



Beyond the Labels: A Shared Care Approach to Understanding Older Persons with Complex Personalities

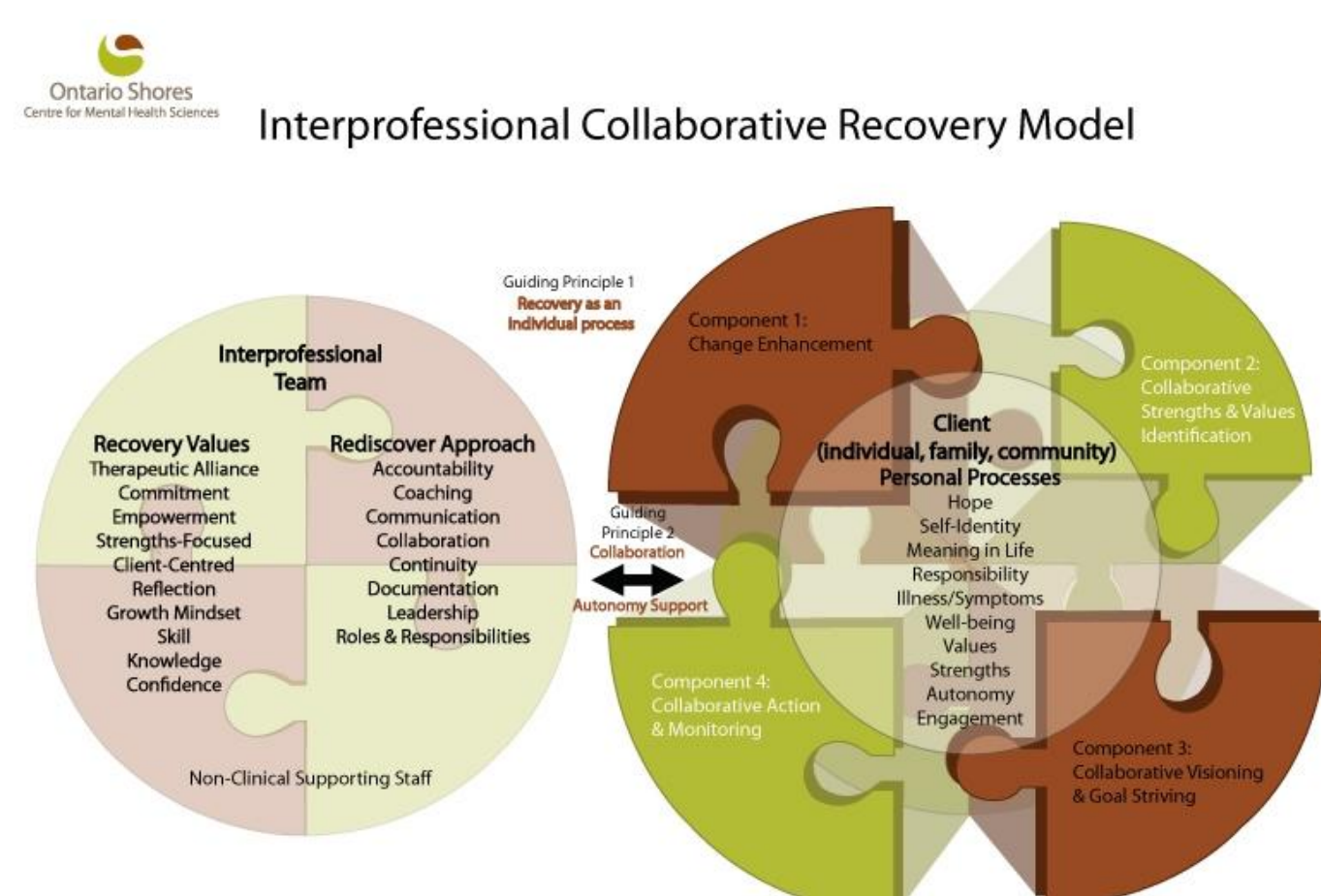
Introduction

In the long term care (LTC) setting a challenging but important consideration is to promote a positive and esteemed view of each individual.

It is also recognized that within the population of older persons needing additional home care supports, those with life-long interpersonal difficulties are often difficult to serve in the community. In fact maladaptive personality features are well known risk factor for nursing home placement (Rosen, Pillemer, & Lachs, 2008).

It is recognized that acute primary psychosis or mood disorder may in some cases be related to exacerbation of maladaptive features in the context of life-long interpersonal difficulties. Nursing homes report however that serious social and personal difficulties that pervade a small segment of some of the individuals' lives, take up disproportionate amounts to staff time (Lilley & Lambden, 2005).

Research suggests that interpersonal difficulties associated with character pathology, are difficult to assess and define in old age because currently psychiatric associations do not specify personality descriptors for the geriatric population (Magoteaux, & Bonnavier, 2009). Likewise mood and psychotic states can be distorted by cultural differences and ageist notions about seniors; making treatment more complicated (International Journal of Psychiatry, 2006).



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Actions

This project gave consideration to the problems associated with accommodating seniors with complex life-long, maladaptive core personality features within communal living setting such as a nursing home.

Goals: To develop an innovative educational program aimed at compiling knowledge for health professionals who care for older persons with complex personality and behavioural living in LTC Homes with a focus on persons labelled as 'hard to serve' with personality features excluding those persons with moderate to severe dementia.

Building on the frameworks of P.I.E.C.E.S.™, and applying the Shared Journey model of care planning, this resource will consolidate research evidence, to suggest a non-pharmacological treatment framework adaptable to each situation to potentially improve the overall provision of care for the client.

In order to address the problem this project was envisioned to create a resource tool that could be easily adopted by interprofessional care teams and used to assist in case based problem solving.

A literature search exploring the field of knowledge about personality disorders in the elderly was completed on line, through Ryerson Library literature search and through the support of Ontario Shores Librarian.

Results

Dr. David Conn (2001) and Dr. J. Sadavoy (1987) have identified a lack of psychiatric literature on the subject of 'character disordered elderly individuals'. The problem is framed as incapacity of individuals to cope with reduced health integrity, uncontrollable external problems, and a host of other psychodynamic factors. There are five basic issues that are central to character disorders regardless of age. They are:

- Fear of or experience of abandonment or empty aloneness
- Real of fantasized narcissistic injury to self-esteem resulting in more rigid thinking and resistance to change
- A lack of mutual sharing and acceptance of affect states
- Failure in development of modulators of rage; over-reliance on the defense of splitting
- An intense need for a reliable other to respond empathically.

Literature confirms that interpersonal difficulties can exacerbate depressive illness in the elderly. The potential relationship between character difficulties and medical illness is hypothesized but there is no research to establish a link. Research does support that depression may exacerbate morbidity and medical burden (International Journal of Geriatric Psychiatry, 2006).

Expressions of anger or grief have in some situations been defined as 'challenging' rather than an adaptive response to a maladaptive environment.

The older person needing support may be rendered invisible and viewed primarily in terms of the challenges they place on the staff.

Likewise suppression of independence inhibits the use of their existing cognitive capacity by constraining a sense of decisional autonomy. This problem although identified by care providers, seldom receives careful attention in terms of management focused interventions within the communal living settings.

Godfrey et.al., (2005) notes that behaviour is often pathologized as resulting from disease rather than understood as constituting a valid response to an inadequate social environment (Boyle, 2008).

Literature supported that a systemic and strategic understanding and approach to working with problems was essential. The literature also highlighted that sometimes behavioural presentations are "not all that they seem to be" (Duffy, 2003).

Challenges

- Little attention has been given to this field of psychiatric disorder in the elderly (International Journal of Geriatric Psychiatry, 2006).
- Therapies for persons presenting with inter-relational difficulties not otherwise specified have not received systemic research study.
- Due to time constraints the presentation is limited to focusing on phase 1 > compiling research that better describes this sub-population.

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Lessons Learned

There are challenges and opportunities for interprofessional teams in accommodating persons within closed community living settings. Some research articles attached strong stigmatizing labels to persons with inter-relational difficulties that to the health professional may signal a poor prognostic outcome. Stigmatizing words such as "hateful patients, dependent, clingers, manipulative" are words that build negative perceptions of the person.

The elderly in nursing homes generally have medical problems however psychosocial circumstances influence the treatment response and medication often masks the problem (Lawrence, 1986). The problem may be as much in the staff's relationship with the person as with the person's behaviour. Communication and inclusion with all of the staff, family and the individual is therefore essential to improving relationships.

In order to effectively build a therapeutic relationship attention must be paid to systemic evaluation of day-to day behaviour and interactions. Boyle, (2008) suggests a concept of relational autonomy that purports that both parties in a caring relationship may have needs for support.

New Evidence/Best Practices

Adoption of the Shared Journey Model of Care was incorporated as strategic direction in 2008 – 2010. The model incorporates tools and a philosophy of care promoting identification of the person's values, beliefs and strengths, their valued life directions / treatment goals and a collaborative action (interprofessional team) approach to planning coordinated care.

Essential to the assessment of a behavioural problem is developing a clear understanding of the person's intellectual and emotional abilities. Tools within the Shared Journey are particularly useful for care planning because they drive collaboration with patients and their families to discover that focus on core values and beliefs.

By identifying the person's values and beliefs, the team is guided towards person centered approaches to care planning while recognizing the rights of both parties to exercise decision-making that optimizes control over the impact risk. The tool incorporates relational approaches to care planning relevant in application. The team is guided to focus on the collaboration in planning care, rather than stigmatizing the poorly understood and unwanted behavioural syndrome. The tool can also be used to guide care teams in the duty to protect [staff] from harassment and abuse by setting boundaries around issues of safety and risk management. The personality dynamics of each staff member must be considered in relation to other staff, the individual and the environment.

Next Steps

Conceptualize a problem solving learning initiative incorporating the Shared Journey Model that will be useful to interprofessional teams working to address problems from a person centered and risk management perspective.

Phase 2: The learning initiative will engage interprofessional teams in understanding the impact of health and psychosocial changes of aging linking caregiver and environmental variables related to difficult behaviours.

Phase 3: Enlisting several different care teams to apply learning program within their organization to address a particular case. Questionnaires measuring indicators including risk assessment staff stress and the individual outcome measures could be used to evaluate the tool. Information could be collected and analyzed to add to a body of research.

Phase 4: Implementation including the train the trainer model of educating coaches or key mentors to guide teams in problem solving care conferencing.