Many persons with brain damage refuse or avoid participating in a therapeutic program. This avoidance is a major obstacle to rehabilitation (Zencius, Lane, & Wesolowski, 1991) and may be due to cognitive impairments (e.g., decreased awareness of deficits, limited insight and judgment) (Alderman, 1991). To avoid participation in therapy, these persons may exhibit undesirable or maladaptive behavior patterns that are incompatible with therapy participation, such as physical and verbal aggression, fake anxiety, motoric disturbances, or frequent use of the bathroom. Exhibition of psychogenic manifestations of anxiety such as "blank staring" is one way these persons escape or avoid participation.

Traditional behavior modification techniques of reinforcement and time-out programs have been found to be ineffective for treating avoidance behavior (Alderman, 1991). Several case studies have demonstrated the effectiveness of indirect confrontation, such as inexact interpretation of the cause of the symptoms, as an initial step in therapeutic management of avoidance behaviors for malingering and conversion reaction (Rabinowitz, Mark, Modai, & Margalit, 1990; Shen, Bowman, & Markand, 1990). Direct confrontation can be a powerful tool, but during the initial intervention phase of psychosocial management in avoidance behaviors and conversion disorders, it can be counterproductive (Behe, 1992; Krull & Schifferdecker, 1990; Lazare, 1981; Lowman & Richardson, 1987). Thus, it raises the issue of when and how to confront the client. Fras (1978) suggested that direct confrontation be avoided until a client–therapist relationship has been established and that confrontation be performed gently and nonpunitorily. Furthermore, an empathic attitude in a supportive environment is important to building and maintaining rapport with the client after the direct or indirect confrontation (Shen et al., 1990).

This case report illustrates the use of confrontation techniques to treat an adult client who exhibited avoidance behavior—elective blank staring—to avoid participation in therapy. The techniques used were based on the rationales proposed in the previously discussed literature.

Background

The client was a 55-year-old married, white man who had sustained a left cerebrovascular accident (CVA). He received inpatient rehabilitation for 2 to 3 months and outpatient services for several months. Outpatient services were interrupted when he developed appendicitis and a kidney stone, for which he had surgery. During this hospitalization, he developed a fever and had a possible seizure; therefore, anticonvulsion medications were...
started and continued throughout his rehabilitation.

The client was admitted to a postacute rehabilitation center 1 year after his CVA to continue rehabilitation. After the CVA, he had been physically abusing his 7-year-old son at home and during the initial period of his stay at the rehabilitation center. The client's wife, who worked full time as a secretary, expressed a desire for him to return home if he could be more independent. Hence, the client's rehabilitation goals were improving his daily living skills and self-management of behavior outburst so that he could return home to his wife and son. His family lived a 4-hour driving distance away from the rehabilitation center and visited him regularly. Both his wife and son attended family counseling monthly regarding adjustments of family dynamics.

Speech Therapy Evaluation

The client presented with severe expressive aphasia, with his verbal output characterized by perseverative letters and phrases. Automatic perseverative phrases included "yes" and "no," "I do, I do," and various profanities. In the area of receptive communication, the client was able to follow verbal directions up to 3 steps and achieved 80% on symbol and word discrimination. The client was oriented to place and person but less oriented to time.

Occupational Therapy Evaluation

The occupational therapy evaluation revealed impulsivity, low frustration tolerance, and perseveration on tasks. Attention span on task, information processing, and initiation to perform self-care activities were considered impaired as evidenced by the client needing repeated prompting for completion. Other neuropsychologic deficits included visuoperceptual dysfunction, apraxia (as demonstrated by an inability to follow commands or pantomime), and inability to write or draw. He achieved 42.5% accuracy in the Test of Visual–Perceptual Skills (nonmotor) (Gardner, 1982). He had no major neuromuscular impairments in the upper and lower extremities except for pain in both shoulders and the left knee.

During the first 3 weeks in rehabilitation, the client exhibited no serious maladaptive behaviors except for the use of profane language. He was considered cooperative, with 80% therapy participation with occasional refusal.

Emergence of Avoidance Behavior

The first blank-staring episode occurred when staff members cued the client to participate in therapy. He was unable to be aroused until deep sternal pressure was applied. During the next 20 days, he complained of episodes of chest pain and upper gastrointestinal discomfort and demonstrated frequent blank staring. As a result, the client did not participate in therapy and personal hygiene tasks and occasionally refused meals. A repeat hospitalization for extensive metabolic, cardiac, and neurologic tests did not yield any explanation for the blank-staring episodes, which were thought to be an absence seizure or seizure-like episode. Thus, the blank staring was suspected to be psychogenic. No medical diagnosis was recorded.

The client's refusals to participate in therapy increased. Additionally, while in therapy, he demonstrated blank staring whenever he was requested to attend to a given task. In at least three clear episodes when the therapist cued him to participate in therapy, the client said no. Further prompting provoked anger and a subsequent episode of blank staring. At this point, the client demonstrated no response to physical cuing, the result being that the therapist gave up and left him alone. At least 10 occurrences of blank staring precipitated by a refusal to participate in all scheduled therapies were recorded within a 20-day period after the first episode. However, he did not exhibit blank-staring episodes during nontherapy time, which was after 5 p.m. Blank staring only occurred after requests to participate in what he seemed to consider nonpreferred activities. Analysis of this information tentatively supported the hypothesis that the client's blank-staring behavior was psychogenic. The client continued to use the anticonvulsant medications (carbamazepine and divalproex sodium) prescribed during his hospitalization throughout this time.

Previous medical records from the rehabilitation center before his hospitalization indicated that the client had, on several occasions, to be coaxed to participate in therapy and had, on at least one occasion, demonstrated blank staring during occupational therapy. On this occasion, he was nonresponsive for 30 sec.

Intervention

The occupational therapist, with the assistance of a behavior specialist, attempted to confirm the psychogenic nature of the client's blank staring. To design the most appropriate treatment plan for the client, an episode of blank staring was elicited by requesting the client to participate in therapy. The therapist and the behavior specialist then used an indirect confrontation by discussing the blank-staring phenomenon as an avoidance behavior in the presence of the client. The professionals discussed that the client's number of blank-staring episodes would be recorded throughout the whole day in 15-min intervals to confirm that the behavior was psychogenic.
then discussed the reasons for the client's blank staring with the psychiatrist and neuropsychologist who both thought that the client's blank staring was a reaction to stressful events. Their conversation went on to relate that no diagnosis related to the blank-staring episodes was recorded on the medical chart.

The day after this indirect confrontation, no episodes of blank staring were recorded, and the client was more cooperative. He participated in both speech therapy and physical therapy but still refused to participate in occupational therapy. The client was also directing profane language at the occupational therapist, but not toward other therapists and staff members. Therefore, other staff members were asked to cue the client to participate in occupational therapy. The occupational therapist reasoned that the client was not responding to the indirect confrontation, the client had needed daily maximum cuing by the staff members to participate in occupational therapy and frequently refused to participate. Whenever he did participate in therapy, the occupational therapist showed a supportive attitude and provided positive feedback.

No blank-staring episodes were recorded until the 14th day after the indirect confrontation when the client needed maximum cuing to participate in occupational therapy and then fell asleep just after he sat down for his session and was unresponsive to gentle physical and verbal cuing. This episode was slightly different from the previous blank-staring episodes but clearly indicated unresponsiveness.

The behavior specialist was called, and the client was awakened by gently sprinkling a small amount of water on his face. The purpose of sprinkling water on the client's face was to awaken him without direct physical confrontation. It was not provided as a behavior modification technique and was only done once. After the implementation of the direct confrontation, the client had needed only one verbal cue to participate (due to his disorientation to time). The client thereafter never refused therapy. He initiated a daily greeting and handshake with the occupational therapist, which was not done before the confrontation.

After the implementation of the direct confrontation, the client's participation in occupational therapy and other organized activities improved dramatically. With the increase in therapy participation, he demonstrated considerable improvement in the areas of self-care, visual perception, and functional communication, and he initiated completion of his morning routine without cuing. Readministration of the Test of Visual-Perceptual Skills (non-motor) 3 months after the initial testing revealed an increase to 90% accuracy. Functional communication improved from "I do, I do" to two-word meaningful phrases 90% of the time.

The client was discharged after 4 months in the intensive rehabilitation unit, and the client was transferred to a community reentry program within the postacute rehabilitation center. No episode of blank staring was reported there. The occupational therapist visited the client monthly, and the client continued to show compliance with functional activities and individual therapy. Two months later, he was transferred to another facility. A follow-up call 1 month after discharge revealed that the client had not demonstrated any blank-staring episodes since the transfer.

Discussion

This report supports the use of graded confrontation techniques for clients who refuse to participate in therapeutic programming by exhibiting avoidance behaviors. My analysis and interpretation of the sequence of intervention follows.

The use of indirect confrontation in the initial inter-
vention phase served as an avenue to increase the client’s awareness that blank-staring episodes were an emotional response to stress. By suggesting that these behaviors were self-induced and controllable, the client relinquished them without losing face. The client, however, directed his defensive anger toward the occupational therapist, who had unveiled his avoidance behaviors. The occupational therapist accepted the client's anger and continued to reinforce the client’s participation in occupational therapy by providing a supportive attitude and positive feedback on his performance.

The role-playing between the occupational therapist and a staff member provided concrete feedback to the client regarding the impact of his avoidance behaviors on his progress in therapy. The therapist nonverbally expressed genuine empathy and support through the direct confrontation to show his understanding of the client’s behavior. As a result, the client believed that the therapist understood him. This concrete feedback provided an effective way of dealing with the client’s avoidance behaviors (Cicerone, 1989), and the therapist’s caring attitude dissolved the hostile feelings and resulted in effective rapport building between himself and the client (Bach & Goldberg, 1974).

The client was repeatedly informed about the rationale for participating in therapy and the expected benefits to be derived from it. His compliance with therapy did not improve until he was psychologically ready to accept the rationale for therapy participation. The underlying reason for the client’s refusal to participate in therapy might have been because of his perception that therapy was a stressful experience, but he was unable to express this verbally as a result of his aphasia. The blank-staring episodes may have served as a means of avoiding thoughts or feelings that could not be expressed verbally. However, the clinical team was unable to find out why the client was compliant during the first 3 weeks after admission and then suddenly displayed the avoidance behavior. To reduce the underlying stressors in order for the client to participate in therapy, therapists and staff members continued to show supportive, friendly attitudes and provide positive feedback to maintain his motivation. It was almost impossible to openly discuss precipitating stressors with the client because his perception of the therapist as a friend may have been distorted, as evidenced by his exhibiting a blank-staring episode whenever the therapist attempted to interact with him.

If the client had been ignored or had not received appropriate intervention to stop his avoidance behaviors, he would have been discharged from the postacute rehabilitation center because of lack of progress as a result of refusal to participate in therapy. Through the client’s active participation in therapies (i.e., behavioral, occupational, physical, speech), he showed considerable gains in the areas of activities of daily living and functional communication, which could not be accounted for by spontaneous recovery in a person 1 year after CVA. Improvement was also noted in his self-control of behavioral outbursts. This improvement was reflected by no further documentation of physical abuse toward his son, who continued to make regular visits during the last 2 months of the client’s stay at the postacute rehabilitation center.

The philosophy of the rehabilitation program in this facility is to start with the least intrusive intervention and progress from there (Yuen, 1990). For this client, ignoring the avoidance behavior would not have worked because this would only encourage his nonparticipation in therapy. Additionally, training in self-control or relaxation techniques was not appropriate because of his aphasia and avoidant behavior. An elaborate operant conditioning program would have been formulated if the original confrontation intervention did not work. A less intrusive strategy that might have been effective in reducing avoidant behavior is videotaped self-confrontation feedback (Alexy, Foster, & Baker, 1983).

Summary

Patient noncompliance with therapeutic programs in postacute brain damage rehabilitation is a common occurrence. Causes of noncompliance range from decreased cognitive skills to a limited understanding of rehabilitation methods. This report described how a client used self-induced blank-staring episodes as a means of avoiding participation in a therapeutic program and the resolution of this negative behavior with graded confrontation techniques. The client’s understanding of therapeutic goals and expectations was also important to improving his compliance in therapy. The case underlines the importance of addressing psychosocial issues during physical rehabilitation to maximize the treatment effects.

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References


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