

Challenging Behaviors

Slide 1

No topic in long-term care has received as much attention as the topic of “difficult behaviors”. Books, videos, training programs and manuals abound on how to deal with the resident who is “aggressive”, “agitated” or “uncooperative” and “non-compliant”.

In clinical practice, the number one reason caregivers request consultation in any long-term care setting is when there is a perceived need to “do something” about someone’s behavior. It is behavior, usually aggressive or non-cooperative, that leads to eviction notices.

This 2 hour session is designed for two purposes: one, to assist you in understanding why the challenging behaviors you encounter occur; and two, to help you feel confident in your ability to communicate with someone who is withdrawn or non-communicative; is suspicious, mistrustful or paranoid; has delusions or hallucinations; is talking about suicide; is angry, threatening or aggressive; is intoxicated. That “someone” could be a resident in a facility, a facility operator, a mental health clinician or a co-worker!

In other words, understanding behavior and understanding and practicing certain basic principles of communication will help you not only with the resident but with everyone involved in the difficult situation.

There are a few basic assumptions that underlie this approach.

First, all behavior has meaning. It may not be immediately apparent, even to the person who is behaving in a challenging way.

Second, many people, including ourselves, do not always ask directly for what we want or need. Often, what is described as “difficult behavior” is an indirect attempt to get some basic human need for security, control or affection met.

Third, it is easier to change our behavior than to change someone else’s.

(*Click)

Objectives: Part One

Slide 2

[To the instructor: you may or may not wish to begin each module with the goals of the training. They are listed here for convenience should you decide to do so.]

The goals of the mental health ombudsman training are two fold: first, to increase the personal comfort and confidence of ombudsman in their abilities to work effectively with residents living in adult homes with multiple, chronic health problems (both mental and physical); and by doing so, to increase their ability to advocate effectively *for* and *with* residents. It is expected that this advocacy will occur at both the individual and systems levels.

The lecture portion of this module is divided into two parts. In the first half, we will review some basic principles of communication, complete an exercise on non-verbal communication, and discuss an approach to understanding any behavior and to look at common environmental, interpersonal and physical factors that contribute to the development of difficult behaviors.

At the end of Part One, (click) you should be able to describe basic principles of communication, (click) discuss what is meant by the statement: ‘all behavior is an attempt to communicate’ (click) and list the common environmental, interpersonal and physical contributors to difficult encounters.

(*Click)

Objectives: Part Two

Slide 3

In Part two, we will discuss specific, challenging behaviors such as isolation, aggression, agitation and hoarding.

We will discuss strategies for dealing with the resident who is withdrawn or non-communicative; is suspicious, mistrustful or paranoid; has delusions or hallucinations; is talking about suicide; is threatening or aggressive; is not making sense, is engaging in prostitution or dealing drugs. We will discuss strategies for dealing with facility operators and clinicians who are defensive, angry, suspicious or mistrustful. The drugs that are commonly used to target certain behaviors will be mentioned but these will not be discussed until module IV.

At the end of Part Two, you will be able to describe common challenging behaviors and describe strategies for dealing with them.

(*Click)

About communication

Slide 4

[To the instructor: Slides 4 and 5 fall into the category of “good to know” and “fun to know”, rather than “need to know.”

I include them because I think they set a good ‘tone’. You may choose not to include them and you will not interfere with the basic integrity of the lecture because much of the information was covered in the homework for today’s session].

Often the most powerful tools are those that are taken most for granted. If you were to consider every situation that can and often has gone wrong between people, ineffective communication of one kind or another was responsible. Conversely, anything that goes right between people is a direct or indirect result of effective, positive, and helping communication.

Why is it, then, when we begin to talk about “communication skills,” heavy sighs and audible “ho-hums” are evident? Probably because we have been communicating since the moment of birth, believing that we are doing a pretty fair job. When problems do arise because of how we communicate, we generally hold others responsible: they didn’t listen, they don’t understand, they always have to have their own way, etc. Since this is the way in which we have always done it, it must be the right way.

How many recall from your homework just what percentage of what we communicate is from words or speech?

Pause for answers then: click 10%

From the tone of voice? Pause for answers then click 40%

From body language? Pause for answers then click 50%

[If the instructor is comfortable with a bit of hamming it up, a good way to demonstrate this is to show all the ways one can say: “good morning. I’m so happy to be here.” Say it with a smile, good eye contact, and relaxed posture: in other words, like you mean it. Then say the same words but role yours eyes and smirk. Ask if anyone believes you’re glad to see them. The instructor may think of other ways to have fun with this.]

About communication

Slide 5

Did you know?

Estimates indicate that the average person can think at a rate of between 1,000 and 2,000 words per minute. Because we can only speak at a rate of 100-400 words per minute, it is easy to see how a person listening may easily become bored and start thinking ahead of the speaker, either on the same topic (or more likely), on a different one. One study on communication indicated that within ten minutes after a college lecture, students had forgotten 50% of what was said. Forty eight hours later, they had forgotten 50 % of that, which means, they retained only 25% of what was said!

(*Click)



About communication

Slide 6

The implications of good communication cannot be overemphasized.

Understanding another person's communication, whether expressed directly or indirectly, whether through verbal, non-verbal, or other behavior- requires a willingness to keep an open-mind and a wish to understand. With respect to challenging behaviors, this can be especially important because so often there is a tendency just to want it to stop, rather than to be understood.

The best vantage point is to try to stand in another's shoes. In other words, try to see the situation from another's point of view. This is not as easy as it may at first seem. If you think for a moment about the times when you have felt most frustrated talking to a facility operator, your spouse, a doctor or your child it is likely because the other person isn't getting **your** point of view! Standing in another's shoes requires, at least temporarily, giving up your point of view.

Standing in another's shoes is one way to describe empathy.

(*Click)

About communication

Slide 7

This first step toward enhancing communication may be taken with very little fanfare. It begins with EMPATHY, a concept at the core of effective communication. Empathy is the quality of thinking and feeling about a situation from another's point of view. In the communication process, empathy means that the sender of message first considers: who is receiving my message? What is the level of understanding of the receiver? What is the sender's attitude toward the receiver and the message? What other things might the receiver have on his mind?

(Click)

A second element in the communicating more effectively is to become more familiar with your own response to certain stress-provoking situations. Each of us, as individuals, can tolerate different situations and different amounts of stress. Further, we all define our DIS-stressors differently. It takes a fair amount of honesty and self-study to recognize and acknowledge those situations. We must then take steps to either change the way in which we react, change the situation, or know when to react.

(Click)

Listening is the third area in which skill building will yield great and swift reward. We at least start out with some degree of listening ability. The challenge is to move from a passive to a more active role so that our listening becomes more effective. It is probably the single most useful skill to have. It is also an easy skill to learn. The difficulty comes in applying what you have learned.

To summarize, in order to communicate effectively, the knowledge we need is SELF-KNOWLEDGE, the skill we need is ACTIVE LISTENING and the attitude we need is EMPATHY.

(*Click)

Communication obstacles

Slide 8

Communication can be complicated by many factors. Speech, language and sensory deficits are fairly obvious but frequently overlooked. Cultural differences may be less obvious but no less important.

Being preoccupied with other, unrelated problems. The emotional state can also complicate communication. We may have to deal with such difficult questions as “Why should I go on?” “I wish I were dead” “I hate it here” “everybody here is out to get me” and so on.

Sometimes we feel inadequate to deal with those kinds of feelings. Sometimes we are trying to adjust to our own feelings about mental illness, about old age, about trauma, about substance users, or about having our best efforts ignored or rejected. Sometimes we see only minimal progress, and sometimes we see none.

(*Click)



Communication obstacles

Slide 9

External factors can also contribute to communication difficulties. Though these may be present in any human interaction, they are particularly potent in nursing homes and adult homes where the residents may have little if any private or personal space, where the needs of the many tend to overshadow the needs of the individual, where the “rules” of the house may often seem quite arbitrary, where the resident feels un-empowered to make decisions, and in the case of those living in a home not of their choosing or receiving treatment involuntarily, the resident actually *has lost some* decision-making power

(*Click)

About Behavior

Slide 10

Thus far, we have focused on verbal communication, even while noting how little of what we communicate is actually through words. So what does this have to do with challenging behaviors?

To answer that question, let's turn our attention to behavior as communication. (Click)

This idea is based on the assumption that all behavior has meaning, even though it may not be immediately obvious.

(Click)

We behave – or act – in an attempt to signal a feeling or to meet some basic human need for comfort, control, security or affection. Often times we ask indirectly – or not all! – hoping another person will simply “know” – or should know – what we want!

Click)

To put it differently, we communicate to effect a change in our environment: we either want something to start happening that isn't or we want to stop something from happening that we find noxious or undesirable.

(*Click)

About Behavior

Slide 11

Generally, the next step in understanding behavior as communication involves asking, if the person *is* signaling the need for a change, what needs to change?

The environment?

My behavior or attitude?

The resident's behavior?

Remember: it is easier to change our own behavior than someone else's.

BREAK here to do the first exercise



Challenging Behaviors - Part Two

Slide 12

Welcome back. Any additional comments about the exercise? Let's begin.

(*Click)

Adult Home Setting

Slide 13

Before beginning our discussion of specific challenging behaviors, let's think for just a moment about what is the situation in which our residents find themselves: whether we are talking about people in a nursing home or in an adult home.

One of the key themes in a group living situation is the sense of loss. We do not have time to explore this in any detail today, but think about what it means to become psychiatrically or otherwise disabled and to be required to move into a group setting that may or may not be of one's choosing. Even when desired, there is a loss of individual identity, of lifestyle, of independence, of control and of others. Choice and control are often restricted, if not altogether eliminated. Any loss of independence or control -- qualities highly valued in our society -- can be a blow to a person's self-esteem. It's difficult for most people who have been self-sufficient to accept increased dependency.

(*Click)

Common Behaviors

Slide 14

Now let me ask you to name some of the behaviors that either you, or the staff, have found challenging.

[To the instructor: Use a flip chart and write down all the behaviors that the participants name. If they come up with some that are not already included in these prepared remarks, tell the group you will discuss that behavior at the end of the lecture to see what they think is being communicated and how best to respond. Then go on with the prepared slides].

(Click)

The behaviors listed here, are those that most commonly trigger a request for HELP! You can read quickly through them as they appear automatically.

On the next slide, you will see those behaviors that are also very strong communicators, but because they aren't causing a problem for *others*, they are often ignored.

(*click)

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### Common Behaviors

#### Slide 15

A person sitting alone, making no eye contact, crying quietly or showing no facial expression, displaying little interest in activities and so forth may be communicating that she is depressed or apathetic. Apathy can be part of a dementia syndrome or schizophrenia. The main point here is that it is important to pay attention to *quiet* as well as *noisy* behaviors.

(\*Click)

## Understanding Behavior

Slide 16

[Instructor: You will not have time to go into all the behaviors listed. I have selected the behaviors that seem to be the most problematic. Feel free to choose any others applying the following basic principles]

So, as we look at individual behaviors, keep in mind the following principles:

1. What is the person's behavior trying to tell me (us)?
2. Does something need to change? If so, what needs to change?
3. Is the behavior seen as a problem? If so, then why? Who is it a problem for?

(\*Click)

**Agitation**

Slide 17

Let's start with agitation and agree to never use the word again!

What do I mean by that? Agitation is a catch-all word that really doesn't describe anything very specific. It is used to describe everything from crying when upset to throwing a chair out a window.

The behaviors usually referred to include (click) (and here I would demonstrate them)

Clapping, yelling, slapping thighs, and screaming. What did you do when I clapped, and banged the table, etc? You looked at me! And that's what I wanted. And that's what I think all agitated individuals are trying to communicate: look at me. So let's define "agitation" to describe those SELF-REFERRED behaviors that attempt to communicate:

(Click)

LOOK OVER HERE! SOMETHING IS WRONG WITH ME: DO SOMETHING.

Who is likely to communicate distress this way instead of directly?

(\*Click)



**Agitation**

Slide 18

Any individual who has lost the ability to SAY: something is wrong. This includes people who have had a stroke, have dementia, are delirious, developmentally disabled, brain injured and so forth. You can probably think of others.

And **what** kinds of things are usually wrong?

(\*Click)

## Agitation

### Slide 19

The common causes of agitation typically include (Click)  
Pain, constipation, discomfort, infection, drugs and hearing loss.

One particular kind of agitation, caused by certain kinds of medications bears special mention. This is the problem of akathisia which you will hear about again in module IV.

***[To the instructor: write this word on the FLIP chart. This allows you to call special attention to it and makes it more likely the audience won't forget it.]***

Akathisia is a drug-induced motor restlessness that is characterized by the inability to stand or sit still. The individual may pace or rock back and forth on the soles of his feet. It is caused most commonly by the older anti-psychotics like haldol and prolixin, but can also be caused by high doses of the so-called SSRIs which you know as the “prozac” type drugs

Now return to the power point:

What to do about agitation: (click)

Make sense of the communication

- 2) Educate the staff or operator as to what it might mean
- 3) Reassure the person you “got the message” that something is wrong
- 4) Correct the underlying problem

(\*Click)

**Aggression**

Slide 20

Aggression, in contrast to agitation, is the term I reserve for use with those behaviors that are **OTHER** – referred.

(Click)

If I am hitting, kicking, spitting, biting, swearing, throwing things, etc., I think my communication is pretty clear: there is something wrong **WITH YOU!**

The change I want to effect is **STOP** doing what you're doing. Go away. Don't come any closer.

(\*Click)



**Aggression**

Slide 21

Who is likely to communicate distress this way instead of directly?

Any individual who has lost the ability to **SAY**: something is wrong with you **AND/OR** any individual who has lost the ability to control his or her behavior because of loss of inhibition.

This includes people who have had a stroke, are paranoid, have dementia, are delirious, intoxicated, are developmentally disabled, brain injured, suffering delusions of persecution and so forth. You can probably think of others.

(\*Click)

## **Aggression**

### Slide 22

The common cause of aggressive behavior is:

Fear, Anxiety, Frustration, Medications, Sensory loss, Crowded or noisy environments and abrupt, tense or impatient staff.

(\*Click)

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## **What helps?**

### Slide 23

What helps when a person is behaving aggressively? (Click)

- 1) Make sense of the communication
- 2) Stop doing what you're doing and back away
- 3) Stay calm
- 4) Speak in a soft low voice and reassure the person you got the message that they want you to back off
- 5) Correct the underlying problem

(\*Click)

**Isolation**

Slide 24

Individuals who isolate themselves do so for a variety of reasons. The communication is pretty simple: I want to be left alone. The challenge to the rest of us is to try and understand why.

(Click)

Is the individual staying in his room because he is afraid? He might *like* to join in but suffers from social phobia or other form of anxiety. Or does the fear run deeper? Is the person suffering from paranoid ideas or delusions?

(Click)

Does the individual stay in his or her room because he or she is hard of hearing and finds it too frustrating to be in a group and unable to hear?

(Click)

Is the individual staying in his or her room to conceal the use of alcohol or other drugs?

(Click)

Or does the person simply like to be alone? As a culture, we tend to overvalue extroverts and socializing. While it is true that forming social connections is associated with better mental health, it is not true that the social connections must always be in a group.

Always find out if the person would like to be less isolated before trying to correct a problem that may not exist! How to find out? ASK them.

(\*Click)

**Communication skills**

Slide 25

How do you talk with residents who may have  
Depression?  
Psychosis?  
Difficult personalities?  
PTSD?  
Substance Abuse Disorders? Or  
Severe Anxiety?

(\*Click)



**Communication skills**

Slide 26

What if they are (click once and they will appear one by one automatically)

Intoxicated?  
Dealing drugs?  
Hallucinating?  
Not making sense?  
Engaging in prostitution?  
  
Verbally abusive?  
Exploiting others?  
Anxious around other people?  
Disorganized?

(\*Click)

## Set the Stage

### Slide 27

Your first step is to set the stage for conversation.  
Use your basic principles of empathy, self-knowledge and active listening to guide you.

(Click)

Consider whether the person has any sensory deficits and make allowances: meet in a quiet place, talk face to face, speak in a low tone and normal or only slightly louder volume. Consider whether the person has any cognitive limitations whether from dementia or schizophrenia and use simple vocabulary and simple sentences. Don't talk "down" to the person but rather give information in simple sentences rather than compound ones. Check in frequently with the listener by asking, *'does that make sense?'*

(Click)

If you want to really have a conversation with someone who is hearing voices or struggling with disorganized thoughts, it is key to make sure you have enough time to be patient.

(Click)

Sitting across from someone or next to him or her, making sure to be alert for how much personal space he or she wants, is a good way to "level the playing field" or "equalize" the conversation. Individuals with schizophrenia, with histories of trauma or of incarceration are very wary of others whom they see as in some kind of power.

(Click)

Try to insure that everything about your tone, posture and gestures communicate respect for the individual and their point of view.

(\*Click)

## Depression

Slide 28

Communicating with the person who is depressed requires knowing that the depressed person is not only depressed but feels bad about being depressed. Sometimes the person who is depressed appears to prefer not to be comforted to avoid the guilt of not being able to respond to the other person's kindness or interest. The depressed person needs diversion and company, but too many demands can increase feelings of failure.

(Click)

What does help the person who is depressed is to acknowledge the sadness and at the same time to remind the person s/he has not always felt that way and won't always feel that way. If you want to try to engage someone with depression, don't ask: *what would you like to do today?* but rather make a specific offer to have the person join you for a particular activity for a specified duration. This relieves the depressed person of having to generate ideas which is often impaired in depression.

(\*Click)

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Depression

Slide 29

What doesn't help the person with depression is to hear: Cheer up! Snap out of it! You have so much to live for!

Sharing one's personal philosophy is also usually experienced as insensitive. The depressed person KNOWS others are "worse off" but it doesn't prevent them from feeling depressed. Don't accuse the depressed person of faking illness or of laziness or disparage any feelings expressed. NEVER ignore remarks about suicide. Always inform the appropriate staff to do an assessment.

(*Click)

Schizophrenia

Slide 30

One of the ways to be most helpful to an individual with schizophrenia is to use the principles you learned in the module on recovery: maintain hope and direct effort toward empowering the individual to participate in managing his or her illness. In practical terms, this might include supporting a request for a second opinion or advocating for alternative treatments. Listen actively. If the individual is distracted by voices, be patient. Many individuals who have heard voices for a long time can control them long enough to talk with you if they perceive you are sincere in wanting a conversation. Ask questions when you don't understand. The most important thing to communicate is that you want to understand but not intrude.

If a person abruptly terminates the conversation, and walks away, don't follow but do let them know when you'll be back.

(*Click)

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## Fearfulness

Slide 31

Persons living in adult homes who live with some degree of fear would include any resident with a history of trauma, individuals with anxiety disorders or any resident suffering from paranoid ideation as a result of schizophrenia or other brain disorder. Take care not to use gestures which might startle or threaten the individual and be very careful with hugging a person or putting a hand on their shoulder unless they have clearly communicated this is desired.

(\*Click)

## Drug Use

### Slide 32

Some of the biggest challenges you may encounter in the adult home will involve becoming aware of questionable sexual activities or frankly illegal activity on the part of the residents. Substance abuse occurs in over 50% of persons with mental illness living in facilities. Often operators seem to turn a blind eye to sales of marijuana or alcohol unless the resident creates a disturbance. Without passing judgment, it is imperative to adopt a zero tolerance towards drug use in facilities.

Not only does ongoing use undermine treatment, individuals who use drugs are at very high risk of exploitation. Women residents with major mental illness provide sexual favors in return for drugs or cigarettes are not uncommon.

Discussing this and helping a resident find alternate ways to acquire legal goods without being exploited requires sensitivity and skill. Underlying the approach however is a willingness to suspend judgment and to report any instances of exploitation.

Perhaps the most important role for an ombudsman in this instance is to become informed of what resources exist and to advocate aggressively for assertive treatment of co-occurring disorders. We'll talk more about this in Module V.

Now let's try another exercise.