Managing Behaviors in Clients with Intellectual Disability: The power of prevention, and other tools

Sarah Coats, Ph.D., ABPP-CN
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Objectives/Goals

1. The participant will be able to identify two common causes of difficult behaviors in clients with intellectual disabilities.
2. The participant will recognize that prevention of behavioral escalation is our most powerful tool in managing behaviors, and will be able to identify three strategies to minimize problem behaviors in clients with Intellectual Disability.
3. The participant will be able to identify two strategies for modifying difficult behaviors, when necessary.

Course Outline

- A review of diagnoses: Defining intellectual disabilities and common comorbid disorders
- Minimizing problem behaviors
  - General strategies for creating a positive atmosphere
- Modification of difficult behaviors
  - Specific strategies for changing behavior, when necessary
  - Scenarios, time permitting

Part 1: Diagnostic Review

Defining Intellectual Disability

- Onset during the developmental period
- Includes intellectual and adaptive functioning deficits
  - Conceptual, social, and practical domains

Defining Intellectual Disability

- Deficits in intellectual functioning such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, learning from experience
  - confirmed by clinical assessment and standardized IQ testing
- Deficits in adaptive functioning resulting in failure to meet developmental and sociocultural standards for personal independence and social responsibility. Without ongoing support, adaptive deficits limit functioning in daily life, such as communication, social participation, and independent living, in multiple environments including home, school, work, and community

Diagnostic and Statistical Manual – 5, American Psychiatric Association, 2013

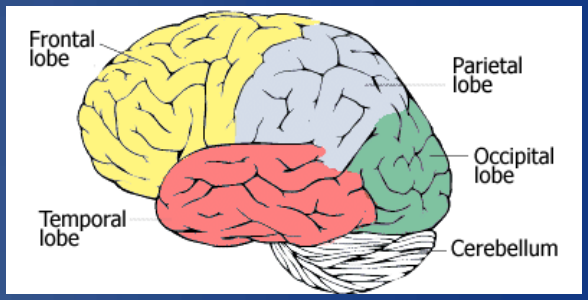
Defining Intellectual Disability

- Severity Ranges
  - Mild
  - Moderate
  - Severe
  - Profound
- DSM-5 removed the standardized testing score ranges to define severity, focusing instead on functional levels within conceptual, social, and practical domains
- Diagnostic and Statistical Manual – 5, American Psychiatric Association, 2013

Comorbid Psychological Diagnoses

- Psychological diagnoses (depression, anxiety, bipolar disorder, etc.) are often used to characterize behavioral patterns, categorize typical reactions, and to justify interventions (including medications).
- However, it is important to consider whether behavior is just a typical manifestation given the client's intellectual, cognitive, and behavioral status
  - e.g., tantrums are a normal developmental stage

Brain Basics (Biological Contributions)



- The brain is a complex organ, responsible for memory, language (understanding and communicating), spatial skills, affect modulation, selecting appropriate response (inhibiting inappropriate impulses and responding appropriately to the environment), reasoning, judgement, directing attention, etc.
- These systems are relatively under-developed in persons with intellectual disability

Part 2: Minimizing Problem Behaviors

- An ounce of prevention is worth a pound of cure
  - Setting the Right TONE
  - This population is especially sensitive to the environment around them

Managing Difficult Behaviors:

"An ounce of prevention is worth a pound of cure"

- Treat all clients with respect and dignity
  - Do not talk down, do not make demands
- Stay calm, stay positive, ***be a good role model***
  - Act like you want the client to act
  - Stay cheerful, maintain a positive tone
  - Model appropriate attitude, behavior
  - Model how to respect the rights of others and others' needs
  - We all feed off of others' negative or positive energy. Be positive energy.

Increase Tolerance and Patience

- Blame the Intellectual Disability and/or psychiatric condition, NOT the Client
    - Don't take the behavior personally

Managing Difficult Behaviors:
"An ounce of prevention is worth a pound of cure"

- Start with empathy
  - "I'm sorry you had to wait for a long time for me to get your pop money"
  - "I know it must be difficult to wait for your medicines when you are ready to go to breakfast.
  - "I appreciate your patience"

Be Consistent

- Enforce rules consistently
  - Every client
  - Every time

Frame Conversations and Directions in the Positive

- Avoid telling the client what NOT to do.
  - Instead, suggest what TO do
    - This strategy teaches more adaptive skills – teaches what ***is*** appropriate, not just what is ***not*** appropriate
    - How do we react when someone tells us “don't, no, can't, etc. all day long?”
    - Be concrete: Use appropriate behavior of peers as examples
    - Catch the client doing something appropriate, and praise that behavior

Avoid The “No”

- Many clients will automatically say “No” if you give them a chance
- Avoid asking questions where a “No” response is possible, unless a “No” response is acceptable
  - Try “Would you like to wear your glasses to breakfast or should I bring them” rather than “Are you ready for breakfast?”
  - Try “It's time for training” rather than “Do you want to go to training?”

Patterning

Help the client get on a string of “yes responses.”

Ask a series of questions where you know the answer is yes/positive

- You look nice today, did you put on makeup this morning?
- I saw a new picture in your room, did you color that?
- I heard you were very helpful in the dining room yesterday, is that correct?
- I need you to be a good role model and head to training now. I'll walk with you.

Increases the likelihood of a “yes” or compliant response.

Prevention of Behaviors: Autonomy

- Provide opportunities for empowerment
- Provide opportunities for clients to feel in control
  - Resident Council
  - Provide choices when appropriate
    - Choices about menu
    - Choices about daily tasks/schedules
    - Choice about daily tasks/schedules
    - Choices about clothing

Choices/Control

- Keep Choices Simple
  - Choices do not have to be open ended, offer a choice between two options
    - “It’s time for your medicine, would you like to take it with water or juice?”
    - Do you want to take your showers in the morning or at night?
- What are some choices you can or do offer your clients?

Assist the Client in Maintaining A Sense of Achievement

- Identify activities that the client has succeeded at and compliment him/her
  - I noticed you have been on time to training all week, congratulations, keep it up!
  - I heard you waited in the dining room without fussing yesterday, that's very helpful, thank you!
  - You look nice today, you must have taken your bath...

Maintain Routines

- Your clients will thrive on routines and will be sensitive to changes in routine
  - Changes in timing of activities
  - Changes in roommates
  - Changes in staff
  - Changes in programming
- Keep routines as consistent as possible
  - Bathing, laundry, meals, training times/location, staff, etc.
  - Educate when changes are coming
  - Provide extra support when routines change

Other Examples?

Behavior Support Programs

- Behavior Support Programs should not just be reactionary – they should include a lot of proactive planning/information
  - When is client at his/her best
  - What calms client
  - What does client find rewarding
  - Who is special to the client
  - What topics/activities does the client enjoy

Provide a Positive Environment

- Identify when client is at their best, and duplicate that environment as much as possible
  - Certain places in the facility, certain staff or peers around, etc.
- Increase availability of activities/coping resources that keep client happy and calm
  - Peers
  - Hobbies
  - Movies/TV, Music
  - Other toys/technology
  - What else works for your clients?

Structure

- Structured, productive activities are good for emotional coping and healthy lifestyles
  - Clients with Intellectual Disability often need assistance structuring their lives
  - Boredom breeds inappropriate behavior
  - We all do better when we
    - Have things to look forward to
    - Do fun things
    - Accomplish something
    - Interact with positive influences

Part 3: Behavioral Modification 101

Conceptualizing Behavior

- Behavior is communication
  - Behavior is not random
  - Behavior is adaptive for that person
  - Behavior is goal directed
- Behavior replaces language as communication skills decline
  - May represent boredome, pain, overstimulation/understimulation, depression/mood disturbance, apprehension

Know Your Behavioral ABCs

A = Antecedent B = Behavior

C = Consequences

- Antecedent conditions or what precedes a behavioral pattern may influence its occurrence
- Consequent events and conditions or what follows behavior “locks in” the behavior
- This model gives us the opportunity to figure out what is escalating the client's problematic behavior, and may point us to what we can control or change to minimize that behavior

Conditioning:
A is for Antecedent

- The environment sets the stage for the behavior
  - Physical environment/Situational Factors
    - The room, lighting, temperature, odors, equipment, sounds, distractions, time of day
  - Other people present
    - Nursing, Trainers, Q's, Administration, support staff, other clients, family
  - Internal state of the client
    - Mood
      - Sad, nervous
    - Thoughts
      - “She doesn't like me.”
      - “This is going to hurt.”
      - Lack of understanding
    - Physical condition
      - Pain, fatigue, limited function

Conditioning:
B is for Behavior

- Behavior
  - We want to MAXIMIZE positive behaviors

  We want to MINIMIZE negative behaviors

Conditioning:
C is for Consequences

- What follows the behavior will likely influence whether or not that behavior will continue
- Consequences can either increase or decrease the frequency of a behavior.

So Now What???

- A: Identify Triggers (Antecedants) to behavior
  - Certain Times of Day?
  - Certain Staff?
  - Certain peers around?
  - Certain Tasks?
  - Hungry? Thirsty? Tired?
  - Recent outside contacts?
- Modify Triggers as possible to minimize problem behaviors

Choose your Consequences Carefully

- Punishment is Not Effective/Not Efficient at decreasing negative behaviors
  - Unethical
  - May elicit aggressive behavior or other undesirable emotional side effects
  - Doesn't teach the person what ***to*** do
  - Causes resentment toward the person administering the punishment
  - May produce other undesirable emotional side effects

Choose your Consequence Carefully

- Reprimanding the client will have much the same effect as punishment
  - “Don't cry at me, it just makes me cry at you” - Wesley, age 2 1/2
- Confronting a behavior head-on is likely only to escalate the behavior
  - How would you react to a coach, teacher, family member, caregiver, or other who only focuses on the things you are doing *wrong,* or a near-stranger who reprimands your behavior.
- Attention (even negative attention) will increase the behavior
- Choose your battles

Think in Behavioral Terms: Positive Consequences

- Research shows that the most powerful way to change a behavior is to reward positive behavior
- Therefore, IGNORE undesired behaviors and PRAISE desired behaviors
- 4:1 rule – frequently focus on positives

Redirection:

- Redirect the client who is focused on maladaptive or negative things/behaviors
  - If a client is getting agitated, try to direct his/her attention to something productive, or talk about something he or she enjoys (e.g. friends, family, hobbies, outings, upcoming events at the center, etc.)
  - If a client focuses on a mistake, point out the things he/she has done right
  - If a client is stuck on something he/she cannot do, focus on what he/she *can* do
  - Point out the appropriate behavior of someone nearby

Pay Attention

- Keep your attention on the client, especially when he/she is exhibiting positive behaviors
  - Clients sometimes act out to get attention (even negative attention), keeping your attention focused on them gives them less of a chance to act out (e.g., Jake)
  - Paying attention to negative behaviors can be reinforcing (e.g. the child who throws tantrums to get attention) and can actually increase the undesired behavior
- Point out what you LIKE
  - If the client isn't doing anything you like, point out someone nearby who IS.

Rewards

- Identify activities that are rewarding to the patient and use these as motivators
  - If you are setting up a reward plan, the reward must be consistently available and attainable (i.e. don't set the client up for failure)
    - Start with an attainable goal, and then slowly increase demands as the patient starts to consistently meet the goal
    - If a reward plan is in place, then the client must be rewarded every time he/she meets the stated goal
    - Reward needs to be delivered immediately after the desired behavior
    - Verbalize what the client did to earn the reward
      - E.g. You arrived at training on time, so you have earned a point toward your trip to the convenience store

Rewards, Continued

- Behaviors necessary to obtain the goal must be concrete and measurable
  - For example…”If you come to your med pass on time without prompting, then you can _____,” rather than “if you do a good job on the hall today, then you can _____”

Behavior Focused Questions*

- 1. What are you doing?
- 2. What are you supposed to be doing?
- 3. What will happen if you continue to do what you're doing?
- 4. Is that what you want to happen?
- 5. So what will do you now?

- *taken from Guiding Principles for Oklahoma Bridge Resource Families: Participant Handbook. OKDHS/NRCYS (2013) p.143

Don't Give Up: Consistency is Key

- Behavioral change is a long, slow, process
- Longstanding behaviors are resistant to change
- Requires **consistent, collaborative** intervention
  - One trial of ignoring the negative/praising the positive is not going to result in significant change
  - One person cannot change the whole problem: Need assistance from all nurses, Q's, trainers, support staff, administration, and care staff
  - Use the Behavior Support Programs as appropriate

Collaboration

- Collaborate with team members within and across disciplines. Sometimes nursing staff, Q's, other caregivers will discover techniques that a certain client responds to
- Ask family for suggestions on successful strategies for approaching a client
- Ask your consulting psychologist or other administrative or consulting staff
  - Observation of interactions/behaviors can be helpful in identifying factors that might be influencing behavior

Questions?

Managing Specific Behaviors

Example: Who is Training Who?

- Brain Injury Patient
  - Patient rests quietly for awhile, so staff goes about their business
  - Patient then becomes agitated and starts banging on the door
  - Staff responds to the banging on the door, gets the patient what he needs and leaves
- What will happen to the patient's behavior over time?
- How do we decrease the door banging?

Managing “Agitation”

- Possible Strategies
  - Alternate quiet and active periods
  - Simplify environment
  - Look for overstimulation/understimulation (bored?)
  - Offer failure free activities
  - Provide choices
  - Consider your verbal and non-verbal message
  - Attempt challenging activities when well rested
  - Join, validate, redirect

Managing Difficulty with Tasks/Personal Cares

- Possible Strategies
  - Demonstrate
  - Provide distraction (something to hold)
  - Offer choices/provide “control”
  - Use Humor
  - Reassure, comfort, distract
  - Maintain routines

A Few Thoughts About Medications

- Medications should be used only in conjunction with behavioral support programs, and only when the previously discussed efforts/interventions are not sufficient to control behaviors.
  - Medications should be viewed as a means to improve the client's ability to benefit from behavioral interventions
  - Medications should not be used for sedation

Medications, Continued

- Medication use should be frequently reviewed, with reductions made as necessary
- Use psychiatry services when necessary
  - Not just for adding/increasing medications, but also for reducing medications
- Consult with physicians and pharmacist about medication side effects, tapering schedules, etc.
- Avoid short-acting anxiolytics if possible

Scenario for Discussion

- 32 year-old female client with mild intellectual disability. Tearfulness, irritability, and self-injurious behaviors increase around the holidays, especially since her mother became ill and she can no longer go home for Christmas
  - What can you do to minimize behavioral exacerbation?

Scenario for Discussion

- 53-year-old male with severe intellectual disability starts to exhibit increased agitation after a room change.
  - Brainstorm factors that hypothetically could be contributing,and how you might address these.

Other Question?

sarahmcoats@gmail.com