IDENTIFICATION AND MANAGEMENT OF PROBLEM BEHAVIORS: A CASELETS BASED INDUCTION STUDY

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ABSTRACT

Behavior modification approaches have long been the mainstay for identifying and managing problem behaviors. This paper uses caselets based inductive approach to raise key questions, problems and issues for consideration at every step of behavior correction program beginning nomination of therapeutic agent, listing of problem behaviours, enumeration of rewards, formulation of baseline, understanding the prevailing attribution of causes and consequences by caregivers for given problem behaviours as prelude to their analysis for planning and implementing remediation strategies. Although seemingly simple, cook-book approaches to behavior diagnosis and change may prove in vain, invalid or ineffective. Similarly, straight jacketed one shot solutions may also turn flawed. Case illustrations are used to optimise the effectiveness of such programs.

INTRODUCTION

Behavior change programs typically distinguish skill-problem behaviors, desirable-undesirable, positive-negative or adaptive-maladaptive behaviors. They are also recognised as challenging, asset, excess, and/or deficit behaviors. A problem behavior is any or all observable and measurable actions of people which are age or situation inappropriate, unproductive, interfering in learning of new behaviors, harmful to self or others, occurring in amount sufficient to cause stress to others (Venkatesan, 2004). They may occur over time, across persons or situations to such a marked degree and nature that it could even adversely affect the acquisition or performance of new positive, skill and/or asset behaviors. Typical categories of such behaviors vary according to different authors. A few specific instances of problem behaviors are: hits others, screams, falls on the floor, cries, tells lies, etc. Contrast this with skill behavior illustrated by examples like buttons, greets others, eats on own, names colours, etc.

Learned behaviors can be unlearned (Bellack, Hersen, & Kazdin, 1990). Behaviourists adopt a unique approach, process or procedure of inquiry by using an assessment technique which focuses on ‘here-and-now’. They spotlight on what happened just before (antecedent) or after (consequence) a behavior. Such observations are kept short, quick, precise, accurate, objective and unbiased. For example, the term ‘does not sit in a place’ is preferred to ‘overexcited’. This may be dubbed as subjective description (Miltenberger, 2012).

Behaviourists typically propose step-wise algorithm for identifying, analysis and change, correction or remediation of behaviors (Martin & Pear, 2016; Gresham, 2015; Kazdin, 2013; Barkley & Benton, 2012). To use a metaphor, planning and implementation of behavior correction programs is like cooking. All the preparations that go into cooking a given dish apply. One must decide the dish to be prepared and who is the chief cook. Similarly, a therapeutic agent needs to be identified. When a child is handled by many caregivers like father, mother, teacher, therapist and baby sitter, it is important that a therapeutic agent is nominated (Scarlett, Ponte & Singh, 2009; Grossman, 2004).

Caselet #1

Ravi, 6 year old, student of upper kindergarten English school, single child, born to twin working parents, was brought with presenting complaints of the following problem behaviours: (1) does not obey commands; (2) does not write; (3) does not sit in a place for even few minutes; (4) interrupts others at work; (5) behaves younger to his age; (6) screams; (7) nags; and, (8) poor attention-concentration. Mother reported problem behaviours #1, 2, 3, 5, 7 and 8. Father listed problem behavior #4 and 5. The teacher mentioned problem behavior #2, 3, 4, and 8. The student therapist identified problem behavior #2, 3, and 8.

The behaviours occur at home and school with differences in their frequency and intensity depending on situation, place or person. For example, ‘nags, screams and does not obey commands’ occurred in front of parents, while ‘poor attention-concentration, does not sit in a place for even few minutes, interrupts others at work’ were the major concerns of school teachers. The student-clinician handling the child for three hours every week for closed-door speech therapy program noted that the child used 2-4 word phrase level speech, could follow several functional commands and few single step instructions only when associated with gestures. The child could not follow 2-step or multiple instructions.

When inquired what could be the ‘causes’ or ‘reasons’ for problem behavior in their child, the parents attributed: (1) ‘owing to primary condition’; (2) ‘as deliberate or intentional actions’; (3) ‘being twin working parents’; and/or (4) ‘due to poor models in school surroundings’.

Consequences:

The reported consequences following problem behaviours were: (1) advising; (2) threatening to complain to teacher; (3) warning that an injection would be given; (4) hitting; (5) going out; (6) ignoring; (7) forcing comply to their demands; (8) putting on television; (9) giving a toy, crayons, colour pencils or cell phone to play; and, (10) promising to give eatables.

Caselet #2

Ajay, aged 14 years, student of class five in English medium school, was brought with complaints of: (1) talking to self; (2) interferes others when they are talking; (3) asks questions repeatedly; (4) gets overexcited when in groups; (5) prefers to play with younger age peers; (6) prefers play with animals; (7) shows disinterest for reading, writing and/or academic work; and, (8) does not obey commands.

Contemporary Skill Sets:

He continues to require verbal prompts for completing few self care activities like bathing, brushing, buttoning, unbuttoning, tying knots, and buckling. He is reportedly independent in eating, washing hands or face, and toilet use. With regards expressive speech, he uses short phrases, cannot use full sentences, make narrations, summarize or
paraphrase messages across people during interpersonal communication. He follows 1-2 step instructions if accompanied by gestures. He knows money is to be preserved, has exchange value, but cannot shop even single items with or without escort. He cannot tell time, identify days in a week or ongoing month of the year. He can say time to complete activities like dressing, bathing, brushing and toilet use. Added problems like stubborn-refusal behaviors, wants his way and/or shouts-screams was reported. During clinical interview and testing, the child showed interest and answered easy questions on names colours, counts 1-20, rote recites A-Z, and/or spells of 3-letter words in English. When insisted to answer tough questions, he became restless, repeating questions of the examiner (seemingly showing echolalia), showed mannerisms or odd stereotypy. A perusal of available records showed short consultations across specialists like psychiatrist, neurologist, paediatrician, psychologist, occupational therapist and special educator with equally wide range of diagnostic impressions like Obsessive Compulsive Disorder, Opposition Defiant Disorder, Attention Deficit Disorder, or Autistic Disorder. Medical history showed intermittent periods of using anti-psychotic, anti-hypertensive and/or psycho-stimulants albeit with temporary respite. Past history showed delay in all developmental milestones. Interview with parents revealed that the boy demanded TV time, i-pod, outings and visits to malls or restaurants as rewards. Based on information from case history, clinical interview, behavior observation, key-informant report and developmental assessment, the current mental age of the child is around 5 years (IQ: 36; Moderate Intellectual Disability; 75 % Disability). On many occasions, the distinction between skill and problem behaviors is blurred. As in caselet #1, the complaint 'does not write' looks apparently to be a problem behavior if it is interpreted as 'refusal behavior' despite the child's capability to write. If the child is not yet developmentally 'ready to write', it is more appropriately deemed as skill deficit. A related example is caselet#2 with complaints: (1) talks to self; (2) interferes others when they are talking; (3) asks questions repeatedly; (4) gets over-excited when in groups; (5) prefers to play with young age peers; (6) chooses company of animals. These complaints are to be understood against the background that the child's current mental age is around 5 years (IQ: 36; Moderate Intellectual Disability; 75 % Disability). Expectedly, this child has still not achieved enough expressive sentence level speech to be able to make narration, summarize or paraphrase message to others. He has difficulties in summarising, making composition or paraphrasing messages between or across in person or on phone.
Quite unlike in the case of unaffected or typical children, caregivers of wards with special needs are more liable to view each and every action of their child as due to the diagnostic condition which they have been told is the problem in their ward. As highlighted in caselet #3, the parents ascribed every problem in their child as owing to the Obsessive Compulsive Disorder, Opposition Defiant Disorder, Attention Deficit Disorder, or Autistic Disorder diagnosed by the specialists. If he took a long time to complete activities of daily living, such as, dressing, bathing, brushing and toilet use or shouted occasionally, it was thought to be because the boy had these ‘serious disorders’. However, they were oblivious to the fact that none of the medicines ever worked at all to improve the child’s condition.

The emergence of problem behaviors owing to mismatch or gaps against targeted teaching objectives is illustrated in caselet #2, wherein the student with current developmental age level around 5 years is expected to learn activities which are equivalent or appropriate for students around 7 years. Emphasis or expectation of performance on academic activities at home and school despite the presence of unachieved lower pre-academic reading, writing and arithmetic skills appear to place these students at continual disadvantage to perform, thereby resulting in many emotional-behavior problems, such as, inability to sustain attention-concentration, poor compliance and difficulties in writing, or being slow to expected speed, with general disinterest mainly for school, and academic related activities (Venkatesan, 2015a; 2015b; Venkatesan et al. 2015).

The role of rewards in behavior management programs has been severely emphasized (Bateman & Cline, 2016; Baker, 2008; Carr et al., 2002). There are guidelines on identification of rewards specific to a given child, how, how much or when to distribute them. More important is when, where, or how not to dispense them. Rewards are usually mistaken for expensive things, activities, money, toys, or eatables. Even a simple praise can be more effective with children than any or many of these things-although it is shown that parents scarcely recognize their reward potency (Venkatesan, Peshawaria & Anuradha, 1996). Caselet #3 shows how some caregivers may fault in the timing for dispensation of rewards. Giving the rewards before the occurrence of the target behavior amounts to bribery just as elaborate discussions with the recipient on when, how or where it has to be dispensed is sheer bargaining that is to be avoided. Most important, rewards are not things or events which caregivers presume will work with their children. They are what the recipients themselves value as rewards.

Summary:

- The number, frequency, intensity or location of occurrence of problem behaviors identified or reported by the different informants do not match for the same child;
- There is lack of clarity in caregivers between what is skill behavior and problem behavior;
- Analysis of causal attributes point to lack of concordance, congruence or consonance between the caregivers for the same problem behaviors in a given child;
- Analysis of listed consequences indicates variety, lack of uniformity and inconsistency in the use of techniques for handling the child following occurrence of problem behaviours. Some consequences appear to favour, while others are seen to be directed against the child; and,
- Rewards need to be identified and dispensed accurately or appropriately to a given child.