

How to Create a Behavioral Plan in a Medical Setting

Conflict of Interest: The author had no conflict of interest to disclose

Learning Objectives:

- 1) Identify clinical situations in which behavioral plans are beneficial.
- 2) Identify drivers of patient behaviors in medical settings that disrupt care and behavioral strategies to minimize these drivers.
- 3) Identify common behaviors in medical settings that occur with patients with personality disorders and strategies for managing through behavioral plans.
- 4) List the necessary steps to develop and implement a behavioral plan.

Step 1: Recognize clinical situations in which a behavioral plan may be useful

- Agitated, aggressive, or verbally abusive patients.
- Family or visitors who interfere with patient care, are threatening, or excessively demanding of staff.
- Patients who are excessively dependent and make frequent, often non-urgent, requests of staff
- Patients who are willfully noncompliant with care (e.g., eloping from the medical unit)
- Patients with inappropriate boundaries with staff (e.g., sexual behaviors or comments, splitting).
- Surreptitious behaviors such as substance use, self-harming behaviors, or manipulation of medical equipment or wound dressings.
- Patients demonstrating problems in relating to the primary team or cooperating with care, creating conflicts that arise out of disordered personality.

Step 2: Examine the problematic behaviors and identify the causes and functions (benefits to the patient) of these behaviors in the medical setting

- Gather data. Interview the patient, staff, and family when appropriate and review the medical record. Outpatient mental health providers and caregivers can provide important context. Nursing staff may have observations about behaviors that are not documented in the medical record. Information about behaviors should include:
 - Timing, frequency, duration, and triggers of unwanted behaviors
 - Interpersonal factors (e.g., particular staff who may be involved)
 - Consequences to patient care or to staff of unwanted behaviors
 - Descriptions of altered sensorium or cognitive problems witnessed
 - Results of objective measures or screening tools that might be used to assess cognition or behavior, such as substance withdrawal screening tools, CAM-ICU, Agitated Behavior Scale, or Overt Behavior Scale
 - Staff response to unwanted behaviors
- Consider the function for the patient (or family) of engaging in the disruptive behavior, whether conscious or unconscious. Potential functions include:

- Attention-seeking
- Improve social connection.
- Increase stimulation in a boring environment or decrease stimulation in a confusing environment.
- Calming (to reduce anxiety and arousal).
- Escape or avoid an interaction they don't like.
- Autonomy or power struggle (to assert themselves when feeling powerless, helpless, scared, confused, or belittled).
- **Investigate possible contributors to the unwanted behavior:**
 - Patient factors:
 - Cognitive impairment
 - Psychiatric disorder
 - Physical distress (discomfort or pain, exhaustion, hunger, constipation, etc.)
 - Fear about medical condition and/or impact on wellbeing
 - Adaptation to patient role
 - Staff behaviors or characteristics that trigger or reinforce behaviors:
 - Demographic characteristics (gender, race, ethnicity) to which patient responds negatively.
 - Frustration or irritation demonstrated with roughness in demeanor, voice, or handling of patient.
 - Use of medical jargon or speaking too quickly for patient to understand.
 - Medical staff team surround the bedside, making patient feel overwhelmed or confused.
 - Environmental factors:
 - Frequent turnover of team members or poor communication between team members leading to poor knowledge of patient care
 - Noise and stimulation of care setting
 - Lack of privacy
 - Rigidity of expectations for patient activities in care environment and limits on behavioral freedoms.

Step 3: Evaluate for maladaptive personality traits or personality disorder disrupting care

- Care settings can be destabilizing since they require patients to cooperate with many different care providers and adapt to the patient role even while experiencing physical and emotional discomfort. Patients with personality disorders are likely to tolerate these expectations poorly and this often leads to conflict.
- Personality disorders are divided into 3 clusters. Patients in each cluster show common behavior patterns in medical settings. See Table 1 for examples of behaviors and proposed staff responses.
- Check the medical and nursing staff's emotional response to competence with caring for a patient with a personality disorder

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- Help the staff recognize that the behaviors are related to a personality disorder, which is a psychiatric illness, and part of the patient’s longstanding defensive strategy for managing a chaotic or frightening internal emotional state.
- Emotional responses may differ between staff and can include overinvolvement, withdrawal, hostility, or anger.
- Validate team’s emotional responses and offer support without encouraging acting on countertransference feelings. Recognize that such patients can be deliberately provocative and that they expect to elicit a defensive response from others. An empathic response from staff can de-escalate these patient behaviors.

Step 4: Identify strategies to intervene with the patient, staff, or environment to modify drivers of problematic behaviors

- Develop interventions that specifically address the underlying driver or function of the behavior. See Table 2 for details.
- Interventions should be:
 - **Practical:** can be implemented by staff without requiring a high degree of psychological sophistication and within the limitations of the environment and staffing levels.
 - **Ethical:** see <https://www.practicalbioethics.org/files/guidelines/15-Difficult-Relationshipsweb-2008.pdf> for ethical guidance in interactions with patients who have difficult behaviors in medical settings.
 - **Time-limited:** expected to produce results within the time frame of the patient’s need for care.
- The medical team, nursing staff and management should contribute to the behavioral plan. Input from the patient may be solicited when they can recognize and reflect on the problem behaviors, can offer input into drivers, and can accept help in modifying behaviors without relying entirely on externalization. Outpatient and other staff affected by the problem behaviors or familiar with the patient may also be solicited.

Table 1. Behavioral interventions and responses to patients with personality disorders

Personality disorder cluster	Types of behavior	Advised Staff Response	Psychiatric Consultant Role
Paranoid, Schizoid, and Schizotypal	Paranoid concerns, mistrust of medical team’s intentions, refusal to accept proposed treatments.	Ignore behaviors that don’t interfere with care.	Evaluate for capacity if there are concerns about decision-making.
		Caring and concern best expressed by conveying recommendations and medical information supporting treatment, rather than with an overly warm or emotional style.	
		Overtly express respect for patient’s autonomy, seek patient’s input in problem solving.	
Antisocial, Borderline, Histrionic,	Insulting staff, splitting staff, overreactions when disagreements or	Reinforce desired behaviors and ignore some negative ones.	Check team’s emotional response. Help manage countertransference and limit acting on negative emotions.
		If patient is threatening or insulting, label the behavior (not the person) and	

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and Narcissistic	limits set, refusal to work with some staff, help-rejecting behaviors.	ask patient to stop. Thank patient and offer to help if behavior is changed.	Offer support to team members. Model neutral affect in communication style and empathic listening. Consider which boundaries and rules are primary and which can be flexed. Help patient with skill building.
		Withdraw social contact if patient escalates, specifying when staff member will return. Re-engage when patient is calm.	
Avoidant, Dependent, or Obsessive-Compulsive	Constant requests for interactions and help. Anxious about their medical condition but help-rejecting.	Arrange regular, frequent schedule for brief staff interaction that is not dependent on patient asking for it. Encourage patient to bundle their requests. Increase social interaction across nursing shifts.	Identify and treat co-occurring anxiety symptoms. Help patient identify coping strategies for managing uncertainty and fears.
	Obsessive requests for information and clarification or correction of minor details. Focused on details.	Set limits on number of requests for interactions but identify planned daily time when requests can be discussed. Specify how much time will be spent during interaction.	Can serve as liaison to team to collect requests for information or clarify medical information to patient.

Table 2. Behavioral interventions to address problem behaviors

Driver of behavior	Sample interventions
Attention-seeking	Brief removal of patient from environment when behavior is exhibited.
	Ignore unwanted behavior to withdraw reinforcement (negative attention).
	Reinforce desired behavior with small rewards and attention.
	Caregiver leaves briefly in response to abusive behavior to diminish reinforcement, announces they will return in a few minutes when they expect patient to change the abusive behavior. Provide specific example of behavior they expect to see.
	Help patient identify alternative words to use that are socially appropriate
Stimulation or anxiety	Address boredom, provide alternative activities, provide comforting objects to hold, listen to music
	Provide behavioral substitutes that are less disruptive (e.g., objects that can be rubbed or touched, headphones for music) or settings that are more appropriate (e.g., for masturbation, ensure a private location if possible).
	Provide regular physical exercise.
	Provide safety barriers or environmental changes to minimize risk to patients who wander.
Escape or avoidance	Caregiver pauses the interaction patient is avoiding, but states that they will return in a certain time to continue.
	Distract agitated patient with pleasant reminders to allow resistance to pass before reattempting.
Autonomy or power struggle	Offer patient choices when feasible to complete the resisted activity (e.g., “Would you like to have the dressing changed before lunch, or after lunch today?”)
	Break up resisted tasks into smaller ones.
Confusion	Modify environment to decrease disorientation (labeling places, objects, patient’s room, provider calendar, etc.)
	Improve day-night cycling. Reset body clock, set bedtime at sundown, out of bed during the day.

Step 5: Communicate and disseminate a behavioral plan

- Choose your audience and means of dissemination.
 - A written behavioral plan in the medical record may be appropriate to ensure that the plan is distributed to all pertinent staff and is implemented consistently.
 - Verbally communicated behavioral plans are appropriate when the plan's goal is to manage staff emotional reactions when a written plan would potentially stigmatize the patient.
 - A written behavioral plan could be limited to recommended staff responses for specific behaviors that do not carry an implied stigma; e.g., requests by patient to go outside or a script for staff to use in response to patient using abusive language.
- A written behavioral plan should include the following elements:
 - Description of behaviors that are causing problems, with pertinent descriptive details (contributing circumstances, timing of events, etc. that may provide context for implementation of behavioral plan).
 - Brief discussion of factors felt to contribute to behaviors (if appropriate) to provide rationale for behavioral interventions.
 - Delineation of any rules or expectations of patient that staff feel patient is capable of abiding by or understanding.
 - Outline of recommended staff response options to various patient behaviors that are disruptive or maladaptive.
 - Expected patient behavioral goals after implementation. Include outcome measures if possible.
 - Plan for evaluation and modification of behavioral plan, with time frames set to evaluate success of plan and anticipated behavioral changes.
 - Discussion of the elements of the behavioral plan that are communicated to the patient (if any) and who communicates this to patient.

Step 6: Evaluate the effectiveness of the behavioral intervention and modify the intervention as needed

- Set a timeline for re-evaluating the intervention. Some unwanted behaviors may initially increase after implementing behavior plan, but with time and consistency it will have desired effect.
- Develop a plan to address barriers to implementation or modify behavioral plan to accommodate barriers which cannot be changed.
- Set reasonable expectations about timelines for behavioral change in patients and evaluate when expectations for patient behaviors may be unrealistic, e.g., patient's cognitive impairment may be more significant than presumed.

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