Behavioural Supports Ontario
Soutien en cas de troubles du comportement en Ontario

Personality Disorder in Older Adults: Understanding the Person, Building Skillful Approaches and Fostering Wellness in Care Teams

Developed by:
The BSO Knowledge to Practice Community of Practice (CoP)

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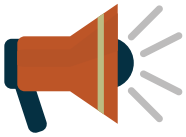
Table of Content



We want to hear from you.

Please take a moment to provide your feedback on this resource and the rest of the Personality Disorder Capacity Building Package.

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Personality Disorder - The Basics

Introduction

This resource offers practical, compassionate, person-centred knowledge and strategies for those caring for older adults living with a personality disorder. It may be a resource for team members themselves, or those that support the team members (e.g. educators and leaders).

Best practice approaches for people living with personality disorders are unique and may vary greatly from those for individuals living with dementia or neurocognitive disorders. Care teams may seek additional support when members feel stressed or fearful towards the person or feel that they lack the necessary skills to support the person effectively.[1,2] At the same time, the person with a personality disorder may feel distress, hopelessness, and stigma.[3] Team members are more likely to succeed in supporting the person if they recognize personality disorder as a mental health condition requiring support; understand the person's complexity; demonstrate empathy; and utilize skillful interpersonal approaches.[1,4]

Caring for individuals living with personality disorders is challenging for several reasons. First, the accuracy of the diagnostic label is a subject of debate, with advocacy groups contending that the terminology can be misleading and stigmatizing, implying something inherently wrong with the person, or ignoring social context and evidence that recovery is possible.[5-9] Not all personality disorders are equally studied.[8] We acknowledge that aspects of these diagnoses are dynamic and may change in future editions of the Diagnostic and Statistical Manual (DSM)[10] as diverse perspectives continue to shape how we conceptualize and understand personality disorders. Rather than focusing on the diagnostic label, care teams are encouraged to avoid assumptions and focus on the behavioural patterns that are causing distress to the person and their care providers.

What is personality?

Personality is what makes you - you! Our personalities are influenced by experiences, environment and inherited characteristics.[11] Personality traits are patterns of thinking, perceiving, reacting, and relating to others, circumstances, and ourselves that are relatively stable over time.[10] Personality is the backdrop for all our experiences and can help explain why one person may find a situation challenging while another excels.[12] The image to the right illustrates a few personality traits.

What is a Personality Disorder?

A personality disorder is a relatively rare mental health condition where a person's thoughts, feelings, and behaviours deviate significantly from cultural expectations, causing distress or dysfunction in multiple domains of life, such as work and relationships.[10,13] Personality disorders reflect long-term, learned patterns of behaviour and functioning that affect at least two of the following areas:

- Way of thinking about oneself (e.g. challenges related to identity and self-esteem)
- Way of responding emotionally (e.g. difficulty managing intense feelings of anger, hate, emptiness or sadness)
- Way of relating to other people (e.g. strong feelings of attachment, fears of abandonment and difficulty seeing others' points of view)
- Way of controlling one's behaviour (e.g. acting impulsively).[10,13]

As a result, people with personality disorders often struggle to maintain healthy relationships because of interaction patterns that create tension. [12]

Types/Clusters of Personality Disorders (PD)

While no two people with a personality disorder are the same, personality disorder diagnoses in the DSM-5 are categorized into three clusters or groupings of traits:[10,12]

Cluster A - Often appears 'odd' or 'eccentric' to others and includes:
Paranoid PD - Mistrust and suspicion of others
Schizoid PD - Disinterest in relationships with others
Schizotypal PD - Eccentric ideas and behaviours
Depending on the individual, we might notice that the person has unusual beliefs, may prefer not to have close relationships, or may distrust others.

Cluster B - Often appears 'emotional', 'dramatic' or 'erratic' to others and includes:
Antisocial PD - Disregard of others, deceitful and manipulative for personal gain
Borderline PD - Intense emptiness, unstable relationships and emotional dysregulation
Histrionic PD - Strong desire for attention, excessively emotional
Narcissistic PD - Self-grandiosity, need for admiration, lack of empathy
Depending on the individual, we may notice intense attachment and turbulent relationships, emotions, and behaviours.

Cluster C - Often appears anxious, worried and fearful and includes:
Avoidant PD - Avoidance of interpersonal contact due to fear of rejection
Dependant PD - Strong need to be taken care of, difficulty with decision-making
Obsessive Compulsive PD - Perfectionism, rigidity, strong morals and detail-oriented
Depending on the individual, we might notice a fear of rejection, unwillingness to make decisions, or a strong need for a predictable environment.

Other PD Specified/Unspecified - This includes those that meet criteria for personality disorder with traits from several personality disorders, but not one specifically.

Factors in the Development of Personality Disorder

Personality disorders are believed to result from a complex interplay of genetic, environmental, and learned factors. Behaviours that appear extreme have at some point been effective for coping with intense emotions or trauma, such as childhood neglect or abuse.[12] The traits that are expressed in personality disorder are often self-protective strategies that the person developed early in life as a result of adversity/ trauma/neglect, and often without an attachment figure to trust or consistently rely on, and/or lacking models of positive and healthy relationships.[12,14]

Diagnosing Personality Disorders

Personality disorders must be diagnosed by a mental health professional who will evaluate historical knowledge and enduring patterns throughout the person's life and across different situations.[11] First, it is important to rule out conditions that impact mood and behaviour, such as depression and anxiety.[15]Personality disorders often co-occur with other mental and physical health concerns,[12,16] especially in older adults.[4] Missing either a personality disorder or its comorbid conditions can adversely impact treatment outcomes.[17]Obtaining collateral information from family, friends, or former care providers is helpful, but not always possible.

In primary care, time constraints and a focus on immediate symptoms can inadvertently lead to the oversight of a personality disorder. Interpersonal functioning may be overlooked, with symptoms misattributed to depression or stress.[16]Certain personality disorders, such as avoidant or dependent types, may be overly compliant or agreeable with care providers, potentially leading to an underestimation of their impact on the person's functioning.[15]Diagnostic hurdles also include limited or biased history, reliance on co-informants with insufficient knowledge of the person's early life, misdiagnosis, limited insight by the individual and a tendency to blame others.[18]Fear of stigma may lead people to withhold their personality disorder diagnosis from new care providers, while care providers themselves may hesitate to diagnosis due to stigma, or a belief that such a diagnosis is outside of their scope of practice.[16]

Treatment for Personality Disorder

The goals for personality disorder treatment include decreasing distressing symptoms, reducing risky behaviours, improving social interaction skills, improving sense of identity, reducing suicide attempts, and/or stabilizing mood.[9,19] Psychotherapy is considered the first-line treatment for personality disorders.[20,21] Specialized psychotherapies, such as dialectical behaviour therapy, are particularly recognized, especially in the treatment of borderline personality disorder.[13,22,23]These require engagement and effort from the person and can be costly, making these treatments challenging to access/implement. Medications are reserved to address comorbid conditions with established medication-based treatments, such as severe anxiety or acute psychosis, not to directly treat personality disorders.[13,23]Care teams should consider the individual's personhood and unique needs to create a tailored plan of care rather than solely relying on a diagnosis to direct care.

Older Adults Living with Personality Disorder

The Impact of Aging

People may live their entire lives without recognizing that they have a personality disorder or related traits for many reasons. Diagnosing older adults can be challenging as current diagnostic criteria were developed based on a younger population.[9,15,22,23] Personality disorders look different in older adults, for example, impulsivity seems to decrease, but emotional symptoms such as feelings of emptiness becoming more prominent.[9,17,18,23,24] Personality disorder traits fluctuate across the person's lifespan and may become apparent during life transitions.[22] Losses and life transitions that often occur in late life can be particularly difficult for those with personality disorder.[12] Losses can include deaths of family, friends or acquaintances; loss of roles in life; financial strain; health changes; loss of functional independence; or a move to a care setting.

Individuals with personality disorder may not have the needed coping skills to adjust to losses, nor the supportive networks to sustain community living.[12] Those who remain in community may be reluctant to accept help and live in poor or isolated conditions. Others may call upon community support so often that they exhaust these resources. Additionally, older adults with personality disorder features are more likely to experience suicidal ideation, poorer physical health, and cognitive changes.[25] Consequently, they may face challenges in aging that impact their quality of life and lead to overrepresentation in care settings.[12,26]

Meet Randy. Randy is a 62-year-old man who recently moved into the care setting where you work. While details about his past are vague, the team understands that he has limited family involvement and has always lived alone. After a fall at home a few weeks ago that resulted in a broken hip and a hospital stay, Randy was unable to return to his home due to his care needs. He requires help with meal preparation, bathing and dressing. He uses a wheelchair, which he can self-propel with his feet. He has a diagnosis of a personality disorder-not otherwise specified. Staff notice that he is particular about how his belongings and furniture are arranged, and how his food is served.

Living in Care Settings and/or Requiring Care

A move into a care setting, or requiring in-home care, for someone living with personality disorder may come with additional challenges and losses including:

- **Loss of control** associated with living in a structured care environment such as fewer food choices, changes to day-to-day routines, increased interaction with others, and feelings of powerlessness.[12]
- **Boredom** associated with limited meaningful engagement and role changes.[12]
- **Emotional needs** such as loneliness, fear, or chronic dysphoria (i.e. profound sense of unease or dissatisfaction).[12,22]
- **Changes in health status** that lead to reliance on others to meet needs can lead to feelings of helplessness, contempt, anger, and/or frustration.[12]
- **Activated interpersonal symptoms** such as abandonment fears or dependency.[4,12]
- **Mismatch between coping strategies and environmental demands**.[27] For instance, an individual with a schizoid personality style may live alone effectively, but might face difficulty in a setting with congregate dining, a structured schedule, and limited privacy.[12]

If personality disorder is suspected, but a diagnosis has never been made, it is important to refer to a mental health professional for further exploration. This can assist the team in effectively supporting the person, as well as rule out treatable conditions that present similar to a personality disorder.[28] If a sudden or drastic change in personality is noted, it is important to rule out other contributing factors such as depression, anxiety, dementia, stroke, as these require unique approaches.[10,28]

Randy used to live on his own in a little house that had a small garage in the back. Neighbours reported that he would spend time in the garage working on his car. He usually stayed up late and slept until mid-morning. He kept to himself and made his own simple meals. He is now in a care setting with routines and an environment that is quite different.

Essential Care & Communication Strategies

Establish rapport

- Introduce yourself, your role to the person and what you are there to assist with.
- Use a warm demeanour that is calm, caring, and compassionate.[13,29]
- Avoid preconceptions that the person is intentionally provocative.[13]
- Recognize behaviour patterns as life-long and may represent the person's attempt to cope with traumatic life events.[29]
- Learn about the person through a completed personhood tools such as the My Personhood Summary©.

Establish and maintain healthy and effective professional boundaries[30]

- Keep interactions warm, yet professional. Avoid sharing personal information or opinions.[13]
- Keep conversations focused on the individual's needs and interests.

Include the individual in creating their care plan

- Include the person in their care plan so that they understand what to expect and have an opportunity to communicate what matters to them. Clarify the person's role/abilities in their own care.[31]
- When creating a care plan, consider the person's strengths and interests.
- Consider posting the care plan in their room as a reminder of what to expect.[12]
- The person should be included in care plan changes, including changes in what to expect from the team, and what the team expects from them.

Offer opportunities for positive interactions/engagement and healthy coping

- The person may be accustomed to negative reactions, and this may be the only way that they know how to connect with other people. Encouraging and modelling positive interactions can help promote independence, trust, and better relationships.[29,32]
- Offer regular structured check-ins or appointments with the person at a predictable timeframe (e.g. hourly checks, or 1x/month with 20 minutes allotted).[16]
- Offer opportunities for positive engagement in person-centred activities.[12,33,34] For example, if the person enjoys art, encourage them to paint or make crafts.
- Offer opportunities for new roles within the community or care setting (e.g. organizing social events or participating in groups), as this can foster a sense of purpose.
- Behaviours may escalate due to boredom or loneliness. As a preventative strategy, assist the person in creating a personalized list of enjoyable activities that they can use to prompt meaningful engagement.
- Offer tools for effective coping strategies during moments of distress (e.g. deep breathing, promoting movement, listening to preferred music).[32] These interventions can be adapted based on the individual and their care environment.
- Validation is also important when the person is distressed and experiencing intense emotions. In these situations we can validate how the person feels, and offer healthier, effective alternatives to express these emotions (e.g. expression through art, exercise).[32]

Set clear and realistic goals and expectations

- Be clear about any goals and expectation set out in the care plan. Specific, clear and practical strategies and goals can give the team a sense of direction and confidence.[12]
- Clear rules and expectations build trust. Inconsistency can make the person feel insecure and more likely to respond negatively. Use positive reinforcement to encourage desirable behaviour. All team members must be onboard.
- We cannot change the person; however, we can reduce behaviour frequency, risk, and distress by modifying our approach, the environment, and our expectations.[12,35]

Ensure team-wide consistency in care strategies

- The entire team (every role/department) must understand and follow the care plan consistently.[13,35]
- Determine what choices/accommodations are reasonable to offer. Only offer options that can be provided consistently. Communicate this clearly to team members and the person.[12]
- Support team members to feel comfortable and confident using strategies that may be atypical of their usual approaches. Remind teams that clear boundaries and expectations are healthy, not punitive. The person's needs will be met.
- Consistent follow-through over time builds trust, respect and a sense of safety.[29]
- Initially limiting the number of team members involved can help ensure consistency. New team members, or those without prior knowledge of personality disorder, may be more likely to deviate from the care plan.[12] It may be helpful to on-board new team members by pairing them with a team member who is familiar with the person whereby they can teach/model effective interactions. This can also foster trust as the new team member is alongside an existing team member with whom the person has established rapport.
- Establish how the plan of care and any subsequent changes to the plan will be communicated to team members. Also, consider how the team will be supported in following the care plan.

Promote regular team communication

- Facilitate regular interdisciplinary team communication through documentation, routine huddles, debriefing, shift report and education.[12]
- Team meetings can be used for education, identifying strategies that work best, building team resilience, and exploring team tensions that might arise.[35]
- Collaborating with external partners such as community mental health agencies, specialist services, and police may also be helpful.
- If the person is moving to a new setting, ensure that their transition is well planned and supported. Utilize the My Transition Care Plan© and ensure the care strategies are communicated with the receiving team.

Address medical emergencies, self-harm, and suicide ideation

- Self-harm can manifest as misusing medications, non-adherence to medication routines or diets, or sabotaging treatment,[4,36] and is sometimes a way the person communicates their distress, or attempts to regulate intense emotional pain or feel a sense of control.[37]
- Suicide attempts in older adults are less frequent, but more lethal than younger individuals living with personality disorder.[4] Expressions of self-harm or suicide ideation should be taken seriously and warrant direct and concise questions (e.g. "Are you thinking of suicide?", "Do you have a plan to take your own life?").[29,38] Risk assessment includes monitoring for changes such as withdrawal and considering recent adverse life events.[32] Refer to your organization's policies around risk assessment and responses, and see page 30 for an additional resource on suicide risk assessment and prevention.

Behavioural Assessment & Care Planning

Despite utilizing preventative care and communication strategies, individuals with personality disorder can express behaviours that are challenging or disruptive. While these behaviours might help the person meet an unmet need, they can have negative consequences to those around them.

Common Behaviour Patterns in Care Settings

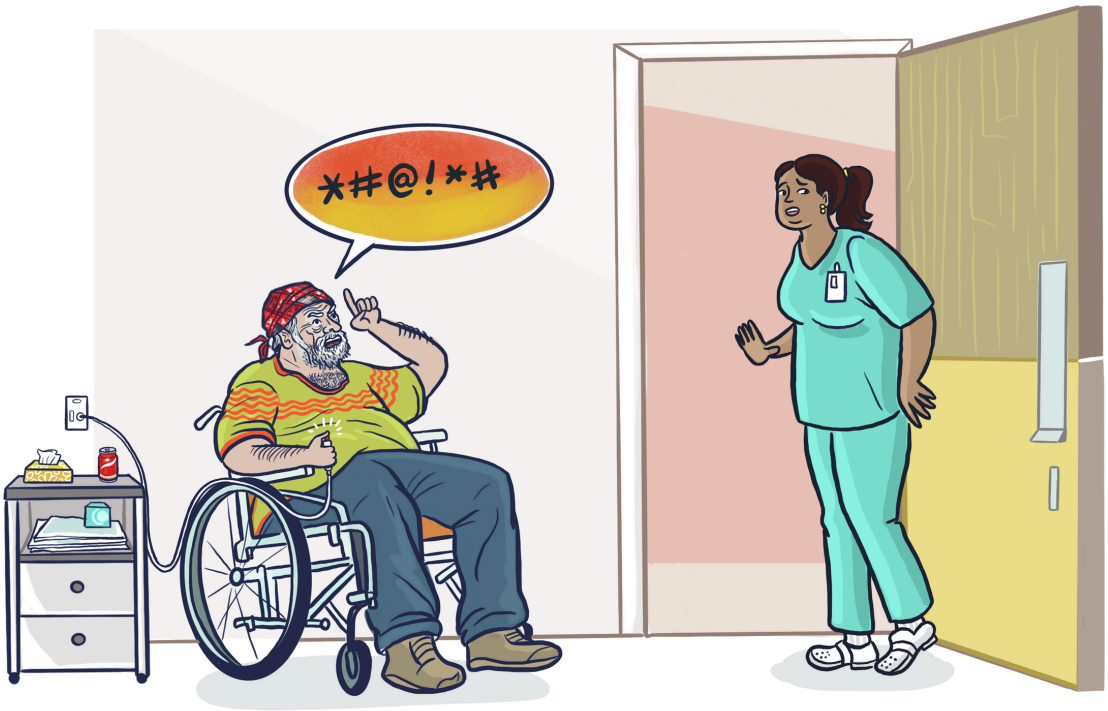
Behavioural patterns with individuals living with personality disorder with unmet needs may include:

- **Intense or excessive requests for help** include frequent use of the call bell, asking for help with tasks where the person is capable or independent, embellishing the urgency of care needs, or making extremely specific requests. Team members may feel they cannot satisfy the demands despite their efforts.[4,23]
- **Help-rejecting behaviour**[4] such as refusing necessary medical treatments, declining help offered by care team members or trying to do things for themselves outside of abilities.
- **Difficulty accepting professional boundaries** such as seeking personal information about team members and sharing what they have learned with others. Misunderstood boundaries can present as a strong attachment towards specific team members.[4]
- **Antagonistic interactions with team members** include rejecting certain care providers, name-calling or critical comments directed at team members, threats to report care providers to an authority for not meeting unrealistic demands, causing fear, shock or overwhelm amongst team members.[4,13]
- **Suspicious/mistrusting of team members**[4] may manifest as accusations directed at team members, questioning team members, detailed instructions and requests.
- **Dependence on team members for decision-making**[4] includes deferring minor decisions to team members.
- **Behaviours that pose physical risk to others** such as striking out or throwing objects at co-residents/patients or care providers.
- **Creating splitting within teams** which refers to tensions, frustrations and/or divisions within teams. It results from a series of events, starting with the individual living with personality disorder labelling team members as 'good' or 'bad', and comparing care provided by different team members.[4,13,27] This dynamic may reflect how the person with personality disorder typically engages with others as a result of intense distress or abandonment fears. The initial labeling of team members as good/bad leads to the person with personality disorder responding and interacting with team members in very different ways depending on how they are classified. This in turn affects how team members experience interactions with the person, and often influences how they respond, contributing to strongly opposing impressions of the person and approaches used.[39,40] These various views easily lead to disagreements and frustration amongst the team. See page 11 for an illustration of this process that results in team splitting. Addressing this dynamic through consistent care and team communication is essential for teams caring for people with personality disorder.[12,40]

Team Splitting

Team members may feel pressured to meet all of the person's demands, fearing that falling short is neglectful. This anxiety may intensify if the person threatens to report the team member to leadership, or to governing agencies. It is crucial to remember that maintaining boundaries is healthy for both the person and the team.[41] In fact, it is not possible or reasonable to meet all demands. It is in everyone's best interest to consistently follow a care plan that has been based on a thorough assessment and is person-centred.

Despite the team's attempt to help Randy adjust to his new home and provide for his care needs, they are feeling frustrated with Randy's responses. Randy uses the call bell frequently asking for minor room adjustments. During these interactions, he calls some female team members degrading names (e.g. "fatty" and "whore") or is angry that they took so long to come. Team members have left his room in tears. He also has thrown a tissue box at a team member when he felt that she did not respond quickly enough to his request, stating that he is being "ignored". He seems to have formed an alliance with certain team members, who he refers to as "the good ones", and will request specific team members if he feels the team member who comes to assist is "not qualified".



Assessment

Individuals living with personality disorders often rely on behaviours that have been effective in the past for coping with unhealthy interpersonal relationships and/or trauma, as well as meeting a need for connection and control.[29] These behaviours continue into the present as the person may not have gained other effective strategies or patterns, or they may perceive some benefit from the behaviour. Therefore, conducting a comprehensive behavioural assessment can help us understand the person's behaviour and to develop personalized and consistent approaches.

1. Know the Person

Complete a My Personhood Summary© to inform opportunities for meaningful engagement and to build understanding/empathy. In the case that the person is unwilling to complete the summary, you may need to build rapport over time and be clear on how the information will be used.

By completing the My Personhood Summary© the team learn the following about Randy:

- He is retired crane operator
- He is adventurous, but likes time on his own
- He likes motorcycles and used to enjoy solo motorcycle road trips
- He enjoys building model cars
- He loves watching action films such as Mission Impossible
- He likes playing solitaire
- He likes classic rock music
- He loves sweets, and his favourite drink is a diet Cola
- Little is still known about his childhood. Randy only shared that his mom worked hard and his step dad was "not a nice man".

2. Consider Contributing Factors

It is important to consider what function(s) the behaviours serve for the person, meaning the reason for the behaviour.[42] What is the unmet need(s) that they are trying to meet? Consider loss of control, boredom, emotional needs and changes in health status that may be associated with aging and/or living in new care settings.[27] Using a trauma informed lens, consider a possible past history of abuse, neglect or trauma.

3. Identify Behaviour Patterns

Tools such as the BSO-DOS© will help identify patterns in behaviours and offer an objective view. The care team should identify the key behaviours of concern based on frequency and risk. Examples of behaviours that may be identified include expressions of suspiciousness, excessive demands, episodes of yelling or cursing at care team members, and asking for help when help is not needed. Behavioural observation tools can also help the care team to identify how the person typically spends their day, and whether anything surrounding their routine is contributing.

4. Document Behaviours in Detail

Documentation is essential for evaluating whether current approaches are working and identifying where adjustments are needed. Behaviours should be objectively documented using ABC - Antecedents, Behaviours, and Consequences.[27]

- **Antecedents** - Describe what led up to the behaviour. This includes context such as location or any interactions that occurred prior. The antecedent can also be an internal experience or emotion that is difficult to identify. Team members should avoid assumptions around the person's internal state or intent; however, there is benefit in considering what the person could have been feeling and determining their unmet need(s). Exploring emotional needs and internal antecedents objectively can be done by using curiosity and avoiding labels.
- **Behaviour** - Objectively describe the behaviour in detail.
- **Consequences** - Describe the consequences or outcomes of the behaviour, including the responses from the person and others involved (e.g. team members). Identify what the person may have gained from their actions.

Documented Wednesday afternoon:

- **A** – Randy had been alone in his room for one hour after lunch.
- **B** – Between 1400-1430 Randy pushed the call bell 9 times to ask for room adjustments such as moving his tissue box to the night side table, asking for the volume to be turned up on the TV even though he was holding his remote
- **C** – Answered each call bell and responded to his requests. Randy continued to call.

Documented Thursday afternoon by:

- **A** – Randy was alone in his room from 1230 to 1330.
- **B** – From 1330 to 1400, Randy pushed the call bell 4 times to ask for room adjustments such as turning off his light, closing the curtains and closing a drawer.
- **C** – Answered the call bell the first three times. Kept interactions at a minimum. Randy continued to ring the call bell.

5. Review BSO-DOS© and ABC Documentation

As an interdisciplinary team, review completed assessment tools and documentation to better understand what leads up to the behaviour, what potential functions or purposes these behaviours may serve, or what solution they offer (e.g. emotional regulation, sense of control, or reassurance-seeking), and how the consequences/responses could further be reinforcing unwanted behaviours.[27] Brainstorm alternative approaches that could accomplish the desired outcome from both the team and the person.

During a team huddle to review the BSO-DOS© and the ABC documentation, the team noted a pattern in Randy spending time alone in his room after lunch, followed by multiple requests of the team. The team identified loneliness, boredom and worry that he will be forgotten as possible contributing factors.

The team also openly shared their frustrations. The team member who documented on Wednesday noted "I don't know what to do! I rushed in every time the call bell rang, and did everything he asked. It never seems to be enough! He just keeps ringing and asking for something else." The team member who documented on Thursday quickly replied "He did the same to me, but I did not rush in and I was in and out as quick as I could! It didn't seem to help! He kept ringing." The team recognized that their approaches have been different, and yet resulted in the same undesirable outcome. In the first approach, the behaviour was reinforced by an over-involved tendency (see page 26). The second approach had an under-involved tendency and may have reinforced the client's inner feelings of loneliness and boredom (see page 26).

The team recognized that they needed to find a way to alter the antecedent (what might be contributing to the behaviour). They brainstormed ideas to help Randy not feel lonely or bored in the afternoons, as well as to help Randy handle those feelings if he experiences them.

Care Planning

Based on the comprehensive behavioural assessment, care plan strategies can be made based on the identified contributing factors, the behavioural patterns and personhood information. Effective interventions should focus on reinforcing healthy boundaries, setting realistic goals and having consistent strategies used by all team members. For the care plan to be effective, a predictable, consistent environment with kind and fair expectations is key to building trust and ensuring success. Even having one team member who is not consistent with the established approaches can be a setback to moving forward with supporting the person effectively and can lead to team splitting.

Strategies for Common Behavioural Patterns

Below are some of the common behavioural patterns of individuals living with personality disorder that lead team members to seek support, with some strategies to consider when creating a care plan. These strategies should be considered in the context of a comprehensive assessment and should be tailored to the needs and unique personhood of the individual.

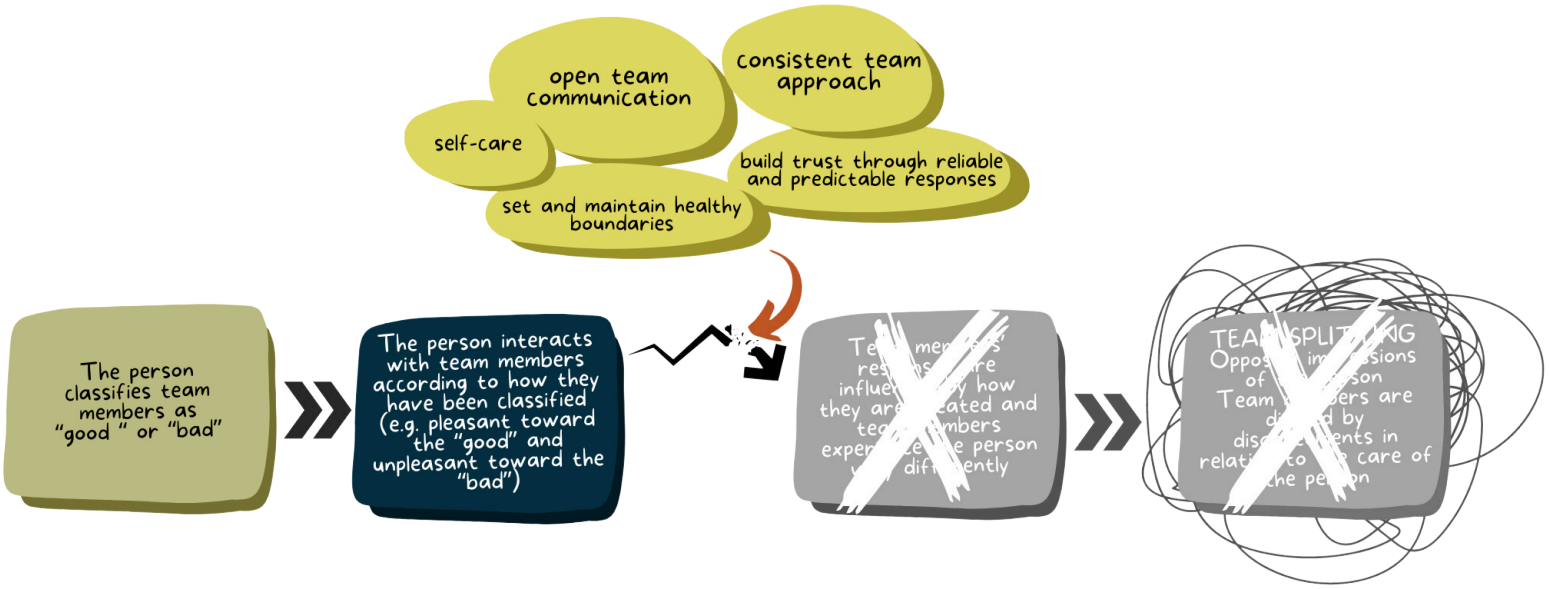
Behaviour	Strategies to Consider
Intense or excessive requests for help[4,23] • Frequent calls for emergency services (e.g. 911) for no emergency reason or use of a call bell beyond its intended purpose (e.g. calling every three minutes with no specific reason or for minor room adjustments) • Asking for help with tasks they are able to complete independently • Exaggerating the urgency of care needs • Frequent calls to community health providers or crisis services, and ED visits • Can also look like attempts to delay discharge in hospital settings[4]	• Encourage the person's independence and praise successes (e.g. "You can do this, and it will feel really good to do it yourself."). • Set reasonable limits for how often team members will attend to the person. • When the person reports symptoms that are medically concerning (e.g. chest pain), assess physical needs according to policy/standards, maintain professional composure and do not show excessive worry. Consider what else is going on in the person's life that could be causing distress that is translating into physical fears or symptoms.[12] • Offer positive interactions at other times. Set up a P.I.E.C.E.S.™ Pro-attention plan: provide opportunities for the person to interact with team members or provide/encourage other positive interactions outside of the provision of care.[43] • Set boundaries/limits - offer choices linked to consequences (see pages 24 and 27). • Refer to occupational therapy for an assessment to determine where support is and is not required. • Explain to the person that calling emergency services can lead to associated fees (e.g. bills issued for ambulance use).

Behaviour	Strategies to Consider
Help-rejecting behaviour[4] • The person refuses help or necessary medical treatment • This person may actually feel discomfort with their dependency on others	• Assess in order to rule out the intention for self-harm[4] • Identify and communicate the risk associated with refusing treatment according to your organization's policies. • Communicate to the person when you are able to return to offer help again, and stick to the timeline offered.
Difficulty accepting professional boundaries[4] • Seeking personal information about team members and sharing what they have learned with others • Strong attachment to specific team members	• Avoid personal disclosures.[13] • Limit conversations about all patients/residents to confidential areas where they cannot be overheard. • Kindly remind the person of the nature of the interaction/relationship (e.g. you are there to assist them as a medical professional). • Provide care consistently, according to care plan. • Seek out opportunities to develop and maintain rapport with the person during and outside of care.
Antagonistic interactions with team members[1,4] • Rejecting a specific team member. • Raised voice, yelling, and/or cursing • Name-calling • Critical comments towards team members • Discriminatory comments • Threats to report care providers to an authority for not meeting unrealistic demands • Creating fear or overwhelm amongst team members (e.g. team is fearful of being reported/fired even though they are following policies/procedures/practice standards) • Telling team members that they are being neglectful by not following all care requests (beyond what is reasonable and detailed in standards/ guidelines) • Sensitivity to interactions with team members, perceiving interactions as criticism	• Stop/pause the verbal exchange. • Set boundaries/limits - offer choices linked to consequences (see pages 24 & 27). • Clearly communicate what support is being offered to the person, including limitations. For example, "We are unable to switch staff assignments. You can have your shower now with PSW Andrea, or you will need to wait until tomorrow. Let me know what you decide." • If the care is non-urgent, it can wait. • There may be circumstances where the team decides it is reasonable to accommodate requests, this is up to the team to determine what is manageable and sustainable. For example, a staff who looks similar to someone who perpetrated past trauma may switch with another team member upon the individual's request. However, it is not reasonable to allow the person to discriminate against team members based on gender, race, sexuality, etc. • Encourage independence and choice where possible as the person may having difficulty accepting that they rely on others emotionally or physically.[4] • Offer privacy in care situations (e.g. personal care).[12] • Utilize a two-person approach to care. Designate one team member to talk, to minimize confusion/mixed messages. • Utilize strategies to not take behaviours personally. Recall that most individuals living with personality disorders have difficulty in interpersonal relationships.[31] *Strategies to consider continued on page 17*

Behaviour	Strategies to Consider
Antagonistic interactions with team members[1,4] *(continued)*	• Affirm the person in their right to refuse care and to contact those in authority. As threats of being reported can be frightening, reassure your team that if they are following standards, engaging in respectful conversations, and documenting their care/approach that their quality care will be evident. • Antagonistic interactions directed at other residents/ patients placing them at risk should be taken seriously with strategies put in place to reduce/eliminate the risk. These situations can benefit from specialist consultation, as some solutions may actually perpetuate other issues. For example, offering a private room to someone who antagonizes their roommate or assigning a 1:1 to them may encourage the behaviours that led to these interventions because the solution offered privacy and attention. • If the care team notices that the person frequently experiences difficulty regulating emotions, it can be helpful to seek help from a trained professional such as a social worker, behaviour therapist, psychotherapist who can offer the person tools and resources to recognize when their emotions are beginning to dysregulate (e.g. losing control of the intensity, or on the other end of the spectrum, shutting down). Dialectical Behaviour Therapy-based skills may be helpful and include distress tolerance, mindfulness, emotional regulation, and interpersonal effectiveness.[32,44] Therapy support can also help the person to begin to notice and identify unhelpful coping patterns (such as cursing or name calling) and substitute for effective approaches.[32] • If the team notices that the person responds well to coping strategies, they may wish to consider posting a sign with a few strategies the person is willing to do (e.g. deep breathing, visualization, self-affirming statements).[32]
Suspicious/mistrusting of team members[5] • May manifest as accusations directed at team members, questioning team members, detailed instructions and requests	• Be clear on what the person can expect from team members and be sure to follow through with commitments consistently in order to build trust. • Communicate concretely and specifically when possible. • Do not engage in power-struggles or trying to convince the person to trust you, rather build trust through consistency. • When responding, be mindful of body language to be warm and empathetic. • Remember that this person may be accustomed to having caretakers who could not be trusted, and this behaviour may be a coping strategy from their history that brings a sense of control and security.

Behaviour	Strategies to Consider
Dependence on team members for decision-making[5] • Deferring minor decisions to team members[5] • Perceived attempts to delay discharge in settings where discharge is imminent[5]	• Offer limited choices as too many choices can feel overwhelming. • Encourage independence in a warm and firm way (e.g. "You can make this decision. It will feel good to pick what you would like best."). This is another form of boundary setting. • Respond positively when the person takes steps towards decision-making and independence. • Remind the person that part of their care is allowing them to do things for themselves that they are able to do.
Behaviours that pose a physical risk to others • Striking out • Throwing objects	• Utilize Non-Violent Crisis Intervention (NVCI)[45]and/or Gentle Persuasive Approaches (GPA)[46] techniques to protect self and redirect others away from the situation. • Utilize a two-person approach for all care. • Set boundaries/limits - offer choices linked to consequences (see pages 24 & 27).
Team Splitting [5,40] Refers to team tensions, frustrations and/or divides due to the individual: • Comparing the care provided by different team members • Stating that they much prefer another team member • Stating that a certain team member goes above and beyond and questioning why other team members don't do the same • Labeling team members as 'good' or 'bad' • Team members may notice that the 'good' team members are frustrated with 'bad' team members for not understanding and attending to the person's needs, and the 'bad' team members may be frustrated with the 'good' team members for catering too much to their needs. • Spreading rumours about one team member to the others	• All team members to remain consistent to the approach that is in the plan of care.[13,40] • Education with the team can be helpful. • Keep open lines of communication as a team and debrief regularly.[12] • Set and maintain boundaries/limits - offer choices linked to consequences (see pages 24 & 27). • Check in with team members around over-involved and under-involved approaches as outlined on page 26. • If the person is complaining about other team members, encourage them to direct those comments to the person in a productive way, do not engage further.[12] • Avoid internalizing the negative criticism by reminding self and others that this is someone who has likely had lifelong difficulty connecting with others and maintaining healthy relationships.[31] • Avoid isolating this person, and continue to offer them opportunities to engage in healthy interactions. • Practice self-care (see page 28). • See image on page 19 that illustrates how splitting can be prevented through these strategies.

Preventative Strategies for Team Splitting



It is not uncommon for the person to present with escalating behaviours even after limits have been set and healthy boundaries established. In this case, consistency and the team's ability to follow through becomes even more crucial. Statements/threats of possible discharge will only cause greater distress and intensify fears of rejection and abandonment within the person, and therefore should be avoided.[4,27] If discharge is being considered, consultation with the multidisciplinary team, leadership and external partners is required. It is also important to have a planned collaborative discussion with the person.

The team created the following plan of care with Randy to help address his needs while also establishing healthy boundaries and consistent care:

- Leadership (e.g. manager) establish with Randy that the call bell is intended for urgent needs and that frequent use of the call bell (e.g. multiple in one hour) does not align with its intended use. It was collaboratively agreed upon with Randy that he will not use the call bell more than one time per hour. If used more often, the team will not be able to attend to the call bell. As Randy appears to need the most assistance in the afternoon, a team member will check on Randy each hour throughout the afternoon. The expectation of respective communication (e.g. no name calling) and personal safety (e.g. not throwing items) was also discussed with Randy.
- After lunch each day the recreation therapist or designated team member will meet Randy in his room. They will first ask if there is anything he needs help with in his room (e.g. adjustment of lighting, has his tissues nearby). Then they will promote meaningful engagement by offering and assisting Randy to initiate an activity (e.g. to watch an action movie, work on his model car, provide him a motorcycle magazine, turn on his rock music or reminisce about his time as a crane operator and/or his motor cycle trips). Upon leaving his room they will remind Randy that someone will check on him every hour until supper.
- Team members to share the responsibility of checking on Randy each hour throughout the afternoon. The designated team member will knock and enter his room when Randy invites them in. Leaving the door open, the team member will introduce himself/herself. If Randy has not rung the call bell in the past hour, they will thank him for not ringing. The team member is to ask if there is anything he needs and provide for that need. They will also use this check-in time to offer meaningful activities (see list above). Upon leaving his room they will remind Randy that someone will check on him in one hour.

- When interacting with Randy, do not share personal information or engage in discussions regarding other team members. Instead, focus on praising him on his success and enjoyment in his activity.
- If Randy engages in name-calling or degrading comments, the team member is to disengage and set a boundary (e.g. “Randy, I see that you are upset. I am unable to help you when you are yelling and cursing at me. When you can communicate calmly and respectfully, I will be able to help you.”). See pages 24 & 27 for details.

- If Randy throws an object at a team member, the team member is to use their NVCI and/or GPA training to move self away from harm and to be at a safe distance. Team member to set a boundary and clear expectation (e.g. Say “Randy, I see that you are upset. However, I can’t help you when you are throwing things. I will be return in 1 hour to check on you. If you are able to speak to me calmly and not throw things, I will be able to help you then.” and then leave the room).
- If Randy rings the call bell more than once an hour, the team will reinforce the boundary established with Randy by responding to the call bell only once that hour.
- Leadership will meet with Randy daily to check-in on how he is doing and will remind Randy of the agreed upon care plan and that all team members are equally qualified to provide his care.

Strategies to implement and evaluate the plan:

- Team members created a plan to share the hourly check-ins with Randy. A simple sign-up sheet is added to the team communication clipboard for team members to sign up at the beginning of the shift. The team lead ensures the sign-up list is completed each day.
- Team members are to continue to document using ABC charting as well as another BSO-DOS© for 5 days to be able to evaluate the outcome of the approaches.
- Leadership will facilitate regular team huddles in order to provide a place for team members to share their experiences, receive support, to review the care plan to promote consistency and to celebrate successes.
- If changes to the care plan are warranted, the leadership will review the plan with Randy and make changes together.

Communication Strategies to AVOID and to TRY in Difficult Moments[47,48]

Avoid Controlling Language and Power Struggles - Instead, communicate using neutral and objective observations, relaxed and open body language, and calm tone of voice. This sets a positive example for the person, and reduces the risk of escalation.

Randy says: *"I rang the call bell and you didn't come. It's your job to answer when I call! I am going to report you and have you fired for this."*

Avoid this: "You can't talk to me that way!"
"I don't have to answer the call bell every time you call, only every hour."
"You're not the only one who lives here you know!"

Try this
"We agreed the team would do check-ins every hour and that you would not use the call bell more than one time per hour. That time is now, how can I help?"

Randy says: *"The call bell is for emergencies and this was an emergency! You ignored an emergency! You're going to be fired for sure!"*

Avoid this: "I am going to report you for how you're speaking to me!"
"I did nothing wrong!"
"I was following the plan, you're the one who is breaking the agreement!"

Try this
"This is the plan you agreed to and I am here now to help you. If you don't need my help now, a team member will be back in an hour".

Accommodating Various/multiple requests - It can be tempting to accommodate multiple requests because it can feel like you are building rapport. However, this can have unintended consequences of setting unreasonable expectations for all team members. Instead, remind the person of the agreed upon limits.

Randy says: *"Yes, I need your help now. I need you to fix my pillow, straighten my bed and get me a drink. I am also hungry, need a snack, batteries for my radio and a charger for my phone because this one is not working."*

Avoid this: "Sure, let me help you with all of that."

Try this
"I am able to help you with two things that are most important to you now. What will they be?"

Offering Too Many Choices - Too many options disrupt routine and are difficult to manage long-term. Instead, stick to routine and offer fair and sustainable choices.

Randy says: *"I am really hungry and thirsty and I don't want what they have on the snack cart."*

Avoid this: "If you don't like what is on the snack cart, I can see about getting you cheese and crackers, cookies, toast, or a sandwich? Maybe some soda?"

"We have juice, muffins and fruit available on the snack cart. If you don't like those options, supper will be served at 5pm."

Internalizing Negative Criticism - Although it feels personal, it really isn't about you. Remember, the person has likely had lifelong difficulty with interpersonal relationships. Their responses, including critical comments, are a symptom of the personality disorder - not a reflection of you. During difficult moments, try to reflect on positive feedback you have received from others.

Randy says: *"I have been ringing the call bell, sitting here waiting for over an hour. You are supposed to answer when I ring! Are you stupid?"*

Avoid this: "I am doing my best here".
"There are other people that need my help, not just you".
"Talking to me that way is inappropriate!"

"You agreed and that you would not use the call bell more than one time per hour. The team agreed to check in with you every hour. Calling me names is not going to change the plan you agreed to."

Developing a Special Bond - Work as a team, remember your professional boundaries, and avoid personal disclosures. Ask yourself, am I spending this amount of time and doing these things for others? If not, reconsider your boundaries and the expectations you may be setting for you and the rest of the team.[43,44]

Randy says: *"I only want you to be the one checking in on me when I ring the call bell. You're the only one I trust, who knows what they're doing. I don't trust anyone else".*

Avoid this: "I understand how you feel. It's hard trusting other people. I have a hard time trusting people myself."

"We all work together as a team. A member of the team will be back to check in on you in an hour."

5 Steps to Set Healthy Boundaries[49]

When you notice that your interaction with the person is not productive, effective, or mutually respectful, setting a healthy boundary is a helpful strategy. A healthy boundary is not an ultimatum for the person, but rather involves establishing limits that include offering choices with consequences. Boundaries can include physical, emotional and task-related limit setting.[30]Avoid committing to actions or timeframes that are not possible. We are not trying to change the person's mind, we are modelling healthy interactions.

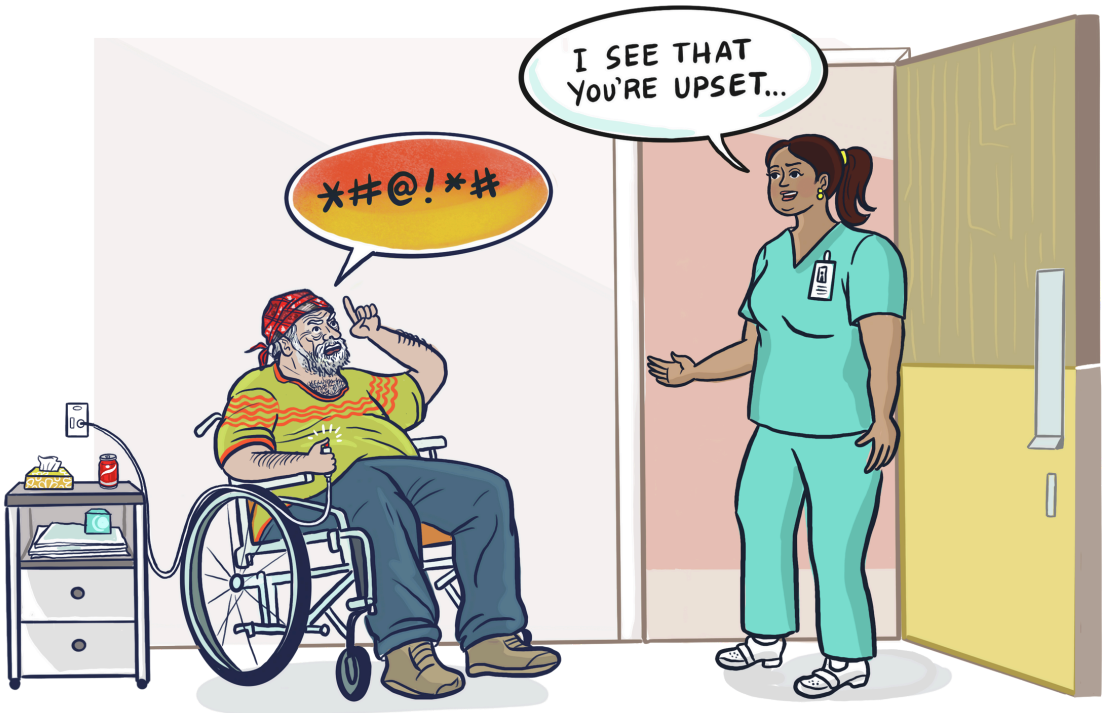
	**1) Stop**	Before responding, take a step back and a deep breath. Recognize that the situation needs a thoughtful approach for everyone's well-being.
	**2) Assess/Reflect**	Reflect on the situation, your own response and any risks. For example, ask yourself: • What isn't working? What contributed to the situation? • Is there a current risk? To whom? What is the level of risk? • Is there a power struggle? Is the person using threatening language? • Are you noticing tension in your own body language or tone of voice?[41] Based on this information, plan your next steps.
	**3) Validate**	Acknowledge the person's feelings. For example: "*You look upset.*"
	**4) Establish a Healthy Boundary**	Clearly and calmly articulate the limit or boundary that you are setting. Examples of starter phrases:[30] • You can _____ when you _____. • When _____, then _____. • I'll help you as soon as you _____ (e.g. stop yelling).
	**5) Follow Through to Build Trust**	Follow any boundary/limit set as this reinforces consequences for undesirable actions and encourages positive actions, builds trust, and reduces compassion fatigue.

See page 27 for more details about establishing healthy boundaries.

Despite the agreed upon plan that Randy will not use the call bell more than one time per hour, there are still times that he rings several times within an hour. On such an occasion, Randy yells and curses at you as you enter the room.

You use the 5 Steps to Set a Health Boundary:

1. **Stop** - Take a step back and take a deep breath.
2. **Assess/Reflect** - Reflect on Randy's interactions revolving around the need for attention from the team. Accommodating all his requests and continuously answering the call bell outside of the allotted hour has only intensified his requests, while ignoring them has led to more yelling and cursing. The team has agreed to set boundaries around the number of times Randy is able to ring the call bell (once per hour) and will respond to his needs at the allotted interval. Now is the time to use those strategies.
3. **Validate** - Calmly state: "I see that you are upset."
4. **Establish a Healthy Boundary** - Calmly state: "I am unable to help you when you are yelling and cursing at me. A team member will be back in the next hour to assist you. When you can communicate calmly and respectfully, we will be able to help you." Then leave.
5. **Follow Through to Build Trust**- After one hour, you return to check-in. "It has now been an hour, I see that you are calmer. I am here to help you, what do you need?"



Individual & Team Wellness

Care team members may face challenges when caring for individuals living with personality disorder, especially when behaviours become particularly intense. It is crucial to be aware of the potential strain on care team members, who may be susceptible to compassion fatigue given the demanding nature of the support needed. Team members are encouraged to adopt a preventive approach such as establishing healthy boundaries and regularly engaging in self-care. This section offers strategies for how team members and their leadership can build skills and coping techniques to enhance resilience and well-being.

Common Responses from Team Members

In response to the behavioural patterns in those living with personality disorders, team members may often feel strong, persistent, and/or uncharacteristic emotions for that person.[13,27,29] These emotions can include feelings of being out of control, manipulated, inadequate, frustrated, irritated, angry, helpless, guilty, hopeless, exhausted, feeling judged, tension with others and/or fearful.[12,13,27,29]

When repeated interactions that evoke intense feelings occur, team members' boundaries are tested. When professional boundaries are too flexible or too rigid, it can result in over-involved or under-involved responses.[49,50]

Over-involved: Some team members may feel compelled to go above and beyond for the individual. They may believe that they are especially skilled with working with that person and that if other team members would follow their lead, they too would be successful.[27,49,50] Challenges arise when others cannot meet the level of care set by one team member, when the demands from the individual continuously increase or become unsustainable, or when this level of care could not realistically be extended to all other individuals cared for by the team. Being over-involved or having loose boundaries can also include taking comments personally, making personal disclosures, viewing the person as a friend or family, or favouring the person. Over-involved team members may inadvertently contribute to team splitting.

Under-involved: Some team members may wish to avoid the individual by minimizing interactions and giving short or abrupt responses when interactions are necessary. This may lead to increased behaviours from individuals with personality disorders, who often harbour deep-seated fears of rejection and abandonment.[27,49,50] Being under-involved poses the risk of overlooking genuine care needs or missing opportunities for positive engagement.

Understanding how to set and maintain healthy professional boundaries that find a middle ground is essential for maintaining the integrity of the professional care relationship. [27]

Warning Signs of Compassion Fatigue

Warning signs of compassion fatigue include ongoing feelings of being overwhelmed, hopeless, powerless, angry, irritable, sad or anxious.[51] Additionally, team members may notice they feel emotionally, psychologically, or physically exhausted, numb, or detached. This can translate to feeling extra sensitive - or not sensitive at all to the stories we hear. The person may notice they have changes to their ability to tolerate stress, and they may find themselves isolating or withdrawing from usual activities. The person may have difficulties concentrating, and decision-making, or find it difficult to be productive at work.

Establishing Healthy Boundaries

Establishing healthy boundaries are not only effective at reducing behaviours directed at team members, they also allow team members to have a sense of control and wellbeing, thus are a preventative approach for reducing compassion fatigue. A healthy boundary is not an ultimatum for the person, but rather involves establishing limits that include offering choices with consequences.[30] Through limits, individuals begin to understand that their actions, positive or negative, result in predictable and consistent consequences. By offering realistic and motivating choices and consequences, we provide opportunity for positive decision-making.[30] Healthy boundaries and setting limits also protect team members from situations that threaten and impact their ability to perform and feel their best.[30] While individual personal boundaries may vary, workplace expectations are typically more clear and predetermined. Boundaries can include physical, emotional and task-related limit setting. See the 5 Steps to Set Healthy Boundaries (see page 24).

Examples of starter phrases to set healthy limits:[30]

- You can _____ when you _____.
- First _____, then _____.
- When _____, then _____.
- If _____, then _____ (positive).
- Would you like to _____ or _____?
- You can either do _____ or _____.
- Do you want to _____ now or in five minutes?
- I'll help you as soon as you _____ (e.g. stop yelling).
- I'll be able to listen as soon as your voice is as calm as mine.
- I'll be glad to discuss this when _____.
- I'll be happy to discuss this with you as soon as the arguing stops.

Example of setting boundaries:
Scenario: Randy is making critical comments, mocking and insulting team members.
Rigid boundary: I am never supporting Randy ever again!
Loose boundary: I don't want to upset Randy, so I'll just accept and ignore it.
Healthy boundary: Saying to Randy in a calm, firm, and warm tone of voice: "I can see it is not a good time - I will return when you stop your negative comments and we can have a respectful conversation."

Here, the issue is not that Randy feels upset, but that he is speaking to the team member in a way that is outside of the professional boundaries set (e.g. raised voices, curse words). A healthy boundary would not be saying, "You can't talk to me like that" because then we are negotiating and engaging in a power struggle. A healthy boundary requires disengaging until the boundary can be met.[41,50]

Self-Care

Regular self-care can help maintain our capacity to successfully manage and cope when challenging situations occur. The tips below are a few ways you can care for yourself.

- **Set Realistic Expectations for Yourself and Your Team**
- **Positive Self-Talk:** Acknowledge your strengths, skills, and caring style. Remember, the situations you support can be challenging. Be compassionate to yourself.
- **Take Moments for Yourself:** Take a moment to yourself when you feel you need it.
- **Practice Mindfulness:** Meditation or deep breathing exercises can help reduce stress and stay present in the moment.
- **Healthy Habits and Sleep Hygiene:** Try to maintain healthy eating habits and sleep hygiene - it helps keep our brain and body fueled, reduce stress, and improve overall well-being.
- **Move Your Body:** Don't underestimate the healing benefits of movement and exercise!
- **Take Regular Breaks:** Recharge and refocus. Even a few minutes of quiet time can make a difference.
- **Spend Time Outdoors:** Time outside and in nature can help clear your mind and boost your energy.
- **Limit Exposure to Negative Media:** Negative media can be emotionally draining so limit or avoid this content.
- **Cultivate Creativity and Joy:** Make opportunities for creativity, hobbies, and things that bring you joy.
- **Support Team Members:** Support and validate team members too. Communicate when you need a break, and team members should provide opportunities to switch off.
- **Laugh and Have Fun!**

Fostering a Healthy Team

Practical Ways for Leadership to Support Team Members as they Care for Individuals Living with Personality Disorder:

- **Provide education and training:** Provide comprehensive training to team members about personality disorders, their manifestations, and effective strategies for care.[12,55,56] When team members recognize the person's behaviours as part of a mental health condition, they are more likely to practice empathy and patience, and respond confidently and effectively.[1]
- **Recognize the impact stigma has on outcomes:** Team members might harbour preconceived notions of who is suitable for their care setting, or may assume that the person has full control over their emotional responses. Both assumptions can impact interactions and willingness to try new strategies.[3,13,16]
- **Offer compassion, support, and encouragement to team members:** Caring for individuals living with personality disorder can be difficult and draining on team members. Regularly acknowledge this. Ensure that team members know that their concerns are understood and being addressed.[27] Remind team members that introducing new strategies may initially lead to an increase in behaviour and this does not mean the plan isn't working.
- **Schedule peer support and team huddles/debriefs:** Establish and maintain regular huddle opportunities where team members can share their experiences, emotions, and coping strategies. This can create a sense of team and reduce feelings of isolation.
- **Foster an open and supportive team environment:** Encourage team members to discuss their feelings and experiences and provide guidance around challenges. These conversations should be held in confidential spaces.[27]
- **Staff strategically and consistently:** Build capacity within the care team by offering training in caring for individuals living with personality disorders. Be consistent in who is assigned to the client; Inconsistent staff assignments impact the care plan's effectiveness and undermine efforts to support the individual.[27]
- **Recognize, acknowledge and celebrate achievements/successes:** Acknowledge when you see interactions that align with the care plan, and continue to recognize strengths of team members.[23] Feeling appreciated can boost morale and reduce the risk of compassion fatigue. This includes acknowledging small improvements in behaviour or observations of effective interactions (e.g. successfully setting a healthy boundary).
- **Offer mental health support services:** Having access to counselling or mental health support services helps team members cope with the emotional challenges of their work. Resources on stress management, mindfulness techniques, and healthy coping mechanisms is also helpful. Encourage regular breaks, and ensure adequate time off to recharge.
- **Visibility and presence:** Having leaders attending huddles and model positive interactions can help team members to feel supported by leadership.[27]

Additional Resources

Resources to Support Care Planning:

- **Suicide Risk and Prevention** – Offered through the Canadian Coalition for Seniors Mental Health, this webpage hosts clinical guidelines, tools for health care professionals, older adults, and their care partners https://ccsmh.ca/areas-of-focus/suicide-risk-and-prevention/

- **Dialectical Behavioural Therapy Tools** – There are many free resources available online that can be helpful for mental health professionals working with people who are living with a personality disorder. Workbooks available for purchase include *The Dialectical Behaviour Therapy Skills Workbook*[44] and *DBT Skills Training Manual*[57]

Supportive Resources for Team Members:

- **Employee Assistance Programs (EAP)** – Counseling and other supportive services offered to employees as part of an organization's human resource program.

- **Health Care Worker Assist Program** – Offered by the Ministry of Health and Ontario Health. Offers support for community and health care workers managing stressors.
  1-877-767-9642 or email CentralizedReferral@ontarioshores.ca

- **Fountain of Health** - The 'Thrive Learning Centre' helps people learn how to put wellbeing science into action in their lives, to help people to thrive.

- **Healthcare Salute** – Offers resources for self-care, compassion fatigue, and mental health support tools to healthcare providers impacted by the COVID-19 pandemic.

- **Self-Care Starter Kit** – A guide on self-care by Homewood Health

- **Self-Care Toolkit** – A toolkit for healthcare professionals who care for individuals with mental illness and trauma created by Dr. Shawn Goldberg.

- **Mindfulness Meditation Resources** – Can be accessed at https://www.anxietycanada.com/ and https://www.freemindfulness.org/download

Personality Disorder Resources:

- **Ottawa Network for Borderline Personality Disorder** – Offers educational resources and support to family members of people living with borderline personality disorder

- **Borderline Personality Disorder Society of British Columbia** – Offers resources and supports to those living with borderline personality disorder and their loved ones

- **National Education Alliance for Borderline Personality Disorder** – An American organization that offers educational resources about borderline personality disorder to the person, family, and professionals

- **The Sashbear Foundation** – Offers educational resources to family members of those impacted by mental health conditions.

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