Navigating Challenging Behaviors: Practical Skills for Supporting Individuals with Personality Disorders

Clinical Strategies & Boundaries for Assisted Living Staff

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Why This Matters

Staff regularly walk away from resident interactions feeling drained, confused, or second-guessing themselves — **especially with residents who have personality disorders.**

Let’s start with one main idea: The relational patterns that have caused these residents distress throughout their lives — with family, at work, in relationships — will usually (always?) replay inside the facility, in the resident-staff relationship.

"We’re supposed to be the good guys— so why does it sometimes feel like we can't do anything right?"

THE DATA

Scope of the Problem

57.8%

of long-term care-residing older adults meet criteria for a personality disorder

vs. just 10.6–14.5% of community-dwelling older adults — roughly 4x higher

In one large study, ~58% of LTC residents had a diagnosable personality disorders vs. just ~15% of community dwelling seniors. The most common:

Avoidant PD	**20.5%**
Obsessive-Compulsive PD	**12.0%**
Paranoid PD	**12.0%**

Source: Personality Disorders in Older Adults: A Review of Epidemiology, Assessment, and Treatment, Current Psychiatry Reports / PMC7002365, 2020.

THE HUMAN COST

The Staff Toll

~42%

CNA turnover (2025)

~40%

Assisted living nurse turnover, running consistently near this rate

18.5%

of assisted living staff report burnout; average job satisfaction 3.05 / 4 = 76% on satisfaction measures.

27%

of all U.S. workplace violence occurs in LTC.

But the Healthcare and Social Assistance industry accounts for the most non-fatal workplace violence incidents: 60-73% of all cases requiring days away from work happen in health care.

Sources: McKnight's Senior Living, AHCA/NCAL, Caring for the Ages, JAMDA (2024–2025 LTC workforce reports); OSHA/BLS workplace violence data.

RISK AWARENESS

Where the real risk shows up: Staff Safety

97.6%
of staff reported verbal aggression from residents

13.7%
reported "annoying" boundary-pushing behaviors

10.7%
reported physical assault

8.5%
reported sexual aggression

35%
of nursing assistants reported physical injury from resident aggression

12%
reported being bitten in the past 12 months

~75%
of physical incidents happen during close-contact care — bathing, dressing, repositioning, feeding

Important: most severe physical aggression is linked to dementia/BPSD, not personality disorders — but personality-disorder-driven emotional intensity and boundary-testing add real, compounding stress to an already high-risk care environment. That's exactly why clear strategies and boundaries protect both residents and staff.

Source: resident-to-staff aggression prevalence studies (LTC nursing literature); OSHA/BLS workplace violence in healthcare data.

Today’s Goal:

1. Shared Understanding

Build shared clinical understanding of personality disorders and how they surface in the resident-staff relationship.

2. Concrete Strategies

Strategies to support residents without reinforcing unhealthy patterns or compromising care.

3. Boundaries

Where the real clinical and emotional work happens.

4. Our Own Triggers

Our own triggers, and the systemic toll this work takes on staff.

Reflection prompt: Hold onto a resident interaction that left you drained or second-guessing yourself. We'll return to it.

What Are Personality Disorders?

DSM-5: enduring, inflexible patterns of inner experience and behavior that deviate markedly from cultural expectations and cause distress or impairment — including distress and impairment in interpersonal and/or caregiving relationships.

Emotion Dysregulation

What feels like a "5" to most people can feel like a "10" — emotional reactions are disproportionate to the trigger.

Distorted Perceptions

Seeing self as worthless, others as untrustworthy or abandoning — including care staff.

Relationship Instability

Chaotic, intense, or unstable patterns that extend into the resident-caregiver relationship.

DSM-5: Three Clusters

Cluster A — Odd or Eccentric

Social detachment and distorted thinking. Includes paranoid, schizoid, and schizotypal personality disorders.

Cluster B — Dramatic, Emotional, or Erratic

Impulse control and emotional regulation problems. Includes antisocial, borderline, histrionic, and narcissistic PD.

Cluster C — Anxious or Fearful

Anxious, inhibited behaviors. Includes avoidant, dependent, and obsessive-compulsive personality disorders.

CLUSTER A

Odd or Eccentric

Paranoid PD

Distrust and suspicion; may accuse staff of stealing, conspiring, or intentionally neglecting care.
Tied for second most frequent personality disorder found in LTC residents.

Schizoid PD

Detachment from relationships; limited emotional expression; may resist social programming or group activities. They genuinely don't want to be around others and OK being alone.

Schizotypal PD

Interpersonal deficits, cognitive distortions, odd beliefs or magical thinking. In younger adults, can lead to diagnosis of schizophrenia or other psychotic disorder.

CLUSTER B

Dramatic, Emotional, or Erratic

Antisocial PD

Disregard for others' rights, deceit, impulsivity, lack of remorse — can complicate roommate and peer dynamics.

Borderline PD

Instability in relationships, self-image, and affect; impulsivity, fear of abandonment, self-harm history — most associated with staff splitting.

Histrionic PD

Excessive emotionality and attention-seeking — may present as exaggerated symptom reports or dramatic call-bell use.

Narcissistic PD

Grandiosity, need for admiration, lack of empathy — may devalue staff or demand exceptional treatment.

CLUSTER C

Anxious or Fearful

Avoidant PD

Social inhibition, feelings of inadequacy, hypersensitivity to criticism — the single most common PD found in LTC residents. They want to be around others and to “fit in” but avoid because of feelings of inadequacy. This often leads to passive-aggressive interactions or comments. Requires a lot of support and encouragement, but this is often met as criticism with dramatic reaction.

Dependent PD

Excessive need to be cared for, submissiveness, clinging, fear of separation — constant reassurance-seeking or call-bell overuse.

OCPD

Preoccupation with orderliness, perfectionism, control — rigid demands about care routine and timing. Distinct from OCD.
This is tied for second most frequently found PD found in LTC.

Again: Symptoms of Personality Disorders in LTC Settings

Pervasive

Shows up across every context — care routines, family visits, peer relationships.

Stable

A lifelong pattern, not a new change — this matters for differential diagnosis.

Ego-Syntonic

Residents often don't see their own traits as the problem — unlike depression or anxiety, which are ego-dystonic.

Real Impairment

Causes genuine impairment in relationships, daily functioning, and care engagement.

In long-term care studies, avoidant, obsessive-compulsive, and paranoid PD are the most frequently identified — not the dramatic Cluster B presentations staff often expect.

A special note on Borderline Personality Disorder

The most explosive symptoms of conditions like BPD — impulsivity, self-harm, intense rage — tend to diminish by middle age and further decline with aging. Overt behavioral symptom (cutting/self-harm, intense rage) often drop off completely.

HOWEVER: the underlying personality traits remain stable — and the quieter symptoms (chronic emptiness, depression, splitting, social isolation, interpersonal friction) often persist well into late life.

Because BPD is often thought of as "a young person's diagnosis," the personality traits can be under-recognized or misattributed in older residents .

Source: geriatric BPD literature (Current Psychiatry Reports; Carlat Report; clinical presentation studies).

Common PD Behaviors You May Encounter

Splitting

Seeing others as "all good" or "all bad" — the day-shift CNA is "the only one who understands," the night-shift CNA is "cruel and negligent.“

Splitting is most often associated with BPD, but this behavior shows up across most PDs.

Manipulation

Usually not malicious — a learned strategy for getting needs met indirectly.

Boundary Testing

Pushing limits to see if staff are consistent and trustworthy.

Emotional Intensity

Anger, fear of abandonment, or impulsivity can surface quickly — especially around transitions like shift change, discharge planning, or family visits.

These aren't things that develop for the first time in old age — they're decades-old coping patterns, formed early in life, that get triggered or intensified by the specific stresses of long-term care.

ON THE FLOOR

How This Shows Up on the Unit

Excessive or urgent call-bell use as a bid for reassurance or control.

Roommate or peer conflict fueled by black-and-white thinking.

Family / POA triangulation — recruiting family members into conflicts with staff.

Splitting across shifts or roles — idealizing one staff member/shift, devaluing another.

Care refusal used as a form of control when a resident feels powerless.

Repeated grievances or complaints that shift focus and content over time.

CASE VIGNETTE-Splitting

"Mrs. Smith"

A resident who uses her call bell dozens of times per shift. On day shift, she tells staff:

"You're the only one who actually cares about me here — everyone else ignores me."

By evening, she's telling the incoming shift and her daughter that day staff:

"...left her sitting in pain for hours" — and threatens to file a complaint.

This isn't manipulation for its own sake — it may be a window into unstable self-image and a terror of abandonment, playing out in real time across a single day's shift change.

"Mr. Whitfield"

A resident who declines the dining room, the exercise class, and every group activity — always politely, always firmly:

"I'm fine, I just prefer to keep to myself. No need to make a fuss."

But in physical therapy — the one place he can't decline outright — the session notes tell a different story:

"Tense, guarded, gives one-word answers — until other residents leave the room."

This isn't indifference to connection — it's a lifelong terror of being judged or embarrassed in front of others. He wants connection; he just can't risk the exposure it requires.

"Mrs. Donnelly"

A resident who re-makes her own bed by hand every morning after housekeeping does it:

"They don't tuck the corners right. I have to fix it myself."

She keeps a handwritten schedule in fifteen-minute increments taped inside her closet door, and has filed three time-stamped written complaints this month:

"Staff are not following the correct procedure." Again.

This isn't about the bed or the procedure — order and control are how she has managed anxiety her whole life, and assisted living has taken almost all of both away from her.

"Mr. Castellano"

A resident who watches every pill get poured from the bottle and examines each one before swallowing:

"You can never be too careful these days."

He's changed his door code twice and overheard two aides talking quietly in the hallway. He confronted them later:

"I know you were talking about me — don't lie to me."

This isn't about any one accusation — somewhere early on, trust got him hurt, and every ambiguous moment since has been filled in with the worst-case explanation.

Behavior IS communication.

Residents often act out unmet needs or psychological issues — control, safety, attention, fear of abandonment — especially when they can't name or regulate what they're feeling.

Approaches to Working Effectively

Supporting residents without reinforcing unhealthy patterns or compromising care.

Guiding Strategies

Stay Calm & Consistent

Don't get pulled into the emotional storm.

Normalize Distress

Acknowledge the resident's pain without reinforcing harmful coping or unsafe behavior.

Communicate Clearly

Avoid vague promises or inconsistent messaging across shifts.

CLINICAL TOOL

Validation—one of the most effective tools

Acknowledge the feeling even when you don't agree with the content.

"I can see how painful this feels for you."

You don't have to agree that "the whole staff is against you“ or “I’m just going to embarrass myself in the dining room” — but you can validate the fear or sadness underneath it.

CLINICAL TOOL

Compassionate Limits for those pushing boundaries

Setting boundaries with empathy — redirect gently, with validation and support.

"I hear that you're in pain right now. I can't stay past the end of my shift, but I'll make sure the next staff member knows to check on you."

Example compassionate limit

CLINICAL TOOL

Collaborative Problem-Solving & Consistency

Collaborative Problem-Solving

Invite the resident to help shape their own care approach instead of only prescribing it.

Care-Plan Consistency

Document the agreed-upon approach in the care plan and communicate it at shift change and IDT meetings so every staff member responds the same way.

This is the single best defense against splitting.

Skills to Practice

Active Listening

Really hearing without judgment.

"Both/And" Language

"I understand you're upset, and I also need to finish my rounds for other residents."

Behavior Support Planning

Anticipate recurring escalation patterns (e.g., around shift change or family visits) and have a documented, team-wide response ready in advance.

Think Back

Think of a resident interaction that pulled you in — where you felt responsible for fixing their distress. What worked? What didn't?

Many of our reactions are driven by our own emotions — wanting to rescue, or getting defensive. That's why structure and boundaries matter.

Boundaries: The Heart of Sustainable Care

Why Boundaries Matter

Protect Staff

They protect staff wellbeing and safety.

Provide Predictability

They provide predictability and safety for the resident.

Prevent Reinforcement

They prevent staff from unintentionally reinforcing unhealthy patterns.

Boundaries are both protective and therapeutic — for residents and staff alike.

Types of Boundaries in a Facility Setting

Time Boundaries

Call-bell response protocols, shift-based expectations, realistic response windows.

Emotional Boundaries

Not over-identifying, rescuing, or retaliating.

Role / Scope Boundaries

Clarity on what's within a CNA's, nurse's, or social worker's scope — and when a mental health consult referral is needed.

Setting Boundaries: Techniques

"I" Statements

"I can check on you again in 20 minutes, but I can't stay right now."

Consistency Across Shifts

Once a boundary bends for one staff member, it loses power for everyone.

Empathic Firmness

Firm limits delivered with warmth.

"I know you feel like you need help right now. I care about your safety. I see that you're OK— I'll be back in 15 minutes."

Validating, expressing care, and holding the boundary — all at once.

MINI-ACTIVITY

Your Hardest Boundary

Think about one professional boundary you find hardest to maintain on shift — answering every call bell instantly, letting a conversation run long, feeling responsible for a resident's emotional state.

What does that boundary tell you about your own triggers? Identifying that issue will help prevent you from burnout and will improve you overall stress management at work.

Self-Care & Team Support for Staff

It's Real, Not a Failing

Recognize the emotional toll of difficult resident interactions — it's real, not a personal failing.

Debrief Regularly

Debrief regularly with colleagues and supervisors.

Brief Grounding

Use brief grounding techniques between rounds as able — a few deep breaths, a short walk.

System-level support matters too: consistent staff assignments, interdisciplinary team backup, and access to psych consultation reduce burnout and improve care consistency.

GROUP DISCUSSION

For Thought or Discussion

1. What emotions come up for you when a resident tests your boundaries?
2. How can we validate a resident's feelings without reinforcing distortions or unsafe behavior?
3. Where do you notice yourself most tempted to "bend" a professional boundary on shift — what does that reveal?
4. What's the difference between empathy and rescuing, in a caregiving relationship?

CLOSING

Key Takeaways

Deep, Lifelong Pain

Residents with personality disorders often carry deep, lifelong pain, expressed through behaviors that are hard to sit with.

Consistency as a Team

Our role is to provide consistency, empathy, and clear limits — as a team, not just as individuals.

Boundaries Are Doors

Boundaries aren't barriers — they're doors with clear rules; they let us provide compassionate, sustainable care without burning out the people providing it.

"Caring for someone who struggles in relationships can feel like walking into a storm — boundaries are the anchor that keeps the whole team steady."

EVIDENCE CORNER

Does Staff Training Work?

Staff training in working with personality-disorder-related presentations shows real gains — much of the direct research comes from psychiatric and residential mental health settings, with clear relevance to LTC:

- Increased staff knowledge & confidence
- Reduced burnout and stigma toward residents with these diagnoses
- Better ability to maintain a steady caregiving relationship through conflict

Takeaway for administrators: investing in this training isn't just clinically sound — it's a retention and safety strategy.

Source: DBT-informed staff training outcome studies in residential/psychiatric care settings.

Questions & Discussion

Share a strategy that's worked on your unit.