

The background features abstract, overlapping geometric shapes in various shades of green, ranging from light lime to dark forest green. These shapes are primarily located on the left and right sides of the slide, framing the central text. The overall aesthetic is clean and modern.

PERSONALITY DISORDERS

Working with Personality Disorders
in Palliative Care

PRETEST!!!

There are NO wrong answers.

:)

Personality Disorders

- ▶ Some of the hardest people we work with.
- ▶ Lots of disagreement what a Personality Disorder is.
- ▶ Even more disagreement about what causes the disorder.
- ▶ Obviously there is disagreement how to intervene.
- ▶ We need some clear guidelines in how to recognize and work with these people.
- ▶ The diagnosis of Personality Disorder usually results in discrimination and harsh judgment. How do we provide care while avoiding the judgment?

Summary of the lectures by Drs. Greg Lester and George Simon

- ▶ Lester: “Personality Disorders and the DSM-5”
- ▶ Simon: “Manipulators & Character Disorders: Interventions, Perspectives & Strategies”
- ▶ Including information from books by Dr. Lester “Borderline Personality Disorder, Today’s Most Powerful and Effective Treatment and Management” and “Personality Disorders, Advanced Treatment and Management”

Personality Disorders

- ▶ Axis I versus Axis II
 - ▶ There are five Axes:
 - ▶ I. Clinical disorders (anxiety, depression, adjustment disorders)
 - ▶ II. Personality Disorders and Mental Retardation (11 personality disorders)
 - ▶ III. General Medical Conditions (things affecting mental disorder, ie: infections, neoplasms, complications of pregnancy)
 - ▶ IV. Psychosocial and Environmental Problems (bereavement, isolation, life-cycle problems, poverty, unemployment, etc.)
 - ▶ V. Global Assessment of functioning (Clinician's judgment as to level of impairment, usually 1-100 scale)
- ▶ Psychiatric Disorders versus Personality Disorders.
- ▶ Take home: Personality Disorders are a global deficiency, not a malfunction.

DSM definition of Personality Disorder

- ▶ “A Personality Disorder is an enduring pattern of inner experience and behavior that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment.” DSM IV

Patients with a personality disorder:

- ▶ Perceive the world differently.
- ▶ Don't think that they have a problem.
- ▶ Usually feel the problems they have are the result of other people and the world.
- ▶ Lack any empathy or ability to perceive the world from another viewpoint.

Personality Disorder Statistics

- ▶ 39-100% of the clinical population
- ▶ Close to 100% of the prison population
- ▶ Probably 100% of addicts
- ▶ 15-19% of the general population
- ▶ 10% of Borderline Personality Disorders are terminal
- ▶ PD accounts for most:
 - ▶ Spree killing
 - ▶ Spousal and child abuse
 - ▶ High risk behavior
 - ▶ Substance use
 - ▶ PD patients are high consumption users of health care

Personality Disorder Traits

- ▶ How do you know? Consensus!
- ▶ Theodore Millon “Disorders of Personality” 1981
 - ▶ 1. Adaptive inflexibility
 - ▶ 2. Tenuous stability
 - ▶ 3. Vicious cycles
 - ▶ The drama triangle:



Neurosis versus Character Disorders

- ▶ The goal of therapy with the neurotic is to make conscious the unconscious.
- ▶ The usual reason a neurotic comes to therapy is personal unhappiness and/or guilt or shame.
- ▶ The PD lacks the capacity to feel guilt or shame. Rarely feels the problem within them, instead it's the outside world's fault.
- ▶ PD usually have a clear understanding of their motivations; the neurotic needs help uncovering their motivations.

DSM-V has ten specific Personality Disorders

- ▶ Paranoid
- ▶ Schizoid
- ▶ Schizotypal
- ▶ Antisocial
- ▶ Borderline
- ▶ Histrionic
- ▶ Narcissistic
- ▶ Avoidant
- ▶ Dependent
- ▶ Obsessive-compulsive
- ▶ NOS

Summary of the Characteristics of a Personality Disorder (Dr. George Lester)

- ▶ 1. A limited set of functioning traits resulting in a failure of flexibility and adaptability.
- ▶ 2. Lack of a functioning observing ego (a lack of productive awareness, resulting in failure of self-corrective ability).
- ▶ The creation of drama (unproductive escalations) instead of problem-solving.

The spectrum of severity of Personality Disorders

- ▶ “Most current thought focuses on the severity of the Personality Disorder’s disruption of the patient’s Life, versus the subcategory of Disorder.” Dr. Simon
- ▶ The DSM V now includes ranking of severity of PD, based on disturbance of a patient’s life.
- ▶ This is a work in progress, but moving in the right direction.

Etiology of Personality Disorder

- ▶ A. Freud and neurosis.
 - ▶ ID/Ego/Superego
- ▶ B. 1952 DSM I first mentions Personality Disorders.
- ▶ C. Kernberg, Matterson, Millon.
- ▶ D. Usually diagnosable by age 5, always by the time of young adult.
- ▶ E. NOT from childhood abuse.
 - ▶ 80% of abused children are okay.
 - ▶ 75% of PD had unremarkable childhoods.
 - ▶ If abused became abusers then we would have mostly female abusers. We do not.
- ▶ F. Probably 80% genetic, with some environmental pressure for expression.

VI. Intervention and Treatment

- ▶ A. Usual treatments for neurotics WON'T work.
 - ▶ Neurotics need to make conscious the unconscious drives that impair their lives. P.D. already know what they want and why they want it. They simply don't care what others think. Often their drives are narcissistic and shallow.
- ▶ Personality Disorders are missing something. Therapy must focus on providing external replacement of that missing part.
- ▶ Treatment/therapy versus Management
 - ▶ In providing Home Health and Palliative care it is likely we are only able to manage a PD, not treat them.

Personality Disorder treatments

Historically treated in similar ways as Axis I:

Psychotherapy

In-depth analysis

Insight oriented therapy

Group Therapy

Family Therapy

Medication

Drs. Lester and Simon have reached the conclusion **NONE** of these work! (I agree).

PD is a totally different operating system and interventions must reflect that.

The bottom line in treatment

- ▶ “It works much better to think of personality disorders as a biological, “neurological” entity than a historical “experiential” entity because:
 - ▶ 1. The cause is primarily biological.
 - ▶ 2. Any environmental causative factors are not yet identified.
 - ▶ 3. Any environmental causative factors are not consistent, even within a diagnosis.
- ▶ THEREFORE:
 - ▶ “Interventions need to focus on repairing the neurological and psychological deficiencies of the self, and avoid getting caught up in an unproductive loop about a bad childhood” Dr. G Lester

Management:

Lay the foundation that inhibits the disordered behavior!

1. Clear and specific agreements.
2. Team approach.
3. Set and maintain firm, reasonable and conscious limits. Don't fall for exceptions.
4. Be willing to "let go" at any time. Over-attachment to outcomes create drama.
5. Stay focused on your purpose!

Management (continued)

6. Be judicious about criticism. PD are deeply wounded despite their appearances.
7. Watch your emotions. Calm down.
8. Don't get caught in the need to be right.
9. Do not race to the rescue. Remember the "Drama Triangle".
10. When in doubt "give them attention", make them feel special.

Find a consequence that matters to them and can be linked to their behavior

1. Direct and non-punitive communication. Active empathetic neutrality.
2. Be active and responsive.
3. Listen compassionately YET without yielding.
4. Don't side track into "reasons".
5. Focus on the outcome you are trying to achieve.
6. Remind them of the positive benefits that will come.

Goals of interventions with a Personality Disorder

- ▶ 1. Try to increase a patient's flexibility and adaptability.
- ▶ 2. Attempt to improve a patient's self management/control.
- ▶ 3. Effect decreases in the frequency and intensity of the drama.
- ▶ 4. Improve a patient's problem solving abilities.

Specifics to management of PD

1. Reinforce desired behavior.

ie: Praise compliance with plan of care.

2. Extinguish undesired behavior.

ie: Remove attention from them. Become disinterested and withdrawn.

Interrupt when they are off focus.

3. Don't directly challenge them.

4. Don't compete for attention.

5. Calmly explain cause and effect.

6. This is NOT about you!

Existential issues for patients with Personality Disorders

- ▶ PD have a different view of the world.
- ▶ PD believe their viewpoint is the only viewpoint (lack of empathy).
- ▶ PD are unable to adapt or respond to changes in their world.

- ▶ How can they possibly adapt or respond in a healthy way to a serious health issue?
- ▶ How can they respond to their bodies decline and disability?
- ▶ How can they contemplate death and non-existence when their world is **ONLY** about themselves?

Management goals for the progressively declining patient with a PD

- ▶ Accomplish the identified goals. Ie: POLST
- ▶ Decrease suffering whenever possible.
- ▶ Anticipate the drama and head it off with clear instructions.
- ▶ Decrease the frequency and severity of the drama.
- ▶ Do NOT engage in the Drama Triangle.
- ▶ Develop clear plans for every possible scenario.
- ▶ Utilize ALL the team.
- ▶ During periods of calm, neutrally discuss death and decline. Norm it.
- ▶ Strengthen a PD support systems.
- ▶ Don't expect change or acceptance, hope for calm.

TV and Movie examples of Personality Disorders

▶ **Seinfeld**

- ▶ George Histrionic
- ▶ Kramer Schizotypal
- ▶ Jerry Narcissistic

▶ **Sex in the City**

- ▶ Charlotte Obsessive-Compulsive
- ▶ Samantha Histrionic
- ▶ Mr. Big Avoidant

▶ **Street Car Named Desire**

- ▶ Blanche Borderline

▶ **Ordinary People**

- ▶ Beth Obsessive-compulsive
- ▶ Calvin Avoidant

TV and Movies examples of Personality Disorders (continued)

- ▶ **Gone with the Wind**

- ▶ Scarlett Histrionic

- ▶ **Fatal Attraction**

- ▶ Glenn Close Borderline

- ▶ **Basic Instinct**

- ▶ Sharon Stone Antisocial

- ▶ **A Fish called Wanda**

- ▶ Kevin Kline Antisocial

Your new patient:

- ▶ Ms. Smith is a 56 year old female with breast cancer. She lives alone. She delayed evaluation of her breast lump until her cancer had spread to her liver, brain and bone. She has had three surgeries that went poorly. She is referred to Home Health for care of her draining breast wound.
- ▶ It took several phone attempts to set up her visit. You arrive at the door, and there is no answer. After a 10 minute wait the door opens. Ms. Smith is tearful and reaches out to hug you. “Oh finally, you are here. Thank God! My wound! My pain! Please, please help. I just don’t know what else to do.

Possible responses:

1. You drop your bag and hug her. Gently you bring her inside and assure her you will take care of her pain and her wound.
2. You step back from Ms. Smith and inquire why she took so long to answer the door, as your day is very busy.
3. You introduce yourself and shake Ms. Smith hand. Asking if you may enter, you explain that you are here to evaluate her draining breast wound.
4. You ask her why she is crying and how you can help.

Ms. Smith looks upset and says “evaluate? I desperately need care. You have to fix this horrible thing now, today. What is the matter with you? I must have help!” You reply:

1. I can't fix you. I'm just doing my job. I'm here to evaluate the wound. If you need more you'll have to call my supervisor.
2. Your doctor ordered an evaluation. I'm here today to do that. Let's work together to accomplish that so you can begin getting the care you need.
3. You poor thing! I can see your pain. I'll go back to the office and get the supplies you need. I will fix this today.
4. I have to go now.

While you are assessing the draining wound, Ms. Smith begins to tell you her life story, which is very sad. You begin to tear up and feel very badly for her suffering. You say:

1. Gosh, your story is so sad. This wound looks like it will benefit from three time a week dressing changes.
2. Let's focus on getting this wound assessed. Tell me what medications you are taking.
3. How am I to do my work while you are crying?
4. Please, lets just get through this. I have lunch in 15 minutes.
5. My mother died of breast cancer, she was younger than you.
6. Did you say you needed a blender to make your smoothies? I have one you can have.

You've finished your assessment of Ms. Smith. You need to explain the plan of care and get agreement from her for the plan.

1. I'll come next week one day with the supplies. Okay?
2. Your wound needs three times a week dressing changes for now. Myself, or another nurse, will do this wound care. I will be back in two days, on Friday, at about 1pm to change this dressing.
3. This is too stressful for me, I'm going to ask my manager to reassign you to someone else. They will be in contact.
4. Here is my personal cell phone, I don't give it out often, but I'll do it for you. Call if you need something.
5. Now you're in Home Health, so you have to comply with our rules. If you don't we'll be forced to discharge you.

Palliative care consultation for a hospitalized patient

- ▶ Mr. Jenkins is a 74 year old patient with end stage COPD. He has been in the hospital five times in the past year. Each time with an exacerbation of COPD and/or pneumonia. He has been in the hospital for three days this time and has been demanding and difficult to care for. He is demanding to go home now. His wife is very quiet and deferential to him. His children live close by, but haven't been in to see him during any of his hospitalizations. Mr. Jenkins has been disabled from work for over 20 years. There is no POLST or Advanced directive. Mr. Jenkins has reluctantly agreed to a palliation consultation "As long as it gets me out of here faster". The palliative care team enters the room and introductions are made. Mr. Jenkins says "who are all you people and what the hell do you want?".
- ▶ What clues do you have that you might be working with a Personality Disorder?

Possible responses:

- ▶ 1. We are a team of health professionals that discusses serious illnesses and ways to manage symptoms.
- ▶ 2. The hospital staff said you were angry and they thought we might be able to help you.
- ▶ 3. What do you know about palliative care?
- ▶ 4. Sounds like you're having a rough time, tell us about that.
- ▶ 5. Lets watch the language please.

Mr. Jenkins glares at the team, but shrugs in acquiescence that the team can sit down. Mrs. Jenkins doesn't make eye contact. Suspecting Personality Disorder, how might you begin?

- ▶ 1. What does it feel like to be dying?
- ▶ 2. How has it been going for you during your hospitalization?
- ▶ 3. Tell us something about your life and family.
- ▶ 4. What is your understanding of your current health?
- ▶ 5. Here is what we need to discuss today.....at our conclusion we will have a plan for on going care for you.

Mr. Jenkins launches into a long series of complaints about his care and all that has going wrong in providing his care. It is clear he has suffered from his symptoms and that his condition has worsened over the last six months. How might you intervene now?

- ▶ 1. Tell us which nurse made the mistake with the nebulizer treatment. We will look into that.
- ▶ 2. Why do you focus on all the mistakes, when so much has been done to help you?
- ▶ 3. Today we will focus on specific things we can do to clarify your wishes for future care.
- ▶ 4. We're so sorry that you have suffered, we will try to help you.
- ▶ 5. What medications do you take and how often do you miss a dose?

After an hour of discussion, Mr Jenkins agrees to a POLST that is DNR, and no intubation. He agrees to consider increased care in the home, as a way of preventing further hospitalization (which he hates), but he is angry with any discussion of hospice care. Which wouldn't you want to do in closing?

Avoid which one:

- ▶ 1. Make sure Mr. and Mrs. Jenkins have the original POLST and understand where to post it at home.
- ▶ 2. Discuss the limits of what home care can provide.
- ▶ 3. Provide antibiotics for future use in the home, with instructions on when to use them.
- ▶ 4. Encourage couples counseling and/or individual counseling to focus on Mr. Jenkin's childhood traumas.
- ▶ 5. Provide contact information for hospice programs for an informational visit.
- ▶ 6. Prescribe antidepressants to help Mr. Jenkin's mood.
- ▶ 7. Provide abuse counseling contacts for Mrs. Jenkins.

REMEMBER:

LOVE IS THE ANSWER,
BUT IT IS NOT ALWAYS THE
INTERVENTION!

In closing:

- ▶ You became a Health Professional to be of service and help people.
- ▶ A major aspect of satisfaction in your job probably comes from your relationship with your patients.
- ▶ You will NOT receive pleasing or supportive feedback from the PD.
- ▶ Personality Disorders have a deficiency that impairs their empathy.
- ▶ These patients are broken and need our help. But our help will look very different than our interventions with other patients.
- ▶ Your relationship with Personality Disorders IS the intervention!
- ▶ TAKE CARE OF YOURSELF and the patient!

Possible focusing Affirmations?

- ▶ I am here to help.
- ▶ I am skilled and competent.
- ▶ I want to provide healing.
- ▶ I am not the Drama. I can not rescue. I will not persecute. I am not a victim.
- ▶ This patient is broken and needs compassionate care.
- ▶ My relationship with this patient is professional ONLY.
- ▶ I will provide neutral and firm external limits and rules to this patient because they do not possess internal restraints.

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Thank you!

Questions?