Managing Behaviours that Challenge in Brain Injured Individuals: The Positive Behaviour Support Approach

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Part 1

What is challenging behaviour?

Getting to know you …

- Where do you work?
- What is your role there?
- What challenging behaviours do you see?
- Is there anything specific you want out of today?

What is 'Challenging Behaviour'?

PSY 101:

All behaviours have a purpose*

***or at least had one at some point!**

- Challenging to who?

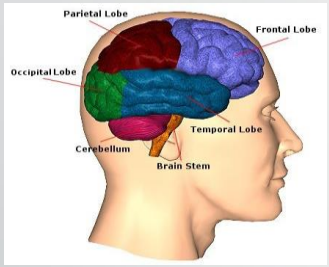
- Behaviours that arise following acquired brain injury that seriously compromise an individual's ability to engage appropriately and productively in their treatment, rehabilitation and in day to day life.

Examples

- Shouting or screaming
- Hitting, punching or kicking
- Disinhibition (e.g. saying inappropriate things in public)
- Non-engagement or passive refusal to do tasks/activities
- Biting or scratching
- Pulling out PEG/Trache
- Damage to property
- Reduced emotional responses
- Not able to make goals about their future
- Chewing objects
- Self harm
- Not able to plan and carry out actions
- Verbal abuse; making inappropriate comments, racial abuse
- Sexualised behaviour (e.g. masturbating in public)
- Swearing
- Limited or no interest in self, others or the environment
- Faecal smearing
- Exit seeking
- Eating non-edible objects
- Spitting
- Over-eating

Why do challenging behaviours occur?

1. Organic Damage



2. Cognitive Impairment

3. Psychiatric / psychological factors

4. Environmental factors

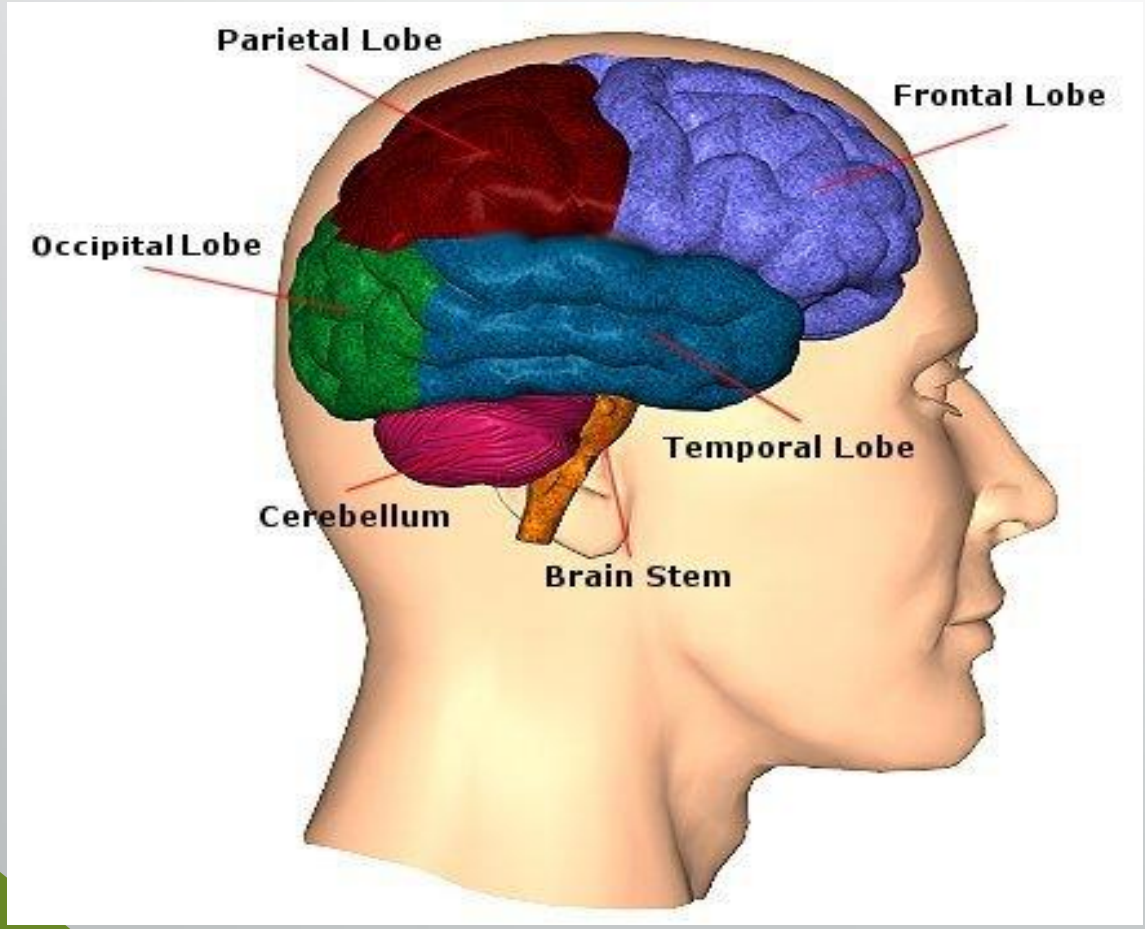
5. Physical factors

Contributing factors to challenging behaviours
1. Organic Damage

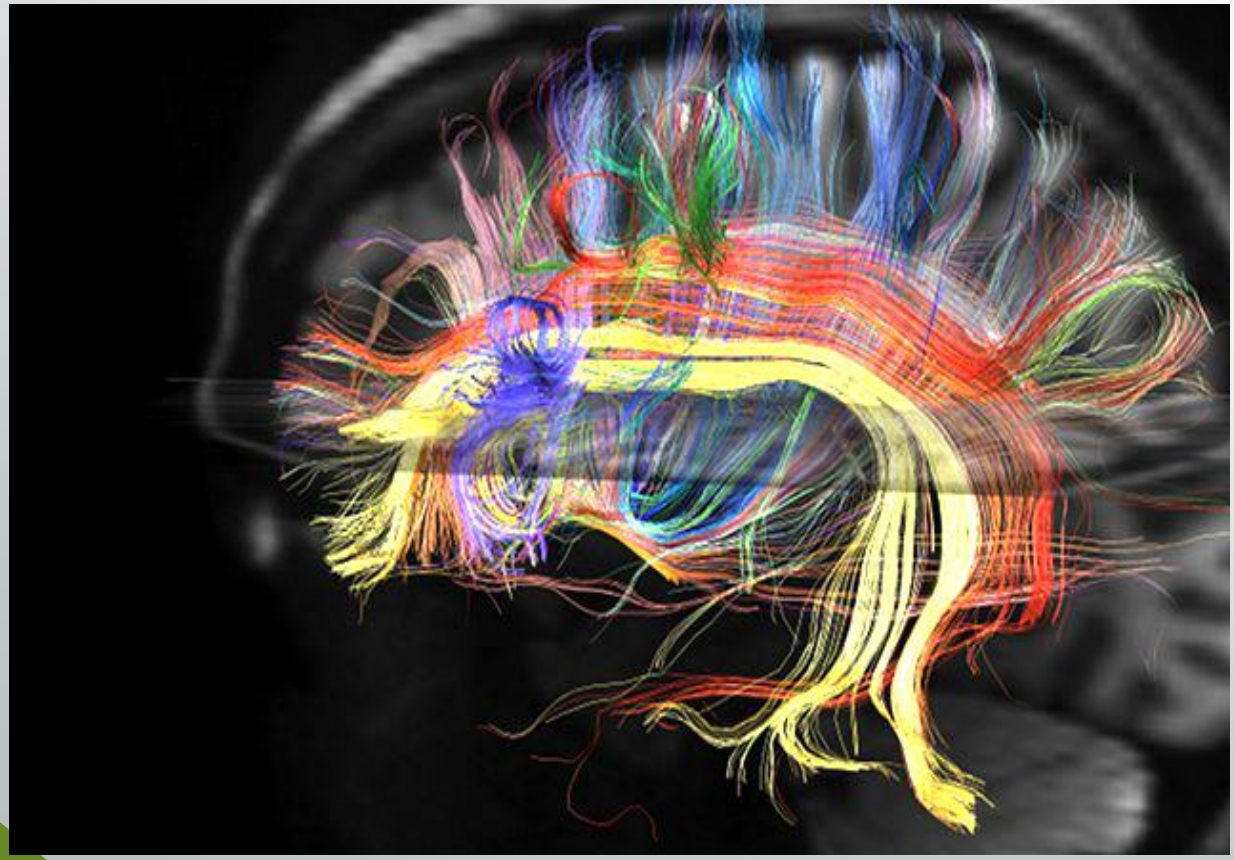
- Challenging behaviour may result as a consequence of damage to certain areas of the brain.
- Different locations of damage *can* lead to different areas of difficulty.
- However, just because someone has damage to a particular area of the brain does not mean that this will automatically lead to challenging behaviour.

Contributing factors to challenging behaviours

1. Organic Damage



Important to keep in mind the pathways between the areas of the brain…



Contributing factors to challenging behaviours

2. Cognitive Impairment

- Language
- Memory & Attention
- Executive Function
- Motor & Visuo-spatial
- Processing Speed

Contributing factors to challenging behaviours
3. Psychiatric/Psychological Factors

- Premorbid mental health problems (e.g. anxiety, depression)
- Post-Injury mental health problems
- Denial
- Loss
- Adjustment to disability

Contributing factors to challenging behaviours
4. Environmental Factors

- Inadequate fit between person and environment
- Over or under stimulation
- Opportunities to engage in age appropriate activities
- Interpersonal (e.g. peers, staff, culture)
- Environment may be supporting certain behaviours …

Contributing factors to challenging behaviours
5. Physical Problems

- Fatigue
- Pain
- Medication
- Constipation
- Infections

Communication is key

Behaviours as communication: What might challenging behaviours that you have experienced be trying to communicate?

Behaviour as communication

- Hungry
- Thirsty
- Pain
- Positioning/uncomfortable
- Lack of stimulation/bored
- Over-stimulation
- Noise or wrong noise
- Cigarettes
- Toilet/incontinent
- Wrong temperature (hot, cold, draft)
- Need company/ lonely
- Want a change/ go outside
- Want to do something else/ change of activity
- Fear
- Change of environment
- Anxiety
- Change of person/ staff/ relative
- Sadness
- Frustration
- Worried
- Being unable to do something
- Confusion
- Things are happening too quickly
- Can't make sense of the world around them

Part 2

How to Assess Challenging Behaviour

The Positive Approach
('Positive Behavioural Support')

- A programme that is **24 hours per day, 7 days per week**.
- Uses non-aversive strategies and does not include punishment schedules.
- **Underlying assumption = all behaviour has a function.**
- The aim is to reduce challenging behaviour over the long term.
- It aims to teach skills and improve quality of life.
- The ethos needs to be integrated throughout the team.
- The techniques are generalizable so they can be used in other settings.

The Learning Equation

Motivation + Antecedent + Behaviour + Consequence

=

Learning

- This is a predictable relationship
- For learning to occur all variable must be in place
- Un-learning can occur if we disrupt any of these variables.

Behaviour: What we do!

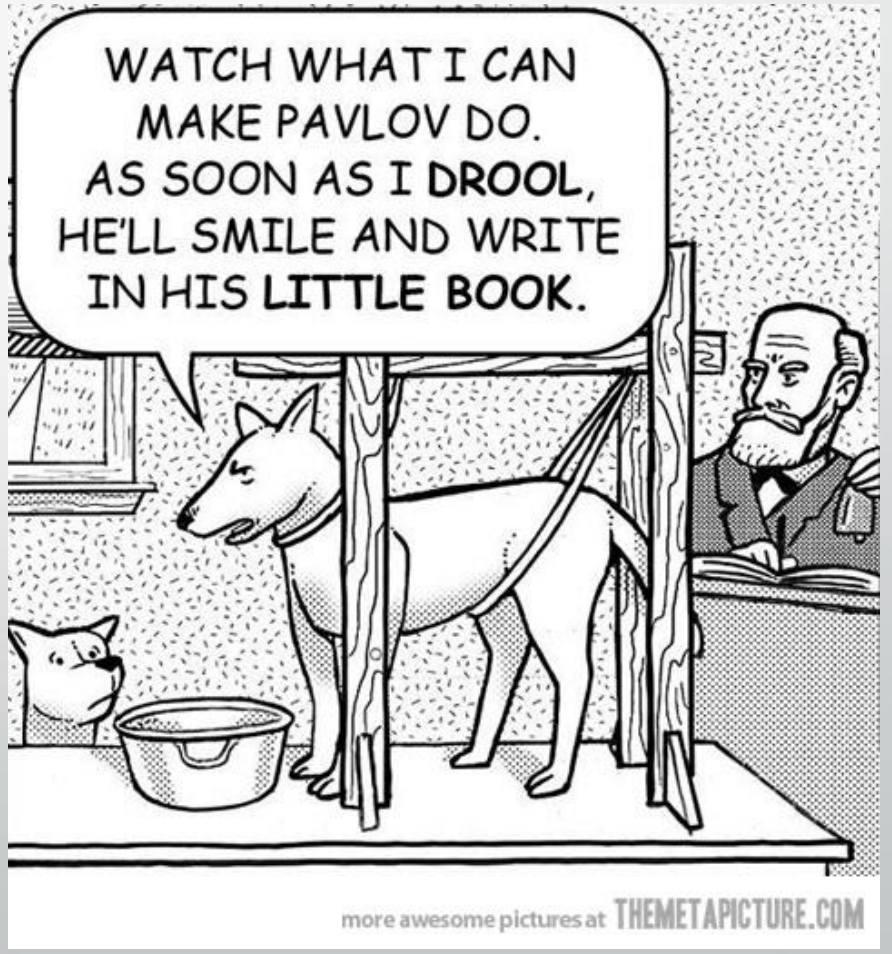
Two types of behaviours: **Adaptive** and **Challenging**

Ask yourself …

- Does the behaviour harm others?
- Does the behaviour prevent the person from accessing the community?
- Does the behaviour cause self injury?

Antecedent/Trigger

- Whatever changes in the environment before a behaviour occurs.
- An event that precedes a behaviour.



Consequences

Two types of consequences

Re-inforcement

The behaviour (strengthens) increases

De-inforcement

The behaviour (weakens) decreases

	Re-inforcer	De-inforcer
Add (positive) +	**Adding something** strengthens the behaviour	**Adding something** weakens the behaviour
Remove (negative) -	**Taking away** something strengthens the behaviour	**Taking away** something weakens the behaviour

Putting the variables together

Motivation	Thirsty	
Antecedent	Notice call bell	See nurse
Behaviour	Press call bell	Bang loudly on tray table
Consequence	Receive water	
Learning	Staff respond to my call bell	Staff respond to my banging

Haven't had water for a given length of time

+

the presence of a nurse

+

requesting water

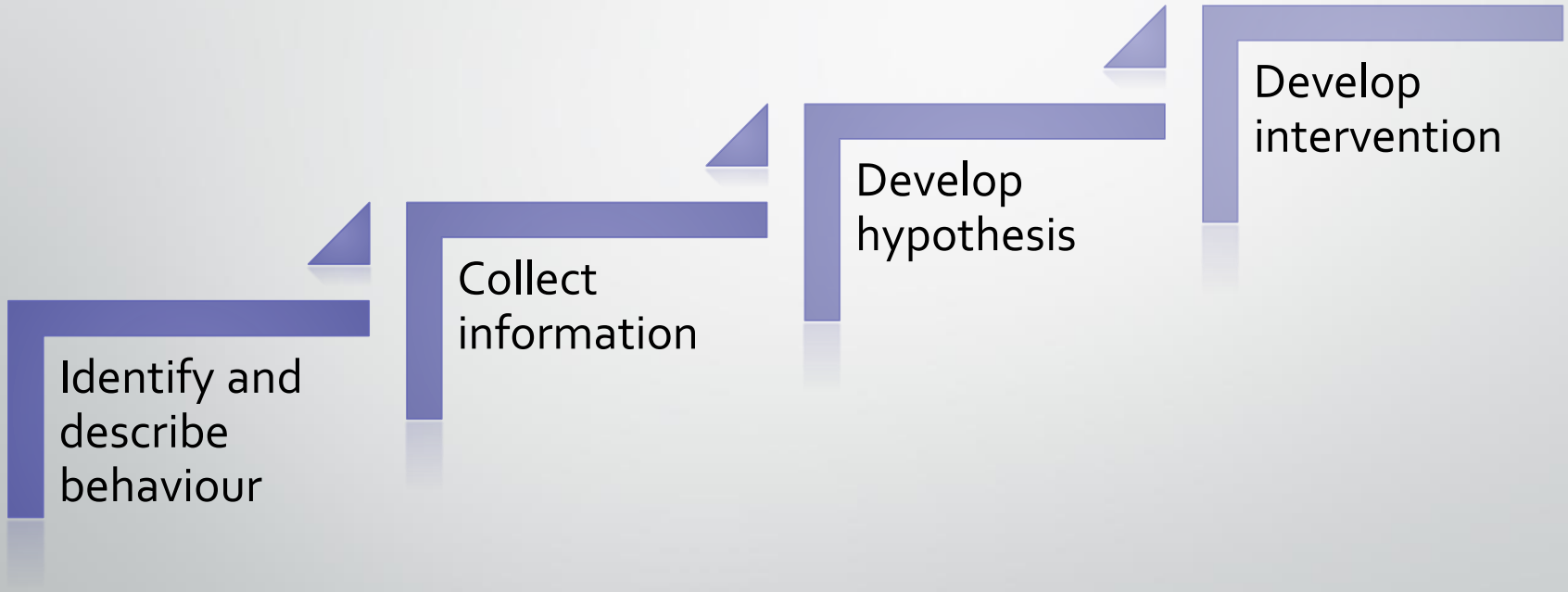
+

Delivery of water

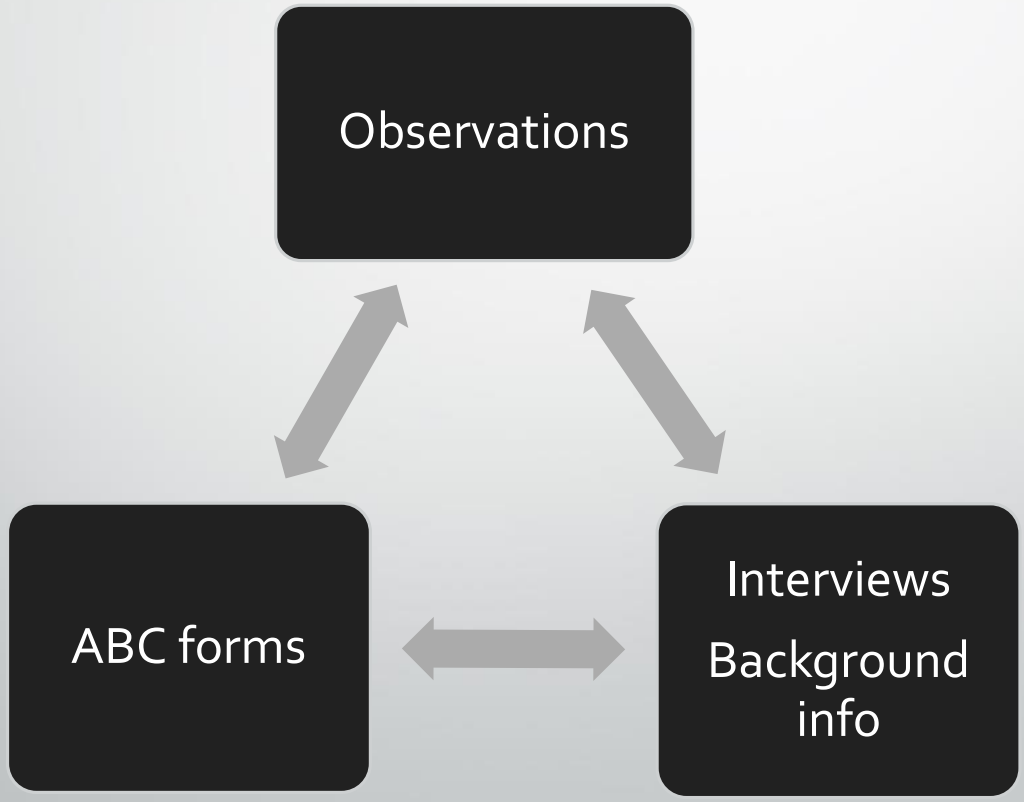
=

Increased likelihood of requesting water in the future

Functional Analysis



Information gathering



What are ABCs?

A = Antecedents B = Behaviours C = Consequences

- A way of recording behaviours, the possible triggers, and consequences.
- A way of spotting patterns in behaviour.
- A way of communicating what interventions work and don't work to the rest of your team.
- Good recording is the foundation of change!

ABCs in practice!

- Watch video – complete own ABC.

The next steps…

- Antecedent and consequence analysis.
- Ecological analysis – to identify mismatches.
- Analysis of the meaning of the behaviour – develop hypotheses about the functions of the behaviour.
- Develop strategies to address the behaviours that are positive/proactive and reactive.
- Intervene and disseminate findings through Behavioural Guidelines and Behaviour Support Plans.


Take a little
COFFEE BREAK

Part 3

Proactive and Reactive strategies

The next steps…

After identifying the behaviours through behavioural analysis guidelines addressing identified behaviours are produced.

Strategies are positive/proactive and reactive.

Aversive v Non-aversive strategies

- **What are aversive strategies? Why are they *ever* used?**

- **Why don't we use them?**
  - Legal and ethical
  - Clinical

Model for treatment planning

REACTIVE STRATEGIES	PROACTIVE STRATEGIES		
	Ecological Changes	**Skills building**	**Direct Treatment**
➢ Active listening ➢ Stimulus change ➢ Strategic recapitulation ➢ Crisis intervention	➢ Settings ➢ Interactions ➢ Instructional methods ➢ Instructional goals ➢ Environmental pollutants ➢ Number and characteristics of other people	➢ General skills development ➢ Functional equivalent ➢ Functional related ➢ Coping/tolerance	➢ Differential schedules of reinforcement ➢ Stimulus control ➢ Instructional control ➢ Stimulus satiation

Risk assessment

Risk assessment can be summarised as having three central components:

1. The likelihood that actions will lead to positive or negative outcomes
2. The relative size or significance of those outcomes
3. Actions that can reduce risk or mitigate the consequences of risk

The brain injured patient will be exposed to varying degrees of risk. They are entitled to have their exposure to risk assessed. The hospital or care facility must take reasonable measures to reduce the level of risk, particularly where adverse consequences would have a significant impact on the patient's health or wellbeing or the health and wellbeing of others.

Reactive strategies: Managing immediate risk

- Designed to gain **safe rapid control** of a situation.
- Has a narrow role in the treatment programme.
- Focus on risk reduction.

Strategies include:

- Facilitative strategies (e.g. active listening).
- Redirection and instructional control.
- Stimulus change.
- Change setting conditions.
- Geographical containment/inter-positioning.
- Counter-intuitive strategies (e.g. strategic recapitulation).

Reactive strategies

- Crisis intervention as **last resort**:
  - control and restraint
  - medication

- Risk of continuously responding reactively:
  - it may reinforce the target response and therefore have a counter therapeutic effect.
  - it may contain an aversive quality and may contribute to escalating the situation instead of controlling it.
  - they do not facilitate long term behaviour change.
  - can't always use the strategies in the community
  - effectiveness relies on consistency.

Reactive Strategies in a Crisis: Personal/interactional style

- Actively ***listen*** to the patient.
- ***Empathise*** with them (e.g. "I understand you must be feeling frustrated".
- ***Validate*** their feelings (e.g. "It's completely understandable you're feeling this way, I would feel angry if I was you".
- ***Normalise*** their feelings (if appropriate) (e.g. "It's completely normal for you to feel frustrated in this situation").
- ***Avoid confrontation*** and/or defensiveness:
  - don't stand with arms crossed or lean over patient
  - be aware of your body position and intimidating patients by accident (e.g. by standing over them when they are sat in wheelchair – get down to their level)
  - don't enter into argument
  - don't worry about teaching lessons or making them learn
- Remain ***calm, clear, concise*** and collected.

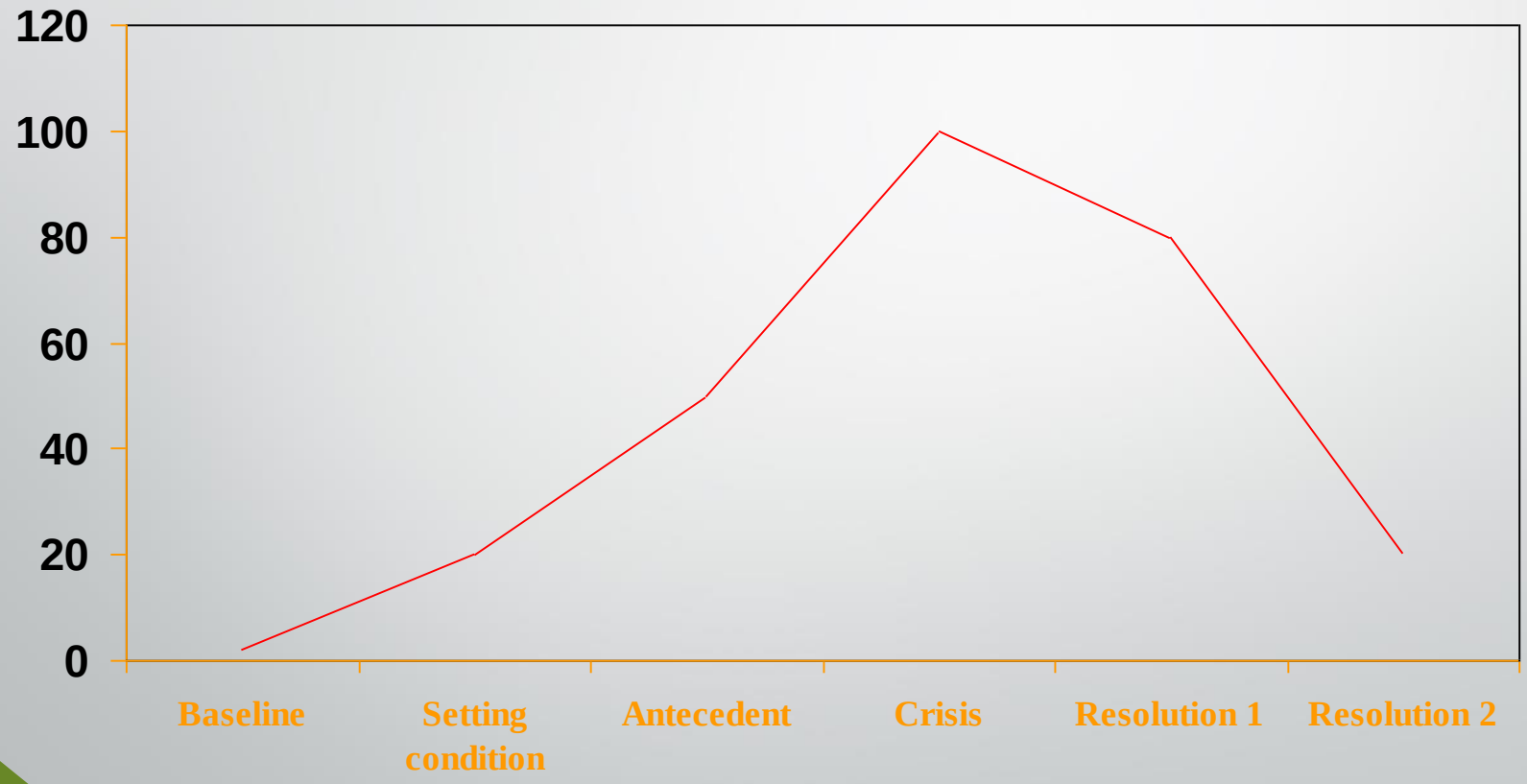
Reactive Strategies in a Crisis: Key Skills

Know the patient

Know the guidelines

Keep consistency across staff

The Crisis Curve



Reactive key points

- Reactive strategies are around gaining **safe rapid reduction** of behaviour
- They work well when you don't know the person very well

BUT

- They are not effective at teaching people better ways of getting their needs met
- Proactive strategies are…

Pro-active strategies: Ecological manipulation

Changes in the interpersonal, service and physical environment to fit the person's characteristics and needs.

- **Interpersonal factors:** social interactions, culture, expectations, inclusion in treatment, ensuring a good match between patient and environment.
- **Service environment factors: t**ask difficulty, guidelines, goals and objectives, opportunities to learn new skills and feel empowered (e.g. involvement in goal setting and guideline creation).
- **Physical factors:** setting, lights, noise.

Pro-active strategies: Skills Building

Teaching the individual more effective and socially acceptable ways of getting their needs met

- General skills development
- Functionally equivalent skills
- Functionally related skills
- Coping skills
- Ability to make choices

Pro-active strategies: Focused support

Strategies used to reduce, and if possible, eliminate the need for a reactive strategy.

Different schedules of reinforcement (rewards):

- Reinforcing lower rates of the challenging behaviour.
- Reinforcing alternative behaviours
- Reinforcement after a specified period of no challenging behaviour.

Real Life is Risky!

As a general rule hospitals are risk averse. We also have structure, rules, limited opportunities, clear roles, and high levels of support.

Positive Risk Taking

- Rehabilitation goals are re-engagement in valued activities, re-integration into the community and improved quality of life.
- We have to take managed risks in order to do this.
- We may know someone well on the ward but will their behaviour be the same and our strategies be effective at Southside Shopping Centre?

Positive Risk Taking

- Lots of risk assessments.
- Aim to reduce likelihood (consequences are often harder to reduce in the community).
- Graded hierarchy: small steps towards the goal with only slight increases in risk each time.
- If we don't take the risks in this setting people often appear to be functioning well but then fail after discharge.

Key Points

Keep in mind…

- Positively reinforcing appropriate behaviour and the absence of target behaviours but not punishing the presence of 'bad behaviour'.
- See the person and not the problem.
- Involve patient and carers in goal planning and guidelines where possible.
- Help the patient to increase their feelings of control and self-esteem.
- Remember, sometimes the behaviour may increase or get worse before it gets better!
- If a strategy doesn't work the first time, it is still worth trying again as it may just take time to work.
- Proactive skills training may take time – team need a reactive plan whilst training occurs.

Part 4

Theory into Practice

Your case examples

- Step by Step
  - Identify behaviours
  - Five Factors that may cause behaviour
  - Functional analysis (ABC charts)
  - Hypothesis
  - Strategies
  - Monitoring / Feedback

Part 5

Managing the Stress that Arises in Working with Challenging Behaviour

Impact on us

What do you think could be the emotional impact of working in an environment of challenging behaviours?

Support in the Workplace

What support do you have in your workplace?

What is helpful to you?

Reactions to stressful situations

- Stress and anxiety
- Emotional changes (e.g. anger, frustration, blaming)
- Behavioural changes (e.g. withdrawal, indecisiveness or inflexibility)
- Low mood/depression
- Post-traumatic Stress Disorder
  - Flashbacks and nightmares
  - Avoidance and numbing
  - Being on 'guard' – 'hyperarousal'

Potential Effects

- May have a negative effect on health – high rates of sick leave
- Rapid turn-over of staff
- Tension within the team
- Staff performance (e.g. interactions with patients, following guidelines)

Defusing

- Term generically used to describe employees getting together after an incident to discuss and make sense of what has happened.
- In many instances this is a naturally occurring phenomenon.
- Almost uniformly the first line of response. In many cases there would be no formal ‘diffusion training’.

Debriefing

An intervention conducted by a trained professional shortly after a catastrophe, allowing victims to talk about their experience and receive information about 'normal' types of reactions to such an event

Functions of debriefing according to DoH:

1) To establish the details of what happened;

2) To provide emotional help.

'…to reduce any possibility of psychological harm by informing people of their experience and allowing them to talk about it.'

Can be delivered to group or individual

Lastly…