HO 5.1

Workshop objectives

At the end of this session, you should be able to:

- list the main behaviour changes following TBI
- outline the main steps involved in analysing problem behaviours
- recall a number of behaviour strategies used for managing common difficult behaviours
- identify when behaviour is being used for communication purposes
- identify early warning signals in an individual who is becoming irritated/angry
- recognise potential triggers in an individual with TBI
- explain how your own behaviour can exacerbate a difficult situation.
- understand the concept of 'anger as a secondary feeling'

HO 5.2

Changes following a TBI

1. Information Processing

– attention and concentration difficulties

– slowed information processing

– fatigue

2. Memory

– difficulties learning new information

– difficulties retaining new information

3. Cognition/thinking

– reduced problem solving/reasoning skills

– poor planning and organisational skills

– rigid and concrete thinking

4. Personality/behavioural changes

– disinhibition and lack of self-control

– egocentricity, self-absorption

– perseveration

– emotional lability

– reduced insight

– poor self-monitoring

– reduced social skills

5. Changes in level of activity

– inertia

– restlessness and increase in energy

HO 5.3a

Strategies for dealing with specific behaviour changes

Impairment	Problems arising	Management strategies
Attention and Concentration	• have difficulty concentrating • be distractible • find it hard to cope with more than one thing at once • get bored quickly • switch off and appear not to listen • not remember what others have said • not complete things they start • change the subject often	– reduce distractions (eg. noise, other people) – use short, simple sentences – encourage the person to stay with the activity for longer periods – change activities when necessary – when distracted, interrupt and bring back to task – give reminders of next step – keep to a routine
Speed of information processing	• take longer to complete tasks • unable to keep track of lengthy conversations and instructions	– make allowances and give the person extra time – present information slowly – present information in chunks – present one thing at a time – check that the person is keeping up
Fatigue	• have an overall reduced ability to cope • get irritable and distressed • have other problems exacerbated	– encourage the person to take rest breaks – schedule more demanding tasks when the person is at their best (often mornings)
Memory	• find it hard to remember new things • forget appointments • forget things people say • frequently lose things	– give reminders – repeat information when necessary – encourage person to rehearse and repeat information – encourage use of external reminders, i.e. diaries, post-it notes – structure a routine by breaking tasks into small steps – keep belongings in regular places

HO 5.3b

Strategies for dealing with specific behaviour changes *(continued)*

Impairment	Problems arising	Management strategies
Problem solving	• reduced ability to find solutions to problems	– train the person to approach new tasks in a systematic manner, eg. break the task into small parts – reduce the demands made on the person – help educate the family and others about the person's problems – avoid giving the person open-ended tasks
Planning and organisation	• have difficulty working out the steps involved in a task • not consider the end result of their actions • have trouble organising their thoughts and explaining things to others	– avoid becoming frustrated with the person – give prompts for the following steps – provide a written list which outlines the steps in order
Rigid and concrete thinking	• take statements literally • insensitive and unable to consider feelings of others • have a simplistic understanding of emotions • be resistant to change • keep doing things incorrectly despite feedback	– use simple and direct language, avoid abstract terms – avoid using hints or sarcastic humour – encourage person to imagine how they would feel in other situations – explain any change in routine in advance, giving reasons
Disinhibition	• be impulsive and act without thinking of consequences • make rash decisions • act inappropriately toward people (including sexually) • behave in a silly, flippant or childish way • disclose personal information too freely	– give immediate feedback, briefly asking person to stop behaviour and explain why – provide appropriate external controls eg. over finances – remind person of the sensitive nature of some information, giving clear examples – ignore the behaviour where possible

HO 5.3c

Strategies for dealing with specific behaviour changes *(continued)*

Impairment	Problems arising	Management strategies
Reduced self-control	• lose temper quickly • physically/verbally abusive • have a lower frustration tolerance	– distract or remove the person from anger-provoking situation – withdraw attention when appropriate – try not to escalate the situation by shouting back – identify anger-provoking triggers and avoid when possible
Egocentricity and self-absorption	• not consider consequences of their behaviour on others • be unable to 'put themselves in someone else's shoes' • appear selfish to others • not appreciate carers	– try to explain situation from another's or your point of view – try not to take offence, understand why the person is like that
Emotional lability	• laugh and cry inappropriately • change moods quickly	– try to identify triggers which result in mood swings – be prepared for changes by having alternative plans
Perseveration	• talk about the same topic repeatedly • return to the preferred topic when doing something else	– remind person gently they've told you the information before – distract the person back to the preferred activity – ignore, as much as possible, future references to the topic – try not to get into arguments, walk away if you're getting irritated
Reduced insight	• be unaware of both cognitive and physical limitations • have unrealistic goals, plans and expectations • resist efforts of carer/staff • not realise that they have made errors because they haven't checked their work	– gently remind person of deficits – explain why proposed action is useful, reason through the steps – point out possible negative consequences of person's unrealistic plans – place external limitations where necessary (eg. removal of driver's licence/access to car) – gradually expose person to reality testing experiences

HO 5.3d

Strategies for dealing with specific behaviour changes *(continued)*

Impairment	Problems arising	Management strategies
Poor self-monitoring	• not realise that they are 'hogging' conversations • be verbose and keep talking when others are no longer interested	– encourage them to check over their work – use signals, agreed in advance, to let them know they're talking too much – encourage turn-taking in conversation – use external aids, eg. graphs and tables to help person monitor their behaviour
Reduced social skills	• interact poorly with others because of all the above problems • lose their ability to relate well with others • not pick up the usual social cues (eg. looking at watch)	– teach specific strategies like maintaining eye contact, asking questions of others, turn taking in conversation – try to encourage awareness of others' reactions
Inertia	• appear to have no motivation and seem apathetic • not act until prompted • not complete tasks • know how to do something, but not do it spontaneously	– encourage person to commence activity – prompt first step of the task – try to find things that are most interesting for the person – reward and encourage any self-initiated activity and persistence – accept that the person may need less activity to keep them occupied and happy
Restlessness	• complain of boredom and be restless and agitated	– remind person of activities they usually enjoy – promote physical activity which may expend some energy

HO 5.4

Checklist for analysing problem behaviour

- **When** does it occur?
- **Where** does it occur?
- **Who** does the behaviour occur **with**?
- Does it start **suddenly** or build up **gradually**?
- **How long** does it last?
- What is the **history** of the problem?
- What **solutions** have been tried in the past?
- How are **people reacting**?

Other factors to consider

- **Physical factors**, ie: excess noise, overcrowding, appropriateness of house or room.
- Are they treated with **respect**?
- Are they part of the decision making process/do they have **choices**?
- Are they **able to communicate** effectively?
- Will they **benefit** from being **taught** coping skills, ie. relaxation etc?

HO 5.5a

Common behaviour management techniques

- **Positive reinforcement**

  This serves to maintain or increase behaviour, as a result of the individual seeing the consequence of the behaviour as something positive.

  Positive reinforcement can be tangible (If I work hard, I will get a raise) or social (praise or smile).

- **Negative reinforcement**

  This also serves to maintain or increase behaviour. In this case we do something to prevent a negative outcome.

  Negative reinforcement can be tangible (If I stick to the speed limit, I will avoid a fine and I will keep my licence) or social (ignore).

- **Punishment**

  Punishment is when something unpleasant follows a behaviour, which results in a reduction of the behaviour. For example, 'The last time I punched someone, I ended up in jail – This time I will not use violence, I will walk away'.

- **Extinction**

  This occurs when you withhold reinforcement for a specific behaviour. It is common when using extinction to see an initial increase in the behaviour. For example, making a commitment to totally ignore inappropriate comments made by a person with TBI will initially result in the person becoming more vocal and explicit. Continue to ignore inappropriate comments and they will decrease/cease over time.

HO 5.5b

- ## Differential reinforcement of other behaviour (DRO)

  DRO involves reinforcing someone for not engaging in a particular behaviour. There are many different types of DRO, such as differential reinforcement of alternative responses or differential reinforcement of incompatible responses.

  With DRO any response, *whether it is desirable or not,* is reinforced so long as it is not the response to be eliminated. For example, if your goal is to encourage an individual to socialise with others, they would be rewarded for just coming out of their room, whether they participated in the program/ talked with others or not.

- ## Timeout

  Timeout is when a person is removed from the source of reinforcement for a specific period of time.

  Timeout may refer to isolation, as in a timeout room, or contingent observation, such as being able to watch activities but not participate in them. Timeout should be no longer than five minutes.

- ## Response cost

  A response cost is the 'price paid' when an individual exhibits an undesirable response, which results in a loss of privileges or other reinforcement.

  For example, if you use a point system, you start with a set number of points and the person is charged a predefined number of points for a particular behaviour. At the end of the week/time period, the points would earn them a reward. For example, 'If you have over 80 points left you can buy the motor bike magazine you want'.

HO 5.5c

• Overcorrection

There are two types of overcorrection procedures that you may be familiar with.

During **restitutional training**, a person is required to make restitution by returning the environment to a better condition than its original state. For example, if you throw some rubbish out in the driveway – then you have to pick up all the rubbish in the driveway.

The other type, **positive practice**, involves the person practicing the correct response repeatedly. For example – if someone does something in a sloppy fashion, then they not only do that task over again but must also perform another task neatly.

HO 5.6a

Case Scenario 1 – Jack

- **Personal details**

  Jack is 44 years old.

  He lives at Hoxten Park with his wife, who works full time.

  They have two children aged 15 years and 6 years.

  Pre-injury hobbies include model shipbuilding and gardening (his wife has reported that he takes great pride in his garden).

- **Details of injury**

  Jack was working as an electrician and fell off a roof. He sustained frontal brain injuries and has residual weakness in his left arm.

  Neuropsychological assessment indicated that he is concrete and rigid in thought. At times he can also be inflexible and mildly impulsive. His memory/learning ability remain fairly intact.

- **Goals within TLU**

  Jack spent some time in the acute rehabilitation ward in hospital before transferring to a share house in the community (a Transitional Living Unit or TLU) to continue rehabilitation. The primary goal within the TLU is to assess his independence and increase the functionality of his left arm

- **Problems arising**

  The TLU is currently full of young males, with whom Jack has nothing in common. Staff find that he constantly gravitates toward them and that he is always hovering around the office doorway. When he speaks with staff, it is mostly to complain about the other residents (complaints range from 'dobbing on them' about tasks not completed to criticisms of their character and the 'youth of today').

  On the odd time, staff have witnessed low level frustration toward the other residents, with the occasional verbal outburst. No real aggression has been noted.

HO 5.6b

Case Scenario 2 – Tim

- ## Personal details

  Tim is a 21-year-old carpenter.

  He lives alone in a house at Bankstown with his German Shepherd dog, which he adores (his sister lives 15 minutes away and will only mind the dog until he is discharged).

  Tim denies having any hobbies, but reported that he used to play indoor cricket on a regular basis. His other interests included rally cars and 'clubbing' with his mates.

- ## Details of injury

  Tim was a passenger in a motor vehicle accident. The driver died.

  Neuropsychological assessment indicated an overall lowering of functioning. He had mild learning/memory problems, poor planning and poor problem solving skills, and his attention and concentration were below average.

- ## Goals within TLU

  Tim spent some time in the acute rehabilitation ward in hospital before transferring to a share house in the community (a Transitional Living Unit or TLU) to continue rehabilitation. The primary goal within the TLU is to assess his independence, improve his fitness levels and returning him to independent living.

- ## Problems arising

  Staff find it hard to motivate Tim to participate in the program. He frequently sits alone and appears lethargic. He occasionally becomes argumentative when prompted by staff to attend appointments and groups – and retreats to his room if allowed.

  He does not understand why he needs to be at the TLU and would prefer to lie in bed all day.

HO 5.7

Potential anger triggers following a TBI

- lack of sleep
- pain/headaches
- noise sensitivity
- changed self-image
- feeling angry about the accident or injury
- worries about future/finances
- coping with change
- lack of understanding from others (friends, family, medical professionals, etc)
- frustration (personal and/or sexual)
- feeling out of control when organising daily life due to numerous medical/legal appointments
- personality clashes/changes to relationships and social activities

HO 5.8

Early warning signals

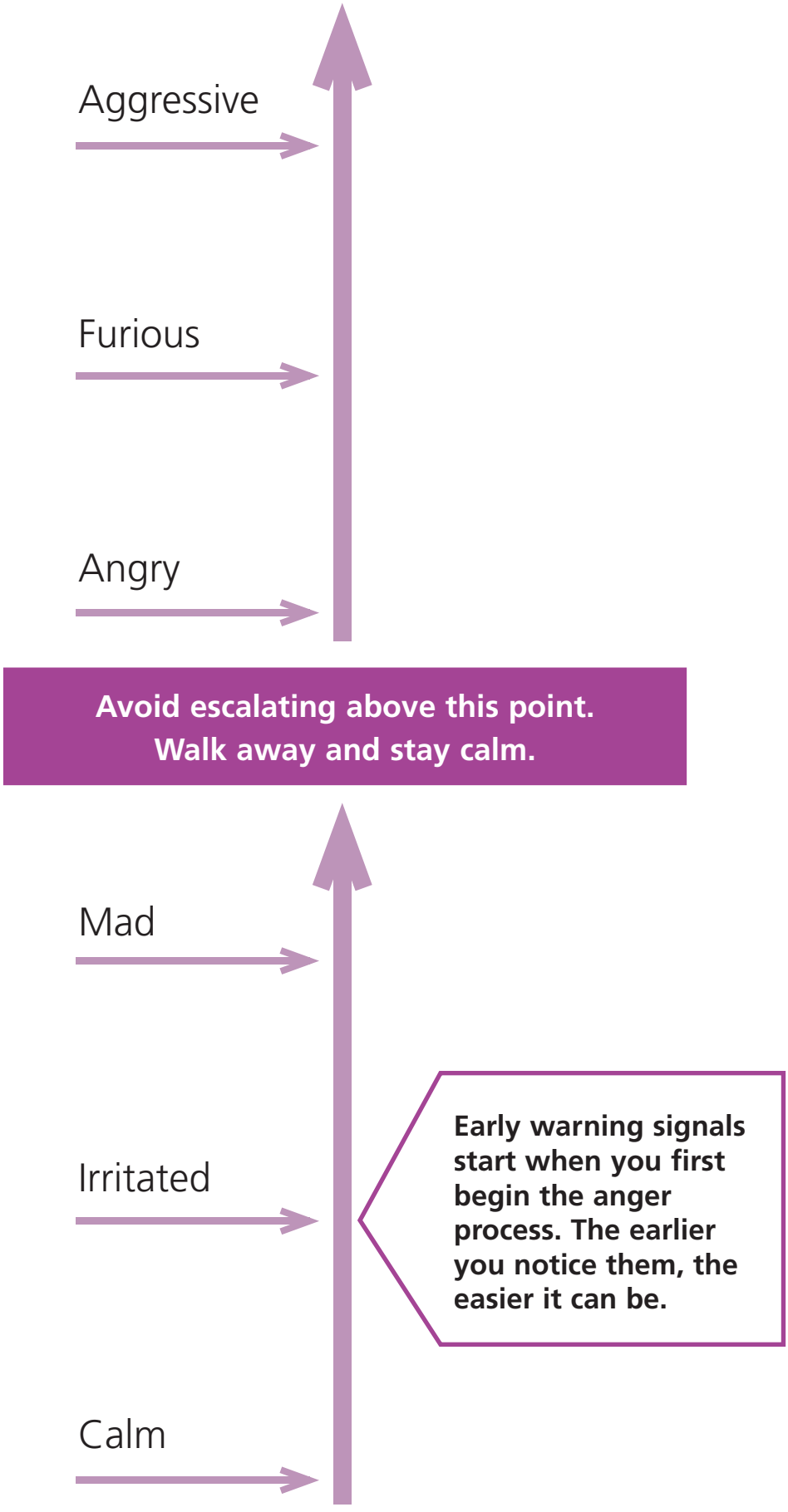
As a person becomes angry, a change occurs at a physical, emotional or cognitive level. If these changes are caught early enough (i.e. before a person loses their temper) then they can be used as an 'early warning system'.

The following changes are often used as guideposts to alert a person that they are becoming angry.

Physical	Emotional	Cognitive
• muscle tension • temperature change • tremor/shaking • sweating • heart pounding • clenched fists	• irritated • frustrated • moody • unsettled • feeling upset	Changes to thoughts include: • racing • jumbled • irrational • jumping to conclusions

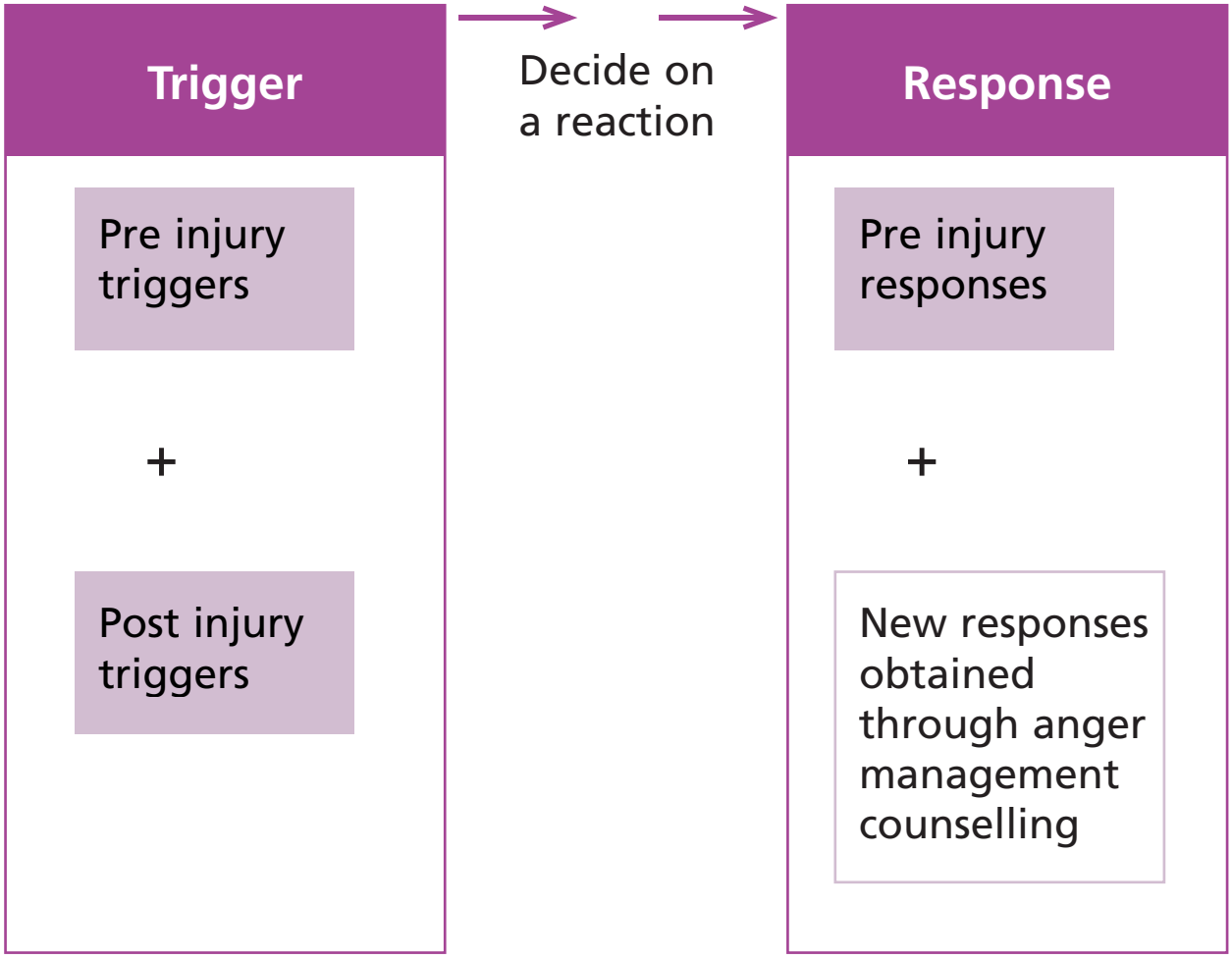
HO 5.9

Anger Scale



HO 5.10

Anger model



HO 5.11

Managing an escalating situation (crisis)

- **Maintain self control**
  - avoid mirroring behaviour
  - control breathing
  - control voice
  - control stance
  - match verbal to non-verbal behaviours
- **Maintain a safe distance**
  - danger zone is 0.4–1 metre from the person (within hitting and kicking distance)
  - area either side of the danger zone is considered safe
- **Maintain a non confrontational body stance**
  - keep hands open and in full view
  - stand slightly at an angle to the person
  - avoid staring or standing with your hands on your hips
  - avoid making fast movements
- **Analyse situation**
  - is anything reinforcing the behaviour?
  - is anything frightening the person?
  - are they being over or under stimulated?
- **Decide on an intervention**
  - can include negotiation, leaving, no action, surprise, diversion, humour, isolating client, removal of other clients/people, requesting assistance and evasive self-defence (only to be used if under attack)
- **Review intervention and decide on next step**
  - monitor situation and intervention
  - decide whether or not to continue, modify or stop the current intervention.

HO 5.12

Managing after a crisis

The body's normal internal reaction to stress is a build up of tension.

Tension can be released by:

- relaxation/breathing techniques
- vigorous activity, aerobic exercise (physical release)
- talking, laughter, crying (emotional release)

Things to avoid

- self-administering drugs/overuse of prescribed medication
- using alcohol, caffeine or cigarettes in large amounts
- using food as means to cope
- releasing tension by aggression and anger

Things to remember

- after any crisis, it is normal for a person to experience an emotional or physical change for up to six weeks
- don't label yourself as crazy
- avoid making life-altering decisions within a few weeks of the crisis
- seek professional help if symptoms persist longer than six weeks.