Managing Agitation after Brain Injury

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Outline

• Describe Agitation – how it is defined, differentiated and measured
• Describe characteristics of Post-Traumatic Amnesia after TBI
• Describe how cognition is related to behavioral issues after brain injury
• Describe multiple behavioral tools to use in the care of brain injury patients with agitation.

Agitation: Definition

• “We suggest that post traumatic agitation be defined as a state of aggression during post-traumatic amnesia. This state occurs in the absence of other physical, medical or psychiatric causes. It can be manifested by intermittent or continuous verbal or physical behaviors....”
• -Lombard and Zafonte (2005)
Agitation: Definition

- Defined as “an excess of one or more behaviors that occurs during an altered state of consciousness” (Bogner & Corrigan, 1995)
- Can include:
  - Restlessness
  - Aggression
  - Disinhibition

Measuring Agitation

- The Agitated Behavior Scale (ABS)
- Corrigan, 1989
- 14 item scale
- Designed for serial assessment of behavior, validated for use with TBI patients.
- Can be completed by staff at the end of therapy sessions, nursing shifts etc.

ABS

- Each item describes a behavior, which is rated in the following way:
  1 = Absent (behavior not present)
  2 = Present to a slight degree (present but not interfering).
  3 = Present to a moderate degree (requires cues, but benefits from them).
  4 = Present to an extreme degree (does not benefit from cues or redirection).
Agitation and Brain Injury

Agitated Behavior Scale

1. Short attention span, easy distractibility and inability to concentrate
2. Impulsive, impatient, low tolerance for pain or frustration
3. Uncooperative, resistant to care, demanding
4. Violent and/or threatening violence toward people or property
5. Explosive and/or unpredictable anger
6. Rocking, rubbing, moaning or other self-stimulating behavior

ABS

• For clinical purposes, a Total Score of:
  - 21 or below = WNL
  - 22-28 = Mild agitation
  - 29-35 = Moderate agitation
  - Above 35 = Severe agitation
  (minimum = 14, maximum = 56)

ABS

• Serial scores are collected, allowing for monitoring of the progression of agitation over time.
• The Total Score + subscale scores for Disinhibition, Aggression, Lability
• The information staff provide is important and helps with the decisions that need to be made about the best way to manage the agitation.
Agitated Behavior Scale

7. Pulling at tubes, restraints
8. Wandering from treatment areas
9. Restlessness, pacing, excessive movement
10. Repetitive behaviors, motor and/or verbal
11. Rapid, loud or excessive talking
12. Sudden changes in mood
13. Easily initiated or excessive crying or laughter
14. Self-abusiveness, physical and/or verbal

Agitation after TBI: Who and Why?

• Incidence (depending on definition) ranges from 11% to 50%
• Difficult to predict who will become agitated after TBI
• Frontal and Temporal lobe injury, biochemistry (serotonin and dopamine) implicated
• Impacts rehab length of stay, discharge to community, decreased cognitive FIM at discharge

Rancho Los Amigos Levels of Cognitive Function

• I – No response
• II – Generalized response to stimulation
• III – Localized response to stimuli
• IV – Confused and agitated
• V – Confused and inappropriate (not agitated)
• VI – Confused and appropriate
• VII – Autonomic and appropriate
• VIII – Purposeful and appropriate
Post Traumatic Amnesia

- Patients who present with PTA:
  - Disoriented (Measured with GOAT, O-Log)
  - Usually won’t remember the injury/accident
  - Often may not remember hours/days before the accident/injury
  - Memory is not recording new information well
  - Likely not remembering from moment to moment

Let’s imagine that we are one of our most confused patients...

Agitation is Difficult

- Stress
  - Families
  - Individual staff members
  - Team
- Fatigue and Burnout
  - Prevention
  - Support
Before Medicating...

- Agitation versus “restlessness” (Akathisia)
- What is the specific unwanted behavior and is it impacting care...if so, how?
- Concern for staff and patient safety vs convenience

Differential Diagnosis

- Other Medical Issues
- Medication reaction/withdrawal
- Seizure
- Infection
- Sundowning (dementia)
- Pain
- Psychosis or Mood disorder

How Agitation is “Treated”

Less Restrictive
- Musical Seat Belts
- Partial Side Rails
- Bed Exit Alarms
- Abdominal binder

More Restrictive
- Medications
- One to One Supervision
- Restraints:
  - Hand Mitts
  - Enclosure Beds
  - Side Rails (full)
  - Rear Fastening Seat Belts
All of these methods are helpful and necessary at times, but...

Are there OTHER Ways to “Treat” Agitation?

- YES!!!
- The main goal of this presentation is to provide you with some ideas and tools to:
  - Minimize the likelihood of agitated behaviors (to the degree that this is possible)
  - Manage behavioral issues as effectively as possible when they do occur
  - Educate other team members and build team consensus

Possible Causes of Behaviors...

- Post traumatic amnesia as a result of a TBI
- Cognitive impairments related to stroke, MS, Parkinson’s etc
- Delirium following surgery/due to illness
- Dementia
- Limited awareness
- Adjustment to disability (emotional)
ABCs of Behavioral Analysis

- For behavioral problems, the classic way to analyze behaviors is the “ABC” method:
  - Antecedent
  - Behavior (positive and/or negative)
  - Consequence

ABCs

- Can’t control the behavior
- Can only influence the behavior
  - Changing/altering the conditions of the antecedents
  - Changing/altering the consequences
- Think both ways:
  - Promoting positive behaviors
  - Decreasing negative behaviors

“Behavior Management” is...

- Based on the ABC Model
- Working to decrease negative/unwanted behaviors
- Aiming to promote positive behaviors

• What strategies can we use to achieve this?
Strategies to Promote Positive Behaviors

- “Brain Injury 101”
  - Environmental Considerations
  - Interpersonal Considerations
- More Advanced
  - Individualized Behavior Plans
  - Behavior Tracking (ABS, Logs)
- Agitation/Agitation Crisis
- Managing other behaviors typical after BI

Environmental Considerations

- Promote a “Low Stimulation” Environment
  - Lighting
  - Sounds
  - Number of people
  - Distractions (cell phones, TVs)

- Increasing physical safety
  - Move potentially harmful objects
  - Add cues (alarms)
  - Secure unit, wander alerts
  - “Reminder” signs
Environmental Considerations

- Provide cues for orientation
  - Clocks
  - Calendars
  - Planners
- Provide a structured daily routine
  - Consistent staff
  - Consistent schedule
  - Written schedule
  - Repetition is key!

Interpersonal Interactions

- Introduce, reintroduce every time
- Get the person's attention before speaking
- Avoid startling or surprising (neglect!)
- Be reassuring, but gentle
- Speak slowly, clearly, and softly
- Keep directions/education brief and simple, while still treating patient as an adult
- One person talks to the patient at a time

Interpersonal Awareness

- While interacting with the person, think about the effects your behaviors may have on them:
  - Drinking/eating or talking about it in front of a patient who is NPO
  - Coming in from a smoke break
  - Talking on a cell phone, watching TV, talking over an individual who has difficulty with overstimulation.
Behavior Plan: Definition

• Targets a few problematic behaviors as defined by the team

• Looks for adjusting the antecedents or consequences to change a behavior

• Written down or discussed formally to gain team consensus and support

Behavior Plans: When?

• Patient is in danger of causing harm to themselves or others

• When behaviors are interfering with the patient’s ability to participate

• When behaviors are socially unacceptable and make others uncomfortable

Behavior Plans

• A single episode of a problematic behavior does not necessarily suggest the need for a plan

• On the other hand, ignoring a problematic behavior for too long may make it more difficult to extinguish
Once a Behavior Plan is Implemented...

A CONSISTENT TEAM APPROACH IS THE ONLY WAY THE PLAN WILL WORK
This means that all staff members who interact with the patient must follow the plan and do/say the same things

Behavior Plans
- Progressive with recovery or improvements
- Just like any part of getting better or rehabilitation
- Increase the patient’s independence and level of responsibility as they are able to participate
Behavior Tracking

• Important at many levels
  – Can track to see if a behavior plan is working
  – Can track to see if medications are working
  – Can track to see if there are any patterns in when agitation occurs (i.e., time of day, particular therapy)
• Agitated Behavior Scale
• Behavior Tracking Logs

IT IS CRITICAL TO BE AWARE OF A PERSON’S COGNITIVE STATUS WHEN EVALUATING AND TREATING BEHAVIORAL ISSUES.

Behavior and Cognition

• A person’s responsibility for their behavior depends on cognitive status
• With changes in cognition, the types of behavior problems change
• Need to alter how behavior is managed depending on a patient’s cognition/level of awareness
Low Level
- Lower Levels of Cognitive Functioning
- Severe Impairments
- May need to manage problematic behaviors by using:
  - Restraints
  - Environment Manipulation
  - Pharmacological Intervention

Mid Level
- Mid Levels of Cognitive Functioning
- May use the following techniques:
  - Feedback (positive vs negative vs urgent)
  - Gestures
  - Redirection or Substitution
  - Simple explanations
  - Frequent repetition

Higher Levels
- Higher Levels of Cognitive Functioning
  - Negotiating
  - Oral agreements and contracts
  - Negative feedback
  - Self management
  - Explanations of long term consequences
Managing Agitation

- Consider time of day, pain, fatigue
- Consider using:
  - Frequent breaks
  - Flexible treatment sessions
  - Behavioral rest breaks
- Permit moving as much as possible
- Be aware of building agitation
- Alternating tasks/environment/auditory or visual stimuli

Agitation Crisis

- Don’t take it personally
- Remain calm in your physical and verbal interactions
- Avoid using logic/guilt/demands/arguments
- If an obvious stimulus present, remove it if possible
- Think in terms of influencing rather than controlling
- Implement the environmental strategies
- Get back up, but don’t overwhelm the person
  - Give brief instructions/directions
  - One person talk at a time
  - Maintain awareness of patient and staff safety

Other Common Issues after TBI

- Non-Compliance/Resistance
- Perseveration
- Confabulation
- Disinhibition
- Lack of Awareness of Impairments
- Impulsivity
Non-Compliance/Resistance

• Provide choices between 2 acceptable options
• Provide positive feedback wherever possible
• Break tasks down into simple steps
• Try to determine what is being refused and why
• Redirect to alternative tasks
• Explain task concretely prior to starting

Perseveration

• Pace interactions to allow disengagement from one stimulus before going on to the next
• Highly structured environment and constant cues for the task at hand
• Use redirection and substitution
• Avoid trying to use logic

Confabulation

• Lower Level Cognition
  – May need to ignore it and not challenge, especially when the patient is agitated as well
• Higher Levels of Cognition
  – Provide non-threatening feedback regarding the inaccurate statements
  – Redirect to another task
Disinhibition

- Commonly presents as sexual inappropriateness
- Don’t reward with negative attention (emotional responses)
- Don’t ignore or indicate that it is humorous
- Provide Feedback:
  - Immediate, Unemotional, Straightforward
- Staff need to be consistent in responding

Lack of Awareness of Impairments

- Can put patients at risk for safety
  - Confront in a direct but sensitive manner
  - Provide consistent and simple explanations
- If it is not putting the patient at risk
  - Address gently
  - Avoid arguing
- Maintain the patient’s dignity and avoid embarrassing them

Impulsivity

- Lack of planning, poor safety awareness
- Safety is the #1 priority!
- Prepare the environment safely before giving the patient the command
- Break down tasks into steps and give instructions for one step at a time
- As the patient improves, give them more responsibility for creating and following steps
Professional Relationships

• A Note...
  – Individuals with cognitive disability are vulnerable due to their limitations
  – May misread social interactions
  – Staff needs to maintain a professional relationship at all times

Key Points

• Be aware of the cognitive status of the patient
• Be aware of environmental factors
• Be aware of your verbal and non-verbal interactions with the patient
• Avoid power struggles (Influencing vs. Controlling)
• Always treat the patient with dignity and respect