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THE DYNAMICS IN JOHN'S TEAM

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THE PROBLEM

John is 44-year-old man with a severe intellectual disability. His biological parents were not able to meet his needs with any sensitivity and he is institutionalised when he is nine months old.

At the age of four, John is sent to live in a foster home. John develops, but after a change in his day care, he exhibits serious self-injurious behaviour. John can no longer be cared for at home and is once more institutionalised. His foster parents remain an important stable factor in his life.

When John is five, a psychiatrist diagnoses John with having been subjected to emotional neglect during the first years of his life, and that he is therefore exhibiting signs of depression. He is only capable of tolerating very basic kinds of human touch. As soon as it stops, or attention must be shared with others, he begins self-injurious behaviour by banging his head against the wall. As a result, John has gradually lost his sight in one eye and his vision in the other is extremely poor.

John displays self-injurious behaviour almost all day, every day. He hits himself and bangs his head on the corners of doors until it bleeds. He also regularly grabs carers and kicks them when they stand in front of him.

Carers often find it hard to understand this behaviour. Some believe that he is experiencing stress and is trying to communicate that, others believe that he simply wants to have his own way or wants to hurt them.

There are also differences of opinion in the team regarding the level of John's functioning. But it is difficult to discuss this because the disparity of

insight is so great, and emotions are running so high that his carers are no longer open to hearing their colleagues' opinions.

John's self-injurious behaviour and his resulting injuries are harrowing for his carers. They try to prevent them by holding him tightly or taking him out of situations in which he exhibits the behaviour. Even though carers are often in his close proximity, this doesn't seem to relax him at all. Ultimately, John just doesn't take participate in many activities anymore.

The team becomes overburdened, feels powerless, and their cooperation and collaboration come to a screeching halt. In this case study, we will be focusing primarily on team dynamics.

IDIOGRAPHIC THEORY

John has attachment issues. His biological parents were not able to meet his needs; and unfortunately, despite their enormous efforts and dedication, neither were his foster parents. At a very young age, John was shuffled between many different carers and guardians. He was unable to develop basic security and basic trust.

John's attachment issues are evident in that you see him needing intimacy and closeness, but when he gets it, he cannot deal with it. When carers get close, whether physically or because they want to be emotionally sensitive to his needs, he pushes them away by kicking, pinching, or hitting. The carers then of course distance themselves from John. But that is also hard for him, because due to his emotional development, he really does need closeness. When carers distance themselves from him, he feels alone and unsafe. John then tries to attract the carers' attention, unfortunately often through negative behaviour such as screaming, or hurting himself. The carers do then indeed hasten to John's side. But of course that means they get close to him... too close! And so we have a vicious cycle of attraction and rejection: a classic dynamic with attachment issues.

This dynamic has been a recurring topic in Cased-Based Learning. I will therefore focus on the care team's role in this case study.

John's behaviour is interpreted differently by different members of his team. There is no consensus that John's negative behaviour is a cry for more intimacy. Some carers believe that he is manipulating them, that he is consciously choosing this behaviour to get his way and to force carers into dancing attendance on him. They respond by calling him out for his behaviour.

Other carers believe the negative behaviour is due to John's stress at not being able to understand the world and feeling unsafe. These carers often offer John intimacy and closeness and try to move in tandem with him.

The difference of opinion within the team results in different ways of approaching and dealing with John. And this then results in unpredictability for him. "Will they call me out for my behaviour and reject me? Or will they be understanding and provide security and closeness?" This unpredictability in how carers respond to John leads to an even greater lack of understanding and feeling of insecurity on John's part, resulting in even more stress.

The differing interpretations within the team play a role in another situation. In addition to his attachment issues, John has a severe intellectual disability. His cognitive age is estimated to be at around two years old. However, some of the carers are convinced that the level of his cognitive functioning is actually higher. Like a two-year-old, John often throws his drinking cup on the ground and then smiles at his carer. This can mark the start of the game 'I toss, you scurry'. But some carers react as if John is doing it to purposely challenge them, although his low cognitive level in fact precludes this. And because they call him out on this supposed challenge anyway, John is becoming overburdened.

There is disagreement within the team about what John can and cannot understand, and team members call one another out when they don't agree with the other's approach.

By assuming that John has insight into his own behaviour, his abilities are overestimated, and he is then overburdened. He doesn't understand what is being asked of him, but he does feel the negative tone in which he is addressed. This increases his stress and thus the self-injurious behaviour.

The self-injurious behaviour as well as differing interpretations trigger strong emotional reactions in the team. Some feel powerless because they don't know how to deal with John or how to prevent his self-injurious behaviour. Everything they try only seems to exacerbate the issue, so they are inclined to have less and less to do with John.

But with other carers, the situation leads to frustration. They try to keep activities going but feel as if they are being sabotaged because not everyone is willing to participate in these attempts. To their minds, John is regressing in what he is able to do and achieve.

Due to these differences in opinions, care approaches, and the strong emotions they elicit, the team can no longer exchange thoughts and ideas in a constructive way. Powerlessness and frustration are paving the way for reproaches and misunderstandings.

The self-injurious behaviour happens multiple times a day, and some days there are almost no moments in which John is relaxed. The team is seriously worried about John's injuries: the open wounds on his head, and the one eye in which he still has some sight. To prevent further injury, they immobilise him by holding his hands, or throwing an arm around his shoulder, and holding his arms during walks outside. But because they are immobilising John so often and in so many ways, they themselves are becoming physically overburdened. Some carers are developing back problems.

The immobilisation also results in some carers being less available to follow the facility's daily programme. Depending on John's mood, they decide whether an activity will proceed or not. Activities for which John needs to be transported by bus are the first to go because of the dangerous situations which could occur during travel. There is a sharp decline in the number of activities in which John participates. This has had an impact on the team. They are sorely grieved by this decrease in his quality of life.

The team's concerns about John's self-injurious behaviour contribute to the feelings of powerlessness on the one hand, because the daily programme is shrinking, and people don't know how to deal with this. And on the other hand, it also contributes to the frustration felt by those who want the daily programme to proceed regardless but are increasingly thwarted by John and by their colleagues.

All these aspects have a negative effect on the team's dynamics. The dynamics are partly responsible for creating the problem, but more importantly, they stand in the way of any solution.

INTERVENTIONS

RET EXERCISE

The team has come to a standstill in John's care and team members can no longer communicate with one another in a constructive way.

Working with the team's manager, I did an RET exercise with the team. RET stands for Rational Emotive Therapy. The basic premise is that it isn't the problems which are causing distress, but the way we see them. The goal is to transform the carers' obstructive thoughts about the problems with John into more positive and helpful ones.

The exercise consists of every team member describing a situation and indicating what his or her obstructive thoughts might be. For example:

'John has it in for me and that's why he scratches me when I'm helping him eat dinner.' After describing a situation and discussing the possible obstructive thoughts with one another, these thoughts are consciously transformed into positive, helpful thoughts. In the example, that might be: 'John seeks out my company and takes my arm because he needs me. He scratches me by accident.' This is first discussed in pairs, and later in the group as a whole.

It is difficult to formulate truly helpful thoughts because the team members keep focussing on what *isn't* working. During the group session, it emerges that every pair discussed the exact same situation: reaching their breaking point after a long day of preventing self-injurious behaviour and getting pinched and hit as a result. Everybody has trouble keeping calm and being patient when that happens. The helpful thoughts formulated for this situation are: 'He's not doing this on purpose, he doesn't understand the situation, he is afraid, he needs me more than ever right now.'

But what really helps is seeing that every single carer has been having the same experiences. The team just didn't know about this. Now that it is common knowledge, a new feeling of solidarity prevails.

During next month's meeting, it becomes apparent that carers are better able to recognise their breaking points and realise that John's behaviour is not aimed at them personally. They are able to find ways to create a little distance for themselves at an earlier stage. There is now a sense of mutual validation and support in the team.

DREAMS FOR JOHN

John's carers have trouble focussing on what *is* going well and what a future perspective for John might be. This is why I posed a few questions to the team. The goal is to show the team that there are still positive

moments, not only during care, but in John's life as well, and that they can contribute to them.

The questions the team must answer are:

- What are John's talents, strengths, and positive traits?
- What are his dreams and aspirations? Or, if that is too difficult to answer: what dreams and aspirations do you think John might have?
- What is going well in John's care and what is your role in that?

The quest to find John's talents and dreams provides clarity about what John needs from his carers. It also provides concrete, practical ideas for activities and disability tools in his physical environment. For example, one carer had the great idea that John might be able to relax by using a hammock in the garden.

By focussing on what is going well in John's care, the team were once more able to see the positive moments and to access their own calm, patience, humour, and creativity. This renewed their energy when working with John.

A side effect is that they also gained renewed faith in their own skills and felt less dependent on the approval of their colleagues and the education specialist.

ADJUSTING THE DAILY PROGRAMME

In accordance with the last intervention, the team adjusted John's daily programme and presented their suggestions to the education specialist. There is more emphasis on experiential activities and time is also scheduled for John to listen to music in his room to relax. John himself can indicate when he would like company when doing so. If not, the carers have time to relax themselves, and then re-engage with renewed energy. Tension and stress levels are going down for both John and the team.

EMOTIONAL AGE AND ATTACHMENT

We wanted to take advantage of the decrease in tension and stress to perform other interventions, focussing on John's emotional age and his attachment issues. To gain more insight, I used the Scale of Emotional Development colour chart with the team and with John's foster parents. Using this scale, we were able to map out John's emotional development.

Working with the CCE, we gave a clinical lesson on attachment and the circle of security. It is beyond the scope of this case study to detail the full contents. But one thing I'd like to mention is that thanks to this class, four of John's carers not only learned how to take better care of him, but they also learned how to coach their colleagues to do so.

This coach-the-coach plan was chosen based on the idea that the team would then independently continue to become increasingly more skilled in observing and working using attachment theory and the circle of security. This will also better anchor the transfer of expertise to new team members. The team is then no longer dependent on outside resources.

RESULTS:

Although most of the interventions focussed on the team, they did in fact lead to positive results for John. His self-injurious behaviour has not completely stopped, but it has diminished in intensity and frequency.

Moreover, John kicks, hits, and scratches his carers much less often. This means that he is no longer restrained as much and can take part in more activities.

Carers have noticed that there are more moments that John seems able to relax. They know this because he no longer clenches his hands into fists, and he lies quietly during therapeutic horse carriage rides and sensory stimulation session.

Carers are better able to meet John at his own level. They also recognise his signals when he needs them. When he wants closeness, he makes eye contact, grabs their hand, or goes looking for them when they've left his immediate vicinity. But even when he doesn't need their proximity, he does need his carers to provide structure. Carers are now able to be flexible and adapt to John's fluctuating needs. This means he has lower stress and exhibits less self-injurious behaviour.

But when there is a lack of clarity, unexpected changes, or substitute carers, however, the challenging behaviour re-emerges.

LESSONS LEARNED

I personally have learned that it is impossible to coach or to provide professional recommendations to a team of carers when there is no openness or trust, be it in me or amongst themselves. Openness and trust are absolute prerequisites for a good standard of care and must be addressed before any attention can be given to attachment issues or emotional development. This means that the manager and the behavioural specialist must work closely together to support the team. They must make themselves readily available to the team and be willing and able to meet individual team member's needs. They need to keep each other apprised of all deployed interventions and measures.

Once team cooperation improves – through RET or dream exercises, for example – the focus can shift to interventions intended to strengthen carers in their support of John.

A second lesson is that the coach-to-coach plan ensures that team members develop more trust in their own skills and are better able to transfer these skills to new colleagues. They feel more like active participants the interventions and take more responsibility for them. Thanks to this new openness and trust, carers coach each other better.

And finally I have learned that using film recordings not only boosted the team's sensitivity to John's tiny signals, but also involved and committed they feel in his care.

CONCLUSION

This was the case study about John and his team. Without the perseverance, stability, and commitment of the team, we would not have achieved the results that we did. Their continual dedication to finding any means of cooperation possible certainly played an important role. We have all been able to learn a great deal from this.

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