WORKING WITH DIFFICULT & COMBATIVE RESIDENTS

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Let’s first focus on DIFFICULT, then COMBATIVE.
   A. Focus on and think about the resident from h____. What is it about this resident that gets to you? Understanding your reaction can be very helpful and empowering.

Qualities of My Most Difficult Resident that Make Him/Her Really Difficult
1. 
2. 
3. 
4. 

B. Image approaching this resident. What are you feeling? Thinking? Wanting to do?

The Human Brain
1. Core (Fight; Flight) [As Archie Bunker said, “I resemble that remark.”]
2. Cognitive functioning (executive functioning; judgment; orientation)
3. The anxious or angry brain
4. Affective Disorder
5. Alcohol abuse in a controlled environment (low frustration tolerance)
6. Personality Disorder (borderline; narcissistic; oppositional defiant)
7. Adjustment Disorder (“My kids put me in here. I don’t want to be here.”)
8. Introverted
9. Abuse survivor
10. Other (Please specify).

BOUNDARIES
Bears, bunnies and bears who look like bunnies
Work from outside physical sphere of aggression (alongside rather than in front)
Ask for permission first
Acceptance of the client feeling and thinking what they feel and think
Attend to and validate resident’s messages; “I hear you”
Read and respond to signals building toward aggressive behavior (distance regulation)
Remain calm; non-anxious presence (Pushing your buttons)

Human Communication (Albert Mehrabian)
What you say = 7%
How you say it = 38%
Nonverbal = 55%
Approach (the 3 most important considerations)
One foot in and one foot out
Personal connection with professionalism
“Whatever the problem, differentiation is the solution.” (Murray Bowen)
On the Same Side If Possible; If Not, Being a Worthy Opponent

Importance of Relationships
Empathy
Warmth
Genuineness

Realistic Expectations
- Manage the behavior; expecting to fix the resident or get rid of the behavior may lead to increased staff frustration
- How can we manage it better? Focus treatment plan to manage the problem behavior
- You may do state-of-the-art care management and the resident may still strike out, just as a top shelf medical doctor may treat a medical condition with appropriate medication or surgery and the patient still dies
- We have control over our efforts but not over the outcome

ABC Model of Behavioral Intervention
Antecedent or Activator
- Triggers that occurred before or even caused the event; the behavioral event is most often in context (i.e., there is an antecedent or activator)
- Might include an event that tests the individual’s underlying coping skills, thereby resulting in response of anger, fear, insecurity, confusion, misinterpretation, etc.
- Frequently the behavioral event is triggered by environmental factor(s) that could be manipulated in the future.
- Environmental/contextual triggers may include various factors such as the area of the building, the caregiver(s), the noise, the ambience the music, the presence of a particular resident, the time of day, etc.
- There is often a pattern of the triggering events, and a pattern of behavior ensues

Behavior
- Any behavioral episode that is disruptive, adverse or jeopardizes the safety of the resident, other persons or objects in the environment

Consequence
- What follows when behavior occurs
- Often influences chances of repeated behavioral occurrences
- May vary with different caregivers
- Consistency is very important due to the power of intermittent reinforcement
- Consequence may be positive reinforcers---receiving a dose of lorazepam, taking a trip to the hospital, avoiding a bath; or frustrating a particular nurse.
THINKING ABOUT AND RESPONDING TO THE DIFFICULT RESIDENT

- The resident is doing the best they can.
- This is not about me. It’s not personal.
- Search for the resident’s need or want; what is the function of the behavior?
- Lamb; part-time polar bear; certified polar bear
- Imagery
  A. Water off a duck, personal armor, invisible protective shield, resident at some distance
  B. Recognizing the resident’s behavior as theirs. “I don’t know what that is, but I know it’s negative and it’s not mine, so I’m just going to let it be there.”
  C. Maintaining your primary focus on yourself, your sphere, what you are doing

- APPROACH; APPROACH; APPROACH
  - Remain calm; use soothing self-talk: “I need to be calm.”
  - Take a deep breath
  - Go slow
  - Make a genuine effort to connect before administering care
- Search for ways to help with calming, soothing, redirecting
- Soothing self talk: “I need to be calm.”
- Speak slowly in calm tone
- Pace, pace, pace, then lead. If resident does not follow, then pace, pace, pace.
- Attentive and responsive: Listen, conveying understanding and acceptance of resident’s feelings; “I hear that you’re really upset, (name of resident). Is frustrated a good word for how you’re feeling right now, Tom?”
- Stay in your professional role.
- If it does get inside you, stay focused, take a deep breath & let it out slowly (literally & figuratively)
- Maintain connection with resident and aspire to respond with warmth—“Oh my”
- If refusing or oppositional, back off and reapproach later
- Document in chart including relevant specifics, writing in clear, descriptive terms with quotes of resident and your response.
- Consult with supervisor.
- Participate in FLUP care planning.

THE COMBATIVE RESIDENT

Factors Associated with Combativeness

- Dementia
  - Receptive and/or expressive deficits
  - Response to confusion and sense of threat
  - Indirect expression of unmet need(s)
- Escalated emotional response
  - Not feeling heard and understood
  - Frustration: wanting to leave, establish distance, be in control, etc.
  - “I want what I want, and I want it when I want it.”
- Reaction to powerlessness
Reducing the Likelihood
A. Identify contextual triggers (time, place, with whom)
B. Understand resident’s internal contributing factors and motivation
C. Identify pattern of aggressive behavior (swinging, punching, kicking, punching)
D. Gather input, discuss and develop care plan.
  ● Staff are bright and creative. In addition to having good ideas, they’ll also be more invested in following the care plan if their ideas are invited and given consideration for inclusion in the care plan.
  ● Think creatively. What will preclude the aggressive response? For example, resident can’t punch if holding something soft, can’t kick you if you’re not in their kicking sphere, and can’t punch if you’re alongside them. If triggered by having full bath, use Golden Gate Bridge approach. If triggered by presence of another resident in commons area, consider ways to avoid this occurring.
  ● Identify signals that aggressive behavior is ahead (resident gets louder, starts to clench fist, etc.) A→B→C→Aggressive behavior
  ● Consider working from outside the sphere of physical impact
  ● Practice response to initiation of aggression, so as to be ready if unable to retreat

Working with the Resident
A. At this moment, is resident a bunny, part-time polar bear or polar bear?
B. “Killing me softly with your love” (what you do and how you do it)
C. Calm, grounded and connecting with genuine care
D. Reading and responding to the feedback
E. Safety first; retreat and seek assistance as needed
F. Continuous improvement; Vince Lombardi about “losing”

Here’s an example of non-contingent reinforcement for escape-maintained aggression in a person with dementia, in case it's helpful. Good luck.