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

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S. Venkatesan

Professor in Clinical Psychology, All India Institute of Speech and Hearing, Manasagangotri, Mysore: 570006

ABSTRACT Behavior modification approaches have long been the mainstay for identifying and managing problem behaviours. 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 preclude 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).

Mini case studies or caselets are abbreviated forms of case discussion. It is used to describe a sequence of events or put forth an issue or problem that requires decision-making. In this approach, the problems are framed as caselets. It helps apply ideas and insights from real life problems contained in the caselet. Being brief and focussed on the core issue, it provides only the relevant or specific facts needed for reflection and necessary action. Each caselet is tailored for an audience and is usually followed by four to six questions.

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) 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 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

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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 the days in a week and tells that there are six days in a week. He can rote recite 1-100 and writes with a prompt from 1-10. He lacks meaningful counting of objects even below 5. He differentiates big-small objects. He cannot discriminate big-small numbers. During play with younger age peers, he imitates their sounds and actions, but does not understand rule based indoor or outdoor games. He rides a bicycle with support wheels only in familiar neighbourhood. He points to darkness-light between two rooms. He cannot distinguish day-night, parts of day and/or yesterday-today-tomorrow.

Pooling information from case history, clinical interview, behavior observation, key-informant reports, and developmental assessment, the current mental age of the child is measured to be around 5 years (IQ: 36; Moderate Intellectual Disability; 75 % Disability).

Behavioral Objectives:

Parents reported that the following goals were being worked upon by teachers at school, student therapist in the clinics, tutor and parents at home: (1) reads passages from class II English text books; (2) solves 2-digit additions without carry over operations and subtraction without borrow operations; (3) Tells time from analogue clock; (4) Reads a calendar; (6) Spell identified English words of class IV text books.

Caselet #3

Vijay, aged 15 years, student of class eight, from upper socio-economic status levels, was reported with complaints of: takes long 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 past 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.

Contemporary Skill Sets:

He needs verbal prompts or periodic physical assistance to bathe, reverse clothing, and wash in toilet, brush, or groom. He cannot tell time in analogue clock. He can read time from digital clock. He cannot convert measurements for hours into minutes, or tell number of hours in a day. He does not identify denominations of currency, fails to use money as means of exchange or calculation. He cannot shop items with or without chits. He can rote recite months in year, but cannot tell the number of days for a given month or read a calendar. He cannot differentiate or give examples of countries, states or cities. He converses in English using 4-7 word sentences, makes short narrations, spells 4-6 letter words of grade III, but cannot solve multi-digit subtraction involving borrow operations, or carry out multiplication and divisions. His grade equivalent score is around class III. He cannot copy 3-dimensional geometric figures, does not understand rule based outdoor or indoor competitive play. He has difficulties in summarising, making composition or paraphrasing messages between or across in person or on phone.

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 9 years (IQ: 61; Mild Intellectual Disability; 50 % Disability) with Academic Delays and Learning Difficulties.

Caselet #4

Santosh, aged 13 years, student of class VII in English Medium under Central Syllabus, was reported with complaints of poor memory, reduced attention-concentration, lazy, disinterest in studies, with no zest for daily life activities. Psycho-educational testing showed the child with average level of intelligence having grade equivalent score of class II-III for reading, writing, spelling and arithmetic. During testing, he was able to sustain attention till completion of all performance based test tasks. Mother reported that he would watch TV or play on i-pod for hours. He turned fidgety, inattentive or showed disinterest only when given academic activities. She noted that if only the boy could be turned more attentive, interested and motivated towards books or studies, then all his academic problems could be solved. She defended that the child was achieving during nursery, kindergarten and class I-II levels. All his problems began only when his writing load increased in class III and the mother also began to leave the child to study by self.

COMMENTS

Absence of convergence, consonance or congruence between therapeutic agents can jeopardize a behavior modification program. A situation, for example, wherein the mother identifies a list, priorities, number, intensity or extensity of problem behaviors for a given child which is different from those given by the father, grandparents, teachers or therapist is likely to bring about disagreements between them on what constitutes a problem behavior or how to handle them. This is illustrated in caselet #1 where the mother reported problem behaviours not matching with the father, just as the teacher's list did not go with the student therapist.

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 across people in interpersonal communication. He can follow 1-2 step instructions only if they are accompanied by gestures. Wherein age appropriate social companionship is unavailable, the child is left to be alone talking to himself, with animals or young age peers. It is evident that the child wishes to socialize with adults, and therefore, asks questions repeatedly or interferes others talking.

Attribution of 'reasons' or 'causes' for the problem behaviors in their ward is an important ingredient in the handling of problem behaviors in children (Venkatesan & Lokesh, 2016; Venkatesan & Vepuri, 1993). Take the example of a father attributing the mother's 'bad' handling as the 'main cause' of problem behaviors in the child, even as the mother faults 'her own fate' or 'heredity' for the predicament. Caregivers have been reported to attribute a wide variety of grounds for problem behaviors, which may be directed against the child, themselves and/or the environment. In caselet #1, the parents attributed the child's behavior problems to: (1) 'owing to his primary condition'; (2) 'as their deliberate or intentional action'; (3) 'being twin working parents'; and/or (4) 'due to poor models in the

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school surroundings'.

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 showed 'additional problems like stubborn-refusal behaviors, wanting to have his way, and/or shouting-screaming 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 severally 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.

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