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# 8 The Resident with Personality Disorder

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### Key points

- Personality disorders are pervasive, life-long patterns of perceiving, relating to, and thinking about others that cause significant functional impairment and/or subjective distress.
- Personality disorders can coexist with and complicate the diagnosis and management of other psychiatric disorders.
- The development of personality disorders has been linked to deficits in the childhood environment. Constitutional factors may also play a role.
- Because of the rigid way in which people with personality disorders cope with living, they are very vulnerable to breaking down under stress. To adapt to the losses, role changes, and dependency that come with aging is particularly difficult for this population.
- The demands of institutional living cause ingrained behavior patterns to surface and because these residents are unaware of their contribution to their problems, they will blame caregivers for all that goes wrong.
- If the powerful impact of these behavior patterns on staff is not understood, it can interfere with clinical judgment, team functioning and the resident's care.
- Setting realistic treatment goals involves accepting the resident's limitations and working within these limitations to promote the optimal coexistence of the resident with others in the institution. Improving communication at various levels, applying behavior management strategies and occasionally using psychoactive medications and/or formal psychotherapy are important aspects of a comprehensive approach to management.

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Just as we recognize a face without consciously analyzing its features, we experience a person's character as unique without enumerating its traits. So intrinsic is the concept of personality to our appraisal of others that we rarely pause to wonder what personality is. To continue with the analogy, expressions alter the appearance of a person's face while the underlying facial structure remains constant and always recognizable. In the same way, personality or character is a stable structure upon which different moods are superimposed. As described in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR), "personality traits are enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of important social and personal contexts" [1].

Our character, comprised of numerous personality traits, determines how we interact with others and how we adapt to changing circumstances. Aspects of our character may facilitate or complicate our interactions, enrich or impoverish our journey through life. When personality traits are so inflexible and maladaptive that they cause significant functional impairment or subjective distress, they constitute a personality disorder. The manifestations of personality disorders are often recognizable by adolescence, and continue throughout adult life into old age. This chapter will focus on the problems that arise when elderly individuals with personality disorders enter long-term care settings.

## Identifying a Personality Disorder

Personality determines both our capacity to adapt and our unique ways of doing so. This is equally true whether things are going well for us or whether we are suffering from a physical or mental illness. Whatever is going on in the foreground will be colored by the backdrop of character. If this backdrop is ignored, it becomes difficult to understand, for example, why one person's recovery from an uncomplicated hip fracture is so much stormier than that of another. The treatment team that fails to identify the presence of a personality disorder cannot modify its management plan to try to prevent or mitigate such storms.

People with depression often report to us that they feel terrible. The symptoms of schizophrenia are usually quite obvious to observers. But people are generally no more aware of their own personality than of the way they walk. Even for the observer, personality disorders are easy to miss. In the DSM-IV-TR, personality disorders are classified separately from other mental disorders to ensure that they will not be overlooked. Psychiatrists first identify the disorder(s) in the foreground, such as depression, schizophrenia or delirium, and classify these disorders on Axis I. The psychiatrist then comments separately on the presence or absence of a personality disorder which is classified on Axis II. This separation from other diagnoses emphasizes that personality disorders can coexist with any other mental disorder. It also encourages clinicians to remember the importance of character as it contributes to and interacts with Axis I diagnoses.

That being said, it can be very difficult to diagnose a personality disorder during an acute episode of another mental disorder. Too much turmoil in the foreground can distract from and obscure the background. Many features characteristic of personality disorders

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may also be seen in people ill with an acute episode of, for example, mania or schizophrenia. The diagnosis of personality disorder should be made only when the characteristic features are stable "over time and across different situations" [1]. Staff in long-term care settings working with residents over extended periods are in a unique position to comment on personality.

People with personality disorders have difficulty with interpersonal relationships. They interact with the people around them in ways that create tension. They may be experienced by others as needy or unpleasant, seductive, threatening, or intrusive. It is unsettling for us to experience others in such negative terms, especially if we are care-givers engaged with them on a daily basis in intense and very personal interactions. These residents threaten our image of ourselves as capable, caring professionals. To preserve our cherished self-image we may end up avoiding the offending residents, blaming them and punishing them. We may also react with guilt, punishing ourselves in various ways for having feelings we consider unacceptable.

When a personality disorder is correctly identified, the tensions between the resident and others are now placed in a context where they can be understood. Staff are both challenged and encouraged by this diagnosis to try to understand the resident and to explore their own previously disavowed feelings and reactions. However painful, this exploration eventually reduces tension. It also leads to the development of a management plan that acknowledges the resident's unique set of needs and balances them with what staff can realistically provide.

## Classifying Personality Disorders

If no two people have the same character, how can we develop a classification of personality disorders? We do know that certain personality traits are likely to occur together. A rigidly controlling person is more likely to be a perfectionist and a stickler for details than is an intensely dramatic and emotional individual. In the DSM-IV-TR, traits commonly encountered together are grouped to define the different personality disorders. Each personality diagnosis or grouping of traits is associated with a particular style of behavior, functional impairment, and kind of distress. To facilitate diagnosis, the personality disorders have been grouped into three clusters. There can be considerable overlap between different personality disorders, especially within one of the clusters and individuals can be diagnosed as having more than one personality disorder. Other individuals have clinically significant personality traits without meeting the diagnostic criteria for a full-blown disorder. A brief description of the different personality disorders is given in **Table 1**. Full diagnostic criteria for each of these disorders are listed in the DSM-IV-TR [1].

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**Table 1** Personality Disorders

**Cluster A: Often Appear Odd or Eccentric to Others**

*Paranoid Personality Disorder*
These individuals have a pervasive tendency to interpret the actions of others as deliberately demeaning or threatening. They do not trust other people and are reluctant to confide in them. They are easily slighted and bear grudges.

*Schizoid Personality Disorder*
These individuals have a pervasive pattern of indifference to social relationships and a restricted range of emotional experience and expression. They have no close friends, are cold and aloof, do not appear to have strong emotions and almost always choose solitary activities.

*Schizotypal Personality Disorder*
These individuals are acutely uncomfortable in close relationships. They have peculiar ideas, beliefs, and experiences such as clairvoyance, telepathy, and sixth-sense experiences. They may display eccentric behavior, speech, or appearance.

**Cluster B: Behavior is Often Dramatic, Emotional, and Erratic**

*Antisocial Personality Disorder*
Criteria for this disorder are more stringent that for other personality disorders. Individuals show evidence of a conduct disorder in childhood as indicated by a history of such things as truancy, running away, fighting, cruelty to animals, lying, stealing, etc. As adults they fail to conform to social norms, fail to honor obligations, are reckless, violate the rights of others, and lack remorse. They are unable to sustain consistent work behavior or function as a responsible parent.

*Borderline Personality Disorder*
These individuals show a pervasive pattern of instability of mood, interpersonal relationships, and self-image. Their relationships are intense and alternate between extremes of overidealization and devaluation. They are impulsive and prone to inappropriate, intense displays of anger. Suicidal threats, gestures, and self-mutilating behavior may occur.

*Histrionic Personality Disorder*
These individuals have a pervasive pattern of excessive emotionality and attention-seeking. They demand constant reassurance, approval, or praise. They may be inappropriately sexually seductive and exaggerated in their expression of emotion, while at the same time being self-centered and shallow.

*Narcissistic Personality Disorder*
These individuals show a pervasive pattern of grandiosity (in fantasy or behavior), lack of empathy, and hypersensitivity to the evaluation by others. They react to criticism with feelings of rage, shame, or humiliation (even if not expressed). They exploit others to achieve their own ends, believe themselves to be unique, special and entitled, and are preoccupied with feelings of envy.

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**Cluster C: Often Appear Anxious and Fearful**

*Avoidant Personality Disorder*
These people show a pervasive pattern of social discomfort, fear of negative evaluation, and timidity. They are easily hurt by criticism and have no close friends. They avoid involvement with others unless they are certain of being liked and fear being anxious or embarrassed in front of people.

*Dependent Personality Disorder*
These individuals have a pervasive pattern of dependent and submissive behavior. They are unable to make everyday decisions or initiate activities on their own. They allow others to make their important decisions and agree with people even when they believe them to be wrong, because they fear being rejected or abandoned. They go to great lengths to avoid being alone.

*Obsessive-Compulsive Personality Disorder*
These individuals show a pervasive pattern of perfectionism and inflexibility. Their perfectionism interferes with task completion and they are overly preoccupied with details, rules, and schedules. They are excessively devoted to work, indecisive, overly conscientious, and restricted in the expression of affect. They want others to submit to exactly their way of doing things and may be unable to delegate.

Adapted from DSM-IV-TR, American Psychiatric Association, 2000.

## The Development of a Personality Disorder

The question of how personality disorders arise has yet to be resolved. A growing body of theory and clinical data suggests, however, that early childhood deprivation, abuse, and neglect are important etiological factors. Why are infancy and early childhood so significant for future development? Very young human beings are neurologically immature and utterly dependent on those around them for survival. Their understanding of themselves and of others is just beginning to form. They are easily overwhelmed not only by the things that happen to them but also by the unmodulated intensity of what they feel.

Through countless interactions with caregivers, patterns are laid down. For children whose needs are usually understood and who come to expect a response attuned to those needs, the world gradually becomes a more predictable place. They gain confidence in their ability to manage their urges and longings, as well as in their capacity to adapt to an increasing range of challenges in their interactions with the world around them.

What happens to the child who is neglected or abused, whose longing for affection is rebuffed or who meets with an overstimulating, sexualized response? How are children affected when they are valued not for themselves but for what they can do, or when their self-esteem is relentlessly undermined? The development of these children is both thwarted and distorted. As a result of repeated failures, their capacity to manage or even identify their needs and impulses is impaired as is their trust in the people around them. Unmet

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needs which cannot be voiced or understood become the enemy. To avoid being overwhelmed as adults, some cling frantically to other people, overwhelming them instead. Some sexualize every interaction to become Don Juans and femmes fatales. Others try to satisfy their hunger through addictions; or they may disavow their needs altogether by martyring themselves to others or withdrawing into the splendid isolation of pseudo-self-sufficiency. These largely unconscious coping strategies constitute some of the symptoms of personality disorders. Later in life, the often rigid defensive structure that has developed leaves the individual ill-equipped to engage in satisfying relationships with others and vulnerable to breakdown under stress. Early world views, once established, are hard to modify. Just as it is more difficult for adults than for children to learn a foreign language, a new emotional language is also not easily acquired later in life.

We cannot predict what kind of personality disorder will result from any particular set of difficult childhood circumstances. We cannot even predict with certainty that unhappy children will develop a personality disorder. But we can say that the likelihood is greater. There are many different reasons why the environments in which people grow up fail to meet the criteria necessary for healthy development. These reasons range from a physical and/or emotional illness in caregivers to socioeconomic upheaval and war.

Apart from environmental variables, there may be genetic and other constitutional factors that predispose to the development of a personality disorder. The possibility that abnormalities in brain biochemistry underlie some of the symptoms is leading to an increasing focus on pharmacological interventions [2]. The notion that problems arise when an infant's temperament and particular needs do not "fit" well with what its environment can provide has also been explored. It is not possible to say, however, that there are any inherent factors that predispose to the development of a personality disorder.

## The Impact of Aging

Aging is associated with many changes, and change is particularly difficult for those with personality disorders. As people age, they generally incur an increasing number of losses. Death of loved ones, loss of important roles, physical deterioration, and, in the case of nursing home residents, institutionalization all threaten a person's sense of self. To mourn these major losses without succumbing to hopelessness and despair requires strengths many people with personality disorders do not possess. The individual's usual means of defending against loss may be curtailed by ill health and changes in mobility and financial status. The socialite can no longer ward off loneliness by entertaining extravagantly. Flights from reality involving drug abuse, sexual promiscuity, or traveling become less feasible. As the aging body becomes a focus of concern, emotional distress may be expressed increasingly in somatic terms. Age- and illness-related changes in brain biochemistry are sometimes an additional complication, affecting the expression of the personality disorder.

Elderly people all have to redefine their role in relation to others, a challenge that involves letting go of cherished aspects of the self: What it meant, for example, to have been a boss, a teacher, a valued employee, or manager of a large household. Many have to turn

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increasingly to others to survive. Individuals with personality disorders, having problems in their interpersonal relationships, often lack the kind of support network that would allow them to continue to function in the community. Even if such networks exist, these individuals may have difficulty acknowledging a need for help. To do so would recall the failures of the early environment. Individuals with paranoid or schizoid tendencies may become reclusive, reject all assistance, and end up living in appalling conditions that sometimes lead to enforced institutionalization. At the other extreme, those prone to helpless panic rapidly exhaust their community resources. For these reasons, individuals with personality disorders are often less able than others to continue living in the community in the face of disability. As a result, they may be overrepresented in the nursing home population.

## The Impact of Institutionalization

Moving into a long-term care setting is an extremely stressful experience often provoking intense feelings of loneliness and abandonment. For people with personality disorders, the difficulties of this process are compounded by their vulnerabilities. Bombarded by the sights, sounds, and smells of aging and thus reminded of their own aging and mortality, they are at the same time put in a situation of enforced dependency and intense, frequent interpersonal contact that resembles family life.

Direct caregivers provide daily intimate physical care requiring intrusions into privacy reminiscent of the nurturing care provided by a mother. For some residents, such care can arouse unconscious rage, grief, and disappointment at never having received the nurturing they craved. For others, caring may evoke feelings of shame, humiliation, and mistrust or precipitate regression and helplessness. The emotional demands of institutionalization may cause vulnerable residents to intensify their reliance on characteristic behavior patterns that give rise to symptoms and interpersonal conflict with staff and other residents. Unaware of their own contribution to their problems, these residents will blame those on whom they are now most dependent – the care providers.

## Diagnosing Personality Disorders in the Long-Term Care Setting

A new resident enters the institution. What factors might alert staff to the possible presence of a personality disorder? There may be clues in the history. Childhood experiences of abuse or severe disruption in the continuity of parenting are often associated with problematic personality development. A history of difficulties in interpersonal relationships or an absence of connections to others is often present. Work histories can also provide useful information. Sometimes it is possible to get a sense from relatives or others that the person is "odd" or "difficult." It must be kept in mind, however, that such opinions are formed on the basis of many factors. Not all those judged by conventional norms as eccentric suffer from personality disorders.

As staff become familiar with the resident, certain persistent behavior patterns become apparent. What initially presents as the resident's conflict with a particular room-mate

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emerges as a pattern of failing to get along with any room-mate. Suspiciousness, inability to adapt to routines, excessive demands, rages, and difficulty establishing social contacts may all be symptoms of a personality disorder.

A personality disorder can also become apparent through powerful ways in which the resident affects others. Experienced clinicians learn to monitor their own feelings and behavior toward the individuals they work with. Strong, surprising, or unusual reactions are important diagnostic clues. When staff feel helpless or demeaned, when nothing they do for a resident is ever enough, or they find themselves consistently doing things the resident can do independently, then the question of a personality disorder should be raised.

In the case of a resident with borderline personality, the diagnosis sometimes becomes apparent when the treatment team finds itself split into feuding camps over how best to manage the resident's apparently insatiable needs. Some staff are experienced by the resident as allies, others as the enemy. When this phenomenon, termed splitting, is not recognized, staff begin to act out the roles in which the resident has cast them. Not surprisingly, chaos can ensue as staff members find themselves pitted against each other. The resident's care is compromised as staff fight among themselves.

Residents with personality disorders have been described in the professional literature as "difficult," "manipulative," "hateful," and "destructive." The feelings that these disturbed but vulnerable people evoke in those who work with them can cause staff to lose sight of and even disbelieve the fact that their behaviors are not intentional. Although they may be defined as maladaptive by the institution's standards, the behaviors represent the resident's attempt to cope. Defenses like splitting are unconscious and beyond the individual's ability to control at will.

Once a personality disorder has been identified, its manifestations become easier to recognize. Although the risk exists that these diagnostic terms may be used in a pejorative fashion to vent frustration and anger, establishing a diagnosis should lead to greater understanding and the development of a sound approach to management.

## Differential Diagnosis

Care must be taken to identify other psychiatric disorders whose symptoms may overlap with those of personality disorders. Depression, which unlike a personality disorder often resolves with antidepressants, also interferes with a resident's interpersonal relations and ability to adapt. Suspicious residents or those with odd behavior may have a psychotic disorder responsive to antipsychotic medication. The rigid behavior, attacks of rage, and other symptoms associated with dementia can make it difficult to differentiate from a personality disorder without a careful history and cognitive assessment. Any of these other psychiatric disorders may coexist with a personality disorder leading to particularly difficult diagnostic and management challenges.

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## Management

### General Considerations

Any development of a comprehensive treatment approach must begin with an understanding of the resident's limitations. Life-long patterns of behavior are deeply ingrained and exceedingly difficult to modify. To expect a resident who has been a loner all his life to adapt to an active schedule of group activities is not realistic. Those who have always been perfectionistic and governed by strict rules will not be able to "relax" or "let got" when their personal routines come into conflict with those of the institution. Someone who was never able to be sensitive to the feelings of others will not suddenly learn tolerance of and consideration for fellow residents. Residents who come with a history of having been impossible for their families will likely be impossible for staff.

Unrealistic expectations can result in feelings of alienation and abandonment on the part of the resident, and feelings of anger, frustration, and helplessness on the part of the staff. By setting more workable goals, staff strive to minimize tension while finding ways for the resident to coexist optimally with others in the institution. Several important aspects of management will be described in the following sections.

### Clarity, Consistency, and Communication

One aspect of developing a management approach involves identifying problem areas and developing strategies to deal with them as described in Chapter 13, Behavior Management Strategies. Clarity is essential when working with this population. Only if the treatment goals are clearly articulated and documented will staff have an opportunity to evaluate various approaches without losing their sense of direction.

Although staff must be flexible in acknowledging a resident's problems and defining their expectations, once a particular treatment direction has been chosen, consistency is important. For example, if a decision is made to respond to a particular resident's need for control by allowing her some choice around certain aspects of daily care, the areas of choice must be clearly specified and consistently communicated to the resident, lest a battle for control develop around other issues such as medications and smoking.

There must be extensive communication among staff in order for the management plan to be applied consistently. This involves charting plans, communicating approaches to consultants who are not familiar with the situation, and reporting between shifts. Particularly in cases where the potential for splitting is high, communication must extend to all those involved, including family and administrative staff. Special meetings may have to be scheduled. The resident, also informed about aspects of the plan, may become a willing ally if the plan is felt to be a means of achieving desirable common goals. Even when such an alliance is not possible, clear and consistent communication to the resident of staff intentions is essential.

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## Staff Support

Most of us need to have some sense that the work we do is valued by others. Being compassionate, caring, and helpful are all part of being a caregiver. The meaning and fulfillment we derive from our role depends to some extent on confirmation from those around us that we are doing a good job. Residents with personality disorders often fail to give us the appreciation we may expect, deserve, and need. Instead, they demean, accuse, demand, and seem oblivious to our efforts. Those providing direct physical care have to cope with these reactions on a daily basis. Nondirect caregivers may become the recipients of a litany of complaints about the direct caregivers. This can lead to divisiveness among staff as the team is split along professional lines. Typically, nursing staff are pitted against physicians, social workers, and administrative staff. Staff meetings, by providing an opportunity for interdisciplinary communication, can foster greater understanding of the resident's impact on care and care providers.

## Understanding the Role of Psychoactive Medications

In the face of the stress of caring for these residents, it can be tempting to seek "magical" solutions for complex problems. Physicians may feel pressure to "do something" in response to a sense of helplessness, urgency, or angry frustration in themselves or staff. A prescription for a psychoactive medication, however appealing, rarely resolves the problems and may complicate the situation. Apart from producing side effects and possibly leading to addiction, the medication may become a powerful symbol to the resident. While the medication represents a sign of caring for some, others interpret it as evidence they are being controlled, silenced, or dismissed as "mental cases."

There are, nevertheless, situations where the use of medications can be helpful. Whenever another psychiatric disorder is superimposed on a personality disorder, the acute illness must be treated in the usual manner, even as staff keep in mind that taking medication is an aspect of relating to others and can become a focus of conflict. Less commonly, the symptoms of the personality disorder itself may be an indication for using medication. Extreme anxiety, agitation, or occasionally even psychotic symptoms can be precipitated by stressful events. A brief course of anxiolytic or antipsychotic medication can help to reduce these symptoms and restore a sense of control to the resident. The use of long-term pharmacotherapy to manage specific aspects of different personality disorders such as impulsivity and dysthymia remains under investigation [2].

## The Use of Psychotherapy

Where resources permit, the use of formal psychotherapy can be considered. Experience and skill are necessary in deciding when psychotherapy may be helpful, and if so, what kind of psychotherapy is indicated. When used inappropriately, insight-oriented therapy can be experienced as very intrusive or exacerbates an already difficult situation by uncovering needs and longings that cannot be met. Evidence supports the use of approaches

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focused on symptom relief and improved adaptation using a variety of supportive, cognitive, behavioral, and interpersonal techniques with the judicious use of insight [2]. Expecting major shifts in life-long personality patterns through psychotherapy is usually not realistic. Yet even modest successes can make an enormous difference to the resident, family, and caregivers.

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## Case Illustration

Mrs. A., a gaunt 80-year-old resident with chronic obstructive pulmonary disease, led a chaotic life characterized by interpersonal difficulties and disappointment in those around her. She berates and demeans her two daughters for not visiting or caring enough. Although the younger daughter, confined to a wheelchair, visits when she can, Mrs. A. is unable to appreciate the effort. Her relationship with her elder daughter is characterized by demands that her daughter intervene and insist that the administrators of the institution accede to Mrs. A.'s every wish.

The daughters tell staff their mother left them with their grandmother, in order that she might travel the globe with her husband. The marriage was chaotic. When infidelity eventually led to separation, Mrs. A. threatened suicide and took an overdose of medication. Yet Mrs. A. idealizes the relationship describing it as "special, like no other marriage; he adored me." Unable to maintain a steady job because of her explosive reaction to any criticism, Mrs. A. was barely able to make a living after the separation. Although clever and articulate, she alienated those around her by demanding their undivided attention and blaming them when things went wrong. Angry and alone, demanding more than the family could provide, she was admitted into a long-term care facility.

Her pattern of relating is replicated with the staff. She hurls insults at them and comments in a demeaning and derogatory fashion on appearance, race, and ethnic background. No staff member escapes her anger. She often refuses to be bathed, forgetting that she had agreed to a particular schedule earlier. She accuses staff of preferring other residents over her. She makes demands incessantly and attempts to keep staff in her room with numerous requests for assistance. She charges staff with taking belongings she has misplaced, but will not allow them to tidy her room. She pits staff against one another, alternating praise with criticism. Staff are never sure where they stand with her, and no one wants to be assigned to provide her care.

## Comment

Mrs. A.'s manner of relating to others, her affective instability and her history of self-harm are typical of borderline personality disorder. The diagnosis helps caregivers understand that her behavior is not new or purposefully directed at them, and that they did not provoke her responses because they are inept. At this point, staff need assistance in containing and responding to Mrs. A.'s behavior. The following can be considered:

1. Providing consistent caregivers as opposed to rotating assignments involving the whole team, will give Mrs. A. the opportunity to begin to develop a relationship with a few of the staff. Because Mrs. A. is so difficult to work with, thought and discussion must take place within the team before the new approach is implemented.

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2. The plan of care should be structured so that all staff can agree upon it and will follow it in a consistent manner. Posting a copy of the care plan in Mrs. A.'s room and having a copy readily available in the nursing station will ensure that it will be used on a daily basis and provide staff with the structure they need when caring for Mrs. A. If it is presented to Mrs. A. in a constructive rather than a punitive manner, the care plan may be reassuring to her, and serve as a concrete sign that she is not being abandoned.
3. As part of the care plan, the verbal abuse may be targeted for behavior management using the techniques described in Chapter 13. Based on their assessment of the behavior, whenever Mrs. A. yells, screams, insults, and makes racial remarks towards staff, she is told that they will leave the room until she is in control, at which time they will return to continue her care.
4. To help reduce the tendency for splitting, whenever Mrs. A. attempts to talk about one staff member to another, she is gently told to redirect her remarks to the caregiver she is discussing. If she continues, the staff member leaves the room until she stops.
5. Administration should be informed of the plan of care and asked to support it by redirecting complaints back to the unit providing the care. Meetings between Mrs. A.'s family and administration should always include a representative from the team providing the care.
6. The daughters can be assisted in setting appropriate limits on their contact with Mrs. A. by involving them as part of the team effort to cope with Mrs. A.'s needs.

### Case Illustration

Mrs. B, a beautiful 85-year-old woman, is described by her daughter as always needing to be the most important person in the family. She remembers how both she and her father struggled to prove to Mrs. B. how much they loved her. Later, Mrs. B. was unable to be genuinely interested in her grandchildren, seeing them as competition for her daughter's time and attention. Living in an long-term care facility where she is one of many residents is difficult for Mrs. B. She is easily offended and reacts to perceived insults vigorously by screaming or refusing to do what is asked of her. She demands instant gratification of her needs, constant flattery, and insists she is not "like those others with no brains," but "of a superior class." She places great emphasis on her beauty and has a portrait of herself on her bedroom wall to which she constantly refers. She refuses to look in the mirror. Mrs. B. has cognitive deficits. She is often unaware that her clothes are soiled and that she needs bathing. She sometimes resists care, insulting and hitting out at staff. At other times, she flatters staff and cooperates with them. Because Mrs. B. is so unpredictable and difficult to work with, staff have come to believe that she is a nasty self-centered old woman who makes their lives miserable on purpose.

### Comment

Mrs. B.'s sensitivity to criticism, her need to be special, her sense of entitlement, and her disregard for others characterize her as having a narcissistic personality disorder. It is difficult for staff to understand that her behavior is not purposeful but a function of her dementing process superimposed on a personality that feels entitled to be treated as a special person. Management is based on the understanding that underlying her need to emphasize her superiority and beauty is a deep-seated fear of worthlessness.

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1. Given Mrs. B.'s vulnerability in the face of multiple assaults on her fragile sense of self, staff can help her by supporting her defenses. This could involve encouraging her to talk about her past accomplishments or discussing her clothes, her picture, and other areas of interest that give her pleasure. Pushing Mrs. B. in the direction of facing truths about her aging and decline would overwhelm her already tenuous ability to hold onto a positive image of herself. What might be construed in a less vulnerable individual as coming to terms with painful realities, would in Mrs. B.'s case likely lead to despair, anger, and an exacerbation in interpersonal difficulties.
2. Understanding that Mrs. B.'s feelings about herself, and her ability to accept the care she needs, fluctuate with her self-esteem, will prepare staff for Mrs. B.'s unpredictability. In this case, the unpredictability is also a function of cognitive difficulties. In order to maintain consistency, the management plan should anticipate conflicts by spelling out, for example, how staff can respond in case Mrs. B. refuses a certain aspect of care. As in the previous case, certain behaviors may be targeted for modification.
3. As in Mrs. A.'s case, Mrs. B. will benefit from continuity and consistency in caregivers. Gradually she may begin to build relationships in which she can feel safe with a few of the staff. Through such relationships, staff may begin to understand Mrs. B. a little better. For example, Mrs. B.'s consistent battle over bathing might be reassessed when it becomes known that she never liked to be touched and that she never bathed except in absolute privacy. Using this knowledge, bubble bath and perfumed soap could be added to the bathing routine. Staff could make sure to turn their backs as much as safety will allow. Although with these changes Mrs. B.'s aggression may decrease, it would be unrealistic to expect it to go away.

## Case Illustration

Mrs. C., an 82-year-old widowed woman, currently lives in the long-term facility that a decade earlier she had visited every day for 4 years until her husband died. Although at the time her children and others encouraged her to take time for herself she was unable to do so. She felt she would be criticized for being a bad wife and said that her husband cried whenever she raised the issue of not coming in the next day.

Mrs. C. was admitted to residential care after she broke her hip. Although competent, she gave her daughter financial power of attorney, feeling she did not want to make decisions about selling her home or managing her money. Since admission, Mrs. C. has been disappointed that staff encourage her to be independent in activities of daily living. She experiences this as staff "not caring" about her or "being lazy."

She has a long history of depression. She tells staff she had a very hard life and "never a happy day." Whenever she is alone she becomes "very nervous." She often mistakenly refers to he daughter as "my mother."

She has some problems with recent memory and worries about becoming like the others who have "lost their minds." She is aware of her need for others and says that, "being between people helps." She goes to craft class and recreation programs and likes to knit when alone.

No amount of family contact diminishes her wish to be with them or her feeling that she is neglected by them. This way of relating to others is replicated in her relationship with the staff. She is disappointed in the direct caregivers whom she perceives as not doing enough for her. Yet she does not tell them this directly, feeling that they will reject her if she does. Instead she becomes unhappy and irritable, expressing her distress in the form of physical symptoms.

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## Comment

Mrs. C. has a dependent personality disorder. Her behavior is characterized by dependency, submissiveness, and an inability to make important decisions on her own. Her attachments to others have a clinging, helpless quality. She is unable to tolerate being alone. Helping Mrs. C. involves the following:

1. An assessment of Mrs. C.'s needs would identify clearly those areas in which she needs assistance, while functions that she can carry out independently will become apparent. Care can then be planned to ensure that Mrs. C. receives help where she needs it. By coming to Mrs. C.'s assistance before she asks for help, staff can begin to build for Mrs. C. a sense that her needs are being taken seriously and attended to promptly.
2. Sharing the results of the needs assessment with Mrs. C. is an important aspect of this approach, because it establishes clearly those areas in which Mrs. C. will be expected to function independently. Whenever Mrs. C. requests help around one of these functions, staff can remind her gently of the assessment and assist her in finding ways to overcome the problem on her own.
3. Mrs. C.'s tendency to somatize (i.e., to express her distress in the form of physical symptoms) can present a significant management challenge. Even though staff recognize that when Mrs. C. says "I feel weak, my head is spinning and I can't breathe," she is unconsciously voicing her fear of being alone, staff cannot dismiss these symptoms without investigating them. In giving her the concern and caring she craves through the investigation, staff unfortunately reinforce Mrs. C.'s tendency to somatize. Particularly in the elderly such patterns can be difficult to avoid. Investigations can, however, be done in a judicious and conservative manner once staff become more familiar with Mrs. C.'s symptoms. Moreover, by linking crises such as her daughter's holidays with an escalation in Mrs. C.'s physical symptoms, staff can anticipate problems. It may be possible to modify the approach during difficult periods by, for example, spending a little extra time with Mrs. C. and acknowledge her feelings about her daughter.
4. Mrs. C.'s character structure and behavior may be difficult to differentiate from depression and may predispose her to developing clinical depression. A trial of antidepressant therapy may be considered, even in situations where depressive symptoms appear to be very long-standing.

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