# Neurobehavioral Programming: Embracing the Challenge with Dignity

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# Objectives

At the conclusion of this activity, the participant will:

- identify how fundamental attribution error in caregivers adversely affects the development of mutually reinforcing relationships within the survivor/caregiver roles.
- identify the neurobehavioral characteristics that necessitate the use of a dignity-based intervention plan and a more traditional behavior plan.
- identify 9 survivor-specific, dignity-based interventions built upon a combination of behavioral treatment planning and sensory / perceptual / communicative / cognitive interventions after brain injury.

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# ABI Continuum of Care at OWL

Post-acute inpatient program with dedicated disorders of consciousness program

Outpatient neuro rehabilitation specialty clinics

Residential neurorehabilitation home

Supported community living

Extended care facility for chronic DoC and severe ABI

# Common Neurobehavioral Challenges Following Brain Injury

| | | |
|---|---|---|
| Emotional Dysregulation | Apathy & Reduced Behavioral Activation | Disinhibition |
| Agitation & Restlessness | Aggression | Suicidal Ideation |
| Perseveratory Thought Processes | Pragmatic / Social Communication Challenges | Anosognosia |

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# Neurobehavioral Challenges in ABI: A Complicated Concept

The role of medical / physical / sensory challenges as etiology for neurobehavioral challenges:

- Pain, UTI, hydrocephalus, medications, sleep/fatigue
- Vision / hearing / language challenges

Response variability across persons served (i.e., an approach that deescalates one person served may escalate another)

There is a dynamic, trial-and-error component associated with evolving recovery and improvements in cognition.

Staff conceptualization and competency re: approach

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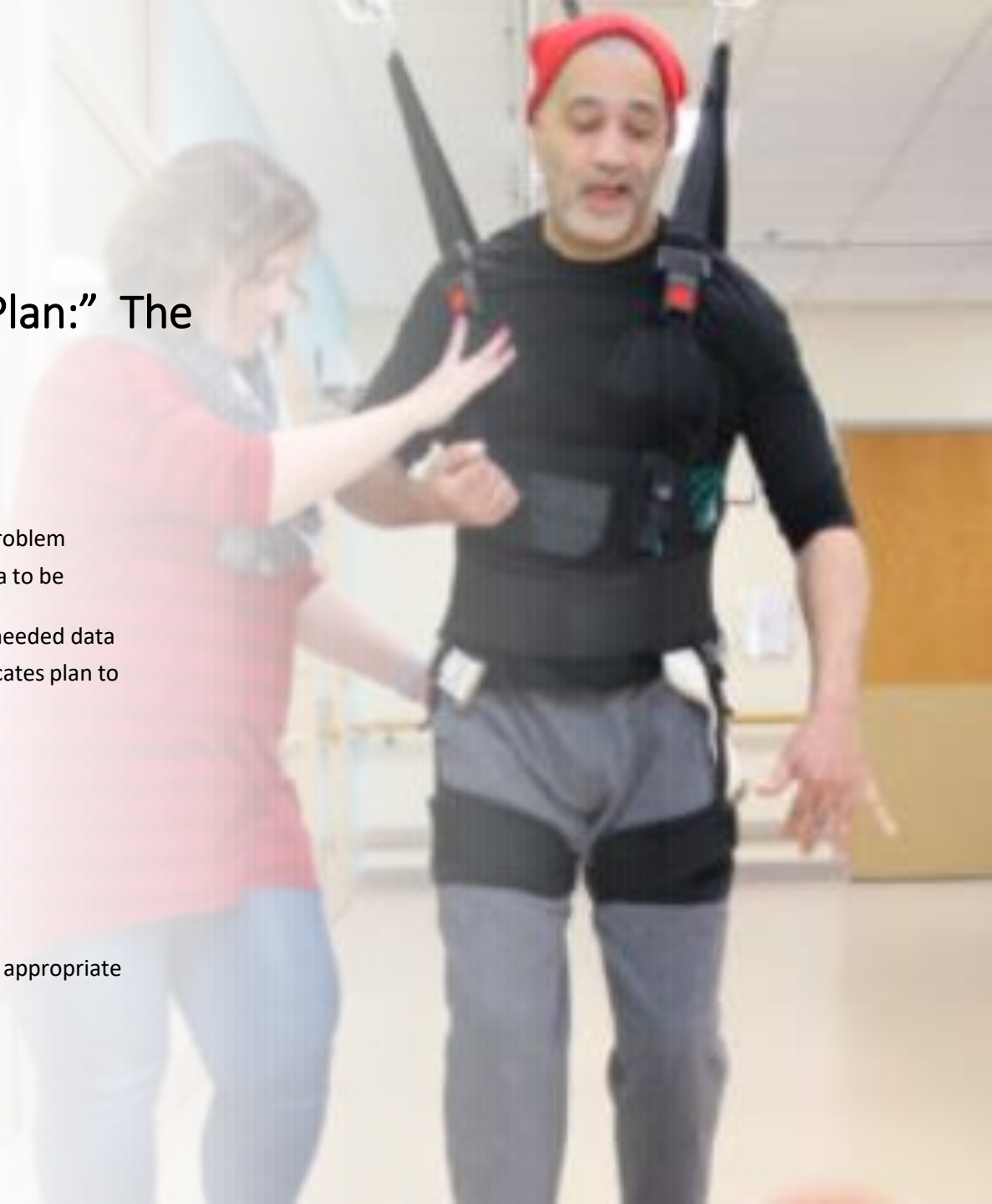
# “Behavior Plan” to “Dignity Plan:” The Transition



**Traditional Behavior Planning:**

- Facility behavior expert is notified of a behavior problem
- Behavior expert observes patient and asks for data to be collected
- Nursing and therapy staff do their best to collect needed data
- Behavior expert implements a plan and communicates plan to staff
- Staff do their best to follow-through on the plan

**Our challenges with this approach:**

- Dependent upon behavior expert’s availability
- Analysis and plan based on snapshots in time
- Inconsistencies in data collection
- Staff “do what works in the moment”…not always appropriate
- Challenges with buy-in and follow-through

# “Behavior Plan” to “Dignity Plan:” The Transition

Dignity Team Concept:

- Transdisciplinary Team Responsibility
  - Person Served & Family (when appropriate)
  - Nursing Leadership
  - CNAs
  - Therapists
  - Neuropsych / Clinical Counseling
  - Social Work
- Full Mandt training for all dignity team members. Relational portions incorporated into direct care competencies
- Rehab 16 Framework

Major focus on helping staff re-frame mindset away from “behavior problems” and toward identifying opportunities to “maintain dignity.”

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The Mandt System®

# 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)

- 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 occurs 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).

**Photo Credit:** http://1.bp.blogspot.com/-v9Y-cwpRbsI/TuFz0vGjthI/AAAAAAAADhU/66OROmPjUq0/s1600/What%2BA%2BJerk.jpg

# FAE “red flags”

- The person served is **being**….
  - Difficult
  - Stubborn
  - Ornery
  - Manipulative
  - Resistive or unwilling
  - Lazy
  - Noncompliant
- The person served is **unmotivated**.
- The person served was **caught**…

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# Influencing vs. replicating the energy in the interaction

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

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# “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_____”

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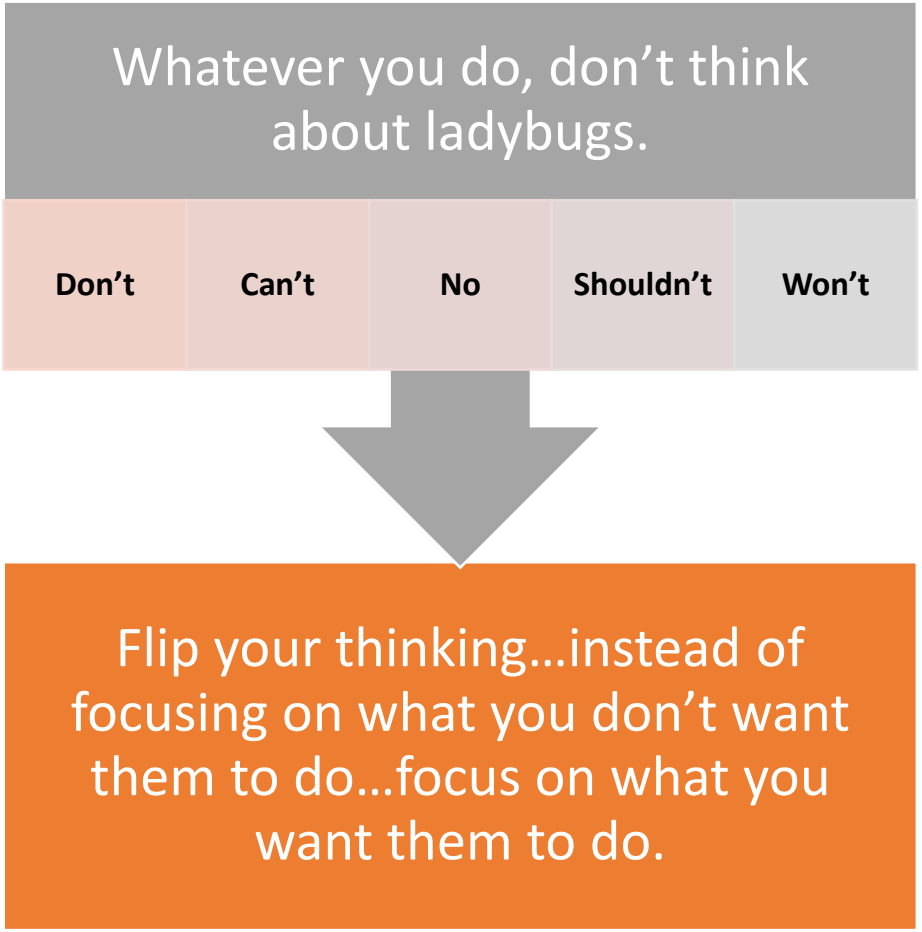
Speak in the Affirmative. Avoid the Negative.



# Case Example: Severe Aggression r/t Unavoidable Triggers

- 27 year old male
- Occupation: Mixed Martial Arts
- TBI secondary to assault
  - Intercranial 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 Ranchos 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

# 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:**

- Make eye contact with John
- Tell him the ultimate goal: “We are going to stand up and transfer to your _____”
- “I’m going to tip your chair forward.” –helps to place a hand on his shoulder during tipping forward or reclining back.
- “I’m going to remove your right leg rest, help me lift up your leg”
- “I’m going to remove your left leg rest, help me lift up your leg”
- Make eye contact again and show him the gait belt
- “John, I need to put this belt around you, can you help me? Lean forward.”
- 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.
- Put the gait belt on.
- “I’m going to unbuckle your seat belt”
- Make eye contact
- “John I’m going to come in close to help you transfer. I want you to give me a hug”
- Make sure both arms are wrapped around you.
- “we are going to turn to the (right/left) and sit on your _____. Help me stand, John”
- 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)
- During the transfer tell him “We are turning to the (right/left) to sit on your _____”
- Once you get to the goal area, give him a minute before starting the next step.

# 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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