care that will not harm her and will not harm other residents
    - Plan care that is “equitable” for other residents
      - Would you or can you do this for others?
Make Them Responsible

- Example of Mrs. Jones
  - Meal time issues
  - Seeing the physician
Prevent Splitting

- Do not allow staff splitting
  - Very consistent
  - No special favors unless all staff are willing to do them
  - No “good guys or bad guys”
  - “We have decided”
  - Do not listen to running down or particular building up of other staff or yourself
  - Do not take gifts which are then seen as, “you owe me”.
1) Staff meeting or case conference
   - Discuss challenging persons and coordinate a consistent treatment plan
   - Challenging behaviors can sometimes be traced to particular activities or staff interactions

2) Convey treatment plan to patient, all involved staff, and caregivers
   - Non adherent patients may need a written contract
   - Recognize that patient may have conflicted relationships with family

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Tough Love

- **Ethical consequences**
  - The consequences must be agreed upon by the health care team and in line with standards of practice and codes of ethics
  - Must be carried out in a matter of fact, non-punitive manner
  - Always use a calm demeanor
  - Must be consistent, only the team changes them
  - The person is aware
    - E.g. Mrs. Jones was aware that she could miss meals
Hear What They are Really Saying

- **Underlying messages and your response**
  - Self injury: “I want someone to hold me like I see a mother hold her hurting child”.
    - Tough love says, we will love you enough to protect you and make you responsible.
  - Self fulfilling prophecies: “It’s me against the world”.
    - Tough love says, we care enough for you to help you function in the real world.
  - Seductive messages: More frequent in histrionic and borderline, “Will someone really care for me”?
    - Tough love maintains professional boundaries and calls for a second staff member to be present.
Your Emotional Checks and Balances

- Employees assistance plans
- Good health planning
  - Go for a walk
  - Eat right
  - Get rest
- Spiritual care
- Avoid overuse of drugs and alcohol
- Managers with empathy
Results

■ For the resident
  ■ security in knowing where the boundaries are.

■ For the staff and family
  ■ relief in knowing that everyone is on the same page
  ■ helps take care of our emotional issues.
On a lighter note!

WHEW! THIS SUMMER HAS BEEN A REAL SCORCHER!

YEAH, IT WAS SO HOT YESTERDAY I DIDN'T WEAR ANYTHING BUT MY HEARING AIDS.

HE DIDN'T REALLY DO THAT, DID HE, MOM?

BEATS ME, IT WAS SO HOT I DIDN'T WEAR MY GLASSES.

Pickles by Brian Crane