

CERTIFIED FAMILY HOME CHALLENGING BEHAVIORS



Definition:

A behavior which limits a person being able to be a part of regular community life, or erodes their personal dignity. Behavior is communication.

Examples:

- Repetitiveness
- Manipulation
- Distrust
- Withdrawal
- Depression
- Hypochondria
- Denial
- Aggressiveness
- Violence

Causes of Difficult Behavior:

- **Loss or lack of independence and personal privacy.** The losses associated with moving into an adult family home may include limited privacy and personal space for possessions, distance from familiar people and places, and schedules over which residents have no control. Residents may feel grateful for having someone to provide for their care needs, yet at the same time resent becoming increasingly dependent on others.
- **Loss of control.** Residents who are left out of decisions affecting their daily lives may respond negatively in an effort to regain some control. Doing "what is best" for a resident can result in your being the target of anger, not gratitude.
- **Stress.** Unrealistic expectations for a resident to do certain things can cause behavior problems. Comments such as "You can do it if you just try harder" often produce results opposite of those desired. Remember that some residents may be stressed by environmental factors that you may not notice, such as glare from a light source or acoustical problems.
- **Inability to Communicate.** Residents who are unable to express their thoughts or feelings in words may express frustration through behavior.
- **Pain.** Chronic pain may limit a resident's participation in activities of daily life. It can cause frustration and depression, which leads to behavioral problems.
- **Medications.** Medications used to treat pain or mental illness can affect behavior, especially when the resident is not taking the proper dosages. The section on medications will discuss this in more detail.

- **Mental Confusion.** Changes in brain function can alter the way people perceive what is happening around them.
- **Depression.** Depressed persons are not always withdrawn or cheerless. They may be agitated, hostile or aggressive.

Assessing Difficult Behavior:

The cause for a resident's difficult behavior may not be apparent. For example, a resident who is hostile and says, "I don't like you, go away!" could be experiencing depression. There could be a medical reason for the behavior, such as a reaction to medication. Perhaps the behavior is a manipulative tactic to gain attention.

The purpose of assessment is to determine the reason for the behavior and the best approach to take. First, rule out possible medical causes for the behavioral problem (e.g., medication reaction or disease). Then ask yourself these questions about the resident's behavior.

Whose problem is it?

Sometimes the "problem" is with the attitudes of others (provider, family, and staff), not in the person's conduct.

Is the behavior appropriate under the circumstances?

Behavior that seems inappropriate may actually be adaptive. You need to examine all aspects of the situation. For example, Mr. Jackson was viewed as difficult because he sometimes urinated in the backyard, although the bathroom was next to his room. When the problem was explored, it was found that he only went outdoors when the bathroom was occupied (there was only one bathroom in the home) and he "had to go." He chose to urinate outdoors rather than soil his clothes. Providing him with a portable urinal quickly solved the problem.

Also, the behavior may not seem inappropriate to the resident if it works (e.g., gains your attention, gives the resident control). If shouting seems like the only way to get people to listen, the resident will shout.

Is there an unspoken message in the behavior?

Is the person using actions to say or gain something? Once you understand the "message" you can respond appropriately to the resident's feelings or needs. For example, Louise, 77, dumps her food on the table while you are in the kitchen discussing Louise's care with her daughter. Why does she do this? What is she trying to tell you both?

Does the behavior fit the resident's perception of reality?

For example, because Martha believes there are rats under her bed, she refuses to go to bed. Her actions make sense in view of her beliefs. Try to understand the behavior from the resident's viewpoint. Ask yourself; if you were Martha, might you also refuse to go to bed?

Do I (staff, family) provoke the person's behavior?

If so, how? For example: Do I violate the person's privacy? Do I try to control the person's daily life? Do I treat the person like a child? Do I talk about the person as if he or she is not present?

How do I respond or reinforce desired behavior?

Am I prompt with praise? Do I tend to ignore good conduct? Do I offer smiles, hugs, or special treats?

How do I respond to negative behavior?

Am I consistent, or do I ignore it (no reinforcement) sometimes, and become annoyed (negative reinforcement) at other times? When you are inconsistent, you reinforce the behavior.

Do I give immediate or delayed rewards?

For example: Do I reward positive behavior when it occurs or do I wait until the end of the day? Do I follow through with stated rewards or consequences? Behavior followed by immediate actions (negative or positive) tends to be repeated. Behavior not followed by immediate actions tends to occur less frequently.

When do I (or other staff), primarily respond to the person?

Is the person left alone when "being good," but given attention when displaying negative behavior? Maximize the rewards for positive behavior and minimize the response to negative behavior.

Approaches to Special Problems:

The following are general suggestions for handling certain types of difficult behavior. When an extreme form of difficult behavior is exhibited, or the problem persists for a long period of time, or you feel frustrated or "in over your head," consult with a mental health or behavioral specialist to determine the most effective methods of coping with the behavior.

- **Repetitiveness:** Use distraction to divert the person's attention.
- **Distrust:** Use passive friendliness to deal with distrustful residents. Wait for them to reach out to you. Be honest. Avoid making promises that cannot be carried out. Such promises add to feelings of distrust even though the intent is sincere. Be as specific as you can about what you will do. For example, instead of saying "I'll go for a walk with you as soon as I can," say "I'll go for a walk with you after lunch."
- **Depression:** Try to build the self-esteem of depressed residents. Reminiscence, care of a pet, and participation in activities and decisions may help. Consult with the health care team about medical treatment for depression.
- **Withdrawal:** Use active friendliness and give time and attention to the resident who is withdrawn. Gently reach out to engage the resident in conversation and activities. Encourage activities that the person enjoys on a solitary basis. If possible, get the person to do these activities in group settings when appropriate.

Gradually expand the activities to include increasing interaction. For example, if a resident enjoys reading poetry, provide the person with books by favorite poets. Suggest the person read in the family room ("where the light is good for reading"). Engage the person in conversation about favorite poems/poets. Look for an opportunity to reminisce with residents, including the person who is withdrawn, about the "first poem you had to memorize for school." Plan "afternoon poetry sessions" with audio poetry readings from the library; seek suggestions from the person and other residents.

- **Denial:** Avoid arguing. Reduce stressful demands and help the person see positive options. For example, an unsteady resident who denies needing to use a walker might be persuaded to use it to do something he or she wants to do, such as getting to the TV room ahead of other residents so he can choose the channel. The questions of "needing" the walker would not be discussed.
- **Hypochondria:** (Excessive bodily complaints.) Do not try to talk the person out of "being sick" or explain that the symptoms are "not real." The pain or symptoms are real to the person. If medical

causes for the symptoms have been ruled out, ignoring the complaints sometimes may be appropriate. Set aside a time to talk about "aches and pains."

If the person complains at times other than scheduled times, remind him or her to "Save that thought to talk about tomorrow morning at 10:30." Talk with the resident about other things at other times of the day. Try to shift the person's interest to the world outside of their environment. Be attentive at times when the person is not talking about health problems.

- **Manipulation:** Provide as many opportunities for decision making and independence as possible. This reduces the need for the person to resort to manipulation. Do not respond immediately to flattery or criticism. Wait until your feelings subside before you decide on an appropriate response.
- **Aggressiveness:** Behavior that presents a hazard to you or others should be evaluated and treated by a professional. Frequently, the person is reacting defensively to a confusing, threatening world.

Provide a consistent, secure environment that allows the individual as much independent activity as possible. Avoid arguing or placing the person in a negative light in front of others. The person may act aggressively to prove that he or she is in control.

When working with a potentially aggressive resident, select an open area where the resident has a choice of places to sit. Position yourself four or five feet away. Sit or stand a little to the side, rather than directly facing the person. This position is less challenging. Try to be at the same physical level as the resident; do not stand if the person is seated. Speak in a normal tone of voice. Offer reassurances.

Remember . . .

- Do not wait until you have reached your limits to discuss the problems, or relocating the resident.
- There are no easy answers when dealing with behavioral problems.
- Ignore difficult behavior (when appropriate), but never ignore the underlying feelings and needs of the resident.
- Tactics that work today may not work tomorrow and what does work for you may not work for someone else.

Communication Stoppers

Communication stoppers are messages that mean "Your thoughts, ideas, and feelings are not worth listening to. Mine are better." Such comments tend to reduce the self-esteem of the other person. They also trigger defensiveness, resistance, and resentment. Communication stoppers include:

- **Criticizing or blaming** — makes a negative judgment.
"Can't you remember anything?"
"If you had done what I told you, we wouldn't be in this mess."
- **Diagnosing, analyzing, or interpreting** — says you have the other person figured out.
"You're depressed, aren't you!"
"You don't like it here because you don't have much privacy."
- **Name calling, ridiculing, or shaming** — makes the other person feel foolish, belittled, or embarrassed.

"You're acting like a spoiled child."

"Where did you get such a silly hat?"

- **Ordering or threatening** — commands another person to do something, or warns what will happen.
"Now, stop that crying!"
"If you don't chew your food more, you're going to choke."
- **Advising or giving solutions** — suggests that the person isn't capable of finding a solution.
"Here's what I advise. Change physicians."
- **Moralizing or preaching** — tells others what they should do.
"Just forget your old home. You live here now."
"You mustn't come to the table dressed like that."
- **Questioning or probing** — suggests finding reasons for and solving problems for the other persons.
"Have you always let your children make all your decisions?"
"Why do you want to stay in your room by yourself?"
- **Diverting or distracting** — suggests that you are not interested, or that the problem is not important.
"Let's have a nice cup of tea and you'll feel better."
"What you need is a good night's sleep."
- **Minimizing or denying** — shows no regard for the person's feelings, values, or position.
"You're just oversensitive."
"I don't see why you're so upset over a little thing like that."
- **Using logical arguments** — discounts a person's feelings.
"Think about all of the things that you still have, not what you have lost."
"Sooner or later all older people need help."