Part 4 – Challenging Behaviour
Challenging behaviour

Challenging behaviour is: “Any behaviour, or lack of behaviour of such intensity, frequency and/or duration that has the potential to cause distress or harm to clients/carers/staff or one which creates feelings of discomfort, powerlessness, frustration, fear or anxiety. It is also behaviour which delays or limits access to ordinary community facilities and is outside socially acceptable norms.” - Emerson E (1995)

‘All behaviour has a meaning….’

Challenging behaviour is a catch-all phrase that encompasses behaviour that is difficult to manage on the ward or in the community. In the current context, it is also behaviour that may interfere in some way with rehabilitation potential, community access and can have a significant impact on housing, relationships, care, health and happiness.

Learning Objective

This section will help to give you the knowledge and skills required to meet the following core competencies:

- To understand the definition of challenging behaviour
- To recognise the importance of having a good understanding of challenging behaviour
- To identify proactive and reactive strategies to manage challenging behaviour

The definition provided by Emerson in 1995 remains popular to this day. It highlights that there is an intensity, frequency and duration to challenging behaviour and this forms a major part of the assessment and monitoring (more of which later). Importantly, the definition alerts us to the consequences of challenging behaviour and that it can create potential for harm and distress. It is important to note that challenging behaviour is only defined as such depending on the person observing it, and different people may have different views depending on their own background and experience. For example, one member of staff may consider
Harry’s swearing during dressing practice as challenging, while her colleague comments “well, that’s just Harry, he means no harm.” It is therefore a social construct.

A list of challenging behaviours is provided in the table below.

Types of Challenging Behaviour (**pick the most suitable**)

<table>
<thead>
<tr>
<th>Physical</th>
<th>Verbal</th>
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</thead>
<tbody>
<tr>
<td>Self-injurious behaviour (hitting, biting, punching, head butting)</td>
<td>Threatening others</td>
</tr>
<tr>
<td>Injury to others through biting, hitting, punching, kicking</td>
<td>Swearing at others</td>
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<tr>
<td>Throwing items at animate or inanimate objects</td>
<td>Shouting/screaming</td>
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<tr>
<td>Grabbing at others (to gain affection, attention)</td>
<td>Laughing inappropriately</td>
</tr>
<tr>
<td>Pushing others away during risky activities</td>
<td></td>
</tr>
<tr>
<td>Inappropriate Sexualised behaviour (taking clothes off in public, masturbating in inappropriate areas)</td>
<td>Inappropriate Sexualised talk (inappropriate comments towards others, talking about sexualised behaviour with others)</td>
</tr>
</tbody>
</table>

A behaviour need not be high in frequency to be challenging. Consider a patient who does not engage at all, and is withdrawn. We may describe this as lack of motivation or apathy. While this behaviour may not be disruptive as such to many staff, it will impact on the person’s ability to benefit from rehabilitation and significantly reduce their quality of life in the long-term. The table below explains what we mean by excess, deficit, inappropriate and asset behaviours.

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Excess</td>
<td>Behaviours that occur at such a high frequency, intensity or duration that they are problematic in the setting in which they occur (e.g. hitting, smoking, obsessive checking, irrational requesting).</td>
</tr>
<tr>
<td>Deficit</td>
<td>Behaviours that occur at such a low frequency, intensity or duration that they are problematic in the setting in which they occur (e.g. eye contact during conversation, task engagement, study behaviours)</td>
</tr>
<tr>
<td>Inappropriate stimulus control</td>
<td>Behaviours that occur at a reasonable frequency intensity or duration and are usually adaptive, but they become elicited by</td>
</tr>
</tbody>
</table>
inappropriate stimuli (e.g., sexual arousal to inappropriate objects or public social interaction).

Asset | Behaviours that are developmentally and socially appropriate and constructive (e.g. hobbies, language and problem solving skills).

**Causes of challenging behaviour**

In previous chapters we have discussed the on-going difficulties that can be experienced by individuals who have received an acquired brain injury such as stroke. Changes to a person's behaviour are very common after stroke. Challenging behaviour after brain injury is usually the result of a complex combination of factors that are related to the physical damage to the brain, the individual's environment, and personal factors. There are many causes of challenging behaviour including medical, environmental, social, psychological, and cognitive.

**Medical/Physical:**

A stroke can cause physical problems such as weakness and paralysis, numbness, pins and needles, spasticity, pain and changes in sensation. Sometimes damage to the brain after a stroke can make normal touch feel more painful or make people hypersensitive to sound or light. These physical and sensory impairments can negatively impact upon an individual's independent adaptive living skills. They can lead to frustration and aggression if the individual has few coping strategies to compensate. Other possible causes of challenging behaviour can arise from the side effects of medication and a lack of appropriate medication.

**Environmental:**

Environmental factors including noise, overcrowding, lighting, or too many things happening at once, can trigger challenging behaviour in an individual recovering from stroke, particularly if they have become hypersensitive to these stimuli. Alternatively, some individuals may find their environment lacking in stimulation, which could trigger episodes of challenging behaviour (particularly if they have sensory deficit).
Challenging behaviour is also more likely to occur when an individual is living somewhere that does not suit them. An example of this may be a young person living in an aged care home. Activities that are not person-centered or not meaningful for the individual may lead to frustration and boredom, which may act as a trigger for challenging behaviour. Other environmental factors that may influence the presence of challenging behaviour include the actions of other people in that individual’s environment. These actions could include: arguing with the person, or giving in to angry demands. The latter can lead to reinforcing of inappropriate actions (in this case: further angry demands).

**Social and Communication:**

Issues such as boredom, social isolation and a limited support network can impact upon the quality of life of an individual following stroke. Injury to certain parts of the brain during stroke can result in impaired interpersonal behaviour.

For example your patient Harry may behave with strangers in ways that are more appropriate for interactions with close friends or family. Some of the patients, and even some staff, may find this behaviour unsettling, and avoid Harry. Inappropriate social behaviour may negatively impact on social inclusion; this in turn may maintain inappropriate behaviours.

In patients with acquired language disorder after stroke (e.g. Aphasia) communication will be very difficult: they may perceive communications as unclear, possess insufficient vocabulary or means of expression, and/or have difficulties understanding communication of others. Therefore, some patients may employ strategies to communicate their needs, wishes and emotions to those around them that are perceived as challenging. Here, challenging behaviours may serve a social interaction function, for example to obtain something material (e.g. social contact, drinks), avoid something (e.g. staff asking them to do something), or they may be used to communicate the person’s emotional state (e.g. anger, frustration).

**Psychological:**

How someone reacts to life after brain injury will depend on their personality, resilience and coping skills. The person who has experienced a stroke is likely to face a range of losses, such as
independence, role in life, fitness, etc. A significant number of patients experience depression, anxiety, grief and frustration following stroke. Some patients might experience post-traumatic stress disorder.

In addition, direct damage to the **frontal lobes**, which contribute to control of emotional behaviour and tolerance of frustration, can create **emotional lability** or mood swings. In these patients even trivial events may trigger extreme reactions, for example bursting into tears because they spilt a little tea. Individuals with frontal lobe damage may also have problems in stopping automatic impulses (such as swearing or lashing out) – their behavioural ‘braking system’ is not fully functioning.

**Cognitive**

Damage to the brain following stroke can result in limited insight or understanding, and this may lead to confusion, agitation and frustration. The person may deny having any significant problems, or acknowledge some problems, but have reduced awareness of their impact on others, daily life and future plans. For example, Dave is looking forward to going home. He still suffers incidents of incontinence about once or twice a day, but insists that he does not need the support of carers. He is adamant that his wife will be able to help him, despite her doubts.

A patient with limited insight may blame their problems on others, or refuse useful assistance. Memory issues are also common and aggression can occur if an individual is struggling to recall or find something. The person might also get irritable if they ‘remember’ an event differently to another person.

**Challenging behaviour as communication**

Thinking of challenging behaviour as a form of COMMUNICATION is useful to consider why it is occurring, and what the person is trying to achieve. This can help us to empathise with the person displaying the behaviour. Challenging behaviour is learned over time. Some examples might be:

*Roger is being transferred from the bed to his chair by hoist. During this process he starts to lash out and grab at the occupational therapist assisting him.*
Barbara starts to shout, throw things and refuses to “co-operate” with staff immediately after her family have left the ward following a visit.

Pat is shouting and screaming at all hours of the day. She only stops when someone goes to her and asks her to be quiet. However, this is quickly followed by more shouting as soon as the nurse has turned her back.

What do you think these behaviours are trying to communicate?

If you thought about these behaviours as a form of communication, what comes to mind? Could Roger be feeling pain when he is hoisted? Or perhaps he feels unsteady and is trying to regain control by grabbing onto something/someone. Barbara may be trying to communicate that she is lonely, or that she wants to go home. Could Pat be lonely too? Or in pain and hoping that the nurse has bought some pain relief? Or perhaps she is just scared. What do you think happens when we go to her and tell her to be quiet? Do you think this will manage that behaviour? The example seems to suggest that the behaviour persists when we ask her to be quiet. In order to address the behaviour, and more importantly the unmet need Pat is trying to communicate, we need to carry out an assessment or functional analysis.

It can be very hard to work with someone who is displaying challenging behaviour, particularly when we don’t understand the reason for it. It can be hard not to take things personally, especially if someone is behaving aggressively or in a threatening manner. For this reason, some patients may not receive as much time or attention from staff during day to day care, meaning that whenever staff members are around them, it tends to be when someone is ‘kicking off’. Over time, staff may learn that dealing with a particular patient is an unrewarding experience, and this can lead to a negative cycle of interaction.

It is not unusual or wrong to feel as though you do not particularly “like” a patient, but this should not stop you from spending time with them, getting to know them a little better and trying to find something that you do like about them. It is often the patients who are showing challenging behaviour that really need the most time with you.
Think about the following questions and try putting yourself into the individual’s shoes:

- What do you like about the patient?
- What do you understand about their situation?
- Do you think he/she is unhappy?
- If you were the patient, what would help you to feel less unhappy or distressed?
Assessment

Before we start thinking about changing behaviour, ask yourself who is this causing a problem for and why? There are ethical considerations to managing challenging behaviour. In fact the term 'challenging behaviour' conjures up negative visions. But what about 'challenging environments' or 'challenging systems' which include others around the individual? A functional analysis needs to take into account interactions from others as well as towards others in order to fully identify triggers and effective means of management.

Needless to say ‘Challenging Behaviour’ (as we will continue to call it in this chapter) usually causes significant problems for the individual and those around them. It is more likely to lead to longer stays in hospital, break down in relationships, breakdown of care, self-harm, rejection, depression, isolation and so on. It is also more likely to lead to the prescription of powerful drugs to regulate the behaviour. Some of these medications impact on cognition, and therefore might interfere with rehabilitation and quality of life. Therefore it is imperative that the behaviour we observe is understood, and interventions are agreed and managed by a team or individual trained and confident in behaviour management.

Functional Analysis

A functional analysis can be used when we want to better understand and sometimes change behaviour. It requires quite a lot of information about the What, When, Who, and Where and Why.

What is the behaviour?

Operationalise the behaviour so that we know what we are looking at. Make this as concrete and specific as possible. Think of James, who has been difficult to deal with over the last week. Describing his behaviour as ‘kicking off’, ‘agitated’ or ‘angry’ does not provide enough information in order to understand the behaviour. Instead note what behaviour you are observing, for instance:

- punches, kicks, nips etc
- shouts at me: threatens to …
• shouts out. Not directed towards anyone in particular
• throws objects at…, or
• throws objects without aiming at anything/anyone

There are some behaviours that can be a little more subjective, such as those that are inappropriate. Some might find the behaviour funny or harmless, for example a patient coming up to give you a cuddle, whilst others might describe the behaviour as potentially harmful in some way. It could be that a behaviour does not directly cause harm, for example someone pacing up in down in front of the TV, but that it makes the patient vulnerable to harm or angry reactions from others.

**When?**

When is the behaviour at its worst? When does it not happen? What time of day is it more likely to happen? This helps to build some triggers and potential hypotheses about the behaviour. If the behaviour happens mainly at night what might that tell us? Your patient is fatigued perhaps? This can then begin to inform possible interventions for the behaviour.

**Who?**

Who is the behaviour most likely targeted at or who does it involve? Who has never seen this behaviour? Who always sees this behaviour? Who is more likely to get the more positive behaviour, for instance, is it worse when family visit or just after family have gone? It might be that an increased number of people around an individual cause some anxiety. Therefore there might be a question of who and how many people trigger the behaviour.

**Where?**

Where is the behaviour at its worst? Is it worse in the bathroom, living room, outdoors, in the car etc? By noting where the behaviour occurs it allows you to make some links over time about a possible trigger point. You might find that a behaviour always occurs in one particular room, in which case you can limit the time spent in that room.

**Why?**
Why is the behaviour happening? A functional analysis asks why is the individual behaving in a certain way? Behaviours tend to serve a function. Algase et al (1996) suggest that what we perceive as challenging behaviours may actually express the person’s goals or needs, for example the need for comfort, or the goal of being free from pain. Therefore, by addressing the unmet need, we may be able to reduce or stop the behaviour.

**Formulation**

Apart from us being able to observe and describe the behaviour in terms of the where, what, when, who and why, we also need to collect information about the person: their background; likes and dislikes; personality; previous mental health issues; physical health status; sensory impairment issues; classification, location, size and likely impact of stroke; pre-existing cognitive impairment; medication they receive; environment. It might be easier to think about this in the following way (Algase et al, 1996):

Let us consider the case of Gwen. In terms of background factors, knowing that Gwen has had a stroke affecting the front part of her brain tells us that she might have problems with planning and impulse control. She currently cannot mobilise herself. We also noticed that she displays visual neglect and her memory is patchy.
She suffers from arthritic pain, and appears uncomfortable a lot of the time. At home, Gwen lives with her husband and the couple have never been separated.

In terms of proximal factors, Gwen is disorientated and experiences anxiety. There seems to be a lot of noise, but she is not sure why; she does not understand why her husband is not with her. She is trying to find him, but her legs do not seem to work properly. Occasionally, nurses come into her room and move her into a wheelchair. This is often painful. Gwen tends to scream and lash out when she is being transferred. She can be heard shouting for assistance when people walk past her room. She also shouts for help when her husband leaves after visiting.

What do you think is going on for Gwen? Why does she lash out, or shout for help? What needs does she have, which we are not meeting?

A very useful model that can help with answering the above questions is the Newcastle Model (James, 1999):

This is a bio-psychosocial model that has been developed for working with people with dementia. The model combines the distal features of the person’s history with
the proximal features of the behaviour, looking at a wide range of factors. The model will therefore not only look at the neurological and physical factors, but take further factors into consideration. We also need to include the person’s life history and their personality, as this can have a great impact on the person’s need, and also on what they believe is happening to them. For example, a person who has lived by themselves most of their life might struggle with a multi-occupancy room, and believe themselves to be back in a time when they were incarcerated during the war.

The model contains elements of CBT, family therapy and functional analysis. It requires staff to engage in a fact finding mission.

We know Gwen suffers arthritic pain. She may not be able to articulate this properly, hence it is worth checking whether she is on appropriate pain relief. Because her memory is patchy, she might not always remember that she is in hospital, and why. This is making her anxious. Therefore, she needs information that will help her to orient herself to her environment. This can be provided by staff explaining this to her regularly, or writing the information down if she is able to read (e.g. “You are currently at the general hospital. You have had a stroke. Your husband will visit you at 2pm”). Further, orientation can be improved by approaching Gwen slowly and talking to her, given her visual field deficit.

We also know that Gwen has never been separated from her husband. She has always been a little anxious, since the time she was sent to stay with distant relatives during the war. Her husband tells us that she was worried her parents would not come back to fetch her, and that she believed they had abandoned her. Therefore, Gwen might find it very unsettling being in a single room, and this again leads to anxiety and thoughts of having been abandoned. Therefore, we may be able to allocate her to a two-bedded room. We also could try to involve her in some group work to ensure she has some company and provide regular orientation when her husband will come to see her.

In the case of Gwen, we were able to build up a good picture of her unmet needs based on background and proximal factors using the model provided. However, for some patients, we may be unable to draw as clear conclusions. In those cases it will be helpful to learn as much about the behaviour as possible, and the context in which it is occurring. As mentioned earlier, it is useful to look at frequency and duration.
Frequently we will be told that patient X is shouting “all the time”, and that he “never stops”. If this is indeed the case, we will need to consider that this to be due to unmanaged pain or neurological damage. However, more often than not a patient will present with a pattern, where he shouts sometimes, and not at other times. By recording the behaviour we may be able to identify the pattern and meet the unmet need.

**Recording Behaviour**

As explained above, we are thinking of behaviour as the result of an unmet need. In order to find out what causes the behaviour, we need to look at the *behaviour*, but also at what leads up to the behaviour (*antecedent*) and the *consequence* of the behaviour. We call this an ABC analysis (Antecedent – Behaviour – Consequence).

Below is a simple example:

<table>
<thead>
<tr>
<th>Time</th>
<th>Antecedent</th>
<th>Behaviour</th>
<th>Consequence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1pm</td>
<td>Fred, who has aphasia, is alone in his room, while people pass by his room chatting.</td>
<td>Fred starts banging against the radiator, which gets increasingly louder.</td>
<td>A staff member enters his room asking “what is all this racket about?” Fred stops his banging.</td>
</tr>
</tbody>
</table>

**What do you think is going on?**

One possible explanation is that Fred feels lonely and isolated in his room, and that he wants some company. People are just passing by. Once he starts banging, someone enters the room and talks to him. He might learn that whenever he bangs against the radiator, someone will come to his room and speak with him, even if this means being asked to stop. In order to meet Fred’s needs (company), we can make sure that a staff member or volunteer comes to his room at regular intervals (before the banging) to have a brief chat and make sure he is ok.

**How to Use Behavioural Recording**

1. Define the behaviour that you wish to observe. Be very specific. For example, ‘kicking off’, or ‘resisting’ are not very specific. Better descriptions would be ‘kicking the wardrobe’ or ‘hitting at staff’. Be sure that your definition is so narrow in scope that others would observe only what you had in mind.
2. Decide which type of behavioural recording is best suited to monitor the behaviour; does it make most sense to look at frequency or duration, or do we need both? For example, using the buzzer or trying to get out of the wheelchair might be best looked at as frequency, while tapping a pencil or paying attention could be recorded as duration.

**Behaviour Event, Duration and Interval Recording and ABC forms can be found in the toolkit.**

3. Decide when you will observe the behaviour. Do you want to observe the behaviour at different times in a number of situations and settings (e.g., ward, community, with family) or just once?

4. Decide how long each of your observations will last. Depending on the behaviour, ten to twenty minutes is usually adequate, but the more time you spend observing, the more accurate will be your results. Repeat your observations at least three more times to give a more representative picture.

5. Observe and record the patient's behaviour, as well as what is happening prior to the behaviour – this is the antecedent. Note who is around when the behaviour occurs – does it happen at a particular time, when someone enters the room, or when someone leaves? Does it happen during care tasks, when it is noisy, when it is hot or cold, etc.

6. In terms of consequences, what happens after the behaviour occurs? Does anything change as a consequence of the behaviour? And does this make the behaviour better or worse? What stops the behaviour? Fred in the earlier example stopped his banging when someone came to his room. Paula on the other hand shouted for 20 minutes during personal care, and only stopped when the task was over.

7. By gaining a better understanding of why the behaviour occurs, and what function it serves, we will be able to meet the person's needs better, thus reducing distress for patients, family members and staff.
How can you help?

Before giving some ideas how to help, we need to make sure that we are applying any change consistently, and that all staff is involved in this.

When implementing any kind of proactive or reactive interventions in order to address challenging behaviours, one of the key factors is consistency. Every member of the team must be consistent in the approach to managing the behaviour and there must be constant communication between the team. Consistency provides stability and predictability for the patient, and no intervention or strategy is likely to work if it is only being used now and again. In fact, research reliably demonstrates that inconsistent responses to challenging behaviour can actually increase the behaviour.

All members of the team should be involved in behaviour management; it is not just the job of an occupational therapist or psychologist. It is the job of everyone who is interacting with the patient or providing any level of care for them. This also includes family and friends. There is no point in trying to reduce external stimulation, take the patient to a quiet room etc if family and friends visit in a large group, talk loudly and put the television on full blast as soon as they enter the room. It has to be a joint up effort if there is any hope of making long term, significant changes to behaviour. Remember that it may not take much in the way of mixed messages to confuse someone, especially when you think of all of the factors contributing to behaviour following stroke:

**Neurological/neuropsychological factors**

- Frontal lobe damage, interfering with planning and inhibition
- Confusion (leading to misinterpretations)
- Delusion or psychosis as a result of deterioration of cortical (temporal/ frontal lobes) and neurochemical changes
- Lack of insight (anosognosia)
- ‘Organic’ irritability, hypersensitivity (e.g. to noise, lights, busy environments – very common after brain injury)
- Boredom or lack of stimulation
- Impulsivity
• Hyper-emotionality
• Sensory impairment

**Psychological factors**

• Pre-morbid abilities/lifestyle/status affected by stroke & adjustment issues
• Feeling belittled, treated as a child, powerless (adult rights violated)

On top of these individual factors, there are environmental factors to consider in an acute, ward setting:

• Complying’ with treatment & Ward procedures
• Power imbalance
• Communication
• Lack of freedom
• Unfamiliar/uncomfortable environment
• Wider life/relationship difficulties
• Waiting

**So, bearing all this in mind, how can we help?**

**Proactive Interventions**

When you are working with individuals who are displaying challenging behaviour, it is important that the strategies or interventions that you use are not all reactive – you should also try to be proactive in preventing or reducing the frequency of the behaviour. We could achieve this for example by modifying aspects of the person’s environment, trying to meet their likes and dislikes as much as possible. As described earlier, challenging behaviour has a function, whether it is a way of communicating, a way of dealing with stress or anger, or whether the individual simply finds it stimulating. What you need to do then, is provide an alternative! Find a different way for an individual to communicate, or teach skills for managing negative emotions in a different way – or provide other opportunities and other ways that the individual can have fun!

Firstly, it is helpful to find out about new patients coming to the ward, so we know what they find helpful and what makes them uncomfortable. For example, a short life story can be put
together with the person and a family member. This should include likes and dislikes, interests, and a little about how they normally live and their family. Do not forget to ask about difficulties with hearing and vision. Keep a booklet like this on the bedside, so new staff can also learn about the person and have something to talk about with them.

You can find an example of the This is Me leaflet which is used in dementia, and a Mental Health CV in the toolkit.

One of the easiest changes to make is to adapt the environment that the individual is in. We can change the surroundings and see what effect this has on the individual’s behaviour. For example, a person might usually live alone and cannot settle in a four-bedded unit. If possible, we could try her in a two bedded or even a single room. Of course you will not always get it right first time, and initially you may feel as though you are making things worse! But try and persist until you find the right set up as this can have a huge impact on behaviour. Your aim is to provide a safe, predictable environment that suits the personality and needs of the individual. This can be done in the following ways:

**Stimulation levels**

We are all different in our preferences for external stimulation. For example, you will probably know someone who always seems to have the radio on AND the television blaring while they are working. You will probably also know people who prefer complete silence and no external stimulation while they are concentrating on something. Of course we cannot always control our environment, but we can still have our preferences.

Think about the environment that the patient you are working with is in. Talk to friends and family to get an idea of what their preferences might be with regards to external stimulation. Do they like light, bright, open spaces? Or do they prefer dim lighting, and more closed environments? Do they often have some form of background noise, like the TV or radio on? Do they cope well with distractions; did they like having lots of visitors, people watching? All of these things can be adapted somewhat within the environment. If someone is a very social person who loves seeing/chatting to people and likes to people watch, on a ward they could be moved
to a bay with other patients, near the nurse’s station where lots of people pass by. If they are the opposite and like to be alone in a quiet environment with little stimulation, consider moving them to a side room on their own.

**Consistency and routine**

After a stroke, so many changes can occur for a person that can be unsettling. Providing consistency and a sense of normality may allow the person to feel safer and more in control. It may help some patients to have some structure and routine to their days. For example, visitors coming at the same time every day, rehab being scheduled in for the same time slot every day, consistent staff, and information to help with orientation (see the section on orientation within the Cognitive section).

**Calming stimuli**

Use previously enjoyed music, smells, pictures and familiar objects to produce a sense of stability and familiarity. Having pictures of family and friends, or some music that you love playing in the background can have a very calming, reassuring effect.

**Provide choices**

Ask the patient to make choices about their own environment. It can be tempting to move someone in a side room if they are displaying challenging behaviour, but what if they do not want to be on their own in a room? Ask them what they would like to do and as best you can, cater to their needs. Of course other factors come into it, such as the distress caused to other patients but within reason, the patient should be given the opportunity to make choices about their environment and their preferences should be acknowledged.

**Variety**

Although most of us quite like a bit of routine and structure to our lives, usually this is only true up to a certain point. We also like variety, and doing the same thing over and over again can quickly become mundane and boring. Sometimes the reason behind challenging behaviour can be boredom and lack of stimulation. Especially on a ward environment, you
can see how this would be the case. Try to ensure that those patients that enjoy some variety in their activities, food, rehab etc., are given the opportunity to enjoy variation.

**Your Role**
Remember that you are part of the patient’s environment and stimulation. Your interactions with the patient are extremely important in influencing behaviour. Ensure that you are not asking too much of the patient and that you are not underestimating the effort required by the patient to take part in rehabilitation. Frustration is only likely to make things worse.

**Stressors**
Reduce stressors such as disruption of sleep and try to remember that external factors such as minor colds and illnesses could have a huge effect on behaviour. Following a stroke, patients may be very sensitive to any changes or disruption in routine or sensation. Other significant stressors include pain (can the patient’s pain be managed better?) and fatigue (is the patient more alert in the mornings or afternoon and schedule therapy accordingly).

**Reactive Interventions**
An important part of any behavioural intervention, and one that is often overlooked, is maximising the effectiveness of the treatment by using appropriate reinforcers. This is used to encourage positive behaviour.

A diagram of positive reinforcement would look like the one shown below:

<table>
<thead>
<tr>
<th>Stimulus</th>
<th>Behaviour</th>
<th>Consequences</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. prompted</td>
<td>e.g. goes</td>
<td>e.g. social praise and tangible</td>
</tr>
<tr>
<td>to attend</td>
<td>to session</td>
<td>reward</td>
</tr>
<tr>
<td>therapy</td>
<td></td>
<td>Increased probability will</td>
</tr>
<tr>
<td></td>
<td></td>
<td>occur again</td>
</tr>
</tbody>
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If the frequency /duration of the above targeted behaviour (here: attending therapy) increases, it has been positively reinforced.

You need to use reinforcers that have been shown to be effective for that particular individual in the past, or that they have indicated would be positive and rewarding. Different types of reinforcers are effective for different individuals, and in different circumstances. If someone has just eaten a big meal, there would be little point in rewarding them with food.

For example, Harry does not enjoy going for physiotherapy, and regularly declines. He does like reading the local newspaper, though does not get it while he is in hospital. You could offer him the following: “I’ll make you a deal, you come along to your physiotherapy session, and I’ll get you your paper when we have finished”. Here, you will have used a ‘material reinforcer’.

Another form of reinforcement might involve using praise for positive behaviours. This tends to work best when you are quite specific about why someone is receiving praise. You could also talk about how that positive behaviour impacts on others and makes other people feel, For example, “Thank you for helping Alyson with her toast. She seems to be really enjoying it.”

We can also use activities to reward positive behaviour, for example watching television, listening to the radio, playing a game of dominos or cards, or going out to the local park with someone.

Generally, reinforcement works best when it happens straight after the positive behaviour rather than hours later. If you offer a patient a reward on completion of a task, you need to make sure that you fulfil your end of the bargain; otherwise the person may not engage with you again. Also, we need to be careful that we link the reward to the positive behaviour. Do not threaten to take something away for punishment.

You can find an example of a reinforcement inventory in the toolkit.
Examples of general behaviour management strategies

Removal

The term removal refers to the removal of a patient displaying challenging behaviour from a bay with several beds, to their own room. This is often one of the first strategies that is employed in a ward environment and could be described as both a pro-active and a reactive strategy. There are times when moving someone is the best way to deal with challenging behaviour – in particular if the person is displaying challenging behaviour because they are being over-stimulated or do not like noise/people around them. However, in some circumstances, removing someone and essentially segregating them can make the behaviour worse as they may become lonely and/or distressed.

If an individual is upsetting other patients on a ward, or being aggressive towards others on a ward, then this obviously needs to be managed as the needs of several patients must be put before the needs of one patient. However, never move a patient simply because it seems the easiest way of ‘dealing’ with them. Ensure that any strategy employed is in the best interest of the patient, and not of staff. Being put into a side room can be very isolating and depending on the cause of the challenging behaviour (for example if it is a result of low mood/depression, or lack of stimulation), this could make things a lot worse.

If we are thinking about proactive ways of intervening and reducing challenging behaviour, then the most proactive strategy would be to try to prevent the challenging behaviour occurring in the first place. This is particularly relevant when the behaviour in question is aggression. Try and find out what is happening with the person using the ABC charts discussed earlier. This might give us an idea what triggers a behaviour, and some ideas for managing it.

Managing Anger, Irritability and Aggression

One of the best ways of preventing aggression is to deal with the irritability and anger that tend to precede it. Generally, someone does not just start acting aggressively out of the blue; there is usually a lead up to this of more subtle anger. Some signs of this could be:

- Change in behaviour
- ‘Restlessness’ or repetitive behaviour – e.g. pacing, looking for things, tapping
- Repeated questions/requests/seeking others/demanding

If you encounter a patient who is displaying the above behaviours, or seems to be irritable or angry, try modifying your behaviour in the following ways to reduce tension and discourage aggression:

- Positive use of space – keep about 2 arms lengths distance – this helps reduce sense of threat to the person.
- Try not to use negative language – e.g. "you can’t", “you must not…”, “do not…".
- Touching – DO NOT use touch as an initial approach – and angry person often react to this with hostility. However, if you and the person get on well, this can be helpful later in the interaction to divert or reassure. DO NOT smile, laugh or joke initially – we can have a tendency to do this if we think someone is being ‘silly’ or if we feel uncomfortable (to reduce tension, act ‘friendly’) – HOWEVER, this could be interpreted as being condescending or belittling.
- Eye contact – try not to ‘stare out’! This will increase sense of threat.
- Keep as calm and relaxed as possible, DO NOT take personal offence.
- Breathe steadily and evenly
- When face with someone who is shouting angrily, keep your face neutral and lower the tone and pitch of your voice.
- Speak evenly in tone and pace (we tend to speak faster, quieter/ louder when nervous – this could give off the wrong message or make it difficult for the person to understand what we are saying).
- Move evenly and gently – when under threat we will unconsciously give off body postures that either signal counter-threat, or submission (which could also escalate aggression in other person).
- Do not rush towards patient.
- Do not crowd and try not to corner the person.
- Use an empathetic approach – ask what is causing the distress! Be flexible and accepting, not rejecting or rigid.

Another strategy one can use is distraction. When you get to know a patient, you should be able to see when they are becoming agitated or angry. Subtle changes in
behaviour will act as cues, and it can be a good idea at this point to try and distract them. This does not mean pointing outside and shouting “LOOK!” Instead, bring up a topic of conversation that you know they are interested in. Perhaps mention something about a hobby that they like, and that you know they like to talk about. We all have certain stories we love to tell others. If you can find out what that special story or memory is for a patient, you can usually easily distract them into talking about it. This can also help to make them feel listened to, and valued as a human being. This ultimately may lead to less anger and irritability, particularly if that anger is aimed at their situation (i.e. having a stroke and/or being in hospital).

These methods will not work for everyone, especially if someone has significant confusion/ delirium or is experiencing delusions/psychosis. If this is the case, they should be referred for a psychiatric assessment.

**Wandering**

Wandering is one type of behaviour that is often an issue after stroke, particularly while a patient is still in hospital. Wandering may be due to a variety of needs or goals under different environmental or personal circumstances. There are a number of reasons why someone might wander:

- The patient might have diminished orienteering ability, or attention deficits that might have interfered with their ability to pursue their destination.
- The person may have a preference for movement in order to reduce stress.
- Separation anxiety – they may be seeking a trusted loved one at a time when they feel frightened, confused and vulnerable.
- Loneliness – they may have had no visitors, very view interpersonal contacts, or if they have memory problems, they may not recall visits/interactions with friends and family or staff members.
- Physical discomfort or pain
- The person may be drawn to or repelled by aspects of the environment, such as noise, or light
- Confusion
Wandering often increases at night-time which could be due to sleep difficulties, increased disorientation/confusion upon waking up, or fear in an unusual, unfamiliar, dark environment.

**What can you do?**

- Always try to remain friendly and calm.
- Try to re-orientate the individual to reality.
- Identify the patient and speak their name.
- Person orientation: ‘Mr Smith, my name is Nurse Jones and I am your named Nurse’.
- Orientate to time if required and use illustration e.g. ‘it’s 3am Mr Smith – can you see it’s dark outside and everyone else is asleep?’
- Provide place orientation if required, using illustration.
- Generally help the person to test reality but do not argue with the patient. Just gently and casually mention things that may test their beliefs, for example if they think they are at home, seeing other patients in hospital beds may test this belief.

Often when you discover someone wandering, especially at night-time, they seem to be intent on getting to their destination or finding the person that they are seeking. Sometimes you almost just need to interrupt this determination for a few seconds and they will become more amenable to talking. Distraction can again be a good technique for doing this. If the person wandering is seeking someone, talk to them about the individual that they are seeking. Again, you could bring up a patient’s interest, or a topic you know they like talking about, or ask them for some help with a task/activity to distract them.

If you have tried the above and nothing seems to be working, walk with the wanderer and build up rapport with them. While doing this, you can ensure they are safe and they may be more likely to listen to you if you have taken the time to walk with them. You could also recruit a second member of staff to help. They can approach you and the wanderer and ask you BOTH to return with him/her. This way, the wanderer sees that you are being asked to go too, and sees that you are doing as you have been asked. We tend to be more likely to comply if the person accompanying us is also complying.
**Vocalisation**

Vocalisation or shouting is a behaviour that can be very disruptive to a ward or care home, especially when it happens with high frequency or great noise level. Why does it occur? Vocalisation may be the result of frontal lobe damage, or it may be the attempt of the person to communicate. We communicate when we have a need, are aware of this need, and have the ability to make the need known to others – either verbally or non-verbally. Vocalisations may occur because the person has reduced ability to communicate:

- If the person has a memory problem, they may have forgotten that they have voiced their need already, or that their request has already been met. This might then lead to repeated questions.
- The person might feel uncomfortable, be experiencing pain, or feel too hot or cold.
- The person might be overstimulated, experiencing too much noise or light.
- The person might be under-stimulated, and the vocalisation fulfils their need for sensory stimulation.
- The person might not be able to inhibit what they say due to damage to the frontal lobe.

**What may help?**

Given the examples above, we may be able to help with reducing behaviour by addressing the cause. For example, Betty shouts and swears during care intervention. Our observation showed that she shouts most when someone touches her arm, and this usually leads to the care being carried out very quickly to settle her again. What might be the cause of her swearing?

- She might experience tenderness or pain in the arm; therefore pain management needs to be reviewed.
- She might have visual neglect, and get startled when someone approaches her from the affected side. Hence approaching her from the unaffected side and orientating her to what will happen, this might help.
- She may have decreased insight into her swearing, and just say out loud what she thinks. In this case staff need to adopt
a consistent approach to re-direct her, e.g. “That is not a very nice word. Please don’t use it.”

- Betty may be frightened by having more than one person in the room and feel crowded. Provide information on what is going to happen, seek her permission to carry out the care task, identify staff members who evoke less of a reaction, or those Betty feels most comfortable with.

Another example, Jack groans loudly a great deal of the day; he sounds very distressed, and this is affecting other patients. He occasionally shouts “nurse”, but is unable to communicate his needs.

Carry out an ABC analysis to get an indication of what makes his groaning better or worse. Is there a pattern, e.g. louder in the afternoon, better in the morning? Does he react differently to light, noise etc. Does anything interrupt the groans? Speak to family about likes and dislikes. Your intervention here might be based on trial and error:

- He might be in pain => review pain medication
- He might be under-stimulated => provide stimulation, e.g. company, music
- He might be overstimulated => ensure he is in a quiet area, without isolating him
- He may be confused about what is happening to him => give regular information about where he is, why he is here and what will happen next
- You may try distraction

**Sexualised Behaviour**

Following a stroke, some patients display changed sexual behaviour. Many patients will initially experience a decrease in libido, which can be very distressing to them, especially when this has been an important part of their pre-stroke life. Other patients display an increase in sexual behaviour. Most of us regard sex as a private matter and tend not to discuss it openly. However, following a stroke a person may have lost their inhibition as result of frontal lobe damage, and openly discuss or even display their previously private thoughts and desires:

- A patient may make advances to others
- They may undress or touch themselves in public
- They might make sexual comments.
It is important to understand that the person does not voluntarily display their private thoughts or act on their desires, but that this is caused by the stroke. To the person themselves, the situation can be very confusing, as they may not understand why their behaviour is upsetting to others. This can also lead to distress and frustration. It can also be distressing to family members, who might find the behaviour embarrassing.

It is important to note that sexualised behaviour is brought on by the stroke damage rather than by the person. Sexualised behaviour rarely involves sexual arousal, but may be a breakdown of the person’s understanding of social norms.

In their factsheet on Sex and Dementia, The Alzheimer’s Society outlines that sometimes what appears to be sexual is actually an indication of something quite different, such as:

- Needing to use the toilet
- Discomfort caused by itchy or tight clothes or feeling too hot
- Boredom or frustration
- Expressing a need to be touched, or for affection
- Misunderstanding other people’s needs or behaviour
- Mistaking someone for their partner.

For staff, this means to observe and identify triggers and consequences to the behaviour. Should the behaviour cease once the patient has been brought to the toilet, a regular toileting regime might be appropriate. In terms of interventions:

- We need to understand the behaviour and address the unmet need where possible; e.g. discomfort from clothing, boredom, needing the toilet.
- We need to ensure that the person maintains their dignity. Should a patient start taking their clothes off in public or start touching themselves in a sexual way, staff need to encourage the person to return to their own room or make sure they have some privacy
- In case of inappropriate sexual comments, staff need to adopt a consistent approach to inform the patient that this is not appropriate, e.g. “This is not an appropriate comment. Please do not say this again.”

It is important to acknowledge that not every staff member will be comfortable dealing with sexualised behaviour. It is useful to identify staff who are more confident
in dealing with this kind of behaviour. It is also a good idea to select staff who may find it easier to care for the patient in question in order to manage the behaviour. The situation may also be helped by choosing staff of the same sex as the patient.

**Lack of motivation**

In the introduction to this chapter, we briefly mentioned lack of motivation and apathy as a behaviour that challenges. It can have serious implications on the person’s recovery, and with that their placement and long-term access to the community.

What do you think are possible reasons for lack of motivation to engage in rehab?

Low motivation can be caused by a number of things, but rarely is the cause laziness. It may be due to frontal lobe damage, resulting in difficulty initiating behaviour or difficulties planning, or damage to the limbic system which is responsible for arousal.

Alternatively, it may be due to mood. Depressed patients tend to present with lack of motivation, while anxious patients may be avoidant as they are worried about a task. Someone who is frustrated may not have made the kind of progress they were hoping for. In addition, a person may be experiencing post stroke fatigue or pain.

As with other challenging behaviours, we need to find out the cause for low motivation and treat it accordingly. Below are some strategies you could use to try and improve motivation in patients:
**Routine**

Having a regular routine or programme for rehab is very important especially for those with lack of initiation. A regular schedule can cue the person into certain tasks; after a few days of always going to the gym at 11:00a.m, it becomes part of the routine. Routine is also helpful for those patients who need to get themselves mentally prepared and ready to participate.

You can find blank timetables along with an example of an aphasia friendly timetable in the toolkit.

**Break tasks down**

This is helpful for patients with lack of motivation due to a mood disorder or due to brain damage. By setting smaller but achievable goals, the person with depression may not find the task as daunting and be more willing to try. The person with planning deficits will find it easier to engage with a task that is less complex. The task can be scaled up over time.

**Ask for just 5 minutes**

The prospect of an hour’s rehab might sound quite daunting and could put people off. Negotiate shorter sessions with the person, e.g. just 5 or 10 minutes. For example: “How about we work in the gym for 10 minutes. We will set the timer, and if you want to go back to your room then, I’ll take you back. If you want to carry on after that time, we can do that, too.” Many patients tend to carry on when they get going, and see out the rest of the session.

**Get dressed and get moving**

Lying in bed all day is enough to make anyone lose their motivation and often just getting someone up, dressed and ready for the day ahead can make them feel more motivated to engage in rehab. For those patients with apathy, getting washed and dressed may be a cue for action.
**Get some fresh air**

Being cooped up in the house or on a ward can make people feel lethargic and run down. You might have experienced this yourself, spending a day on the sofa just watching TV. Going for a short walk, or taking someone outside in their wheelchair can give the person the energy to be more active, whether physically or cognitively.

**Find their motivation**

When a person lacks motivation, it is important to find a goal that they feel strongly about – even if this might not be our first goal. It might be possible to break rehabilitation tasks down in a way that will be relevant to their goal. For example, if someone wants to get back to spending time on their own with their grandchildren, relate everything you are doing to their ability to do that. It is much easier to stay motivated when you are working towards something that is meaningful to you.

**Visualise**

Being in hospital is hard. Especially after lengthy stays during rehab, it can be difficult to imagine being discharged and returning to some quality of life. Especially someone who is depressed may focus on what they can no longer do, and how their lives have changed for the worse. This will lower their motivation.

A useful technique in this case can be to look back at how far they have already come and visualise life several months or even a year into the future. By visualising life further down the line, people can often see how the small things they are working towards now will add up to a better quality of life and more independence in future.

It can also be helpful to get a patient to visualise or reflect how they will feel after the session of rehab if they go ahead and take part instead of declining. “How do you think you will feel in an hour if you do not take part in our kitchen practice? … And how do you think you might feel afterwards if you do join in, and you achieve what we set out to do?”
If they do not engage in therapy, they might feel guilty, disappointed and unhappy with themselves. However if they do engage, they may feel proud of their effort and potential progress.

**Pros and cons list**

Help your patient to put together a pros and cons list for attending physiotherapy/speech and language therapy/occupational therapy. This might help them to identify the benefits of attending, but also the cost of not attending rehab. This is usually most successful when the patient can generate the list themselves rather than staff telling them.

**Deal with failures**

A patient might lose motivation when they fail to meet a goal they had set for themselves. They may think of themselves as a failure, and this can impact on their self-confidence when working towards new goals.

In such a case, it will be helpful to talk to the person about how they feel not having reached their target. Normalise the situation for them – it is part of the rehabilitation process to have ups and downs. Think of the reasons why the goal was not met - was it too ambitious? Ensure future goals are realistic and achievable, even if this means slowing down for a short time. If you have the capacity to offer an extra session to someone who is struggling, you may find that their motivation improves as they become determined to make a success of their goals.

**Encourage groups and socialisation**

A patient may feel isolated and lonely, be that on a busy ward or after returning home when they cannot join into their usual activities. This can impact on their level of motivation.

In these cases, group work can be very beneficial. We acknowledge that this is not always practical, as many stroke survivors will need one-to-one sessions. However, some OT sessions for example lend themselves to group work (e.g. newspaper group). Groups need not be formal; they can also involve getting patients together to screen a film in the day-room, or making use of befrienders and former patients who
now volunteer. Spending time with others who understand what we have been through can be great for morale and mood.

**Small wins**

Research has shown that people are motivated by “small wins” or accomplishments on their way to reaching their end goal. Computer games take advantage of this by allowing people to complete levels on their way to finishing the game. This helps to keep people motivated right to the end of the game – it is almost addictive as you crave the feeling of success. Therefore, it can be a good idea to split people’s goals up into smaller steps so that they feel rewarded upon achieving each of the individual steps.

**Make a mantra**

Sometimes it can help people to have a mantra, something they say to themselves over and over again to encourage them to work hard and try to reach their goals. This can be particularly helpful if you are working with someone with poor self-efficacy or self-esteem, as it can give them a confidence boost if they tell themselves that they WILL succeed (e.g. “I can do this, I can do this”).

Mantras can also be helpful when working with individuals who have problems maintaining attention, or are easily distracted. Try getting them to repeat what it is they are doing while carrying out the task – e.g. “left foot, right foot, stop, left foot, right foot, stop”.

**Write goals down**

Some patients may find it helpful to write down their goals and aims for the future to keep them focused. Although you will no doubt do formal goal setting with them, it can be nice for patients to have their own space or notebook for their goals, thoughts, and feelings.

You can also use the information about motivational interviewing in Part 1 of this manual to help get people motivated. Although much of the information refers to giving up a behaviour that is bad for you, motivational interviewing is just as helpful for getting people to embrace new behaviours that would be beneficial to them.
Further Issues

Communication of Support Plan

We have mentioned the need to be consistent in our approach several times; staff needs to make sure to give the same message when dealing with a patient who displays challenging behaviours. Therefore, use the information you have gathered and share this with the rest of the team to support a consistent approach to working with this patient. Using the suggested intervention consistently and adapting it based on feedback/evaluation will increase the potential of your intervention working.

If your intervention does not appear to have worked this does not mean your assessment and conclusions were wrong. You are not likely to change behaviour quickly, hence it might need a little more time. Remember that challenging behaviour is learned and it may have been shown to be successful for the patient. For example, Joanne, who feels lonely and bored, has learned that a staff member comes when she shouts for help. She may continue to do this from time to time even when she has more company or activities.

We also need to consider that our conclusion was not correct, and rethink what might be driving the behaviour based on feedback about our interventions.

Medication

In an ideal world, medication would never be used as a method of resolving challenging behaviour – particularly medication that has a sedative effect on patients. However, there may be some situations where there is little option (for example, severe confusion that is leading to violence). It is important that medication is not seen as a quick fix, or an easy way out – a full functional analysis should still be carried out to try and find the reasons behind the challenging behaviour. Before any type of drug is prescribed, you should think about the following questions:

- Why is the medication being prescribed?
- What underlying disorder is thought to be present that is known to respond to the medication?
What are the risks of such treatment? What are the benefits?

How will you monitor the outcome of the intervention?

How long will the individual be taking the medication? What dose will they be taking and what reviews will be undertaken?

Has the person given consent? Does he/she lack capacity to consent and if so, is it in their best interest?

Can you reasonably justify the use of this medication?

Below are some of the most common categories of medication which are used to “treat” challenging behaviour.

As the graph shows, there is a range of medication employed to treat challenging behaviours. As with most medications, these also have side-effects (this is not an extensive list), hence need to be chosen with care. This is especially true in older adults, who tend to metabolise medication less well.

**Antipsychotic Medication**

In some cases, an individual’s challenging behaviour may develop or be maintained as a result of a psychotic illness. Psychotic illness is characterised by a change in a person’s mental experiences, for example, they may start to experience delusions, hallucinations, or a general deterioration in their ability to think. For some people, this can result in challenging behaviour as they lose their grip on reality.
In this instance, the use of antipsychotic medication is appropriate and may well be effective in reducing challenging behaviour. Essentially, you are working to reduce the cause of the challenging behaviour, therefore treating the root of the problem rather than just masking the symptoms.

There are two classes of antipsychotics, typical and atypical. Atypical antipsychotics such as risperidone and quetiapine may increase the risk of stroke, hence they are not recommended in the use of this patient group. Antipsychotics also have a range of side-effects that need to be considered before prescribing these with stroke patients. These include rigidity or tremors, which is of particular concern with those experiencing physical difficulties following stroke. Another possible side-effect is cognitive decline; hence the prescription of this class of medication needs to be considered very carefully in patients with stroke.

**Anti-depressant Medication**

The most commonly prescribed antidepressants come from the group of drugs referred to as selective serotonin reuptake inhibitors (SSRIs). Depression can be associated with an increase in irritability and poor concentration; both of which can contribute to the onset of, or deterioration in pre-existing challenging behaviour. Some anti-depressants are also helpful in treating significant anxiety or obsessive behaviours, which again can contribute to challenging behaviour.

If after assessing an individual's behaviour, depression is thought to be a key component in the cause of the behaviour, then antidepressants could be an effective and appropriate form of medication. Again, rather than simply treating the behaviour (or the "symptom"), the medication will hopefully have an impact on the actual root cause of the behaviour.

**Sedative and anti-anxiety medications**

The use of sedatives is problematic and controversial with regards to challenging behaviour. Sedatives should never be used as the only strategy for dealing with challenging behaviour; they should only ever be used in extreme circumstances alongside other behavioural techniques, such as reinforcement and teaching patients the skills to express themselves in other ways. Sedatives should never be used on a long term basis, but at times in an acute setting, it may be necessary to use them on
a “prn” basis. If an individual has become highly aroused, frightened, or aggressive towards their self or others, a sedative may help to take the edge off and diffuse the situation.

The problem with sedatives is that they treat the behaviour (or “symptom”) for a short while, but they do not treat the cause of the behaviour. For this reason, as soon as the medication wears off, the behaviour will tend to return. Also, considering the side-effects this kind of medication can have (e.g. confusion, dizziness, impaired thinking) they may interfere with the rehabilitation of the patient.

This type of medication should only ever be used as a small part of an established plan with a range of other strategies for tackling challenging behaviour. When sedatives are being used, they should be monitored very closely and you should always be thinking of the questions on the previous pages – in particular, you need to consider the issue of consent and the legal justification for using this particular type of medication.

In summary, medication may have a role to play in treating/managing challenging behaviour for some patients. It should always be used for clearly defined reasons and should be within the context of a treatment plan specific to that individual. Particular attention should be paid to issues with consent, as many individuals will experience cognitive difficulties after stroke that will affect their ability to consent.

**Summary**

There are many types of interventions for challenging behaviours. The one you select should be based on several considerations. These questions may help guide you:

- What behaviour do I want to treat? Some interventions are not suitable for certain types of behaviours.
- How do I want to change the behaviour? In other words, do I want to increase, decrease, maintain the behaviour, or change the situation in which it occurs? This decision comes from the classification of the behaviour.
- Is the behavioural intervention likely to maintain the change in the behaviour in the long term?
Common difficulties in implementing change

We need to be aware of some of the difficulties in treating challenging behaviours. What difficulties can you think of that would make implementing a support plan a challenge?

It is helpful to consider the following difficulties (and those you thought of) when undertaking work with challenging behaviours:

- The assessment and implementation can be time consuming
- It may be difficult to maintain consistency amongst staff – due to staff shortages and turnover, and lack of communication
- Diversity of problems amongst patient group
- Fitting plans around institutions routines can be hard
- Change can be slow, while we are hoping for a quick result
- Staff that design the programmes are not the people that implement them
- Support for staff – staff may lack the training and skills to cope with their own reactions to distressing behaviour
- Limited generalisation, that is, a behaviour might improve in one setting, but not in another.

By being aware of the difficulties, we may be able to problem solve around them. For example, with regard to new staff members who might be less well informed about the patient, we could use care plans that every person needs to read and sign before care tasks. With regard to staff’s own reaction, supervision could be put in place in order to deal with difficult emotions.