

# Management of Behavioral Outbursts in Developmentally Delayed Children, Adolescents and Young Adults in the Hospital Setting

“Proactive and Trauma- informed Approach for the hospital setting”

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# Disclosures

**No conflicts of interest.**

# Agenda

## What We'll Cover Today

- **Understanding the "Why"** - Causes & Triggers
- **The Goal: Prevention First** - Proactive Strategies
- **Responding with Care** - De-escalation & Intervention
- **Learning & Improving** - Team Debriefing

# Define “behavioral outbursts”

*“intense, often aggressive episodes that can include yelling, physical aggression, and self-injury”*

Common in developmentally delayed populations due to:

- **Communication difficulties**
- **Sensory processing issues**
- **Emotional dysregulation**

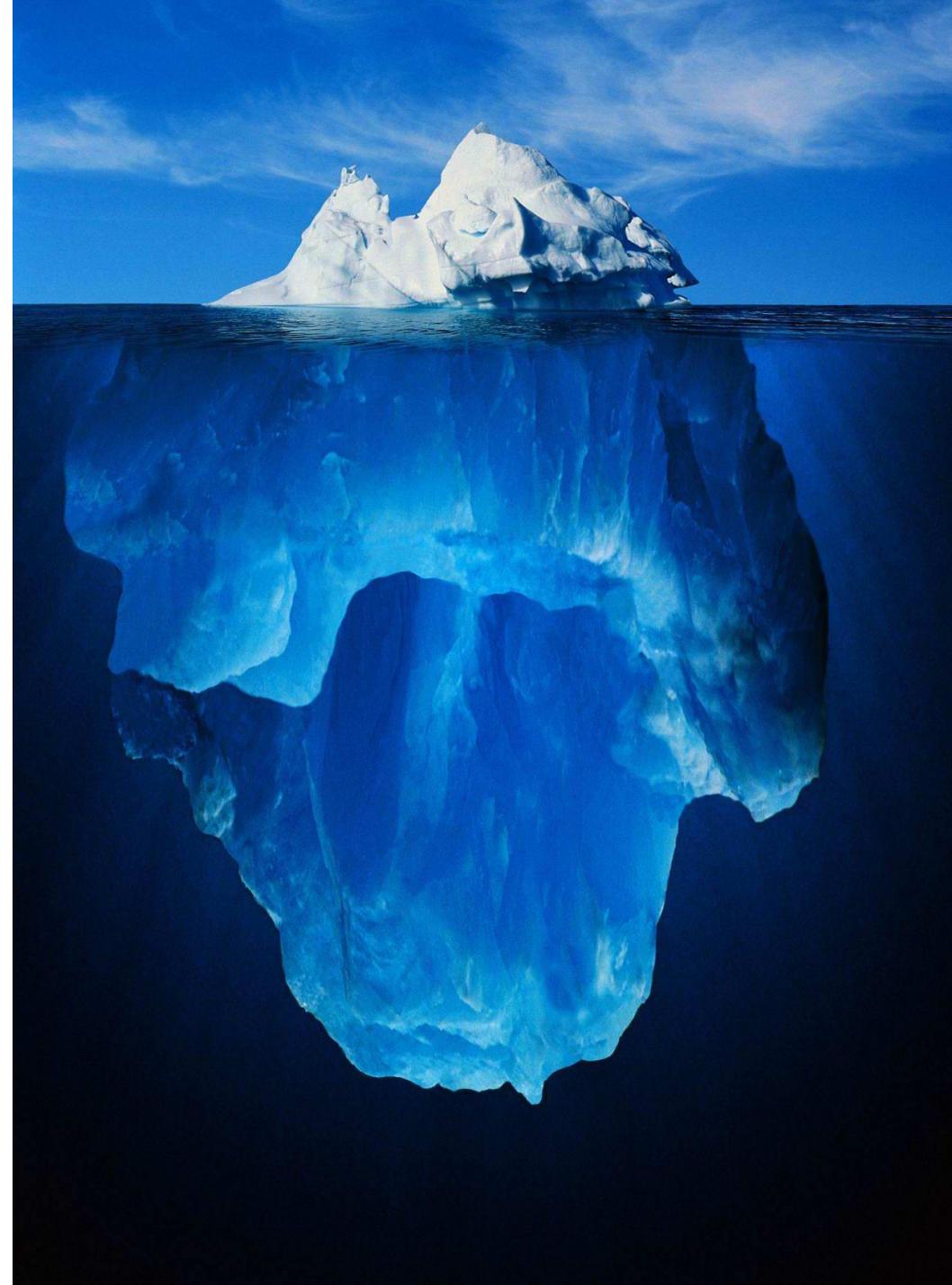
# The Iceberg: What We See vs. The Root Cause

## **ABOVE THE WATER (The Behavior)**

- Yelling
- Hitting / Kicking
- Self-Injury

## **BELOW THE WATER (The Root Causes)**

- Communication Frustration
- Sensory Overload (Noise, Light)
- Fear of the Unknown / Change in Routine
- Unrecognized Pain or Discomfort
- Anxiety & Emotional Dysregulation



# Why This Matters: The Stakes Are High

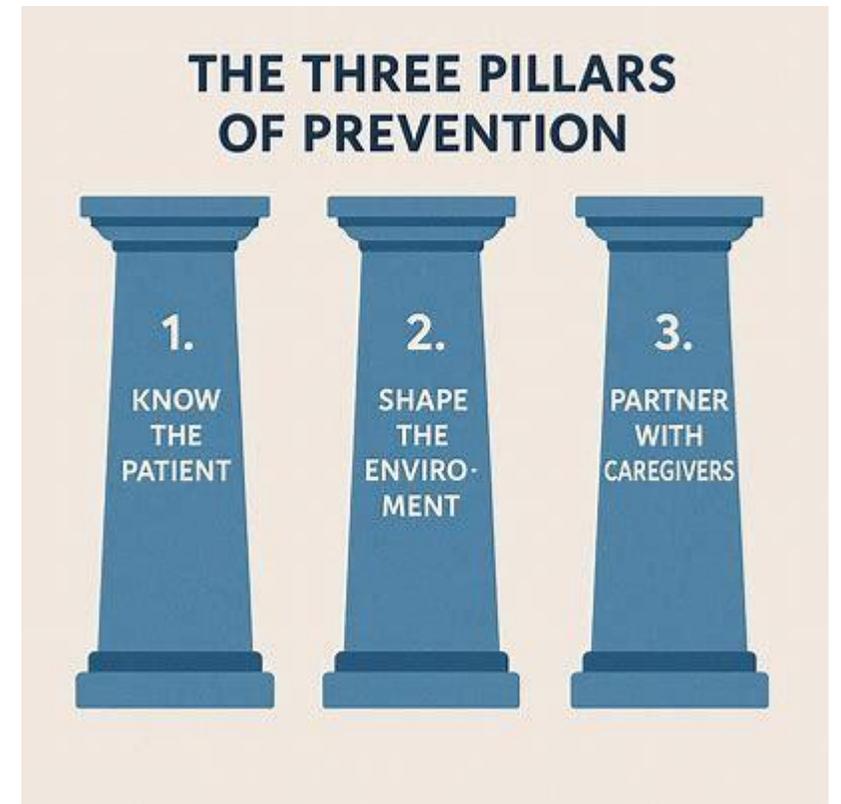
- **Children with autism or intellectual disability accounted for 44% of all behavioral emergency incidents.** (Mitchell M et al., 2022)
- **Children with autism or intellectual disability use inpatient care at 1.8 times the rate of the general child population.** (Rosenberg RE et al., 2020)

# The Trauma of Restraint

- **RESTRAINT IS A LAST RESORT**
- **It carries significant risk of:**
  - **Physical Harm:** Bruises, fractures, death.
  - **Psychological Trauma:** PTSD, fear, loss of trust.
  - **Long-Term Consequences:** Social isolation, damaged therapeutic relationships.
- **Its use as anything other than a last resort in imminent danger is considered abusive and unethical.**

# Our Goal: A Proactive Foundation

- **Prevention is Our Most Powerful Intervention**
- **The Three Pillars of Prevention:**
  1. **Know the Patient**
  2. **Shape the Environment**
  3. **Partner with Caregivers**



# Pillar 1: Know the Patient

## **Gather a Detailed Behavioral History:**

- **Triggers:** What situations are difficult?
- **Communication Style:** How do they express needs, pain, or fear?
- **Calming Strategies:** What works at home? (Deep pressure, music, specific objects?)
- **Baseline Functioning:** What does a "good day" look like vs. a "bad day"?

# Pillar 2: Shape the Environment

## **Reduce Sensory Overload:**

- Dim lights, reduce noise.
- Limit staff and visitors in the room
- Provide a low-stimulation quiet room

## **Offer Sensory Tools:**

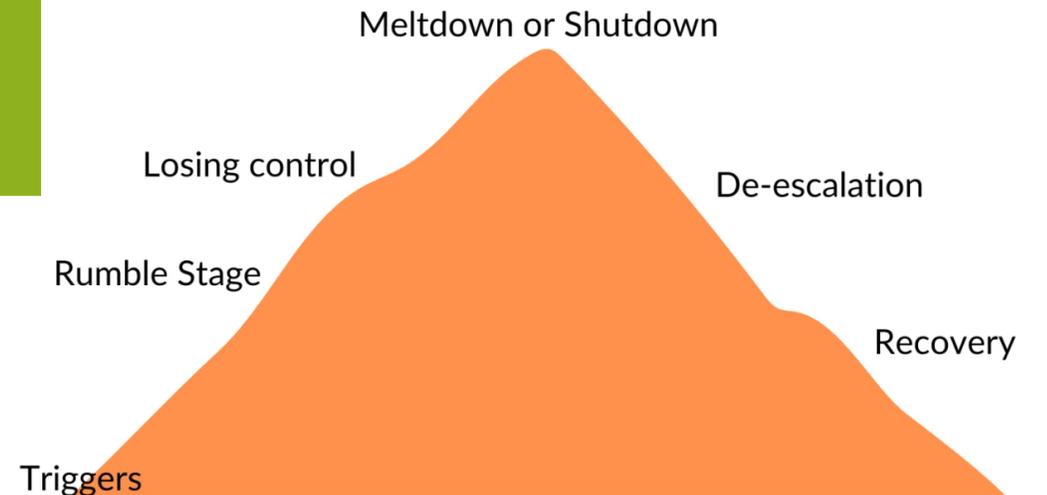
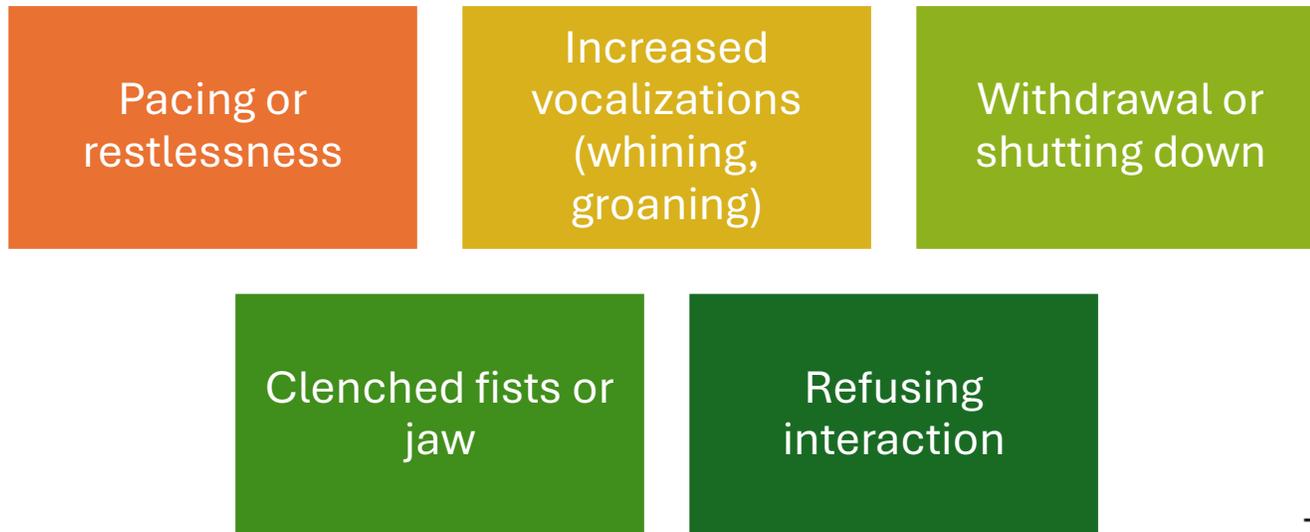
- Weighted blankets
- Noise-canceling headphones
- Fidget toys
- Comfort items from home

# Pillar 3: Partner with Caregivers

- They are the experts on their child.
- Involve them in planning.
- Allow their presence for procedures and for reassurance.
- Learn their successful home strategies and incorporate them.

# Early Warning Signs

## Intervene During the "Rumble Stage"



# De-escalation: First Line Response



**When you see early signs, deploy these tools:**



**Give Space:** Step back, create physical safety.



**Use Calm, Simple Language:** Short, direct instructions.



**Offer Choices / a Break:** "Would you like to take a walk or sit with your tablet?"

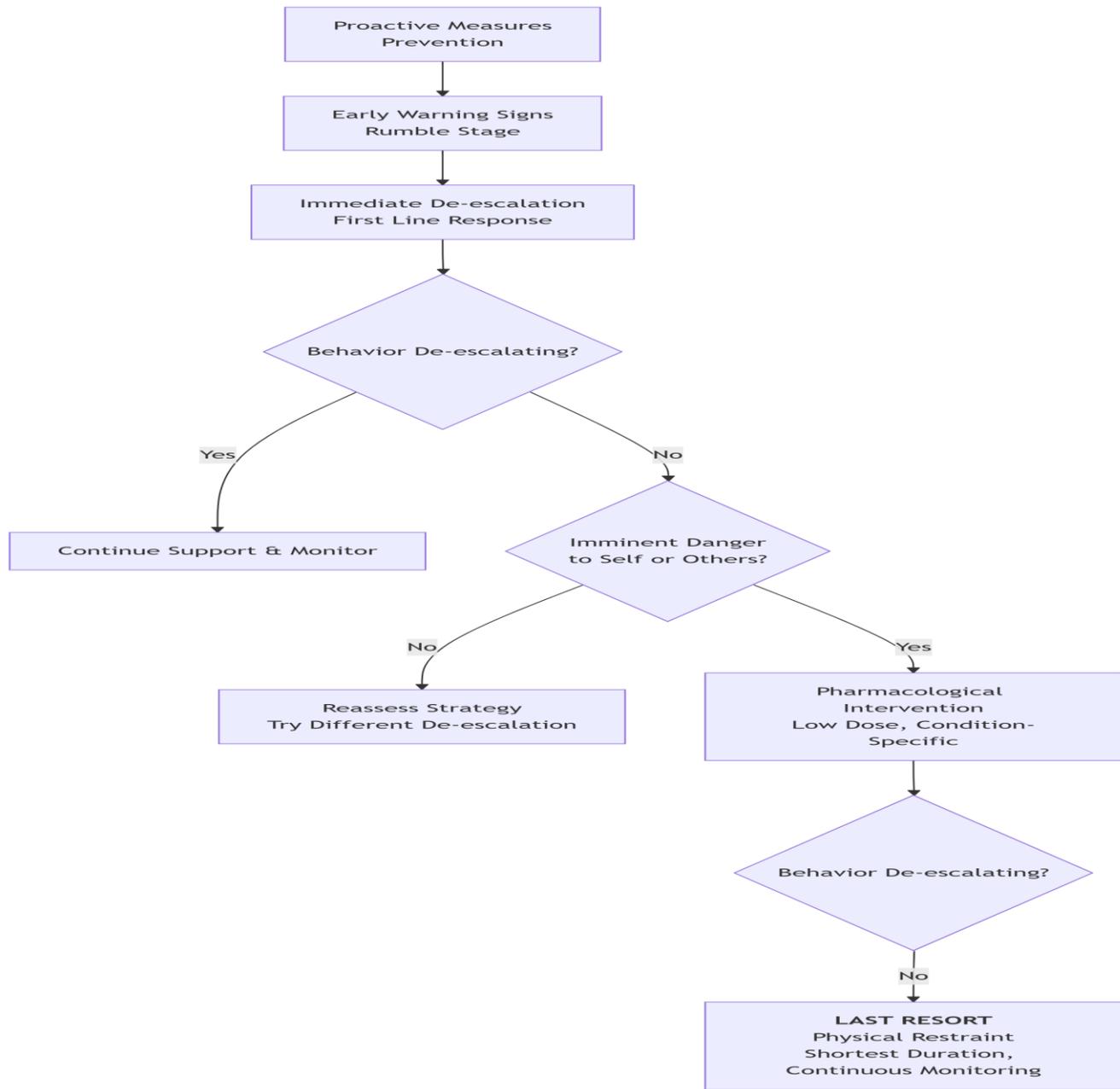


**Provide a Sensory Tool:** Offer headphones or a fidget.



**Involve a Familiar Caregiver:** Their presence is calming.

# The Intervention Decision Pathway



# Pharmacological Interventions

**When non-pharmacologic measures are insufficient and there is imminent risk.**

- **Use as an adjunct, not a sole treatment.**
- **Low-dose, condition-specific medications** (e.g., risperidone, aripiprazole).
- **Benzodiazepines used with extreme caution.**
- **Tailor to diagnosis, weight, and history.**
- **Monitor closely for side effects.**

# The Critical Importance of Debriefing

**Every Incident is a Learning Opportunity**

**Conduct a non-punitive post-outburst review:**

- What was the trigger?
- What de-escalation techniques worked? What didn't?
- How can we prevent this next time?
- Update the behavioral plan accordingly.

# The Multidisciplinary Team

- **No one does this alone.**
- **Success depends on collaboration:**
- Physicians & Nurses, Psychiatrists & Psychologists, Occupational & Speech Therapists, Child Life Specialists, Parents & Caregivers

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# **DISCRETE-TRIAL TEACHING OF MEDICAL STAFF FOR EFFECTIVE MANAGEMENT OF PATIENTS WITH ASD AT A STATE HOSPITAL IN TEXAS**

Goal: Training staff using discrete-trial teaching (ABA-based)

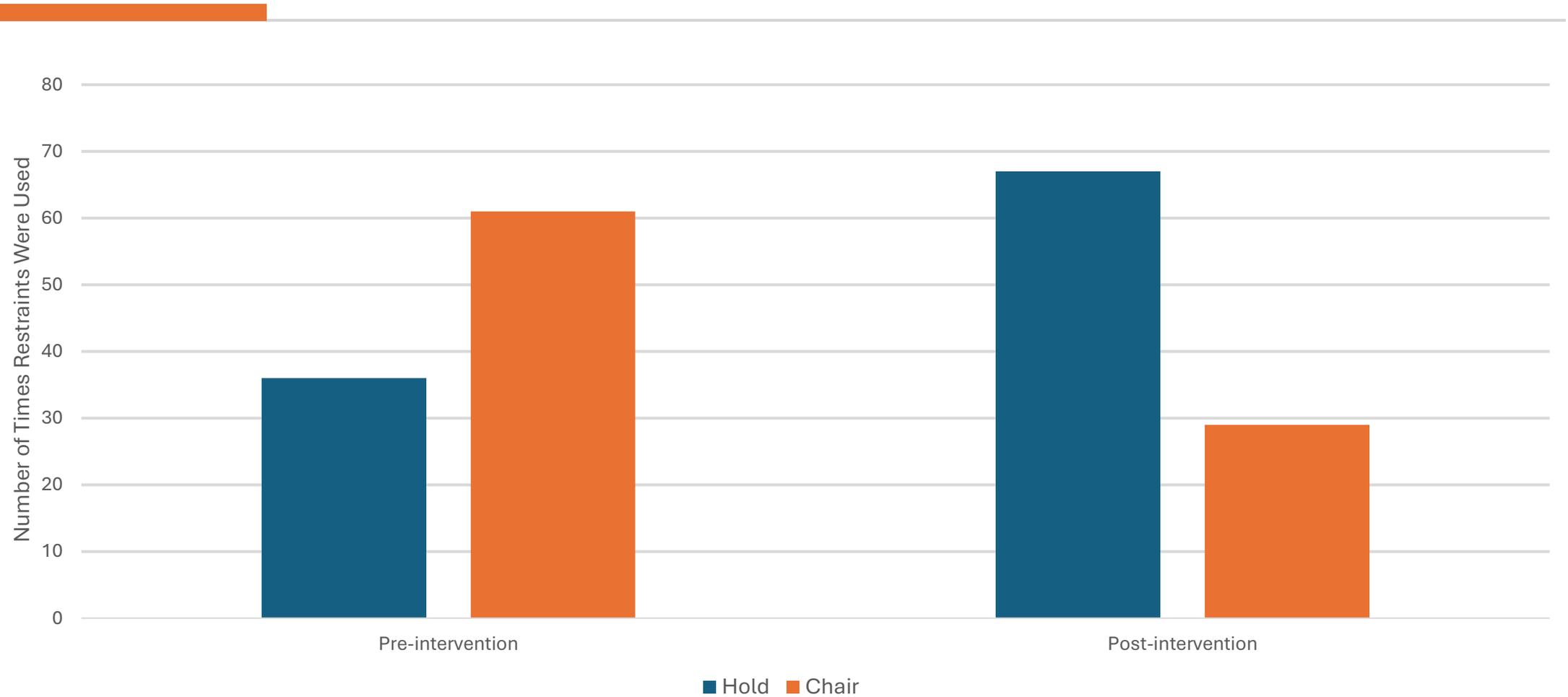
## **Methods**

- Participants: Physicians, social workers, nurses
- 2-day ABA training led by Autism Coach.
- Pre- and post-training assessments measured knowledge & comfort.
- Compared the number of restraints 6 months before and after training.

# Results & Conclusions

- N = 25 participants
- Pre-training mean = 13.72 (SD 1.18)
- Post-training mean = 14.88 (SD 0.97)
- Mean difference = 1.16 ( $p = 0.0006$ )
- Cohen's  $d = 0.79$  (large effect size)

# Number of restraints comparison



# Conclusions

- Training revealed baseline knowledge gaps
- Statistically significant improvement post-training
- ABA principles improve staff ability to manage ASD patients
- Critical for inpatient psychiatric settings

# Summary: Our Balanced Approach

- **Behavioral First, Pharmacological Judiciously**
- **PREVENTION** is paramount.
- **DECELERATE** early and calmly.
- **MEDICATE** responsibly only when necessary for safety.
- **DEBRIEF** every time to learn and adapt.

*Our mission is to provide exceptional medical care in an environment that is not only safe but also healing and respectful for some of our most vulnerable patients.*

Thank You