

WORKBOOK

Behavior is Communication

Strategies for Understanding
Challenging Behaviors

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Introduction

For a moment, imagine being hungry, but having no access to food and no way to tell anyone that you need to eat. Imagine being happy after a trip to the park, but not being able to share your thoughts and feelings about the experience with anyone. Imagine being saddened at the death of a family member, but not being able to communicate what you are feeling and why to the people around you. Now imagine that the people you are with most often are paid to be with you and that you have few (if any) friends or family close to you for support. To make matters more difficult, some of those around you think that you are not able to understand or even have intense feelings and emotions. If you could express what you were feeling, it would not make a difference because few people would believe you. No matter what you do, no one takes your feelings and thoughts seriously. If you felt something intensely, but could not use words to help others understand it, what would you do to have your needs met?

The situation becomes even more difficult when mental illness is added to the picture. Imagine having a frightening hallucination and not being able to tell someone what you are seeing. While the other person would not be able to see what you do, being able to communicate what is happening might help others to recognize that you need psychiatric help. At the very least, they might be able to reassure you that you are safe and would stay with you to help you through the situation. If you are not able to communicate, and others assume that you are not capable of having those experiences, the world you live in can be a frustrating, scary, and lonely place.

To work effectively with people who have intellectual disabilities/autism (ID/A), or with those who are dually diagnosed (who have both ID/A and a mental illness), it is important to realize that they have hopes, dreams, wants and needs, just as anyone else does. They can and do experience the full range of emotions that any other human being would: happiness, anger, sadness, fear, excitement and many others. However, these individuals sometimes lack the skills needed to communicate these experiences. This can contribute to the mistaken notion that they cannot experience strong feelings. Inability to communicate these experiences, as well as the inability to cope with intense emotion and feeling, can also contribute to challenging behaviors – including self-injurious behaviors.

Challenging behaviors in those with ID/A and mental illnesses has long been a difficult issue for families, professionals and the individuals themselves. Often times, the challenging behaviors that are seen in people with ID/A are treated in terms of curbing the behaviors without getting to their actual causes. It is similar to plugging one's finger into a hole in a dam that has several leaks. The water will stop coming out from the first hole, but will rush even faster from the others. So what can caregivers and professionals do to help individuals with challenging behaviors?

In the case of ID/A, the only behavior that can be directly attributed to it is the slower learning of new information. A challenging behavior is not a given because a person has ID/A and/or a mental illness.

For those with ID/A who do have challenging behaviors, it can be a learned behavior or coping skill, as well as an expression of physical, emotional or psychological pain. When seen in people with ID/A and mental illness, this behavior can be a signal that symptoms of the illness are worsening. The many possible causes of challenging behaviors should be examined by those caring for the person to rule out what is and what is not causing the problem. This can include a full physical and psychological evaluation, as well as examining the person's environment, developmental needs, methods of communication, and support system (Citrome, 2017; Charlot & Shedlack, 2010). This manual will point out some basic assumptions and strategies that can guide families, caregivers, doctors, nurses, and other professionals who work with people with ID/A on a daily basis. By keeping the facts outlined in this manual in mind, it may be possible to avoid a crisis situation, or hospitalization, by addressing potential problems before they reach a serious level – something that will benefit both people with ID/A and those who care for them.

Basic Premises About Mental Illness

There are some basic facts about the symptoms of mental illness that will help caregivers to be the eyes and ears for an individual's doctor by making more accurate observations of symptoms and behaviors.

1. Symptoms never occur alone. A cluster of symptoms (criteria) need to be present at the same time for a person to be given a diagnosis. For example, to be diagnosed with depression, a psychiatrist will look for at least five of the following symptoms in a person over a two week period:

- A. Depressed mood most of the day, nearly every day
- B. Diminished pleasure or interest in previously enjoyed activities
- C. Significant weight loss or gain
- D. Insomnia or Hypersomnia (sleeping too much)
- E. Psychomotor agitation (restlessness) or retardation (moving about slower than normal for the person)
- F. Fatigue or loss of energy every day
- G. Feelings of worthlessness or excessive/inappropriate guilt
- H. Diminished ability to think or concentrate
- I. Recurrent thoughts of death/suicide

Having just one or two of these symptoms for a day or two does not mean that the person is depressed. The symptoms have to occur in clusters over extended periods of time in order for them to be considered as evidence of a mental disorder.

2. Symptoms can be observed behaviorally. This is often what lets others know that a person may be experiencing an illness. The following are some examples of how to observe and report symptoms of a mental illness:

- A. Depressed mood can be described behaviorally as "crying" or "not smiling for any reason."
- B. An auditory hallucination can be described behaviorally as someone "having a conversation with no visible person."
- C. A symptom of obsessive compulsive disorder may be described as a person "washing her hands 15 times over the course of 30 minutes."

3. **The key in identifying possible symptoms is to notice, describe and capture changes in a person over time.** This means that caregivers are familiar with the person and have a good idea of what he or she is usually like compared to what happens when that person is ill. Some important things to note about changes in a person's behavior are:
 - A. Onset — When did the change in behavior first start (or when was it noticed)?
 - B. Increase/Decrease — Has there been a change in the frequency of a behavior (is it happening more or less often)?
 - C. Intensity — Has the intensity of a behavior (or behaviors) changed?
 - D. Are there any noticeable patterns, episodes, or cycles of behavior?

4. **The cluster of symptoms are a significant change in how the person acts and has an impact on his or her ability to function.** It is normal every once in a while for someone to not feel like getting out of bed; but if a person is not getting out of bed consistently, is seen crying frequently, has no interest in activities that she or he once enjoyed, does not want to eat, and talks about wanting things to be 'over', it is possible that these are symptoms of depression. In any case, behaviors that are not ordinary for the person need to be observed and reported as accurately as possible without any form of judgment.

5. **To understand the significance of a change in someone, caregivers need to understand how the person is when he/she is functioning at their normal, healthy level.** This may mean that the person's caregivers (or doctors) need to talk with those who have known the individual for a long period of time. Conversations like this can aid in finding out if what is happening now is a drastic change from how the person used to function.

In order to best help a physician and the person, caregivers must remember to observe and report only what is seen and what is heard. This must be done without assumptions or guesses about what illness or diagnosis the person may have, although it can be difficult to resist making those assumptions. Though caregivers, people should understand a person's diagnoses, it is not caregivers' role to make them. Caregivers are most effective when they are able to describe what they see and hear. If you are a caregiver who must report on a person, remember not to interpret what you observe or why you think it might be happening. All that is needed is a description of what is happening with the person in the clearest terms possible.

To describe what is seen and heard clearly, follow these steps:

- A. **Don't interpret** — simply describe what happened.
- B. **No "suitcase" words** — avoid terms like 'aggressive', 'isolative', or 'defiant'; they do not describe what happened, but rather the observer's interpretation of what happened; they can also be understood in different ways by various people, creating a loss of needed information.
- C. **Take one symptom at a time** — describe each symptom as it is seen in the person; try not to cover every symptom in one or two sentences or needed information may be lost.
- D. **Capture behaviors at the person's best (healthiest) and worst (most ill)** — this will give both caregivers and doctors an idea of how the person is when he/she is well versus when he/she is ill.
- E. **Don't argue or decide if something is a symptom or not** — again, this is best left to professionals trained in making these decisions.

When working with people with ID/A, making assumptions about behaviors can leave out vital information. For instance, if a person is banging his head against the wall and crying, one could assume that he is angry, frustrated, or just seeking attention. However, it may be that the person is experiencing pain that he cannot describe to others. Also, the act of beating his head against the wall may be the person's way to distract himself from any pain that he is feeling. In this situation, the best way to report this behavior is to describe what is seen: the person is crying and banging his head against the wall.

The best way to report on observed behavior is to imagine that you are watching the behavior on video or in a movie. Imagine how you might answer if someone asks, "What happened in that movie you saw?" To answer the question, it would make sense to talk about what the characters did in the movie instead of why they did it.

Practice — Basic Premises About Mental Illness

READ THE FOLLOWING REPORTS ON BOB'S BEHAVIOR DURING DINNER TIME.

Bob came to dinner with housemates; was irritable and moody; became defiant when given a meal, and was given a verbal warning.

Question 1: Do you know what happened with Bob at dinner from this report? What specifics can you see reported here?

READ THE FOLLOWING REPORTS ON BOB'S BEHAVIOR DURING DINNER TIME.

Bob frowned when caregivers gave him meatloaf and mashed potatoes – he said, “I hate this stuff” and shoved the plate away. Caregivers asked him to try and eat – Bob threw his plate to the floor yelling, “I hate this stuff!” Caregivers asked Bob to please leave the dining room – he yelled, “I hate this stuff!” as he left.

Question 2: What do you know about the incident with Bob after reading this report? What do you think may be the meaning behind the behavior?

Practice — Basic Premises About Mental Illness

READ THE FOLLOWING DESCRIPTIONS OF AN INDIVIDUAL AND ANSWER THE QUESTIONS.

Kenny; bad day. Very manic. Into everyone's business, not redirect-able.

Question 3: What can you say about Kenny based on the report you just read?

READ THE FOLLOWING DESCRIPTIONS OF AN INDIVIDUAL AND ANSWER THE QUESTIONS.

Kenny paced around the house most of the day; talked very loudly and got into everyone's face quite often; was not able to follow redirection from caregivers; said that he was going to be elected president next week.

Question 4: What can you say about Kenny's behavior after reading this report? Does anything here get your attention in regard to his behavior as something that the rest of the team (including the psychiatrist) should know?

Practice — Basic Premises About Mental Illness

Question 5: Which report does a better job of recording observations about Kenny on this particular day?

Caregivers and the psychiatrist must work together as a team to provide the greatest help to a person. The caregiver is the psychiatrist's eyes and ears; if needed information is not reported, the psychiatrist does not know what is happening. This can lead to treatment approaches that are not as effective as they should be, and can contribute to a person becoming more ill and experiencing more challenging behaviors. Conversely, the psychiatrist must respect and listen to the information that the caregiver presents in order to be most effective. When caregivers and doctors are respectful of each other's roles and work together, the person gains the benefit in the long run.

Challenging Behavior

There are basic assumptions about people with challenging behaviors that are respectful, nonjudgmental, and consider the whole person, not just the behavior.

- 1. There is an unmet need or want** — Challenging behavior is the expression of an unmet need or want. In essence, it is a way of communicating with others. A good question to ask when working with a person who exhibits challenging behaviors would be, “Why would this person need to do (fill in the blank with a behavior that may be challenging.)

- 2. Challenging behavior is meaningful** — The behavior can be understood upon closer investigation and exploration of the person and his or her behaviors. If the meaning of the behavior can be discovered, the person’s team can help to meet the need or want and minimize the challenging behavior.

- 3. People have good reasons to do what they do** — The use of the word “good” here does not mean that the person’s reasons are “just”, “positive” or “socially acceptable”, but “valid to themselves”. For instance; if John does not like to sit next to Ted at workshop because Ted hits him, caregivers may find that John will act out in difficult ways. He may hit Ted or others who are near him, or yell as loudly as he can until he can move. These behaviors are not socially acceptable, but for John, he has a good reason to engage in them, as it lets others know that he does not want to sit with Ted. As the person gains trust and begins to reveal his or her reasons, the actions may be better understood by the person’s team.

- 4. People do the best they can with what they have at that time and in that context** — People with ID/A who also have challenging behaviors experience daily stressors, just as people do who do not have ID/A. The difference here is that those with ID/A may lack effective coping skills; therefore, they are doing the best they can with what they have. For example: When Bob is under stress, his symptoms of pica worsen and he tries to eat inedible objects. This is his way of coping with stress and anxiety, as the behaviors that he engages in help him to feel relieved. In tough moments, Bob is doing the best he can to handle the stress that he faces, but his coping skills are limited. Just as anyone else, he does the best he can do with the skills that he has in place.

- 5. Challenging behaviors interfere with an individual's daily life** — Refusal to take medications, use the bathroom normally, practice personal hygiene routines, or participate in activities of leisure or work can all be difficult for both the caregiver and the individual. When faced with these behaviors, it is best to allow extra time to complete an activity, or to offer frequent breaks. For example, if a person refuses to take a bath when first prompted, it may help to sit and chat with the person. Keep the conversation light and find areas of interest to the person, such as discussing the program she is watching on television, her choice of clothing, how her haircut is flattering to her, or anything else that the person enjoys. Building a friendly rapport helps to solidify the relationship that the person has with caregivers, and this relationship can be used to help support the person in working on ways to overcome challenging behaviors.
- 6. Challenging behaviors may result from differences in culture and limitations in abstract thinking** — In many cases, people with ID/A grew up in institutionalized settings, be it group homes or state hospitals. Even those who lived with family may have been treated in a much different way than others in the household. These different experiences may have led the person to develop ways of achieving goals and meeting needs that differ from what is normally expected. Think about the person who seems to inhale all of the food on his plate at meal times and then seeks out more food from others. This challenging behavior may be the result of living in an institution where meal times were first come, first serve. If the person did not eat quickly, his food would be taken and he would go hungry. Therefore, he learned to eat a great deal of food quickly to avoid being hungry. The person in this case may also lack the ability to think about the situation in an abstract way – namely that no one in this new setting is going to steal his food because everyone around him has plenty of their own. Of course, this behavior is not well suited for community, but understanding where it comes from can help caregivers in teaching the person new ways of coping in a different setting.
- 7. Challenging behaviors threaten the safety of the person or others** — A crisis situation can be defined as one where a person poses a threat to him/herself and/or others. Challenging behaviors can pose danger to the person or others, and can be directed at caregivers or those offering support. Though it may be difficult in such a stressful situation, try to understand the person's wants and needs. Make sure the environment is safe. Remove any objects from the immediate area that can be thrown or used to cause injury.

8. Challenging behaviors are likely to limit or deny the person access to the use of various facilities — The nature of these behaviors is often considered unacceptable, intentional, puzzling, and/or dangerous. These types of behaviors are even deemed to be “inappropriate” in certain settings. For instance, it would be difficult to take a person out to dinner if she spent the entire meal smearing her food on the table, herself, and anyone who came near her. As a result, this person might be left at home when others go out to eat, thereby limiting her ability to live as full a life as possible. This can cause feelings of isolation and loneliness for a person, as well as compounding any feelings of frustration they may already have. Put those feelings together and it becomes clear why a person might experience challenging behaviors. Here the challenging behavior represents a vicious cycle; the person is denied the ability to engage in certain activities because of the challenging behavior, so the person responds by engaging in more challenging behaviors to express her or his feelings. This is why it is so important for caregivers and professionals on a person’s team to determine what the meanings are behind these behaviors and to help the person meet those needs and wants. Failure to do so results in a person being shut out of the opportunity to live an everyday life.

Doing this work requires knowing about the person, their behaviors, the diagnoses the person has, and the use of good observation skills and tools to describe observations. Of course, this requires a lot of work on the part of caregivers, but it is important work in figuring out the meaning of challenging behaviors. If we know what the behavior means, we can work to meet the person’s need and eliminate the need for that person to use behaviors that others find scary, unsettling, or intrusive.

Practice — Challenging Behavior

THINK ABOUT THE FOLLOWING SCENARIO AND ANSWER THE QUESTIONS.

Amy is a 24 year old woman with ID/A who has been exhibiting some very challenging behaviors ever since arriving at her new group home. She attempts to bite caregivers and her housemates when they come close to her, yet she screams, bangs her head off of the wall or punches herself in the face when left alone. The caregivers at her group home believe that no matter what they try her behavior will not change, and her housemates are afraid to be in the same room with Amy.

Question 1: What do you think is the meaning behind Amy's challenging behaviors?

Question 2: What would you do to help Amy?

Practice — Challenging Behavior

READ THE FOLLOWING HISTORY ABOUT AMY.

At the age of five, Amy was abandoned by her mother. She was sent to live with her father until she turned 18. Amy’s father used illegal drugs, drank heavily, and sexually abused her. He also called her ‘stupid’, ‘worthless’ and ‘trash’, and frequently threatened to drop her off in the middle of the city to fend for herself. Being non-verbal, Amy was not able to respond to this or tell anyone what had been happening while she grew up; but she fully understood what her father was saying to her and that his actions caused her both physical and emotional pain.

Question 3: Taking her history into consideration, make a respectful guess as to what Amy’s needs and wants may be.

Question 4: What strategies would you use to help Amy?

Practice — Challenging Behavior

The team working with Amy made a respectful guess based on this information that Amy was exhibiting challenging behavior to express her need for a sense of belonging and security. Her fear of touch may have also stemmed from the sexual and physical abuse she endured while growing up. The team guessed that her experiences with her father caused her to feel afraid and anxious about relationships with others. Once her team understood this, they were able to more effectively support her by including her in more outings, giving her chores that she could manage, slowly increasing the amount of time they spent sitting and talking with her, encouraging her to make her own choices about how she wanted to spend her time and praising her when she did make choices. All of these actions were forms of communication from the caregivers to Amy; they were responses that said to her, "We are here to help and support you; you don't have to be afraid of anyone hurting you here." After some time (and consistent work by the caregivers), Amy no longer engaged in challenging behaviors because her needs were now being met. Caregivers were also able to recognize that Amy would continue to be cautious around others due to her past (and the high incidence of sexual abuse of those in the ID/A population), but that she was able to make strides towards better relationships with others in her own time.

Question 5: Look at your answers from questions 1 & 2 and compare them to your answers from questions 3 & 4. Did your answers change? If so, how and why did they change?

People may exhibit challenging behaviors for many reasons, and do so in a variety of settings. Due to the physical, cognitive, and communication challenges that people with ID/A may have, their most innocent behaviors can be seen as puzzling or challenging; as a result, they may be misunderstood by those who are there to help them. Challenging behavior often results in people with ID/A being given negative “labels” that describe their actions (i.e. John is a biter, Mary is a kicker). Behavior may be avoided by investigating the reasons behind it and addressing the person’s needs. However, doing so requires that caregivers and doctors understand two fundamental truths about ID/A:

- 1. Intellectual disabilities/autism do not cause challenging behaviors.** — Many people believe having ID/A will automatically lead to a person having challenging behaviors. This is far from the truth, as challenging behaviors are an expression of unmet needs. The fact of the matter is that anyone, regardless of intellectual ability, could have an occasional challenging behavior. Limitations in communication and abstract thinking increase the chances that a person may have these behaviors, but these limitations do not guarantee that they will occur.
- 2. The only behavior that can be attributed directly to intellectual and/or developmental disability is slow learning of new academic information (Ryan, 1993; Sulkes, 2016)** — People with ID/A can and do learn, though it may take more time for a person to take in and use the information. Think about a person with ID/A who is deaf, but knows sign language... now think about yourself. Do you know sign language? If so, did you have to study and practice it in order to learn how to use it? The person who has deafness and ID/A had to learn how to use sign language as well; it is simply not a skill the person was born with to compensate for not hearing. In fact, if you did not know any signs, the person with ID/A may be able to teach you some signs – which completely dispels the notion that a person with ID/A is unable to learn.

Simply put, a person who has ID/A does not automatically have challenging behaviors. Those behaviors are not meaningless and can serve as a way for the person to meet her needs. Also, a person is not destined to have these behaviors for life. If those working with the person can take the time to teach new skills, the person can learn other ways of handling stress that are safer and more acceptable in society.

Identifying triggers that can lead to challenging behaviors can help avoid a potential crisis situation. Triggers are people, places, or things that serve as reminders of a feeling or event for a person. These reminders are different for everyone; for instance, a belt may seem like an ordinary article of clothing to one person, but may be a frightening reminder of being tied down for someone else. Triggers can literally be anything: a smell, a person who resembles someone from the individual’s past, a television show, a song and even someone’s voice. Triggers can give rise to memories of trauma, abuse, or emotionally

difficult times in a person's life; memories that may still influence that person's emotional and behavioral state years later. Triggers can also evoke happy memories which can sometimes cause a person with ID/A to become overly excited to the point that they have great difficulty controlling themselves. Being unaware of a person's triggers can make his or her reactions and behaviors difficult to understand. Be sure to know as much as possible about a person's past and triggers in order to respond appropriately in a given situation. Speaking with those people closest to the person can help in determining what triggers to watch for so that they can be avoided whenever possible. However, remember that there will be times when it simply is not possible to avoid a person's triggers, no matter what steps are taken. Every effort should be made to speak with the individual's caregivers and family (if possible) to learn about any triggers that may elicit challenging behavior in a person.

Practice — Challenging Behavior

IDENTIFY YOUR OWN TRIGGERS.

Question 6: What are the people, places, and/or things that annoy, irritate, or generally upset you?

Question 7: How do you respond when you are faced with your triggers?

An important consideration about triggers should be noted here as well – there may be times when the caregiver’s response to a person’s challenging behaviors can be triggers themselves. Oftentimes, caregivers want to do what is right and most helpful for a person, but are not aware that their actions may increase a person’s anger, fear, anxiety or other intense feelings. It is important to pay attention to the whole person when working with them in these situations – this means listening to what the person says, seeing what they do, listening to their tone of voice and respecting their immediate requests.

Practice — Challenging Behavior

TO SEE HOW THIS MIGHT PLAY OUT, READ THE FOLLOWING SCENARIO ABOUT JOE.

Joe enjoys being outdoors and has since he was a young boy. He will often tell people about his trips hiking with his father when he was young and how much he loved seeing nature up close. However, Joe has had some trouble with impulse control which has led him to get into some unsafe situations. At one point in his adult life, he ran out of his home and into the street just as a car was coming and was hit. Luckily his injuries were minor since the car was not going fast, but there was potential for a serious incident. Ever since then, his behavior plan has stated that caregivers must not allow Joe to go outside without one caregiver being with him. It is not always possible to have the appropriate number of caregivers available when Joe wants to go out, so there are times when the caregivers will tell him that he is not allowed to go. It is in these situations that he is most likely to attempt to bolt outside. When caregivers try to redirect him, he begins to scream and curse at them. There have even been incidents where Joe has physically attacked caregivers when they stood between him and the door.

Question 8: Thinking about the above scenario, how might the caregivers be inadvertently contributing to Joe's challenging behaviors?

Question 9: How can caregivers help Joe have control over when he wants to go outside while maintaining his need for safety?

Aspects to Consider When Analyzing Challenging Behaviors

When thinking about why a person may have challenging behaviors, it is often helpful to consider each of the five following areas:

- Communication
- Environment
- Emotions
- Unaddressed Medical/Physical Needs
- Trauma

Communication

At the heart of any behavior is communication. A person who frequently checks his watch during a meeting may be saying non-verbally that he wants the meeting to be over; a woman who rolls her eyes whenever her husband starts to talk about football may be saying to others that this is a topic she is tired of hearing about. Behavior is a form of non-verbal communication that all people use, those with ID/A included. In order to best support a person, caregivers must be able to communicate with the person in a way that is simple and effective. Otherwise, both the person and the caregivers become frustrated due to each not knowing what the other wants or needs. The person with challenging behavior is often communicating wants and needs. This challenge can only be met by caregivers who take the time to listen to the person and figure out the individual's needs.

Here are some ways to improve communication between caregivers and individuals:

- **“The 18 Second Rule”** — allow at least 18 seconds for the person with ID/A to process and respond to a question or directive. This gives the person time to process and understand what was said and to respond accordingly.
- **Give direct attention to the person** — do not do paperwork, have conversations with other caregivers or housemates, or perform other tasks while the person is talking. This promotes respect and a feeling of being heard.
- **“Communication Partners”** — people closest to the person who usually know them best, usually family or caregivers. They can read the person's body language and may be able to explain the meaning of the person's behavior.

- **Communication Tools** — items that help to facilitate communication between the person and others. These include the following devices:
 - **Communication Board:** a device printed on paper, board, as a poster, or in other formats; it lists frequently used words and phrases that are specific to a person.
 - **Social Stories™:** developed by Carol Gray to help individuals with ID/A understand what is going on in specific situations; the story is created to help the person know where the situation is happening, what others who are there may be feeling and thinking, what the person may be expected to do or say (if anything) and strategies to help the person remember how to respond to the situation in the future. (The Gray Center for Social Learning and Understanding)
 - **Augmentative Communication Devices:** electronic devices that can be used by individuals to communicate verbally. These can be in the form of a computer, electronic notebook or tablet which contains pre-loaded words and phrases and can be personalized by the individual.

People with ID/A may have their own form of communication (personal signs). The more information that can be received from family and caregivers who know the person best, the better the support for the person will be.

Environment

One of the most obvious and most overlooked reasons why a person may have challenging behaviors is the environment itself. Sometimes a small change to the environment can impact the person's life and their behavior, both positively and/or negatively. When we talk about the environment in this respect, we think not only about the person's immediate surroundings, but also who is with the person. Remember that relationships with other people help to shape the environment just as much as where a person is physically. Here are some aspects to think about when it comes to determining if the environment is contributing to challenging behaviors. As you read these, think about how you would be affected by these conditions:

- Is the person feeling too hot or too cold?
- Is the person hungry or thirsty?
- Is the person tired or sleepy?
- Is the environment too stimulating for the person?
- Does the person need or want to exercise or move around?
- Does the person need to use the restroom? Sometimes individuals are anxious about asking to use a restroom, or are not able to ask due to communication issues, so it is always a good idea to check with the person.
- Does the person feel their privacy and personal boundaries are respected?
- Does the person like the people he or she is near and/or interacting with?

It is always a good idea to think about how someone's behavior may simply be a reaction to the environment. Some people do very well in settings where there is a lot of activity going on around them, while others have more success in quiet and easy-going settings. Everyone is different, so it makes sense to keep those differences in mind when trying to assess what may be triggering a challenging behavior. Positive practice includes taking steps to change people's environments to meet their needs. Doing this is one way to relieve distress and reduce challenging behavior.

Emotions

Emotional wellness is a core aspect of positive practices. Any emotion that a person feels will fall under this category, be it anger, happiness, grief, excitement, or irritability. It also encompasses disorders that affect someone's emotional well-being, such as bipolar disorder and depression. No matter why a person is feeling a certain emotion, caregivers must be able to respond to the individual in an appropriate manner. Telling a person who is sad and crying to "just get over it" is not the best way to help that person achieve emotional wellness; in fact it may lead to a crisis situation. A person's experiences and feelings have a direct impact on how he perceives and copes with stress in his life. Having people around who are supportive and understanding of that fact will do two things:

- It will help the person cope with the stress that he is experiencing
- It will strengthen the relationship between the person and the caregiver.

Again, a strong relationship is a good antidote to challenging behavior and one of the most effective tools that caregivers can use.

A key aspect of emotional wellness is safety. Safety is a basic need for everyone, no matter the setting. If a person does not feel safe where she is, or with the people around her, her emotional well being will be compromised. Constantly being afraid can lead to sadness, grief, anxiety, and even anger and aggression.

Add to that and people who do not seem to understand what the person is going through and it becomes clear why a challenging behavior may appear. If these needs are not met, challenging behaviors may result, such as clinginess, wanting a favored caregiver present, continually asking the same questions, refusing medications and/or treatments, attempting to elope from the group home - all out of a sense of fear and anxiety.

Also keep in mind that people with ID/A may have come from abusive living situations, or have experienced major traumas in their lives. These events do not just go away overtime. They can continue to influence a person's feelings of safety and security for years afterward. Some with ID/A feel more secure when they are in environments that offer stability, protection, structure, order and some limits. This helps combat the anxiety and fear they might have from not knowing what is happening from a day to day basis, or even hour to hour. Others with ID/A may not do as well in this type of setting because it seems too restrictive to them. As previously stated, people are different and will respond in different ways to similar circumstances, so it is always a good idea to get to know the individuals with whom you work.

Unaddressed Physical/Medical Needs

People who have ID/A are susceptible to the same physical diseases and mental health diagnoses as the general population. Many individuals with ID/A are diagnosed with multiple medical and psychiatric conditions. Having just one health concern can have a significant impact on a person's behavior, and multiple illnesses and conditions only complicate matters for the person even more. Challenging behavior may result from symptoms such as pain, numbness/tingling, fatigue, ringing in the ears, nausea, and others. Additionally, there may be a loss of independence from having an illness or condition. This lack on independence can cause feelings of anxiety, fear, frustration and anger.

Common conditions associated with physical sensations are:

- Migraine and chronic headaches
- Constipation, diarrhea, and other gastrointestinal conditions
- Degenerative joint disease and arthritis
- Premenstrual syndrome (PMS)
- Chronic immobility
- Cardiovascular disease
- Neurological conditions

Whenever challenging behaviors occur, caregivers should consider any possible unmet physical and medical needs as a source. The use of communication boards, modified pain scales and physical check-ups by a person's primary care physician can help to determine if medical and physical needs are contributing to behaviors. Caregivers should also be familiar with some basic behavioral and physiological indicators of pain in a person. Some of the more common indicators are:

- Guarding or altered body position
- Moaning
- Sighing
- Grimacing
- Withdrawal
- Crying
- Muscle twitching
- Restlessness
- Elevated or decreased blood pressure
- Quietness
- Dilated (large) pupils

- Diaphoresis (excessive sweating)
- Muscle tension
- Nausea and/or vomiting
- Weakness
- Dizziness
- Unconsciousness
- Lethargy
- Fever
- Hitting the painful area
- Staring

When trying to determine what may be happening to a person who displays these behaviors, ask “Are any of these behaviors typical for this person? Are these behaviors signs of something out of the ordinary he or she may be experiencing?” Although this list is extensive, there are many other behaviors that could be seen in a person experiencing pain or illness. Be alert and aware to any sudden behavior changes or complaints that a person may have; take note of them, report these changes to others, and have the person checked out by a physician if needed.

Trauma

In a 1991 study, Dick Sobsey and Tanis Doe stated that individuals “who have some level of intellectual impairment are at the highest risk of abuse.” In a survey of people with disabilities, over 70% of participants stated that they had experienced some form of abuse (Baladerian, Coleman, & Stream, 2013). There may be a variety of reasons why this is the case, ranging from being unable to tell others when abuse occurs, being unable to defend oneself while abuse is occurring, thinking that the abuse is ‘normal’ because of who is doing it or the circumstances in which it occurs, and/or simply believing that one deserves it due to his or her disability. A person who experiences trauma and abuse is likely to have a reaction to it – however, when it is long term and done by people who a person is supposed to trust for her or his safety and care, the effects of that trauma can run very deep.

Challenging behaviors may occur as a response to trauma, even if the trauma happened several years ago. Trauma is defined as an experience that the person didn’t ask for and can’t stop or escape. It is perceived as a life threatening experience and involves intense fear and helplessness. Trauma entails loss: physical, emotional, spiritual, and/or social. It is important to remember that trauma is a subjective experience and that what is traumatic for one person may not be for another.

There are some signs that a person who has experienced trauma may display. It is especially important to be aware of these signs in people who are non-verbal, as this may be their primary way of telling others that something is not right and that they need more attention and help. The signs of trauma include the following:

- Mood instability or mood swings
- Unexplained outbursts of anger
- Depression
- Nightmares
- Flashbacks
- Hypervigilance (always looking for threats/danger in the environment)
- Anxiety/panic attacks
- Avoidance
- Inability to experience pleasure
- Sexual problems
- Unexplained grief reactions
- Hopelessness
- Poor concentration

- Eating too much or too little (outside of person's normal eating behavior)
- Self abuse
- Poor self-esteem, shame, guilt
- Unexplained physical pain
- Headache, stomachache, dizziness

The first step in helping someone who has experienced trauma is to recognize that they need help in dealing with it. There are some strategies that caregivers can use to help a person who has been traumatized. Working with a victim of trauma means that caregivers recognize that the person has some basic needs, which are:

1. **To feel relatively safe** — a person who has experienced abuse needs to feel safe in the environment and with other people. This involves a level of trust that may take time for a person to build. In order to help the person build trust, show her kindness and compassion. At times, the person may even want to be left alone.
2. **To know you will respect his/her boundaries** — Always defer to the person. Ask the person what he or she needs or wants and respect the answer you are given. Ask the person if you can help before stepping in to help.
3. **To feel accepted, validated, and listened to** — Often, people who have experienced trauma will have guilt, fear, anger, and confusion about the event. They may question why they survived when others did not, or what they did that was so wrong that caused them to be hurt. Offer reassurance that they did nothing wrong, that they deserve to live just like anyone else and that you are there to help.
4. **To talk and be listened to** — Some people need to talk about their trauma; others do not want to talk about it at all. Listen if the person wants to talk, but do not push the person to discuss things that they do not want to discuss. Sometimes simply talking about or thinking about a traumatic event can retraumatize a person and cause them to have feelings of terror, dread, hopelessness, and extreme anxiety—just as if the event were occurring again.
5. **To have their feelings paid attention to** — It is important for someone who has experienced trauma to know that others will not judge them for having certain feelings and emotional reactions. Allow the person to experience emotions and do not question why they are experiencing them, or tell them how to get over it.

Mental Health First Aid Action Plan

When you notice that a person with ID/A and a mental health disorder is in crisis, steps need to be taken in order to ensure that person's safety and that he or she has access to emergency care. For example, a person with depression and ID/A may have gone for days without eating and is now threatening to hurt himself in some way. In this situation, caregivers who are present with the person need to take action to ensure the individual's safety and address the unmet wants and needs as best as they can. In another example, a person with schizophrenia may begin to have frightening hallucinations of people coming to attack her; she may attempt to escape the threat by trying to climb out of a window. Again, prompt action needs to be taken to make sure that the person (as well as others) are safe and that proper treatment can be provided. However, there may be times when caregivers and others are not aware of how to best help a person in this situation.

To meet this need, Professor Anthony Jorm and Nurse Betty Kitchener from the University of Melbourne, Australia composed an action plan that can be followed by anyone who is trying to assist a person in the midst of a mental health crisis. The plan they came up with is known by the acronym "ALGEE". (Kitchener, B.A., Jorm, A.F., and Kelly, C.M. Maryland Department of Health and Mental Hygiene, Missouri Department of Mental Health, and National Council for Community Behavioral Healthcare (2009).

- A – Assess for risk of suicide or harm;** this means asking the person "Do you want to hurt yourself or anyone else?" or "Do you feel like killing yourself or anyone else?" It may be an uncomfortable question to ask, but it is necessary in helping to get the right kind of help for a person in crisis.
- L – Listen non-judgmentally;** allow the person to talk about what is happening if he or she chooses to talk; do not attempt to force the person into conversation. Avoid making judgments about what the person says – the key is simply to listen and let the person know that you want to help.
- G – Give reassurance and information;** let the person know that you understand that this is a difficult time. Let the person know that there is help available to them in this moment and in the future, and tell the person what you know about any available help (i.e. counseling, medication adjustments, doctor or psychiatrist appointments, caregivers who are willing and able to help at home, etc).
- E – Encourage appropriate professional help;** let the person know that a therapist, psychiatrist, or other professional may be able to help them deal with the feelings, thoughts, and symptoms that may be most troubling.
- E – Encourage self-help and other support strategies;** this includes anything that the person can do to feel calm or relaxed (i.e. favorite hobbies or topics to discuss, deep breathing, relaxation techniques, talking to friends or family, joining a support group, etc).

Signs of Escalating Behavior

There are times when understanding triggers and using all of the tools at one's disposal may not be enough to help a person to stay calm. Sometimes events are so overwhelming that the person feels out of control and his or her first instinct is to do anything it takes to regain control. This is what happens when we see escalating behavior, and there are some observable signs that it is occurring. Those signs include:

- Faster breathing
- Talking louder
- Stiff, rigid movements
- Quick movements
- No eye contact
- Reddening in the face

Keep in mind that there is a difference between challenging behavior and escalating behavior. Challenging behavior is the product of unmet needs and wants. Escalating behavior occurs when a need or want has not been addressed or paid attention to, even after caregivers may have attempted to do so. A person may not display all of these changes or signs, but observing two to three of them taking place at the same time can be an indication that a person is becoming agitated or angry.

Techniques for De-escalation

De-escalation techniques are tools to help caregivers manage challenging behaviors before they become crises. The true key to de-escalation is investigating the reasons why the person is engaging in challenging behaviors.

Situations that call for de-escalation will be different for each person. Also, the past can be a good indicator of how a person may respond to something in the future, but it is not a means to tell the future. It is important to be aware of the triggers for behaviors that can result in a situation escalating. Being proactive means being involved with the person and being active in accommodating his or her needs.

Some proven techniques for de-escalating challenging behaviors are:

1. **Proximity** — try to be out of arm's reach of the person while being close enough to converse with him or her.
2. **Pace** — be aware of your own anxiety levels; try not to speak too quickly or make sudden movements; acting calm conveys a sense of calm to the person.

3. **Purpose** — keep in mind that your actions and words will have meaning to the person; avoid making promises that you cannot keep or that are not realistic, as the person will remember this down the road; it may help to let the person know that you think she seems upset and want to help her figure out a way to feel better.
4. **Process** — stay flexible; tune your actions and responses to the person; if the person wants you to stay and talk, do so – if the person asks to be left alone, respect that request (but be sure to check in with the person to ensure safety).
5. **Plan** — think about possible crisis situations, or past situations; determine what worked (or what may work) in handling those situations successfully.
6. **Practice** — Practice techniques that have worked with the person; having experience using techniques in a situation can relieve anxiety and enhance the sense of calm you want to convey.
7. **Presentation** — be aware of your body language and voice tone when dealing with a person in crisis; keep your arms at your sides and your palms facing outwards to let the person know you will not harm them; do NOT fold your arms across your chest, put your hands in your pockets, or clasp your hands behind your back – all of these actions may invite the person to wonder what you are hiding from them, which can further escalate the situation.
8. **Pivot** — if your attempts at de-escalation are not working with the person, or you feel unsafe, make sure you have a clear escape route and can use it quickly.
9. **Persuasion** — know the person and use your relationship with him or her to aid in de-escalation; talk with the person about what is going on or reassure the person that you want to help and are willing to listen.
10. **Preempt** — knowing what a person’s triggers are can be a great help in managing the environment and maintaining clear and respectful lines of communication; a person who feels that his or her needs/wants are being met may be less likely to use challenging behaviors to be heard.

(adapted from “Top Ten De-escalation Tips” by PMT Associates, Inc.)

A Word About Restraints

The goal of de-escalation is to help a person calm down so that she is able to process ways to deal with whatever may be bothering them. However, there may be times when the best efforts of caregivers are not enough to help a person become calm. When behavior escalates to the point of becoming dangerous to the person and/or others, restraint may be a necessary step. Follow your agency's policies on restraint use.

Once a restraint has been implemented, the goal should be to discontinue the use of the restraint as soon as possible. All too often it is believed that once a restraint is implemented, the "problem" is solved. The person can no longer engage in the challenging behavior, and therefore, is no longer a threat of harm to him or herself or others. Regardless of how long a restraint is implemented, leaving the person exhausted and no longer physically capable of causing harm, the restraint does not solve the person's problems, or give the person a chance to consider other ways of dealing with those problems. Relying on restraint only may take care of the immediate situation, but does little to prevent future episodes. The person may come to think of restraints as the only way to feel safe and may engage in even more challenging behaviors in order to achieve that sense of safety. Professionals should be diligent in teaching the person and caregivers alternative ways of feeling safe. However, if a restraint is unavoidable caregivers should continue talking to the person in as calm a manner as possible. There are some things that caregivers should tell the person during the restraint that may help the process of de-escalation, such as:

- 1. Prevention of physical harm** — let the person know that the restraint is being used to keep him or her safe from injury.
- 2. Asking what the person needs** — if the person is able to talk, ask what you can do to help them feel calm, safe, and heard; be sure to restate what the person says to better understand and to let the person know that you are listening.
- 3. Assist in relaxation** — if the person is able, engage him or her in relaxation exercises (i.e. deep breathing, thinking about a calm and peaceful place or person, concentrating on a good memory or experience, etc.)
- 4. Ending the restraint** — let the person know that the restraint will end when he or she begins to feel less angry or anxious; reiterate that you are there to help; ask the person what he or she would like to do once the restraint ends.

Restraints have many negative consequences that can be far-reaching and long-lasting for the person being restrained.

- Restraints can not only cause physical harm, but can also have damaging psychological effects.
- Restraints can also re-traumatize individuals by reminding them of past experiences, particularly when restraints were used inappropriately.
- Restraints can induce fear and powerlessness because a person's choice and control are lost.
- Restraints don't teach the person how to be in control of self.

Restraint use should be a last resort only. Once a restraint has been implemented, it may be difficult for caregivers to regain a person's trust or rebuild a feeling of safety in the home.

Practice — Signs of Escalating Behavior

Read the following scenario and think about the questions asked afterward.

Bob is a 22 year old man with Down Syndrome who packs envelopes at the workshop. He currently resides with two other young men, both of whom are in wheelchairs and have profound ID/A. Bob enjoys helping his housemates and taking them for evening walks around the block. He also enjoys listening to music, building model cars, and watching movies about racing.

Bob has a girlfriend named Kathryn. Lately, he’s been calling her several times a night, sometimes as late as 11:30 p.m. As a result, Kathryn’s mother called Bob’s caregivers and asked them to keep Bob from calling the house so frequently. Bob’s caregivers became upset upon hearing this, as he has been lying to them about the calls. Caregivers confronted Bob with this information and a yelling match ensued; caregivers eventually told Bob that he is not to call Kathryn again, and if he does he will have his phone privileges taken away.

When Bob was told not to call Kathryn anymore, he became extremely angry. He swore at his caregivers and began calling them terrible names. When caregivers responded by saying that his behavior would not change anything and that he could lose even more privileges, Bob threw a lamp to the floor and ran to his room, slamming his door. Caregivers instructed Bob to let them in and he refused. They used a master key to open his door, which upset Bob even more. This time he threatened to hurt himself and held a pencil to his neck; when caregivers moved in to grab the pencil, he punched one of the male caregivers in the face. Bob was restrained and held down for ten minutes while he struggled. Finally he got tired and promised his caregivers that he would be good – caregivers ended the restraint when they agreed that Bob was calm.

Question 1: What’s your impression of Bob in the first paragraph?

Practice — Signs of Escalating Behaviors

Question 2: As the story unfolded, what changes did you notice in Bob?

Question 3: Regarding Bob’s phone calls to his girlfriend, do you feel that you have enough information to really understand what was going on?

Practice — Signs of Escalating Behaviors

Question 4: What other information would you like to know about this situation?

Question 5: Do you think that this situation was handled properly? Why or why not?

Debriefing

Debriefing is any process that helps you to make use of personal experiences for your learning and development. This is a process to explore why something happened, how it happened, and what can be learned from it – in essence, it is a form of story telling. Debriefing is a formalized way to evaluate our interactions and relationships following a reportable event. This includes one’s own performance and actions or inactions of others just before, during and following an event. This process is a tool that can be used to do any and all of the following:

- Analyze a critical event
- Examine what occurred
- Reverse or minimize negative effects from an event
- Identify possible organizational issues (i.e. better ways to manage time, providing choices for individuals, recognizing needs for increased caregiver training)
- Facilitate an improved outcome in the future (better managing events or avoiding them)

When debriefing occurs, it is important to have as many members of the team present as possible. This includes those who may not have been present during the event as well as those who witnessed it or played a role in de-escalating. Remember to include:

- **Clinical staff** — doctors, nurses, psychologists, psychiatrists
- **Administrative staff (supervisors, managers)** — those who can make organizational changes if need be
- **Treatment team members** — direct support caregivers, behavior specialists
- **Participants (hands-on & witnesses)**
- **The Person** — should be invited and involved as appropriate; there may be times when a person is not able to talk about what happened (i.e. it was traumatizing or the person still feels upset about the situation); use judgment but remain respectful of the person’s experience and input

To debrief appropriately, the process should involve the following steps:

1. **Reflect on the experience** — ask “Who was there?”, “What events occurred directly before the event?”, “What occurred during the event?”, “What occurred afterwards?”

2. **Analyze the experience** — consider possible triggers of an event; ask “Who should have been present to help?” and “Who did not need to be present?”; think about what the person may have been trying to communicate through his or her actions – what needs or wants were not being met? What were you and others communicating to the person through your voice tone, body language, and actions?
3. **Make sense of the experience** — now is the time to put reflection and analysis together; create a story of what happened that includes the lead-up to the event, the event itself, and the aftermath; also include your best and most respectful guesses as to what the person in crisis was communicating during the event. Finally, think about how the person may have interpreted your actions, tone of voice, and body language.
4. **Communicate about the experience** — talk with others present in the debriefing process about your impressions and recollections of the event; include your own thoughts and feelings about what happened and how you responded, as well as your thoughts about how others responded. Remember to offer praise to others for what worked and to respectfully suggest other strategies if you believe that something could have been done differently.
5. **Learn from the experience** — as a team, review everything that you have come up with throughout the debriefing process. Think about what actions worked best, what did not seem to help, who should have been there, and how the person in crisis was communicating his or her needs and wants. Also consider what triggers may have contributed to the event, what circumstances surrounded the event, and whether it would be possible to either better manage or avoid those circumstances in the future.

In some instances, the person will be able to talk about what happened with the team. When this is the case, there is a helpful process called “The Life Space Interview (LSI)” that was developed by Fritz Redl, that the team can follow to help clarify the person’s perspective on events, as well as capturing possible triggers, unmet needs and unmet wants. The “I ESCAPE” acronym is a way to review this with a person.

- (I) Isolate** — Change the environment, reduce stimulation; having the person in a different area than where the crisis occurred can help him think more clearly and to remain calm when discussing what happened.
- (E) Explore** — Ask the person to talk about what she was feeling, thinking, and experiencing during the event. Pay attention to the responses and use them as guidelines to tailor your approach in the future.
- (S) Share** — Allow the person to talk about his feelings, then share your thoughts and feelings about what happened. Remember to do so respectfully – do not blame the person or tell the person “You are bad/wrong”, but instead say “When you did this, I felt scared and confused as to how to help you.”

- (C) Connect** — Put yourself in the person’s shoes. It may be helpful to say “That is how I would feel in that situation” as a way to validate the person’s experience and to create a bond with the person.
- (A) Alternative** — Ask the person to help with problem solving. Asking him “What do you think we should do when that happens?” is an effective way of generating new ideas and involving the person in the process.
- (P) Plan** — Ask for the person’s input in creating a plan to prevent future situations. It may even be helpful to role play with the person to practice better ways of handling a stressful scenario.
- (E) Enter** — Now is the time to ask the person if she is able to go back to the place where the event happened together with caregivers. As this is happening, caregivers should be talking with the person about the strategies that they came up with during this debriefing process. However, if the person is not comfortable returning to the setting or situation, caregivers should not force the issue.

Another helpful tool to use when debriefing with a person is a form that outlines the conversation caregivers and the person can have after an incident. This debriefing form, developed by Guy Legare and Supportive Concepts for Families, Inc., aids in capturing the person’s experience of the event (i.e. what he or she was feeling, thinking, doing and what needs/wants the person was trying to have met) as well as how the caregiver(s) experienced the event. In using the form, those involved sit down and talk about what happened and how they felt, then write down the responses of both the person and the caregivers. This creates a document of the event, but more importantly a document of how to help the person in the future. Capturing what the needs are of a person can help caregivers in recognizing how to be more helpful in the future – as well as how to avoid having a crisis situation happen again.

Caring for the Caregiver

Fear, frustration, anxiety, and even feelings of hopelessness and helplessness can make the job of providing care to others extremely difficult. Often, caregivers may feel overwhelmed and overburdened with their responsibilities, which can contribute to caregiver burnout and eventually caregiver turnover. To be effective for the people you serve, and to take better care of yourself, there are some tips that you can keep in mind to help improve your own coping skills.

- 1. Try not to take challenging behaviors personally.** Remember that this person is trying to communicate a want or need through the challenging behavior. It is not being done to frighten, annoy or insult you. The individual is doing his or her best to cope, and challenging behaviors occur in response to the person's unmet needs and wants. Being mindful of this fact can help reduce your own anxieties and maintain your professional composure.
- 2. Acknowledge what causes your own anxiety.** Think about how you can identify and address the things that cause you stress. Talk with your co-workers, friends, family or anyone that you feel comfortable with; rely on your social network to help you through tough situations. It is important to be proactive because anxiety left unattended will only continue to grow. Taking initiative in working on your anxiety will help to model better strategies for dealing with stress to the individuals in your care.
- 3. It is okay to ask for help.** People with ID/A sometimes require extra care and attention, adding to an already busy workload. Don't hesitate to ask for help when you need it and be willing to help others when asked. Take care of yourself so that you can provide the best quality of care.

Stress Reduction Tools

Breathing Exercises

Take five minutes to breathe deeply and slowly. Draw the air in through your nostrils and push it out through your mouth. It can be helpful to think about a person, place or thing that is calming or is something that you enjoy.

Take A Break

Take a short break whenever possible. Listen to music, read something interesting, watch a few minutes of a television program, take a short walk, or just spend a few minutes alone in some silence. Find ways in your work environment to make time for yourself – everyone needs breaks now and then. If need be, ask your co-workers to cover for you for a few minutes; but be willing to do the same for them as well.

The Stress Ball

Stress balls or other small items that can be carried around can be great sources of stress relief. They help to expend some of the mental and physical tension that may build up over the course of a day, and can help ease frustration and anxiety. Any item that you find relaxing will do; some people twirl pens or pencils, for instance, while others play with rubber bands. Find what works for you and use it.

Finally, don't be afraid to share these techniques with the people you work with. Just as you may feel stressed during a shift, they feel stress as well. Giving a person ways to let the steam off a little bit at a time is much better in the long run than having a situation where the lid blows off of the pressure cooker.

Conclusion

The strategies and tools included in this manual are not all inclusive. Caregivers and individuals are free to use these tools to brainstorm new ways of dealing with issues. The more creativity that caregivers and individuals are given in coming up with strategies, the greater the chance of those strategies being effective; remember that each person is an individual and will respond in unique ways to a variety of experiences, feelings, events, and situations.

Challenging behaviors are a method of communication, as is all behavior. These behaviors themselves are strategies that individuals use to meet their needs and wants in the best ways that they know; unfortunately, these ways are not always the most beneficial or healthy. The key to working with people who have any challenging behavior is to understand what that behavior means and what it communicates. To discover what a behavior means requires the care, attention, knowledge and skill of direct care professionals, psychologists, psychiatrists, nurses, family members and most importantly the individuals themselves.

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