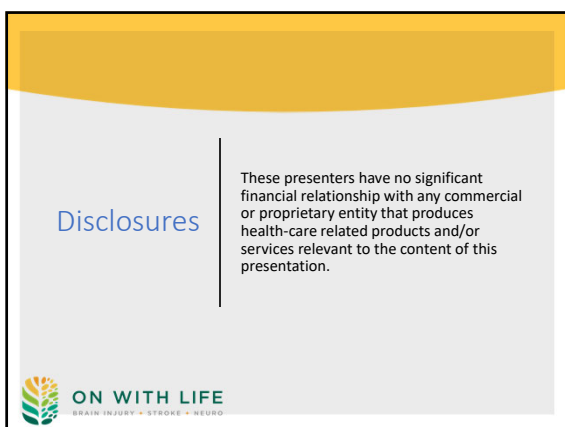


1



2



3


What is behavior?

Observable action or inaction.

Behavior is a communication tool to:

- Access/obtain
- Attention (establish a connection)
- Avoidance
- Escape
- Automatic reinforcement (sensory-based)

What is this person trying to communicate?



4

ABCs of Behavior

Antecedents

- Triggers
- What others were doing right before the behavior?
- External and internal states

→

Behavior


- What actually happened?
- Remain objective

→

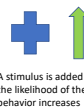
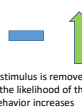
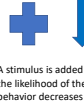
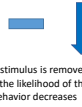
Consequences


- What happens after? Does anyone get anything out of it?
- Usually, this reveals the "why" of the behavior - which drives the interventions

Throughout all these steps - be asking:
Who? Where?
What? When?
How?



5

Behavioral Management Principles		Examples							
	Positive	Negative							
Reinforcement	 A stimulus is added - the likelihood of the behavior increases	 A stimulus is removed - the likelihood of the behavior increases	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Positive</th> <th style="text-align: left;">Negative</th> </tr> </thead> <tbody> <tr> <td> Behavior A student earns an A in algebra Stimulus Parent gives \$20 Outcome Student is more likely to get an A in future classes </td> <td> Behavior A child puts toys away Stimulus Avoids being nagged by parents Outcome The child is more likely to put toys away next time they play </td> </tr> <tr> <td> Behavior A driver speeds Stimulus Officer give \$200 ticket Outcome Driver is less likely to speed </td> <td> Behavior Siblings fight over toy Stimulus Parent takes toy away Outcome Siblings are less likely to fight over toy </td> </tr> </tbody> </table>	Positive	Negative	Behavior A student earns an A in algebra Stimulus Parent gives \$20 Outcome Student is more likely to get an A in future classes	Behavior A child puts toys away Stimulus Avoids being nagged by parents Outcome The child is more likely to put toys away next time they play	Behavior A driver speeds Stimulus Officer give \$200 ticket Outcome Driver is less likely to speed	Behavior Siblings fight over toy Stimulus Parent takes toy away Outcome Siblings are less likely to fight over toy
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Behavior A driver speeds Stimulus Officer give \$200 ticket Outcome Driver is less likely to speed	Behavior Siblings fight over toy Stimulus Parent takes toy away Outcome Siblings are less likely to fight over toy								
Punishment	 A stimulus is added - the likelihood of the behavior decreases	 A stimulus is removed - the likelihood of the behavior decreases							




6

What is behavior? – Brain Injury

Neurobehavioral challenges are the result of complex, changing, and evolving interactions between:


Person Served's pre-injury characteristics including coping techniques, behaviors, thoughts, cognition, and emotions	Type, location, and severity of brain injury	Resultant cognitive, emotional, and physical changes/challenges	The way in which the environment responds to the Person Served <ul style="list-style-type: none">Loved ones, friends, care-partners, systems (health system)
--	--	---	--



7

Common Neurobehavioral Challenges Following Brain Injury

Difficulties regulating their behavior	Apathy	Disinhibition & Impulsivity <i>"No filter," does things without thinking them all the way through"</i>	Sexually inappropriate behaviors & hypersexuality
Agitation & Restlessness	Aggression	Suicidal Ideation	Cognitive Changes Perseveration Memory
Emotional dysregulation & lability	Social Skills & perception	Decreased Insight & Awareness Anosognosia Anosodiaphoria	



8

What is behavior? – Brain Injury

There is no "one size fits all" approach.

The exact right approach for one Person Served can be the exact wrong approach for another Person Served.

There is a trial-and-error component that is important. Accounts for individual approaches along with evolving recovery and improvements in therapy.



Also.... A brain injury doesn't tend to make you better than you were before. It tends to magnify pre-injury personality characteristics and psychological issues.



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Other factors and considerations for behaviors in PS with brain injury


- Medical Status
 - (UTI? Bone flap considerations?)
- Pain
- Medication Changes
- Sleep Hygiene
- Participation in rehabilitation efforts overall
- Staff response



10

Put Away Your Inner Parent

Feelings	Thoughts	Reactions
Feelings are almost always out of your control. It is what it is.	needs to be "what are they trying to communicate to me?" or "what can I do to help?"	A direct reflection of your thoughts

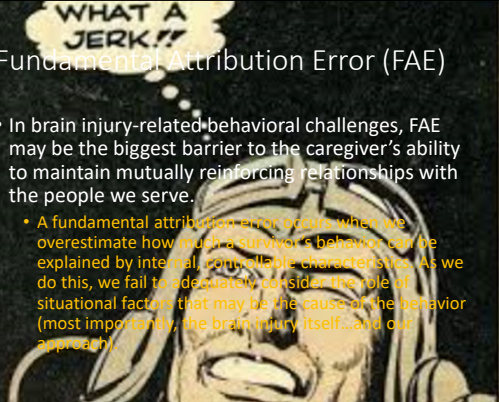


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Fundamental Attribution Error (FAE)

WHAT A JERK!!

- In brain injury-related behavioral challenges, FAE may be the biggest barrier to the caregiver's ability to maintain mutually reinforcing relationships with the people we serve.
 - A fundamental attribution error results when we overestimate how much a survivor's behavior can be explained by internal, controllable characteristics. As we do this, we fail to adequately consider the role of situational factors that may be the cause of the behavior (most importantly, the brain injury itself...and our approach).



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FAE "red flags"

- The patient is being...
 - Difficult
 - Stubborn
 - Ornery
 - Manipulative
 - Resistive or unwilling
 - Lazy
 - Noncompliant
- The patient is unmotivated.



13


Influencing vs. replicating the energy in the interaction

1 Quiet your voice	2 Slow your movements	3 Control your nonverbals
------------------------------	---------------------------------	-------------------------------------

14

"I need" vs. "Do you want to?"



- If you ask "do you want to _____" and the Person Served's response is "no," you've forced yourself into a difficult situation.
 - Do you cash in chips and push your original plan?
 - Do you exercise flexibility and move to another task?
- Instead:
 - "I need you to _____"
 - "The doctor needs you to _____"
 - "Your husband / wife / son / family needs you to _____"



15

Speak in the Affirmative. Avoid the Negative.

- Whatever you do, don't think about ladybugs.
 - Don't
 - Can't
 - No
 - Shouldn't
 - Won't
- Flip your thinking...instead of focusing on what you don't want them to do...focus on what you want them to do.




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16

One Plan is not Enough

- We need to come into therapeutic activity with multiple options in mind. If the Person Served shoots down your only options, 1 of 2 things will happen:
 - 1. You will be forced to push your original plan and risk increasing agitation
 - 2. You will abandon your original plan and lose the structure of the interaction...resulting in increased risk for agitation
- Anticipate the need for a break. Movement (going for a walk or pushing the Person Served in the wheelchair is often enough to reduce agitation).




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Talk Less

- Say what you need to say with as few words as possible. This is not dumbing down your communication...it is shortening and tightening it.
- Our knee jerk reaction is to try to rationalize / reason / use logic to convince the PS to change their behavior. In most cases, this will serve to increase agitation because... by definition...PS who are escalated are not able to access these skills...particularly when escalating or in crisis.



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Neurobehavioral Challenges at OWL: Our Philosophy

Dignity Team

Mandt Training

Rehab 16 Framework



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Neurobehavioral Challenges at OWL: The Dignity Team

Members:

- CNAs
- Clinical Counselor
- Clinical Director
- Neuropsychologist
- Person Served Care Coordinator
- Physician's Assistant
- Social Worker
- Therapists (OT/PT/SLP)
- Others as warranted

The Process:

- Meet at least weekly to collaborate regarding neurobehavioral challenges
- Mixture of what is seen on nursing end, in therapy, and reported in individual sessions
- Create / modify a dignity plan that is then disseminated to all therapists and nursing staff




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Dignity Team Plan

Person Served: Person Served (COGNAME) Date: MM/DD/YYYY

Rationale: Ms. PS is a 55-year-old woman with a right-hand parietal hemorrhagic stroke. She is currently exhibiting neurobehavioral challenges that include:

- Marked fluctuation of affect
- Difficulty of change initiation, switching task, motivation, medication, meals, and medical procedures
- Cognitive challenges including limited memory, cognitive rigidity
- Behavior including starting of self when attempting to place an item on, continuously running wheelchair into entrance door, frequently entering wheelchair canopy in the patient area
- Refusal to engage with and implement strategies
- Soliciting food and drink through other PS family members
- Dismissing staff and therapists assistance for tasks she is able to complete independently (e.g., will find staff)
- Psychiatric concerns such as seeing a blurry maniac around another PS, or reporting she feels like she is in a dream

Interventions that have been consistently worked include:

- She enjoys music
- Yelland has consistently been an effective redirection tool and distraction
- Rehearsing the task and/or attempting the (particularly when verbal cue is present)
- Lois has been consistently helpful
- Effect on behavior and response to staff requests is more consistent when Brenda is present
- Art may be helpful. She has participated in art group previously with good efficacy
- She enjoys the therapy practice
- If staff note that PS continues to access PS's family for food, please address this in the moment. Please seek out the family member as person and instruct them to use a response such as "the nurse and therapy staff are the only ones allowed to give you food like you outside."
- She is helpful to identify a good person for strategy to reduce "staff shopping" for desired answer and avoid response strategy

Interventions that have consistently worked, but worth attempting:

- Use a data and Exact instruction (e.g. Do not give options, or the option to opt-out)
- Script include: "It is time to check your blood sugar". Rather than, "It is time to check your blood sugar?"
- Staff reported that when offered a non-preferred task either "now" or in a later time, she has been compliant when the later time.

Other directing tasks for non-preferred tasks, such as driving blood sample tasks include:

- o Consistent in lower choice between no parking
- o Providing a path (between in labors)
- o Engaging in a conversation
- o Talking

It may be helpful to presenting strategies to access her "buy-in" or engagement level in therapy. Please be available if/when ever the team requires and let her Dignity Team Members (select) know of any successful strategies.

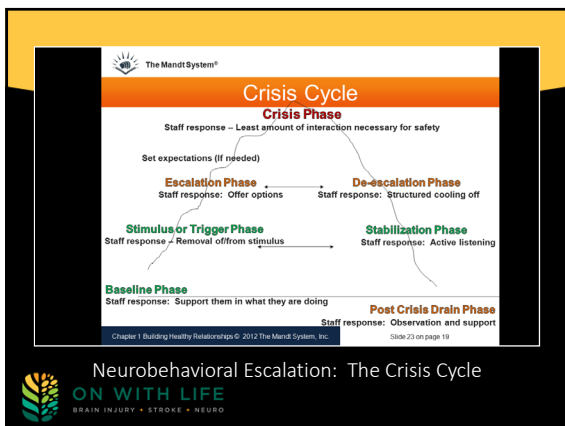
Relevant Medical Concerns:

- Recently assessed by Dr. Greenfield. No medication changes made
- She continues (DND) and needs for "continuous" care due to level of fluctuation and gagging over of strategies between sessions. Please be mindful of this when others offer food.

If you have any further questions or concerns, please contact anyone on the dignity team: CNA, CCC, SLP, OT, PT, CC, Neurorehabilitation, Dignity of Therapy.

The Dignity Plan

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- ### Common Behavioral Challenges Following Brain Injury (Case Examples)
- Apathy or low activation
 - Disinhibition/Impulsivity (“No filter,” does things without thinking them all the way through)
 - Sexually inappropriate behaviors/hypersexuality
 - Agitation/Restlessness
 - Aggression
 - Suicidal Ideation
 - Cognitive Changes
 - Perseveration
 - Memory
 - Emotional dysregulation or lability
 - Social Skills and perception
 - Lack of awareness of challenges, or doesn’t fully understand the extent of their challenges (anosognosia and anosodiaphoria)
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Case Example: Suicidal Ideation

32-year-old gentleman with a medical history significant for cerebral palsy and resultant physical limitations.

Has a significant psychiatric history that includes severe depression, anxiety, and trauma.

Presents with pervasive suicidal ideation that includes voicing these thoughts to staff, family, and calling suicidal hotline

Reduced behavioral activation and inconsistent activity refusal.

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Case Example: Suicidal Ideation

The conceptualization:

Due to the chronicity of these thoughts and through repeated evaluation, Mr. YYY does not currently appear to be an imminent risk to himself. He has voiced a plan to end his life which includes refusal of CPAP and self-removal of his enteral feeding tube. However, this plan does not place him at immediate risk of death, nor does he have the physical means to follow through on it. Mr. YYY has not acted on these thoughts in the past, and at times they appear to be incongruent with his affective and behavioral presentation. We recognize that Mr. YYY has a history of depression and anxiety that may exacerbate suicidal ideation; however, it is conceptualized through discussion and consultation with the dignity team that his suicidal thoughts are not reflective of true desires of self-harm. Given the nature of his specific presentation, it is felt that asking follow-up questions or giving increased attention to Mr. YY after he voices these thoughts is directly reinforcing these thoughts and results in their increased prevalence. Rather, attention and reinforcement should be given to more adaptive behaviors such as activity engagement and positive thoughts about the future.

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Case Example: Suicidal Ideation


The interaction guidelines:

- Redirection
 - Alternative Behaviors (use open-ended questions and choices)
 - Remind him of the progress he has made, and continued work with his counselor
- Continue to schedule unique and personalized goals
- Conversations and interactions should remain focused on the positive including fun and engagement with others.

Interactions that are *not* currently useful:

- Refrain from using open-ended questions.
- If he is endorsing suicidal thoughts, sitting and giving it attention is not helpful. Asking follow-up questions or spending extra time with him as a result of these thoughts likely increase the prevalence.


Continue to assess for severe depression (changes in sleep, appetite, activity refusal, time in bed, voicing a specific plan).



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Case Example: Apathy & Decreased Behavioral Activation

- 50 year-old gentleman with a left MCA stroke, diabetes mellitus (uncontrolled)
- Participated in our inpatient stroke program, then moved to our RNR house for continued intervention
- While on inpatient, neuropsychological testing revealed weaknesses in processing speed (slowed), variable attention, and novel problem-solving.
- Additionally endorsed depression and anxiety
 - "I am concerned for vegetative symptoms related to depression including reduced motivation and initiation.
- No neurobehavioral challenges while an inpatient person served..... However
- Once admitted to RNR, significant apathy, lack of motivation, poor participation in anything.



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**Case Example:
Apathy &
Decreased
Behavioral
Activation**

SO many challenges came up once at RNR home

- Medication changes (consultation with psychiatrist)
- Utilities turned off at his home (even before his stroke)
- Owed back taxes
- Financial information stolen

Pre- and Post-Injury psychological make-up because very important:

- External locus of control
- Receiving difficult messages from males versus females
- Does not like to be told what to do

Dignity plan became less about specific interventions and shifted more towards balancing dignity versus risk.

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**Case Example:
Severe
Aggression
r/t
Unavoidable
Triggers**

- 27 year old male
- Occupation: Mixed Martial Arts
- TBI secondary to assault
 - Intracranial Hemorrhage
 - Subarachnoid Hemorrhage
 - Subdural Hemorrhage
 - Diffuse Axonal Injury
- Admitted 6 weeks post-injury to the Disorders of Consciousness program
- Emerged from disorder of consciousness shortly after admission
- At discharge, functional status was as follows:
 - Communicated verbally, with limited content in verbal expression secondary to perseveration, echolalia, and empty speech
 - Auditory comprehension was variable secondary to attention and cognitive challenges
 - Cognition was assessed at a Rancho Los Amigos Level 4-6 (Confused-Agitated to Confused-Appropriate). He was inconsistently oriented to time, place, and situation.
- Behavior was characterized by verbal and physical aggression, particularly during hands-on cares

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BRAIN INJURY + STROKE + NEURO

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Known Triggers:

- Peri-cares
- Any task requiring staff to be in PS' personal space
- Injections
- Auditory overload (e.g. too many people talking)
- G-tube cares
- Being exposed during showers and peri-cares

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Dignity Plan: Transfers

Transfer Instructions:

1. Make eye contact with John
2. Tell him the ultimate goal: "We are going to stand up and transfer to your _____"
3. "I'm going to tip your chair forward." -helps to place a hand on his shoulder during tipping forward or reclining back.
4. "I'm going to remove your right leg rest, help me lift up your leg"
5. "I'm going to remove your left leg rest, help me lift up your leg"
6. Make eye contact again and show him the gait belt
7. "John, I need to put this belt around you, can you help me? Lean forward."
8. If he doesn't help, don't force it. Give him the cue again to lean forward. May help to use gestures or tactile cues to show him what you want.
9. Put the gait belt on.
10. "I'm going to unbuckle your seat belt"
11. Make eye contact
12. "John I'm going to come in close to help you transfer. I want you to give me a hug"
13. Make sure both arms are wrapped around you.
14. "we are going to turn to the (right/left) and sit on your _____. Help me stand, John"
15. If he doesn't help, don't force it. It may take several attempts for him to kick in his legs to help (has taken up to 7 or 8 in therapy)
16. During the transfer tell him "We are turning to the (right/left) to sit on your _____"
17. Once you get to the goal area, give him a minute before starting the next step.

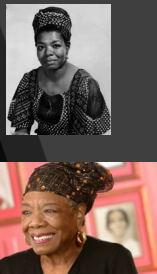
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Dignity's Bottom Line...

"I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel."
~Maya Angelou

View **every** interaction as an opportunity to help the people you serve feel:

- Safe
- Heard
- Understood
- Respected
- Celebrated
- Hopeful
- Secure
- Empowered




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Thank You!

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