An 85-year-old former municipal fire department chief with severe Alzheimer’s disease resided in a nursing home dementia unit. His agitation with manic and paranoid symptoms had responded well to an atypical antipsychotic and he was manageable. But his residual irritability and disruptive pacing lasting up to two hours during the middle afternoon prompted the staff to ask the consulting psychiatrist to increase the dose of the patient’s antipsychotic medication.

For a number of reasons, the psychiatrist did not feel this was the optimal approach. Instead, he requested that the family bring in the patient’s old firefighting gear (coat, boots, helmet), and he recommended that the staff have the patient “suit-up” every afternoon shortly after lunch. The patient would then be given a chart with all the room numbers in the unit, a clipboard, and a pen, and be assisted in conducting “fire safety” checks. During this time, most other residents were occupied in...
Author Disclosures
The American Association for Geriatric Psychiatry requires that the authors participating in a continuing medical education activity disclose to participants any significant financial interest or other relationship (1) with the manufacturer of any commercial services discussed in an education presentation, and (2) with any commercial supporters of the activity. The authors reported the following:

Marc E. Agronin, M.D.—Reported receiving grant/research support from Boehringer-Ingelheim, Bristol-Meyers Squibb, Forest, Janssen, and Novartis. Reported being on the speaker’s bureau of AstraZeneca, Forest, Janssen, Organon, and Pfizer.

Mark D. Miller, M.D.—Reported being on the speaker’s bureau of Forest, GlaxoSmithKline, and Wyeth-Ayerst.

Jules Rosen, M.D.—Reported having no actual or potential conflict of interest in relation to this educational activity.

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Educational Grant
This activity is supported by an educational grant from AstraZeneca Pharmaceuticals LP.

Intended Audience
This activity is intended for psychiatrists.

Release date: November 2004
Expiration date: November 2005

Learning Objectives
Upon completion of this activity, participants should be able to:

• Explain the improvement of depression in nursing home residents when interventions provide control and autonomy.
• Develop a psycho-social treatment plan for nursing home patients with depression.
• Cite the key principles of non-pharmacological treatment of depression.
• Describe the four foci of interpersonal psychotherapy (IPT).
• Compare the traditional and modified IPT approach to role transition in the context of depressed elders with cognitive impairment.
• Cite the prevalence of personality disorders (PD) found in epidemiological studies of individuals 65 years or older.
• State factors that may hamper diagnosis of PD in late life.
• Describe treatment strategies to manage disruptive behavior in individuals with PD.
the day room in a structured activity. The intervention was dramatically effective. No increase in medication was required. Although a team very familiar with the use of behavioral interventions staffed the dementia care unit, the situation required the perspective of an outside consultant to identify such a simple but elegant plan.

This case and those described subsequently in this final issue of Volume II of The Clinical View illustrate the importance of eclecticism in long-term care psychiatry. Jules Rosen’s description of control-relevant interventions illustrates the usefulness of behavioral plans that are individualized and enhance locus of control. The case of the fire chief demonstrates the possibility of adapting this approach for very demented patients. Mark Miller’s article describes another example of modifying a specific psychotherapy, in this case interpersonal psychotherapy for depression (IPT), for use with cognitively impaired geriatric patients. The four foci that IPT addresses are highly germane for long-term care residents with depression. The modified approach thus seems highly suited for treatment of cognitively impaired long-term care residents.

Requests for psychiatric consultation in long-term care often are prompted by difficult behavior of patients, which takes an emotional toll on the staff. Marc Agronin’s discussion of personality disorders in long-term care highlights the importance of considering personality disorders in the differential diagnosis of such problems, as well as the difficulty of making an accurate diagnosis. Agronin nicely illustrates the key role psychiatrists should play in helping caregivers understand the origins of patients’ difficult behavior and in helping caregivers to modify their expectations of patients who are interpersonally disabled.

In this era of reimbursement restrictions, psychiatrists all too often find their practices limited to managing medications. Good long-term care psychiatry, however, requires a broader approach that affords a richer professional opportunity for psychiatrists to utilize the range of skills they value. While it is incumbent upon psychiatrists to consider thoroughly medical and neuropsychiatric diagnostic and treatment possibilities, the ability to develop multi-modal treatment plans that adapt psychotherapy, behavioral, and environmental interventions separates the psychiatric chaff from the wheat in the long-term care setting.

On a personal note, it has been a pleasure to serve as editor-in-chief for Volume II of The Clinical View. I would like to thank the AAGP staff and contractors with whom we worked for doing such a superb job, the Editorial Advisory Board, the authors, and, most of all, AstraZeneca for providing a generous unrestricted educational grant that made this educational publication possible. If we interested any psychiatrists in exploring a long-term care practice or helped to rekindle enthusiasm in seasoned long-term care clinicians, then we accomplished our goals.
Ruth, at 82 years old, was fiercely independent. She raised three children as a single mother, while working full time and taking care of her home.

After her children were grown, she lived alone for many years enjoying her retirement and managing her diabetes. Progressive visual loss and multiple strokes did not inhibit her daily pursuit of card games with friends and living independently. It was not until doctors amputated her infected leg below the knee that reality set in. She could no longer live alone. In her typical independent fashion, Ruth made all the arrangements for her nursing home placement from her hospital bed...and then she told her children.

Once she got to the nursing home, Ruth’s world fell apart. Her friends visited at first, but soon they stopped coming. She described her world as shrinking into the area between her bed and her chair. She tried to make friends with other residents on her floor, but soon realized that many of them were confused. For Ruth, even the simple things in life, such as choosing her lunch menu, became ordeals. “They gave me tuna fish for lunch. I told them, ‘No fish, ever.’ Then I got a stomach ache.”

Within four weeks of admission, this once vibrant woman became socially withdrawn, lost weight, had trouble sleeping, and lost her will to live. Yet, no one ever requested a psychiatric evaluation for her. Our research team met her when it screened all cognitively intact residents in the facility for participation in a randomized study of a non-pharmacological treatment of depression in nursing home residents.

Control, Autonomy, and Depression
About 30 years ago, researchers demonstrated that nursing home residents improved in a variety of ways if they were given “control” over relatively specific aspects of their lives. Schulz reported on the benefits of empowering nursing home residents to participate in scheduling the next visit of a volunteer, as opposed to random visits. Rodin et. al. demonstrated the positive impact of empowering nursing home residents to care for plants. These studies were conducted with nursing home residents without regard for their emotional state prior to the interventions. Given the loss of control of everyday life that people such as Ruth describe as contributing to depression, the research team...
Every resident being treated for depression should have three components to their care plan: 1) pharmacological management, 2) non-pharmacological management, and 3) an education plan.

wondered if promoting autonomy, choice, and control would reduce depression.

The Study
In search for answers, the research team conducted a randomized, controlled study with 31 cognitively capable nursing home residents with either major or minor depression. They created personal socialization plans based on their life-long patterns and interests. The residents determined the social activities and schedule, rather than following a pre-ordained activities calendar. Some residents took advantage of the recreational and spiritual activities in the nursing home; others developed social activities with residents with similar interests, people they did not know existed. Finally, for many residents, families played an active role in many of these interventions. The interventions continued for six weeks. Prior to the end of the study, the residents designed plans to continue activities without participation from the research staff.

Residents who met criteria to enter the study were randomized either to non-intervention standard care for six weeks or to active intervention care. Those receiving standard care initially were subsequently admitted into the intervention group. Almost 50 percent of the residents were “responders” during active intervention, compared to 0 percent in the non-intervention group during the control period. Responders were significantly more likely to rate the environment as inadequately meeting their needs prior to intervention and were significantly more compliant with their own plan of social activities. This study identified a subset of residents with major or minor depression who needed more environmental support, who participated in enhanced activities of their choice, and who significantly improved in terms of their depression. Ruth was one of the participants in this “control-relevant study” in the active intervention group.

Back to Ruth’s Story
Ruth described her pleasure in playing cards with her friends twice a week before moving into the nursing home. Her favorite game was bridge but she was content to play many other games. With the help of the research activity therapist, three other residents in the facility were identified with a similar recreational interest. Twice a week, for six weeks, the foursome played cards for two hours, talked, and enjoyed themselves. Prior to this intervention, none of the four residents had met each other. Over time they became friends and would meet for meals or other occasions outside of the structured recreation time designated through the study.

Ruth began to feel better. “I had something to look forward to. I knew that on Tuesdays we would meet to play cards,” she said. She also derived great pleasure in learning to communicate with one of the foursome who had an expressive aphasia but was otherwise cognitively intact. Ruth was enjoying life again.

After the intervention period ended, Ruth and the other three tried to continue to meet, but were unable to sustain their activities. Two of the people required nursing home personnel to wheel them to the meeting place at the prescribed time. If no one was available, they could not go. As physician appointments or health problems arose, no one would contact the others to alert them that there would be no meeting. Six weeks post-intervention, Ruth’s depression was back worse than ever.

Her physician started Ruth on antidepressant medications and she improved. Yet, she still had lost her will to live. Finally, one of the women from her foursome needed a new roommate. Ruth was moved into that room and lived there depression-free until her death three years later.

Control-Relevant Interventions in Clinical Settings
This study demonstrated that within a research program, a psycho-social intervention that promotes autonomy and pleasurable activities can result in dramatic improvement for some residents. How does this knowledge help depressed nursing home residents who are not in a research setting?

Every resident being treated for depression should have three components to their care plan: 1) pharmacological management, 2) non-pharmacological management, and 3) an education plan. Most of us know that antidepressant medication can be very helpful to nursing home residents. We also know that the research evidence supporting their use is fairly sparse. The psychosocial stressors inherent to nursing home placement demand attention to non-pharmacological treatments as a component of care. In addition, an education plan means that family and professional caregivers need to know enough about nursing home depression and treatment modalities to effectively participate in interventions in the absence of a structured research program.

As an example, Mrs. Gordon was an 84-year-old widowed woman who had been a resident of a nursing home for more than two years. In addition to multiple medical problems, she was nearly blind. Her only child, a son, who was a professor of physics at a local university, was distraught by his mother’s persistent complaints of
Virtually every resident will have some interest or activity that could be used in this type of intervention. Watching sporting events on television, planning family gatherings, working on photo albums, and going out to lunch have been used at various times in a control-relevant intervention.
Eclecticism in Nursing Home Psychiatry: Using Your Whole Bag of Tricks

November 2004

The CLINICAL VIEW
Geriatric Psychiatry in Long-Term Care

Interpersonal psychotherapy (IPT) is a form of short-term individual psychotherapy that has been shown to be effective for depression. Its success has led to modifications for other conditions and for use in geriatric patients with cognitive impairment. This article discusses the use of IPT in a depressed woman with cognitive dysfunction.

THE CASE OF MRS. ANDERSON

Mrs. Anderson is an 82-year-old married female who was admitted to a psychiatric unit for severe depression. She had no prior history of depression. An MRI of the brain showed multiple white matter hyperintensities and volume loss but no large infarcts. Mrs. Anderson responded slowly to treatment with antidepressant medications and spent a large part of her day staring into space. When asked what bothered her, she made negative statements about how her life was over as she could no longer perform the usual activities—cooking and baking—that she had been best known for in her family and in her community. Mrs. Anderson could not see any reason to be hopeful or to get out of bed in the morning. Neuropsychological and functional assessment showed mild cognitive impairment (MCI) and executive dysfunction.

The case of Mrs. Anderson is a typical one. The cognitive dysfunction reduced her ability to use insight and made it difficult for the treatment team to help her to grasp a “roadmap” to imagine herself restored to better functioning. Despite adequate trials of antidepressant medication and some improvement in vegetative symptoms, Mrs. Anderson remained hopeless and pessimistic about her future.

THE USE OF IPT

IPT involves four foci for intervention in depression: role transition, interpersonal role disputes, grief, and interpersonal deficit, each of which has specific techniques tailored for it. Using IPT in depressed elders with cognitive dysfunction focuses on role transition encompassing any of the following:

1. Increased dependence on others for basic functioning.
2. Decreased memory (painful awareness that memory loss is interfering with quality of life).
3. Decreased problem-solving ability or intellectual power and awareness that one now cannot figure out solutions to previously solved problems.
4. Decreased freedom and mobility due to physical disability, visual impairment, memory loss resulting in getting lost, loss of driving ability, feeling trapped in one’s home or dependence on others for transportation.
5. Decreased capacity for a sense of fulfillment and enjoyment of usual hobbies, sports, etc.
6. Fear of further decline or death.

APPLICATION OF IPT FOR MRS. ANDERSON

In the case of Mrs. Anderson, the traditional approach using antidepressant medication with some form of supportive therapy did not work well. After three weeks in the hospital, however, Mrs. Anderson was judged to have made enough progress to be discharged home to the care of her husband. She showed some improvement in vegetative symptoms and was beginning to take better care of her personal hygiene but was poorly interactive and extremely negative about ever improving.

Upon arrival at home, Mrs. Anderson wanted to stay in bed and withdraw from her environment. Any thoughts of attending family gatherings brought intense anxiety as she could not imagine herself having any meaningful role. She steadfastly refused to cook, saying that she no longer knew how.

In attempts to engage Mrs. Anderson in IPT in the outpatient setting, she was pessimistic about anything possibly helping her. She felt she had nothing to return home to. Mrs. Anderson began outpatient treatment always accompanied by her husband. He was doing all the cooking and showed signs of frustration in attempting, unsuccessfully, to get his wife to
try some of her old recipes. Mrs. Anderson sat motionless during an early joint session stating that she could not remember any recipes. A daughter lived within a few miles and accompanied Mrs. Anderson and her husband a few times. She was concerned that her father was too stern with her mother.

Despite extensive experience using IPT in the elderly, the team was frustrated that traditional IPT did not seem to be adequate to address Mrs. Anderson’s depression and cognitive impairment. Mrs. Anderson’s family was also frustrated; they wanted to help her but did not know what to do. Experimentation with some modifications of IPT was started. Any chance of helping Mrs. Anderson through weekly sessions required the participation of caregiving family members.

Because cooking and baking were Mrs. Anderson’s forte, her willing daughter was enlisted to visit one afternoon and bake cookies with her. Mrs. Anderson’s daughter was instructed to encourage her mother’s participation but if she saw her mother becoming frustrated, she was to take the lead and ask Mrs. Anderson to do specific, limited tasks such as mixing the batter. She was instructed to limit the interaction to two hours and to praise any and all effort that contributed to edible results. The next week’s visit detailed the success of the interaction. The obvious patience demonstrated by the daughter became an example for the husband on which to model his behavior in his everyday cooking attempts with his wife.

Evaluating Mrs. Anderson’s husband about what she could do (single or simple steps but not multiple steps or multitasking) was a relief to him. He commented, “I guess my methods weren’t working so good.” With continued encouragement and support, Mr. Anderson was able to enlist his wife to cook meals together under his watchful eye. He was always ready to jump in when her frustration rose and to praise whatever contribution she made. With continued practice, she began to cook some dishes on her own and she began to smile more with the earned praise.

Mrs. Anderson’s confidence and self-esteem improved and her affect and personal grooming both brightened. Eventually, both she and her husband attended church-based cookie baking sessions and worked side by side. Email reports from the daughter confirmed her mother’s progress. She also reported that her father, who for years expected to be waited upon by his wife, had become a husband willing to share household tasks such as cooking, cleaning, and shopping, and who seemed to be happier in his new role facilitating his wife’s recovery.

Subsequent fine-tuning was still required as Mrs. Anderson did not recover to her former functional baseline, tired easily, and showed limited judgment. Methods needed to be adjusted over time to avoid overextension and streamlined to avoid overtaxing activities such as holiday baking rituals. Overall, Mrs. Anderson is now holding her own. She is cooking again with minimal oversight. She still harbors unrealistic expectations at times but seems to accept suggestions from her caregiving family members. She continues to take antidepressant medication as well. She describes how frightened and useless she felt prior to hospitalization. She now seems to understand that having depression impaired her functioning. Now that her depression is relieved, her functioning is returning.

CASE DISCUSSION

Mrs. Anderson’s painfully slow progress with antidepressant medication regimens alone (frequently seen when depression is comorbid with cognitive decline) could have been designated a poor outcome. However, interventions that combine pharmacotherapy with IPT for cognitive impairment (IPT-CI) appear to have contributed as much or more than solely the pharmacotherapy to regaining a meaningful and satisfying level of functioning. Educating her husband about her cognitive capabilities was an undertaking but with persistence and practice he eventually understood and modified the way in which he approached his wife, with far greater success and mutual appreciation.

Realistically, Mrs. Anderson still suffers from poor insight and she still requires some supervision to avoid demoralization. Without these supports in place, undoubtedly, her demoralization would lead once again to a state of depression. Compared to her baseline in the hospital, Mrs. Anderson has greatly improved in mood and quality of life. The caregiver burden her husband experienced has become much more manageable now that he has a better appreciation of her abilities.

As this case example clearly illustrates, Mrs. Anderson became depressed as she found herself failing to fulfill her former role, especially the tasks she found meaningful and had once managed with ease. Given her nihilism and lack of hope for recovery, Mrs. Anderson’s perceptions could be characterized as a “core loss,” the most severe form of role transition.

In addition, her husband was initially unable to recognize that his former expectations of Mrs. Anderson were no longer realistic. The couple had reached a point where disputes pervaded their interaction and remained unresolved. Each party expressed little hope for improvement in their situation. While the depression was partially amenable to treatment, Mrs. Anderson would not return to her former level of engagement in life. Once these issues were clearly articulated and psychoeducation regarding depression and cognitive impairment was provided to Mrs. Anderson and her husband, it was possible for the couple to revise and renegotiate their roles. This led to more accepting and realistic attitudes for both spouses.

MODIFYING IPT

Experience with IPT led to the conclusion that IPT offers many advantages for depressed elders but requires modification for those with cognitive impairment. Memory deficits and impaired insight preclude many patients from benefiting from traditional IPT or other psychotherapies dependent on intact recall and the capability for insight. Furthermore, the combined effect of the depression and cognitive impairment demands that caregivers become integrated into the treatment process. A combined patient-
and-caregiver approach seems to make the most sense as these patients, by virtue of their cognitive decline and attendant dysfunction, require more input, help, and supervision from caregivers to maintain independent living and to maximize functioning and overall wellness. Another area for potential modification of IPT is to develop strategies that instruct caregivers to recall therapeutic work in the weekly sessions in order to build upon prior gains. Caregivers should be an integral part of treatment strategy. Caregiver well-being is thus inextricably linked to the well being of the depressed elder with cognitive dysfunction.

For example, Table 1 illustrates a modified approach to thinking about role transition in the context of depressed elders with cognitive impairment, recognizing that there may be limited options for exploring new roles in the face of irreversible cognitive decline and increasing dependency.

### Table 1: Comparing the Traditional Approach to Role Transition and a Modified Approach

<table>
<thead>
<tr>
<th>Traditional IPT</th>
<th>IPT for depressed elders with cognitive impairment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Help the patient to accept the lost role</td>
<td>Help the patient to accept the lost role</td>
</tr>
<tr>
<td>Help the patient explore positive aspects of the new role</td>
<td>Remind the patient of abilities that remain intact that could be further developed or enhanced to help compensate for lost abilities</td>
</tr>
<tr>
<td>Acquire new skills to meet the challenges of the new role</td>
<td>Help the patient to foster new attachments commensurate with their current abilities and, when necessary, help them to accept increased dependency on others</td>
</tr>
</tbody>
</table>

**IN SUMMARY**

A modified version of IPT holds particular relevance for depressed elders with cognitive impairment and may have effective application in long-term care settings. In order to optimize treatment outcome for this population, the target for intervention must include an interpersonal frame. The treatment approach of IPT offers an interpersonal formulation that links the onset and perpetuation of depression to changes in current close relationships, patterns of relational engagement, mutual role expectations, and current interpersonal life stressors. Thus it is highly suited for depressed elderly patients with cognitive impairment and loss of function necessitating long-term care. For these patients, depression is frequently linked with the role transition from independent, self-directed older adult to one who is reckoning with the loss of self-sufficiency and autonomy and who now needs some form of assistance. Traditional IPT includes some specific strategies that help patients negotiate difficult life transitions. In this group of patients, however, the role transition sometimes includes developing dependency and loss of autonomy. Therefore modifications are proposed that take into consideration the caregiver’s corresponding role transition. Since both the patient and caregiver are experiencing simultaneous role transitions and role reversals that are not common in other stages of life, the IPT-CI therapist must strive to help both patient and caregiver clarify, articulate, and adapt to the new role challenges that each faces. The aim is to help both parties come to terms with the loss of their former roles. Work is done collaboratively with both patient and caregiver to renegotiate current and future roles.

**References**


Personality disorders are less frequently diagnosed in long-term care settings compared to cognitive and mood disorders, but patients experiencing such disorders, known as PDs, often exert a disproportionately disruptive effect on staff and milieu.

These patients’ behaviors may range from being demanding, rageful, and odd, to inappropriate, or isolative. Long-term placement and other late-life stressors, such as physical illness or loss of social supports, can exacerbate these maladaptive coping styles. In turn, such behaviors disrupt caregiving and promote conflict with family, other residents, and staff. When caregivers, consultants, or administrators begin to view these individuals as intolerably hateful, demanding, or strange, they may avoid and neglect them, medicate them inappropriately, and ultimately seek to eject them from the nursing home. In addition, PDs frequently precipitate crises that limit the opportunity for careful diagnosis and sabotage adequate treatment. Consider the following case.

Mrs. Smith in the Nursing Home

Mrs. Smith was a 70-year-old woman admitted to a nursing home after a stroke left her unable to walk. For five years prior to admission, she had lived in a spare bedroom of her daughter’s house after her husband died. During that period of time, the relationship with her daughter was severely strained by Mrs. Smith’s frequent rages and obscenity-laced screaming. On several occasions Mrs. Smith had threatened to kill herself after having a fight with her daughter. Sometimes she would refuse meals or medications. Mrs. Smith was calm and charming when visited by a psychiatrist from a local mental health center but then refused to take the recommended medication or attend a day program.

In the six months that she had lived at the nursing home, Mrs. Smith was described by staff as difficult, hateful, and vicious. She would scream at aides and tell them that they were “fired”
when she was unhappy with their care. She had constant complaints about the food and cleanliness of the ward. She didn’t tolerate her first roommate, and accused her second roommate of stealing. Her behavior escalated when she was moved unexpectedly to another floor: she spent her days wheeling up and down the hallways, yelling at other residents about how “terrible” the staff was. She began to throw her linens into the hallway each day after her bed was made. After an angry confrontation with her physician, Mrs. Smith threatened to jump out of the window. She was transferred to an inpatient psychiatric ward, with the expressed hope that an alternate placement could be found.

In this case, Mrs. Smith had a previous history of disruptive behaviors that were predictive of future behaviors. A longitudinal history confirmed the presence of similar behaviors since her early 20s. She alienated family, other residents, and staff, and was unable to adapt to the demands of institutional living, such as having to accept the help of aides or live in close proximity with a roommate. An abrupt change in her environment overwhelmed her brittle coping style, and made a bad situation much worse. She was eventually diagnosed with borderline PD and major depression.

**Epidemiology**

Mrs Smith’s case is indicative of many nursing home residents suffering PDs. In community epidemiologic studies, the prevalence of PDs in individuals 65 years or older ranges from 5 to 13 percent. A recent large epidemiologic study that assessed a representative sample of more than 43,000 individuals in the United States found an overall prevalence rate of PDs of 14.79 percent. In elderly psychiatric patients, studies have found the prevalence of PDs to range from less than 5 percent to more than 50 percent depending on inpatient versus outpatient setting, comorbid diagnoses, and diagnostic method. However, there is insufficient data to estimate the prevalence rate of PDs in long-term care settings. This is not surprising as the diagnosis of PDs in late life is hampered by several factors. Elderly patients and their informants are not always able to provide a reliable longitudinal history, especially when it may span 50 years or more. Their history may be distorted by recall bias (the tendency to present more socially-desirable traits), memory impairment, or the very PD in question. Previous records, if available, often lack extensive longitudinal psychiatric and psychosocial information needed to make a diagnosis of PD. This is especially true for nursing home records. Even when such information is available, a clinician’s own bias may get in the way. Disruptive behaviors are all too often considered normal for elderly patients.

Without a complete, reliable longitudinal history, it is difficult to distinguish acute symptoms from more chronic behavioral patterns. Many elderly psychiatric patients also have chronic medical conditions that will interfere with diagnosis. Chronic pain and disability can lead to excessive patterns of dependent or avoidant behaviors that resemble those seen in PDs. In such situations, clinicians must be more reliant on informants to provide a longitudinal history of premorbid personality characteristics. Without cooperative informants, clinicians are limited to recent history and readily observed symptoms, and often end up deferring the diagnosis of a PD. But there is a cost to this: patients consequently may be labeled as treatment-resistant when short-term psychotherapy or pharmacotherapy fails to alleviate the distressing or disruptive behaviors that actually reflect long-standing personality characteristics.

**Treatment Strategies**

Management of PDs in long-term care settings is challenging and often results in improvement without
resolution. Given the chronic and pervasive nature of PDs, the overall goal is not to cure the disorder but to decrease the frequency and intensity of disruptive symptoms. Management strategies should draw upon the efforts of multidisciplinary staff working together to decrease environmental stressors such as pain, depression, and conflicts with roommates that exacerbate disruptive behaviors. It is also important for the mental health clinician to offer a tentative psychiatric diagnosis as well as a practical case formulation to account for likely personality dynamics. When staff members understand these deficits in personality functioning, they are less able to blame themselves or overreact to outrageous behaviors, and are more apt to have empathy for the individual.

The initial admission to a long-term care setting poses a unique stress on patients experiencing personality disorders. The loss of a familiar environment, personal items, privacy, and the control over one's schedule can lead to a sense of disorganization and prompt a behavioral crisis. Conflict on the ward begins when patients with PDs try to cope with the stresses from their new environment by exaggerating their maladaptive behaviors. An obsessive-compulsive individual may attempt to maintain a sense of control by demanding rigid adherence to schedules and rules of hygiene. Dependent individuals may feel helpless and panicked without enough attention to their needs and respond with clinging behaviors and excessive questions or requests for assistance. Paranoid, antisocial, and borderline patients may aggravate staff by refusing to cooperate with treatment plans or institutional rules. When possible, it is important to clarify the presence of such vulnerabilities prior to the patient's admission and to anticipate which institutional stresses might be most noxious. When current and antecedent stressors have been identified, staff can work to manipulate the milieu to accommodate the patient. Disruptive behaviors can sometimes be traced to particular activities or staff interactions, which can be adapted as part of an overall treatment strategy.

A staff meeting or case conference often provides the best forum to discuss the development and the coordination of a consistent treatment plan. Treatment plans should be well documented and communicated to the patient, involved family members, and caregivers. Sometimes a written contract, signed by all parties, eliminates ambiguity. Although it is important to involve family members in the treatment plan, clinicians must recognize that patients with PDs often have family relationships based on conflict. Attention also should be given to individual staff members who must work with difficult patients. They need opportunities to vent feelings of anxiety and frustration and to feel acknowledged and supported by administrative staff.

Individual psychotherapy can be useful when a patient is willing to engage in a therapeutic relationship, especially for borderline, histrionic, narcissistic, dependent, and obsessive-compulsive individuals. Cognitive-behavioral treatments tend to be the most practical in adults, in particular the use of dialectical behavior therapy or DBT. DBT, in particular, focuses on borderline PD, but has been extended for use with other PDs and for elderly individuals with depression and comorbid PD. The goal of therapy is to train the patient to be more aware of both adaptive and maladaptive behaviors, to understand and learn to modulate the consequences of their behaviors, and to identify and avoid triggers. In adults, DBT has been shown to reduce the incidence of self-injurious and suicidal behaviors, decrease the degree of depression, anxiety, and hopelessness, and decrease the number and length of hospitalizations.
In long-term care settings, however, the use of specialized psychotherapy may be limited by the availability of trained therapists or by clinical problems, such as cognitive and sensory impairment, pain, comorbid medical conditions, and functional decline that may interfere with a patient’s ability to participate. In addition, antisocial, paranoid, schizoid, and schizotypal individuals are often incapable or unwilling to form strong therapeutic relationships.

In the long-term care setting, pharmacologic therapy often becomes the most practical and quickest way to reduce the frequency and severity of disruptive behaviors associated with PDs. It is important to recognize, however, that there are no pharmacologic panaceas for PDs. Clinicians must select realistic target symptoms. Such symptoms may include depressed or anxious moods, transient psychosis, and agitated or impulsive behaviors. Reviews of pharmacologic treatment of PDs in older adults indicate that the entire range of agents has been utilized, selected on the basis of target symptoms and not the PDs themselves.10,11 In addition to treating symptoms of anxiety and depression, antidepressant agents can reduce impulsive aggressive behaviors in some patients. Mood stabilizers and atypical antipsychotics also can treat symptoms of aggression and impulsivity, while the atypical agents are best used for transient states of psychosis as well as behavioral crises. In any long-term care setting, the use of pharmacologic agents must comply with OBRA guidelines, and should be minimized or even avoided when there is noncompliance, reckless, or abusive use of medications, or med-seeking behaviors that serve to exacerbate maladaptive personality traits.10

Treating patients with PDs in long-term care settings requires clinicians to use a host of strategies, such as milieu manipulation, psychotherapy, and pharmacology. These approaches are currently among the best ways to serve these individuals as well as the people who live and work with them.

References


The Clinical View, Volume 2, Issue 4

On the answer form located on the next page, please circle the letter that corresponds to the single most appropriate answer for each of the following questions.

The deadline to receive credit is one calendar year from the date of publication. A CME Certificate for 1 hour of AMA Category 1 credit will be sent to you, should you earn a passing grade of at least 70 percent.

1. Researchers have demonstrated that depression among nursing home residents improves when:
   A. Patients are assigned more activities
   B. Patients are allowed to keep more personal possessions
   C. Patients are given more control over planning their daily activities
   D. Patients are given roommates

2. Aside from a pharmacological plan and a non-pharmacological plan, a nursing home resident under treatment for depression needs an education plan that:
   A. Enables residents to pursue their interests
   B. Educates family members about depression in nursing home patients and ways to treat it
   C. Trains staff on specific methods of treating depression in long-term care settings
   D. Sensitizes nursing home administrators to the intricacies of treating depression in long-term care patients

3. Nursing home residents with cognitive impairment respond well to treatment for depression using:
   A. Modified interpersonal psychotherapy
   B. Psychodynamic psychotherapy
   C. Cognitive-behavioral therapy
   D. Geriatric nutrition

4. Patients with cognitive impairment are often:
   A. Peppy and energetic
   B. Pessimistic about their future
   C. Sexually disinhibited
   D. Addicted to their medications

5. Interpersonal psychotherapy involves four foci or treatments: role transition, interpersonal role disputes, interpersonal deficits, and:
   A. Low self-esteem
   B. Repressed anger
   C. Learned helplessness
   D. Grief

6. The well-being of a depressed elderly patient is inextricably linked to:
   A. The absence of friends
   B. The number of staff helping the patient
   C. The presence of plants or pets in the patient’s life
   D. Caregiver well-being

7. A nursing home resident whose personality disorder has not been diagnosed may be viewed as:
   A. Hateful and strange
   B. Possessive and bossy
   C. Sweet and lovely
   D. Whining and sad

8. According to community epidemiology studies, the presence of personality disorders in people 65 years old and older is:
   A. 5 to 30 percent
   B. 10 to 15 percent
   C. 5 to 13 percent
   D. 12 to 25 percent

9. A unique stress on a patient experiencing a personality disorder is:
   A. Death of a relative
   B. Admission to a long-term care setting
   C. Loss of driving privileges
   D. Failure to communicate with caregivers

10. The quickest way to treat personality disorders in a long-term care setting is:
    A. Pharmacology therapy
    B. Psychotherapy
    C. Physical therapy
    D. Group therapy
Personal Information

I certify that I have completed this educational activity and test. Expiration date: November 2005

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Activity Evaluation

You must complete this evaluation to ensure processing of your self-assessment test.

Please circle your answer.

Have the following educational objectives of this activity been met?

Explain the improvement of depression in nursing home residents when interventions provide control and autonomy. Yes No

Develop a psycho-social treatment plan for nursing home patients with depression. Yes No

Cite the key principles of non-pharmacological treatment of depression. Yes No

Describe the four foci of interpersonal psychotherapy (IPT). Yes No

Compare the traditional and modified IPT approach to role transition in the context of depressed elders with cognitive impairment. Yes No

Cite the prevalence of personality disorders (PD) found in epidemiological studies of individuals 65 years or older. Yes No

State factors that may hamper diagnosis of PD in late life. Yes No

Describe treatment strategies to manage disruptive behavior in individuals with PD. Yes No

Comments:

Relevance in your practice:

Very Relevant

Irrelevant

Amount of knowledge gained:

Great

None

Level of material presented:

Too Advanced

Too Simple

Overall evaluation of activity:

Excellent

Poor

Hour(s) spent reading this issue? (circle one)

1.0 1.25 1.5

Would you recommend this publication to a colleague?

Yes No

Ideas for future publications and/or your comments:

Eclecticism in Nursing Home Psychiatry:
Using Your Whole Bag of Tricks:
CME Self-Assessment Test Answer Form

Please circle the letter that corresponds to the single most appropriate answer and fax this page to the American Association for Geriatric Psychiatry at 301-654-4137 or mail your response to:

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Fax: 301-654-4137
The American Association for Geriatric Psychiatry's

Late-Life Depression: Progress and Hope
Lessons Learned from Geriatric Psychiatry

By Karen Blank, M.D., Editor in Chief,
Gary J. Kennedy, M.D., Melinda S. Lantz, M.D.,
and Lea C. Watson, M.D.

A monograph on late-life depression with accompanying PowerPoint presentation on CD-ROM to educate health care professionals on the diagnosis, risk factors, etiology, clinical course, and outcome of late-life depression. Ideal for geriatric psychiatrists who present to other health care professionals or for general psychiatrists, geriatricians, and other primary care professionals interested in learning more about this illness.

Completely updated and clearly written, this monograph covers important advances including: the association of late-onset depression with brain abnormalities and vascular disease, the mutual reinforcement of depression and functional disability, the importance of minor (subsyndromal) depression, the efficacies of new antidepressant treatments including standardized psychotherapies, the need for long-term treatment, the importance of depression in the general health care system, and the clear association of depression and late-life suicide.

The monograph includes comprehensive tables, graphs, resources, and references.

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