Behavior Management in Children with Cancer

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Behavior matters

Behavior problems in children and adolescents can interfere with:

- Safety of patients, parents and staff
- Delivery of medical care
- Adherence to treatment
- Quality of life

“Behavior”

- “the way in which one acts or conducts oneself, especially toward others”
- “the way in which person acts in response to a particular situation or stimulus”

Externalizing behavior:

- Yelling
- Hyperactivity
- Aggression
- “Agitation”
- Resisting procedures
- Destroying property
- Substance abuse

Consultation question:
Who is most distressed?

- Child's expression of distress
- Parental distress, grief, frustration, helplessness
- Medical caregiver distress, frustration, helplessness
- Over/ underestimation of suffering by parents/ medical providers

What motivates problem behavior?

- Brain dysfunction/ confusion
- Pain
- Lack of familiarity/ misunderstanding
- Sadness
- Fear
- Anger
- Interpersonal interactions/ parental behaviour

How much control does child have over behavior?

Behavioral Formulation

Bio

Developmental delays

Acute Brain dysfunction

Pain

Environmental support

Medical Interventions

Psycho

Misconceptions

Sadness, fear, anger

Procedural support

CBT

Social

Culture

Parental Distress

Family Conflict

Cultural navigation

Parent Problem-solving

Family therapy

Comprehensive assessment

Multiple informants:

- Developmental/ temperamental baseline
- Timing
- Triggers
- Exact behaviors
- For how long
- What makes it worse
- What calms child

Identify triggers

- Medical context: anemia, pain, NPO, steroids, medication
- Who is with the child?
- What is expected of child: hold still, allow procedure, take PO med, wait, stop playing
- Limit setting – by whom?

Delirium

Hyperactive, Hypoactive, Mixed

- Impaired consciousness, attention, cognition
- Disturbed thought process and behavioral control
- Develops over short period of time
- Fluctuates
- Caused by physiologic consequences of medical condition

Standard assessment: P-CAM, CAPD

Smith HA et al, 2011
Traube C et al, 2014

Treatment of Delirium

Non-pharmacologic

- Address underlying medical cause
- Re-orienting and re-assurance
- Familiar people, objects, routines
- Minimize stimulation
- Circadian rhythm

Pharmacologic

- Melatonin
- Dexmedetomidine, Clonidine
- Anti-psychotics

AVOID benzodiazepines

Turkel and Hanft, 2014

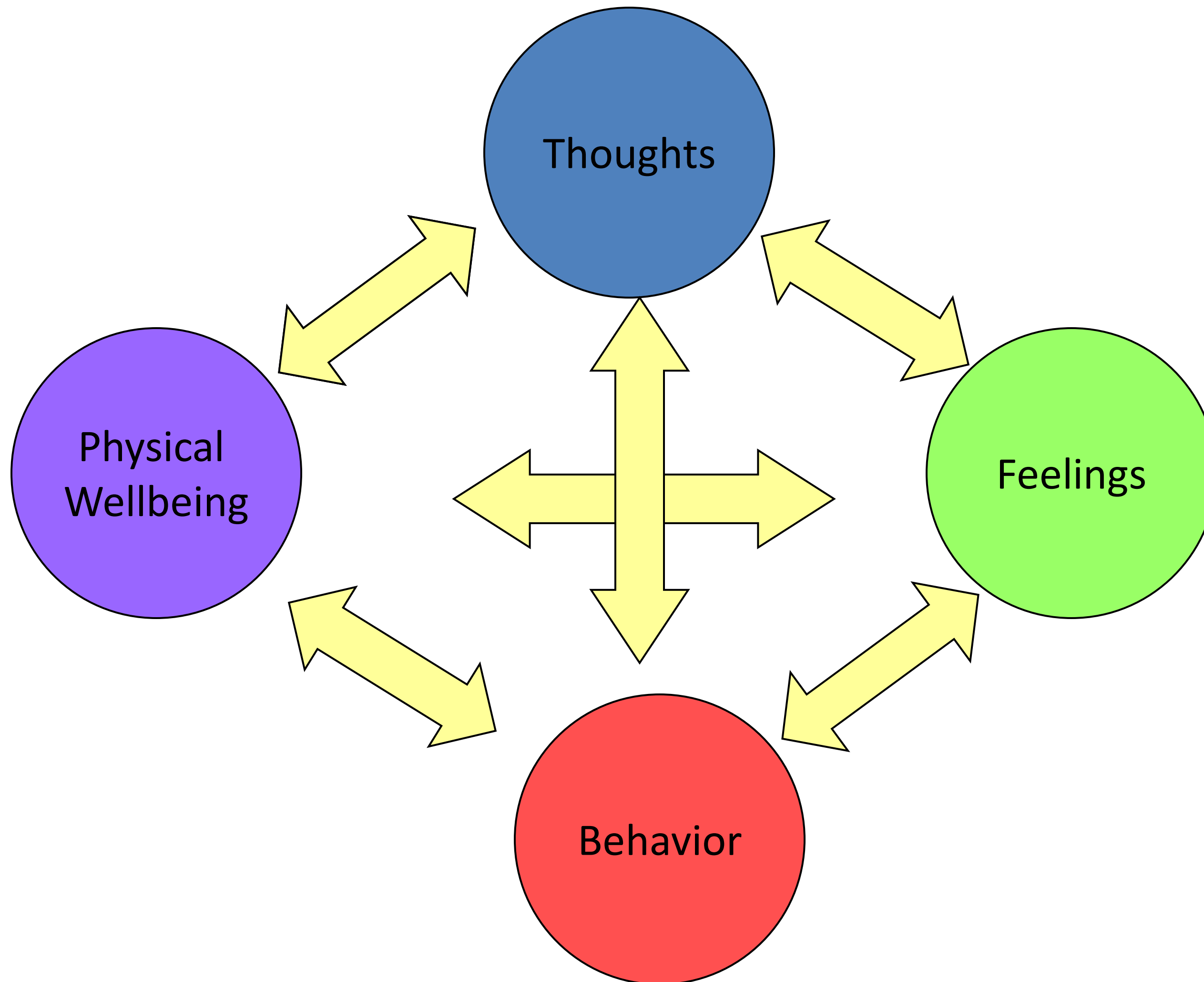
Psycho-education

- Honest communication about the illness, procedures, inpatient admission
- Help child/ parent understand reasons for limits, procedures
- Prepare child for what to expect

Procedural support

- Education
- Preparation
- Medical play
- Relaxation
- Distraction
- Incentives

Cognitive Behavioral Approach



Cognitive behavioral therapy

- Child therapy and Parent guidance/ coaching

  - Reframing negative cognitions
  - Distraction, behavioral activation
  - Relaxation training/ biofeedback/ hypnosis

Parental Distress

- **Parental distress is related to child distress**
- **Parent mood and function impacts child adjustment illness**

- Pediatric cancer is stressful and traumatic for parents and puts them at risk for mood and anxiety symptoms that compromise their capacity to care for ill children
- Parents of children with cancer have higher levels of internalizing ssymptoms than parents of healthy children
- Parent QoL predicts parent proxy reports for Child QoL

Gerhardt, 2006, Robinson, 2007, Eiser, 2001, Upton, 2008

Evidence-based Parent intervention: Problem Solving Skills Training

- Parent problem-solving therapy is an effective and specific intervention that reduces negative affectivity in parents.
- The beneficial effects of PPST continue to grow after the intervention ends.
- Non-directive Support is an effective intervention while being administered, but its benefits plateau when active support is removed.

Bright IDEAS: Sahler OJ, 2002, 2005
and JCO, 2013

Bright IDEAS: Problem-Solving Skills Training

PSST uses a generic, cognitive-behavioral coping skills training approach applicable to situations commonly encountered during pediatric cancer treatment. The manualized intervention is delivered in weekly, 60 minute sessions

- **I**dentify the problem
- **D**etermine the options
- **E**valuate options and choose the best
- **A**ct
- **S**ee if it worked

Psychopharmacology

- When cognitive- behavioral approaches are not effective
- When behavior is dangerous to self or others
- When behavior interferes with medical care

Benzodiazepines

For Anxiety, Agitation (without confusion)

- Short acting - Lorazepam
  - procedures
  - sleep initiation
- Longer acting - Clonazepam
  - lasts 6-8 hrs, ½ life 22 hrs
  - double potency

Caution:

- Sedation, paradoxical reactions, worsening delirium

Neuroleptics/ antipsychotics

For Delirium, Agitation, Behavioral dyscontrol, extreme Anxiety

	Route	Dose range	Considerations
Risperidone	PO, solu-tab	0.25- 1 mg bid	Risk of EPS
Olanzepine	PO, solu-tab	1.25-5 mg bid	Sedating, anti-emetic
Haldol	PO, IV, IM, percut	0.25-5 mg q 4	Rapid action, 1st gen, EPS
Quetiapine	PO	12.5-100 mg hs	Most sedating
Apiprazole	PO	2-5 mg hs	More targeted
Ziprazodone	PO, IM	5-20 mg hs	Newer

Caution:

Sedation, QT prolongation, extra-pyramidal sx

Behavioral Response Team

- Preparation
- Nursing guidance
- Emergency response
  - De-escalation
  - Physical Restraint
  - Chemical Restraint
- Security

Prevention is best

- Identify children at increased risk of behavior problems
- Integrate psychosocial approaches
- Involve primary nursing team, child life
- Create consistent care plan

New Psychosocial References