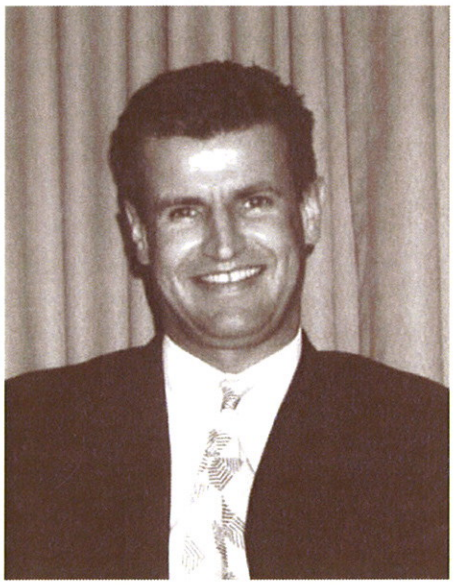
From the President



Where to start. I know that I must have led a sheltered life post-my Acquired Brain Injury because I've only ever really *read* about "challenging behaviours". Or *heard* about them from family members and service providers – and I know that, for the latter group, professional development in the area of behaviour "management" is one of their areas of greatest unmet need. The research wisdom tells me that almost two-thirds of people with a Traumatic Brain Injury will manifest degrees of irritability, impatience, mood swings, poor impulse control and verbal and physical aggression sufficient to "challenge" anyone they come in contact with. But I do want to pick out two words from that sentence – "manifest" and "challenge" – just so you can see my difficulty in writing. (And because I've never been directly "challenged" by these behaviours, my naivety's my excuse for what follows.)

I chose "manifest" just to reinforce the idea that some part of these behaviours are bound to be due to damage to a particular area of a person's brain – that these behaviours are not necessarily the person's "do-ing". But there may be other behaviours that are learned or adopted as an adjustment to disability. And there may be still others the person had before their injury, and the injury "pushed" them (I often hear that a person is the same as they were before their injury, only... moreso). Picking which behaviours are which – as much as "managing" them all – is, I reckon, the responsibility of a professional's practice.

And, while I don't want to underestimate the potential for distress (and physical harm) that can result from such behaviours, what they "challenge" are no less – or more – than socially acceptable norms. These norms don't just happen. They are the stuff of culture. And they move - in time, with place. For instance, I've *heard* of people post-Acquired Brain Injury masturbating in public. Certainly illegal. And probably *culturally* unacceptable. But the norms such behaviour "challenges" may be partly accidents of history. Pardon me if I go off on a tangent (I'll come back). I've long been fascinated by the Cynics – the first genuine mass philosophical movement, from the fourth and fifth centuries B.C. Greece – and their founder Diogenes. Masturbating in public was part of his everyday practice and he encouraged it in his followers. It was part of the Cynic ideal of what they called "autarkeia", or self-sufficiency. (Diogenes also lived in a wine barrel and liked to urinate on people he disliked, but I'll pass that by. And, no, I don't know whether he'd sustained an Acquired Brain Injury in his earlier life.) But perhaps one reason why Western cultural norms are the way they are is because Plato – who, along with his mentor, Socrates, and his student, Aristotle, helped lay the foundations for all Western philosophy and Western science - dismissed Diogenes as "Socrates gone mad". The written works of Plato and Aristotle remain. All that's left of Cynic thought are fragments of secondhand commentary.

(I'm back now.) I've chosen an extreme example of behaviour only because some of the "management" techniques I've heard or read about seem equally extreme in their response to behaviour – many of them wrapped in platitudes about all behaviour having "meaning" and how it is the responsibility of professionals to look for the "message" the person with an Acquired Brain Injury is "communicating" through their behaviour. "Medication management" seems to be on the increase as a first line response. For some service providers concerned about their bottom line, this could mean bombing out high-maintenance clients on anti-psychotics. Other techniques seem to treat people with an Acquired Brain Injury almost as a cross between naughty children and laboratory rats. One United States brain injury "unit" (apparently highly regarded there) introduced a "token economy" to reward - and punish - residents for "appropriate" behaviour. They say "we originally 'charged' residents for meals. In the event that not enough tokens were available to 'buy' a meal, the resident was offered Complan [a powdered shake for undernourished], very nutritious but devoid of taste and interest (though the manufacturers would have us believe otherwise!)"

There's little point in being precious about such extreme "management" techniques when the behaviours may also be extreme (especially without my having direct experience of service delivery in such circumstances). But such behaviours are hardly new and hardly isolated – an ageing population succumbing to stroke, dementia and falls-related Traumatic Brain Injury is a guarantee of that. What is disturbing is that, even given the fact no two Acquired Brain Injuries are the same, a generally applicable "best practice" does not seem have emerged and that some "management" techniques seem to be evolving in almost experimental circumstances – with the clients as test tubes. And that evolution doesn't seem to have progressed much beyond, depending on which norms you follow, "One Flew Over The Cuckoo's Nest" or the Middle Ages.