

Module VI: Providing Positive Behavioral Intervention and Support

MONTY

Monty is a first grader who fell while riding his bike through a construction site near his home. He was wearing a bike helmet, but it was his older sister's, and it didn't fit him properly. The helmet was jarred loose by the impact of Monty's fall. When he fell, he hit his head on a nail protruding from a board; the nail penetrated his head above his right ear.

Following the accident, Monty was transported to Heartland Community Hospital. He was unconscious for approximately 22 hours. His Glasgow Coma Scale score was 9. CT scan results indicated that Monty sustained right frontal, temporal and parietal lobe injuries. There was evidence of a focal injury to the right temporal lobe. Monty's physician noted there was probably also diffuse bleeding and tearing of axons not evident on neuro-imaging. Monty's brain injury resulted in left-side weakness (hemiparesis). He also sustained a broken left arm. When Monty regained consciousness he recognized his family, but he did not remember any events of the preceding day. He repeatedly asked his mother what had happened to him. By the next day he was able to remember that she had told him he was in a bike accident, but he remained confused about the details and asked about them several times. Monty experienced a few days of confusion and irritability; he then seemed to "come around," and he was more like himself. The doctor told Monty's mother his prognosis was very good. His mother was relieved and optimistic that Monty would recover fully.

Monty was hospitalized for two weeks. During the second week he was on a rehabilitation unit where he received physical therapy, occupational therapy, and speech therapy. Monty has recently been discharged to his home. His mother wants him to rest at home for a week before returning to school. He continues to receive occupational therapy.

As his return to school approaches, Monty continues to experience left-side weakness, but his doctor says he is making good progress. He is able to walk unassisted, but his judgment about space and distance is poor, and he fatigues easily. His mother thinks he is having difficulty seeing. She is also frustrated because she thinks Monty could do more for himself, but "he just doesn't seem interested." He used to be such a responsible boy; he always got himself ready for school in the morning and helped with chores around the house. Now his mother describes Monty as impulsive at times, but generally passive. She has to prompt him continually to get dressed, brush his teeth, and finish eating. He becomes irritable when he is tired. Monty's speech is somewhat slow, but intelligible.

When asked, Monty says he is looking forward to going back to school. Several of his friends visited him in the hospital, and his two best friends came to Monty's house for a while the day he was released from the hospital. Monty's friends think Monty's arm cast is cool. Monty's mother heard Monty and his friends laughing a lot while they were visiting, so she is confident things will be fine with his friends.

Prior to his accident Monty was placed in a combined first- and second-grade classroom where he was progressing well learning to read; his teacher had reported to Monty's mother that Monty was "a whiz in math." Monty lives with his mother and older sister (age ten).

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SERENA

Serena is a twelve-year-old girl who sustained a brain injury in a motor vehicle accident. Serena hit her head on the dashboard when her father lost control of his car and struck an oncoming car. Neither Serena nor her father was wearing a seatbelt. Serena's father sustained minor injuries; no one in the other car was hurt.

Serena was transported to a local emergency room and then taken by medical air transport to Glenview Hospital, a regional trauma center about 100 miles from her home. Immediately following her accident Serena had a Glasgow Coma Scale score of 6. She underwent surgery to insert an intracranial pressure monitor. Serena was unconscious for 36 days, and she has been hospitalized for three months. She sustained frontal and left temporal and parietal lobe injuries, in addition to a broken leg and severe skin lacerations. For several days following her injury, Serena's family did not think she would live. Now that she is about to return to school they are hopeful that their lives will return to normal and Serena's recovery will accelerate. Serena is an only child.

At this time, Serena's parents expect her to be released from the rehabilitation unit in the hospital within two weeks. She is medically stable. She requires a wheelchair for mobility. She is just beginning to learn to propel herself, and she has limited endurance. She continues to receive physical therapy, occupational therapy, and speech therapy. Because of difficulty swallowing, she is fed through a G-tube. Immediately after her injury, Serena talked only in single words, but she is able to put together short sentences now. Sometimes she is difficult to understand. Serena is taking Tegretol to prevent seizures.

Serena requires cuing and assistance with self-care activities, such as toileting. While her parents are concerned about how they will provide care for Serena's physical needs at home, they are most concerned about Serena's impulsivity and agitation. Sometimes Serena tries to get out of her wheelchair, and sometimes she yells repeatedly when she wants something. They think someone should be with her at all times.

Serena experiences memory difficulty; for example, she has difficulty remembering specifics about events earlier in the day and week. However, Serena remembers lots about her life before the accident, and she is eager to return to school and to see her friends. The parents of Serena's best friend brought three girls to visit Serena in the hospital a few weeks ago, but they haven't been back since. Serena's mother called the other parents who told her the girls were upset at seeing Serena "so different."

Before the accident Serena was a good student, getting mostly B's and some A's in her classes. She especially enjoyed creative writing activities; her friends loved her humorous stories. She is in the seventh grade at Washington Middle School and rides the bus to school. Serena's parents have met with the Special Education Director from Serena's school, and they are hopeful that the school will help Serena become her old self. However, they are confused about many of the labels and processes the Director described.

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JERRY

Jerry is an eleven-year-old fifth grade student who was transferred by air ambulance to the Midwest Medical Center intensive care unit. He was injured in January while sledding near his home. Jerry rode his toboggan down a hill into the street and was struck by an automobile. Upon admission he was unconscious, with a Glasgow Coma Score of 8. He remained unresponsive for eleven days. An MRI conducted six days following his injury revealed that Jerry sustained midbrain and right frontal-temporal contusions. No other focal findings were evident. An EEG at the same time revealed a generalized disturbance with focal findings to the left hemisphere. Jerry is right-handed.

When Jerry was in the fourth grade his teacher raised concerns about Jerry to the school's Building Team because Jerry was not "working up to his ability." The teacher reported that Jerry was not completing his homework, he appeared uninterested in classroom activities, and he had few friends. When efforts to intervene to improve Jerry's performance failed, an IEP team evaluation for learning disabilities was conducted. Jerry's performance in reading, spelling, and math were consistent with late third grade skills. On the WISC-III Jerry obtained a Verbal IQ of 115, a Performance IQ of 112, and a Full Scale IQ of 115. Jerry did not meet the criteria for learning disabilities. The IEP team concluded: "In summary, it appears that Jerry demonstrates adequate intellectual abilities and academic skills needed to achieve expected tasks. However, he is experiencing what appear to be feelings of insecurity and increasing disinterest in school. Jerry has few friends in school, but he participates in community activities such as little league baseball." Jerry's fifth grade teacher initiated a behavior program with Jerry. She gave Jerry a baseball sticker each day he turned in his math homework. It seemed to be working, and before Jerry's injury, she was planning to expand it to language arts and science homework.

Once Jerry regained consciousness after his injury he was transferred to the Anderson Rehabilitation Center near his home. His doctor and parents were encouraged by his progress. Initially, Jerry experienced significant left side weakness, limited expressive language, and limited fine motor control. However, with therapy, Jerry rapidly regained skills. As his recovery progressed, Jerry was able to walk moderate distances with brief rests when he became tired. His speech improved, but Jerry experienced difficulty with word finding, which frustrated him. His memory for remote events was excellent; he could remember the names of all the teams in his little league division. However, his parents were puzzled by his spotty memory for recent events. For example, one day he remembered that his grandparents had visited earlier in the day, but he didn't remember what he ate for lunch. While Jerry was in the hospital the staff monitored him closely because at times he wandered into other patients' rooms.

Jerry is about to be discharged from the rehabilitation center 60 days after his injury. His parents are eager for Jerry to return to school, but they want Jerry to recover at home for a week or two first. His teacher referred Jerry for an IEP team evaluation as soon as he regained consciousness, and several IEP team members have visited Jerry in the hospital. They are concerned about meeting his needs in school because his needs have appeared different every time they have seen him. The IEP team has agreed to complete their evaluation as soon as possible so Jerry can return to school within two weeks.

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Example: Serena

Recently Serena's homeroom teacher, Ms. Grafton, went to talk with Serena's case manager. According to the teacher, Serena had been very difficult to work with that day. Because of a sixth-grade field trip in the afternoon, all sixth grade classes were following the "B schedule" in the morning, which meant that all classes were shortened, and afternoon academic classes started first thing in the morning. As classes were beginning, Ms. Grafton explained the schedule changes to Serena, but Serena wouldn't go to her math class; she insisted it was time for her social studies class. Ms. Grafton said Serena "wouldn't listen to reason" and had a real temper tantrum. She pushed all the materials off the table in front of her, reached out to hit the teacher, and swore at the teacher. Ms. Grafton took Serena into the hall and Serena calmed down. The teacher then let Serena do some social studies alone while the other students were in math class. Because of her behavior, Serena was not allowed to go on the field trip to the botanical gardens that afternoon. Serena's mother was upset because she had taken off work to accompany Serena on the field trip with her class.

Ms. Grafton said "I'm tired of these outbursts; they happen at least once a week. I have been very patient with Serena, but no student can swear at me or hit me. Something has to be done."

1. What is the problem stated in observable, measurable terms?

2. How often does the behavior occur? With what intensity? For how long?

3. What slow and fast triggers influence Serena's behavior?

Slow triggers:

Brain injury factors:

Other slow triggers:

Fast triggers:

4. What consequences might influence whether Serena's behavior occurs again?

5. What functions does the behavior serve for Serena?

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Example: Jerry

Jerry's core teacher, Ms. Walters, has been feeling better about her work with Jerry and his progress since the last IEP team meeting. The case manager gave her some resources about TBI that were helpful, and brainstorming with others about how to meet Jerry's needs provided her with some new ideas. She liked the music teacher's suggestions about letting Jerry help decide what level of participation he could tolerate each day. Ms. Walters adapted the idea for her own classes. For example, she now asks Jerry to help decide how much independent work he can complete before asking for help and what reward he would like to work toward. Jerry sets a goal that he marks on his paper. He is getting better at setting a realistic expectation for himself and getting the reward he chooses. He usually chooses to play a game of Trouble with Ms. Walters after lunch. Also, in the last two months Ms. Walters has used several strategies to help Jerry interact more with other students.

However, Jerry's interactions with peers have caused a new set of problems. Jerry's behavior with the other kids in his class and with other children on the playground is often inappropriate. In particular, he has initiated "kissing games" on the playground with the fourth and fifth grade girls. The girls let Jerry kiss them, and then they laugh and run away. Ms. Walters has talked to Jerry, but the games have continued. Today, the principal called her because he had received a phone call from the parent of a second grade girl. The mother was concerned because the girl reported that Jerry tried to kiss her and pull up her dress on the school bus. The principal wants Ms. Walters' assurance this won't happen again.

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Ms. Grafton said "I'm tired of these outbursts; they happen at least once a week. I have been very patient with Serena, but no student can swear at me or hit me. Something has to be done."

- 1. What is your goal? What do you want Serena (or others) to do?**
- 2. What triggers, consequences, and functions of behavior would you address?**
- 3. What targets of intervention would you identify?**
- 4. What specific strategies would you use?**
 - A. Antecedent strategies**
 - B. Strategies to increase appropriate behaviors**
 - C. Strategies to decrease inappropriate behaviors**
 - D. Communication and group strategies**
 - E. Self-management strategies**

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Example: Jerry

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- 1. What is your goal? What do you want Jerry (or others) to do?**

- 2. What triggers, consequences, and functions of behavior would you address?**

- 3. What target(s) of intervention would you identify?**

- 4. What intervention/strategies would you use?**
 - A. Antecedent strategies**
 - B. Strategies to increase appropriate behaviors**
 - C. Strategies to decrease inappropriate behaviors**
 - D. Communication and group strategies**
 - E. Self-management strategies**

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Interventions Across Stages of Recovery.

These stages represent a typical pattern for students recovering from serious (moderate to severe) TBI. Remember, however, that each student's recovery pattern may be unique.

Stage of Recovery

Interventions Most Likely to Succeed

Early

The student may display agitation, confusion, extreme impulsivity, and very slow information processing. Student may not tolerate stimulation. During this stage the student is usually still in a hospital or rehabilitation setting.

Antecedent interventions are most appropriate. Control the environment to provide as little unnecessary or aversive stimulation as possible. Sometimes, however, necessary stimulation, such as physical therapy and medical treatments, must be provided and can cause the student to display challenging behaviors. Encourage **appropriate behaviors** through positive reinforcement of appropriate. Use **redirection** to reduce inappropriate behaviors. Use **repetition** and try to **anticipate** the student's needs and responses. The student will not remember the consequences of behavior and is unlikely to learn new positive behavior.

Middle

The student may display disinhibition, continued impulsivity, limited attention, difficulty with new learning, and unawareness of deficits. Behavioral demands may be great. During this stage students often return to the school setting.

Continue use of **antecedent interventions**. Avoid challenging behavior by creating a school environment, curriculum, and instruction that facilitates the student's performance. **As the student's memory and attention improve**, increase appropriate behavior by **teaching new skills and behaviors**, by using **consequence control strategies** such as positive reinforcement of appropriate behavior, and by introducing **group strategies**, such as social skills groups. **Be sure the student is able to connect the behavior and the consequence and to remember consequences** (such as planned rewards). Pay attention to generalization of skills across settings, including home. The student is probably not yet ready to use self-control strategies, but might benefit from some **group strategies**.

Late

The student may display lasting cognitive, sensory, or other deficits. Attention and learning increase, but likely are still below normal. Awareness of deficits may result in depression, frustration, anger, and risk-taking. During this stage the student is typically in school.

Continue use of **antecedent strategies**. Increase use of **consequence control strategies** if student is able to remember consequences. Stay focused on positive consequences (positive reinforcement). Introduce **self-management strategies** such as self-monitoring, self-evaluation and self-reinforcement, and **group strategies** such as support groups and social skills groups. Generalize interventions to settings outside of school, such as community recreation and work sites.

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SPECIFIC STRATEGIES TO USE WITH SPECIFIC PROBLEMS

DISINHIBITION

Example: *The student uses inappropriate language in classes.*

Limitations or Factors that May Influence Behavior

- *Neurological changes leading to reduced behavioral control
- *Reduced self-awareness and self-monitoring skills
- *Reduced ability to read social cues
- *Reduced tolerance for frustration
- *Limited behavioral repertoire
- *Inability to discriminate among settings and people

Sample Interventions

- *Teach the student what words are unacceptable
- *Brainstorm acceptable alternatives with the student; make a list
- *Provide opportunities to practice alternatives
- *Role-play appropriate responses
- *Reinforce appropriate language
- *Teach difference between public/private and settings
- *Reduce frustrations/hassles
- *Avoid reinforcing inappropriate behavior
- *Provide structure to help student self-monitor
- *Teach other students how to react

IMPULSIVITY

Example

The student raises his/her hand immediately as the teacher begins to ask a question.

Limitations or Factors that May Influence Behavior

- *Neurologic deficits leading to reduced impulse control
- *Reduced ability to listen and reflect
- *Reduced self-monitoring skills
- *Anxiety
- *Strong associations between stimuli and response

Sample Interventions

- *Develop physical or verbal cues to help the student wait
- *Provide practice in role plays and real settings
- *Warn the student that a question is coming
- *Rehearse specific questions and answers in advance
- *Teach the student a sequence of steps to take before raising his or her hand
- *Provide physical support for waiting
- *Reinforce appropriate behavior

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AGGRESSION

Example: *The student hits other students on the playground and in the lunchroom.*

Limitations or Factors that May Influence Behavior

- *Reduced ability to filter internal and external stimuli
- *Agitation in highly stimulating environments

- *Reduced ability to read social cues and intentions
- *Limited means of gaining social attention or interaction
- *Inability to self-monitor
- *Reduced problem-solving skills

- *Limited behavioral repertoire

Sample Interventions

- *Evaluate communicative intent of behavior; what is the student trying to say?
- *Teach alternative forms of communication; for example, teach appropriate ways to approach others or to join in activities
- * Determine antecedents or consequences of behavior
- *Identify cues of escalating behavior
- *Examine specific traumatic brain injury related deficits, for example, cognitive, perceptual, physical; do they influence behavior?
- *Use peer modeling and role playing
- *Reduce stimulation
- *Provide structured activities with adult supervision

CONFRONTATIONAL BEHAVIOR

Example

The student refuses to attempt an activity.

Limitations or Factors that May Influence Behavior

- *Lack of confidence

- *Lack of comprehension of task demands
- *Delayed response time
- *Lack of awareness of need to complete tasks
- *Influence of prior experience (either a similar task or an unrelated experience that just took place)
- *Physical discomfort

Sample Interventions

- *Be sure task demands match the student's abilities
- *Set clear, reachable goals; ensure success
- *Break tasks into small steps
- *Provide an extrinsic reward

- *Begin activity with other students; reward them
- *Give the student choices
- *Allow the student adequate transition time
- *Avoid power struggles; do not argue with the student
- *Examine conditions in settings in which the student is more successful; what helps?

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WITHDRAWAL

Example: *The student refuses to participate in small group activities.*

Limitations or Factors that May Influence Behavior

- *Lack of confidence
- *Awareness of deficits
- *Difficulty handling the pace or stimulation of the group
- *Fear of embarrassment

- *Uncertainty about the role or task demands

Sample Interventions

- * Carefully define or limit role and task demands
- * Allow the student to observe the group
- * Include a member of the student's "circle of friends" in the group
- * Create individual goals for the student that may differ from goals for other members
- *Provide adult or peer support
- *Examine factors (such as noise, pace, physical proximity) that may affect the student
- *Educate other members of the group about roles and procedures
- *Use the MAPS (McGill Action Planning System) process

EGOCENTRICITY OR INSENSITIVITY

Example

The student makes unkind remarks to others.

Limitations or Factors that May Influence Behavior

- *Inability to take others' perspectives
- *Limited insight
- *Reduced awareness of others' feelings
- *Poor cognitive problem-solving
- *Need for attention
- *Inability to interpret subtle feedback

Sample Interventions

- *Teach appropriate social remarks
- *Provide practice, role plays, modeling
- *Provide peer or adult coaching
- *Provide scripts for some situations
- *Reinforce appropriate behavior
- *Provide direct feedback about impact of social communication
- *Draw on the support of a "circle of friends"
- *Provide support for peers

Adapted from Corbett and Ross-Thomson (1996)

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Summary of Medications for Children with Challenging Behaviors

NOTE: This list is not intended to be complete. New medications continually become available. Consult with a physician or school nurse about other medications and possible side effects.

Behavior	Medications	Possible Side Effects
Hyperactivity/ Inattention	Ritalin (methylphenidate) Dexedrine (dextroamphetamine) Cylert (pemoline) Adderall (dextroamphetamine amphetamine)	Reduced appetite Stomachaches, headaches Insomnia Rebound effects (increased hyperactivity when when medication is discontinued) Irritability, sadness (when these occur, children are usually given a lower dosage or taken off the medication) Liver toxicity (effect of Cylert, not Ritalin, Dexedrine, or Adderall) May exacerbate tics
Anxiety	Xanax (alprazolam) Librium (chlordiazepoxide) Klonopin (clonazepam) Valium (diazepam) Ativan (lorazepam)	Drowsiness, sedation, lethargy Slowed speech, mental confusion Amnesia Extent of effects depends on dosage Impairment of motor abilities, unsteadiness Dependence develops when taken for a long long period of time. When removed, symptoms for which the drug was prescribed return, possibly with greater intensity
	Ambien (zolpidem) BuSpar (buspirone)	Some drowsiness; upset stomach Upset stomach; restlessness; Headaches
Depression	Tofranil (imipramine) Norpramin (desipramine) Pamelor, Aventil (nortriptyline) Elavil (amitriptyline) Anafranil (clomipramine)	Sedation Dry mouth Constipation Weight gain Heart racing (if this occurs, dosage may need to be lowered or medication removed) Increases or decreases in blood pressure There have been reports of sudden death in children taking desipramine

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Behavior	Medications	Possible Side Effects
Depression cont.)	Wellbutrin (bupropion)	Restlessness, insomnia Dry mouth; Anxiety; Weight loss Seizures, psychoses (rare)
	Prozac (fluoxetine) Paxil (paroxetine)	Minor difficulties with sleep, restlessness, insomnia Headache; Dry mouth; Sweating; Nausea Feeling jittery, nervous, or anxious Rare cardiac complications Virtually no medically serious side effects There have been reports of self-destructive and suicidal behavior in adults taking fluoxetine, though research has not supported this as an effect of the medication
	Nardil (phenelzine) Parnate (tranylcypromine)	Dietary restrictions include foods containing tyramine (a by-product of fermentation). Foods with tyramine include cheese, wine, beer, liver, and some beans Medicinal restrictions include adrenaline-like drugs found in nasal sprays, anti-asthma medication, and cold medicines Interaction with these products causes an increase in blood pressure, severe headaches, vomiting, and possibly death Weight gain
Bipolar Disorder	Lithium	Nausea and gastrointestinal complaints Lethargy, muscle weakness Metallic taste; Dehydration; Slight tremors Possible effects on thyroid gland, including hair loss, dry or rough hair, rashes, and hoarseness (this may be an indication to lower the dosage) High concentrations can yield coma, renal failure, cardiac arrhythmias, and death Blood levels must be closely monitored

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Behavior	Medications	Possible Side Effects
Bipolar Disorder (cont)	<p>Tegretol (carbamazepine) Depakene (valproic acid, valproate)</p> <p>Catapres (clonidine)</p>	<p>Lethargy, drowsiness Headache Changes in sleep pattern Dizziness, blurred or double vision Gastrointestinal disturbances</p> <p>Fatigue, drowsiness Headache, stomachache Dry mouth Dizziness Lower blood pressure Depression</p>
Psychoses Aggression	<p>Clozaril (clozapine) Haldol (haloperidol) Loxitane (loxipine) Mellaril (thioridazine) Moban (molindone) Navane (thiothixene) Prolixin (fulphenazine) Risperdal (risperidone) Stelazine (trifluoperazine) Thorazine (chlorpromazine)</p>	<p>Sedation Lower seizure threshold Weight gain Dry mouth Blurred vision Skin flushing Rapid heart beat Reduction in white blood cell count Tardive dyskinesia (uncontrollable body movements) Parkinsonian side effects (tremors, drooling, muscle spasms). There are drugs to treat such side effects (e.g., Cogentin (benztropine) or Benadryl (diphenhydramine))</p>
Aggression Post-Traumatic Stress Disorder	<p>Inderal (propranolol) Lopressor (metoprolol) Corgard (nadolol) Tenormin (atenolol) Visken (pindolol)</p>	<p>Lower blood pressure Nausea, vomiting, diarrhea Fatigue</p>

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Guidelines for Understanding Stages of Challenging Behavior and Stages of Support

Stages of Challenging Behavior

ADAPTIVE:

Mood is even
Relaxed posture
Ability to concentrate
Normal facial expression
Even breathing
Interactive

TENSION:

Change in breathing
Facial expression
Eye contact
Decreased concentration
Muttering
Voice tension
Argumentative
Withdrawal

EMOTIONAL DISTRESS:

Yelling
Swearing
Threats
Pacing
Increased movements
Decreased rational thinking

PHYSICAL DISTRESS:

Aggression
Destruction
Self-Injury

RECOVERY:

Tension is released
Normal breathing
Normal posture
Embarrassment
Crying
Withdrawal
Remorse

Stages of Support

REINFORCE:

Positive attention
Praise
Promote positive activities
Provide incentives for adaptive behaviors
Be vigilant to life situations that could cause tension/distress

RESPONSIVE:

Increase attention
-Creative talking strategies
-Review precursors
-Empathy
-Therapeutic touch
Give Space
-Lower or change expectations
-Provide diversions

DIFFUSION:

Decrease or stop talking
Focus on challenging behavior
Neutral presence
Use talking to contain behaviors
Respect positioning

SAFE BOUNDARIES:

Proceed from least to most restrictive supports
1. Remove self and others
2. Practice self-protection
3. Protect the person from self-injury
4. Provide safe physical support

TALK OUT:

Reflect on the confrontation
-Explore precursor
-Discuss better ways to deal with precursors
-Offer support
-Enforce consequences if warranted
Provide closure
-Smile, handshake, positive statement
-Help return to adaptive lifestyle