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Applying Cognitive-Behavioral Approaches to the Carers of People with Learning Disabilities who Display Challenging Behavior

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Editor's Note: Albert Kushlick is a behavioral psychiatrist practicing in Great Britain. In addition to having Albert as a friend, we were very fortunate to have Albert attend as one of the participants in our very first two-week Summer Institute held in Los Angeles in 1989. Albert has specialized in addressing what in our opinion may be the biggest challenge facing the Multielement approach, i.e., its social validity. In particular, Albert and his colleagues have applied the principles of Albert Ellis' Rational Emotive Behavior Therapy to this problem. We hope their article inspires your own clinical practice and stimulates the further research that is very much needed in this critical area of the Multielement Model.

We are extremely grateful to the authors and Routledge for granting us permission to reprint this chapter in Positive Practices. This chapter appears in a new book published by Routledge entitled Cognitive-Behaviour Therapy for People with Learning Disabilities edited by Bisa Stenfert Kroese, Dave Dagnan, and Konstantinos Loumidis (ISBN/ISSN 0-415-12750-5 for the hardback edition and 0-415-12751-3 for the paperback edition). It is available in the US and Canada from Routledge (29 West 35th Street, New York, NY 10001, USA, Telephone: (212) 244-3336, Fax: (212) 564-7854) and through Routledge ITPS, Ltd (Cheriton House, North Way, Andover, Hampshire SP10 5BE, UK, Telephone: (+44) 01264 3429264, Fax: (+44) 01264 343005). It can also be ordered on-line at Routledge's web site (<http://www.routledge.com>).

Introduction

In recent years a great deal of research has been developed in the area of working with people with learning disabilities who have additional challenging behaviors (e.g. Jones & Eayres, 1993; Emerson, McGill, & Mansell, 1994a). Challenging behavior has been defined as:

‘...behavior of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behavior which is likely to seriously limit or delay access to and use of ordinary community facilities’ (Emerson et al., 1987).

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Editors' Note...

As promised, in this issue of *Positive Practices* we continue to share information presented at our International Conference in London last February. In doing so, for the first time we give the lead article to someone other than ourselves. Albert Kushlick and his colleagues in Great Britain have been doing excellent work in addressing staff feelings, which can sometimes become a barrier in their effort to provide support to people with challenging behavior. Albert described some of this work for us at the International conference and we reprint a recent article on this topic here. We are also pleased to publish in this issue an article by Taj Edwards and her colleague in which they describe the use of video tape in an application of imagery based role play practice to solve a difficult problem behavior occurring in a regular classroom in a Detroit Public School.



Gary W. LaVigna, PhD
Clinical Director

As has been our practice, we also provide further examples of a procedural protocol, this one for a Stimulus Change procedure, and a behavioral definition, this time for perseveration. People have told us that they find these regular features very useful as they are building their libraries of protocols and behavioral definitions for future adaptation and use.



Thomas J. Willis, PhD
Associate Director

Please make note of the "save-the-date" notice for our next International Conference scheduled for January, 1999 in Orlando Florida. We hope you can join us there and we hope you enjoy this issue of *Positive Practices*.

Gary W. LaVigna and
Thomas J. Willis
Co-editors

The Use Of Edited Videos For The Treatment of Selective Mutism

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Editors' Note: Taj Edwards participated in the Longitudinal Training Program we provided a number of years ago for the Detroit Public School system. She also presented a very interesting case at our International Conference in London. It involves a positive program in which imagery based role play practice was achieved through the creative use of edited video tape in which the student was able to see herself engaging in the desired behavior. The strategy produced rapid and lasting change and proved to be very cost effective. We thought you would be interested in learning more about this very promising strategy.

Introduction

Selective mutism is a childhood disorder characterized by the absence of any speech in at least one specified situation (usually school), while speech in any other situations is present (American Psychiatric Association, 1994). In the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) the name of the disorder was changed from “elective mutism” (based on the belief that these children were “electing” not to speak) to selective mutism (based on the belief that these children do not speak in “select” situations). It appears that the recent edition of the DSM-IV shifted in the etiological view on selective mutism, de-emphasizing psychodynamic factors and instead focusing on biological mediated, temperamental and anxiety factors (Black & Uhde, 1992; Crumley, 1990). Recent reports in the literature suggest that selective mutism may simply represent the most severe end of the spectrum of childhood speech inhibitions and social anxiety (Black & Uhde, 1995).

An informal derivation from the etiology and definition of selective mutism can be reviewed as follows: a specific situation or environment (school) promotes the manifestation of a severe anxiety response (mutism). The removal of the anxiety

provoking situation (school) eliminates the anxiety response; resulting in speech. Using this model as the basis for formulating an effective treatment approach, it would stand to reason to address the anxiety factors which elicits the mute response.

The behavioral interventions in the treatment of selective mutism are based primarily on the contingency management and the use of positive reinforcement with stimulus fading. These interventions, in addition to inconsistent results, involve extensive manpower, funding and professional consultation and rarely address the anxiety component of the selective mutism disorder.

The most efficacious treatment strategy, and least utilized, is the use of edited videotapes for self-modeling. Self-modeling is defined as the “behavioral change that results from repeated observations of oneself on videos that show only desired behaviors” (Dowrick & Dove, 1980).

A case study by Kehle, Owen and Cressy (1990) employed an edited video depicting a selective mute boy responding to the questions posed by his teacher with his peers present. The results yielded complete remediation within five, 5-minute treatment sessions. The therapeutic procedure involved very little technical expertise and may be the least restrictive and intrusive of interventions used to treat selective mutism (Kehle et al., 1990).

Ann

Ann is an 8-year old girl in the third grade who had not spoken in class since kindergarten. During the initial weeks of kindergarten she was described as quiet and shy. But within several weeks verbal production in school completely ceased. Occasionally she would whisper to a neighborhood peer on the school's playground, but no other verbalizations were heard or observed. A basic shaping and fading procedure was employed to remedy the situation but it had minimal success.

During the first grade the selective mutism persisted. The school was ill-equipped to intervene and

the parents were forced to implement a home based intervention. This consisted of a reward system contingent upon school verbalizations and the imposition of sanctions for the failure to speak in school. These strategies did not work. There were no apparent rewards that were powerful enough to consistently motivate Ann, and the sanctions employed, omission from family outings, did not have the desired effect either. The net result was increased family tension and continued selective mutism in school.

The assessment confirmed selective mutism and ruled out other developmental disorders...

During the second grade, Ann continued to be mute in school and further attempts for remediation were considered. A school evaluation was performed and Ann was labeled as “speech and language impaired.” A speech teacher was assigned to her and they, Ann’s parents and the teacher, developed a shaping strategy for the teacher to use with Ann during the half-hour per week speech therapy sessions. The teacher viewed this shaping strategy as an imposition to her overwhelming case load and it was abandoned.

During the summer between Ann’s second and third grade, she and her family moved to a rural school district. It was during this time period when an independent school social worker conducted a full behavioral assessment based on the Behavior Assessment Guide (Willis, LaVigna, & Donnellan, 1993). The assessment confirmed

selective mutism and ruled out other developmental disorders: childhood schizophrenia; speech and language disorders; neurological disorders; depression and psycho-social factors.

Ann’s selective mutism was not confined only to the school situation. She would not speak in front of unfamiliar adults; even in the presence of her parents and in the comfort of her own home. However, after approximately 2-hours of exposure to the unfamiliar adult she would begin to ease into speech. Initially, she would whisper to her parents and these whispers would be audible to the unfamiliar adults. Eventually Ann would begin to speak. Situations such as restaurants and social outings were also areas where she would be selectively mute. She also refused to answer the telephone or make telephone calls. Within the school setting Ann would speak to her parents, but only if no one else were present.

Despite her pervasive mutism in school Ann exhibited adequate social skills. She would smile and silently laugh at amusing situations; she played and interacted with most of her classmates during free-time and recess; she creatively used hand gestures and nods to indicate needs and desires; and she displayed a wide range of affectual expression. She maintained a “C” average throughout her three years of elementary school, despite failing grades for areas which required verbal participation.

The behavioral assessment revealed a parental history of social anxiety. According to Ann’s father, he was described as “shy” and “quiet” in social situations and when he was in school. His remediation of the problem began later in high school when he became involved in the performing arts. Ann’s maternal grandmother also reported ex-

treme shyness and social anxiety in school as a child.

Ann is the eldest of three children. At home she is very verbal and assumes the dominant role of eldest child. She is described as “happy,” although sometimes obstinate to parental authority. The family assessment did not reveal any familial violence, abuse, neglect or any other traumatic events.

The Plan

A three-faceted approach was implemented in treating Ann’s selective mutism. The first strategy involved relaxation training within the school setting. The rationale for this strategy was to teach coping and self-soothing skills for anxiety management. The relaxation techniques were taught in 30-minute sessions at least 1-time per week by the school’s social worker. The primary relaxation techniques utilized were: “Sitting at the Desk,” “Autogenic Phases for Hand Warming” and the “Progressive/Gross Motor and Facial Relaxation” (Cautela & Groden, 1978).

The second strategy involved teacher and social worker home visits. The rationale for this strategy was to establish a rapport with Ann in an environment where she spoke and interacted normally. Ann never spoke to the teacher or social worker in her home environment. She would whisper to her parents in their presence, but their length of stay may not have been sufficient for her to acclimate.

These strategies took place for approximately two months prior to the initiation of the third phase: The use of edited videos for self modeling. On the day of taping, Ann’s father was brought into the her regular education class and was instructed to read ten questions (e.g., “Who is the president of the U.S.?” “What is your phone number?” etc.). No other person was present in the

classroom and Ann answered each question on the tape without a problem. A second videotape was then utilized to video the entire class (including Ann) with the teacher reading the same set of 10 questions. The two tapes were then edited with the results depicting Ann responding to the teacher's questions in the presence of the entire class. The class was videotaped from the back of the classroom with close-up shots of Ann answering each question. The total length of the tape was approximately two-minutes.

Initially, the edited tape was viewed at home with Ann and her family. The following day she viewed the video for a second time in the presence of her family, the social worker and her teacher. This viewing also took place in her home. On the same day, a third viewing took place in front of the entire class. The response of her class was of excitement and praise.

Immediately following the third viewing, Ann began to vocalize in the presence of her social worker. She spontaneously answered "uh-huh" and "un-unh" to questions posed by the social worker. She was reinforced by giving her the opportunity to hold "little guy" (a pet hamster) when she answered the social worker and she was allowed to feed the gold fish when she answered the school secretary. She was then taken to other staff persons and she responded to their questions. During that week she produced only simple syllable utterances.

No further progress was noted for approximately one week following the third video session. During this time another videotaping was conducted in order to improve the sound quality of the tape. It was hypothesized that the poor sound quality of the first tape may have contributed to the subject's lack of continued progress.

The second tape was remarkably improved in sound quality. The pro-

cedure for taping the second video was the same procedure used in taping the first with the addition of a remote microphone. The length of the tape remained approximately two-minutes in duration. This tape was viewed initially at home with Ann and her family. The next day the revised tape was viewed with the social worker, the teacher and Ann in her home and the following day the both tapes (the original and revised) were viewed with the entire class. This viewing was made into a classroom event; the tapes were formally introduced and popcorn was served to the students. Again, the classmates were jubilant and supportive of Ann after viewing the revised tapes.

Results

After the class viewing of the revised tape, the social worker began to tell each staff person in the school to "expect" Ann to communicate verbally. One week later from the classroom viewing, Ann verbalized the words "basket," "yes" and "no" while working on a basket weaving project with the social worker. The social worker immediately took her to each staff member; where she answered "yes" and "no" to their questions.

A week later Ann abruptly answered "uh-huh," "un-unh" in the presence of her classmates. Her peers were elated; they simultaneously asked her questions as she excitedly responded.

Following a six-week period and viewing the videos eight times, Ann began speaking one-word vocalizations in the classroom. During the seventh week she progressed to two-word vocalizations and eventually began to read out loud in class. The social worker continued to encourage and support each progression of her verbalization.

Initially Ann would only speak to others in the presence of the social worker while she was holding the social worker's hand. The social worker began to gradually fade out her "support" by moving away step-by-step. Towards the end of the semester Ann attended a mother and daughter tea at the school; Ann giggled, played and conversed throughout the event.

Her progress was consistent until the last two weeks of the semester when the social worker decreased her days at the school from five-days per week to one-day per week. Ann responded to the change by relapsing. As a response, the social worker successfully established a contingency plan to support Ann in her continued progress. In preparation for summer break, Ann was introduced to her 4th grade teacher four-times.

The following semester after summer break Ann began to speak fluently after the first two-weeks of discomfort and hesitancy. Her transition into the new semester was

Towards the end of the semester Ann attended a mother and daughter tea at the school; Ann giggled, played and conversed throughout the event.

supported by the social worker and a best friend.

One year following, Ann continues to speak in school. Her grades have improved dramatically and she has delivered several verbal book reports, speeches, and she won "best performance" for a poetry recital. Her success has also generalized to

all other situations including: restaurants, social outings and telephone speaking.

Discussion

According to the DSM-IV: social phobia or social anxiety disorder is a marked and persistent fear of one or more social performance situa-

fear stimulus until toleration is accomplished. "But in social situations it is difficult to arrange a hierarchy, because they are so diverse, complicated, and unpredictable. It is difficult to guarantee exposure sufficient to diminish anxiety. Besides, patients can not judge their accomplishment as easily as they can after overcoming a fear of bridges or spiders." (The Harvard Mental Health Letter, 1994). With the use of edited videos the person can clearly assess their accomplishments in a created social situation that approximates reality, with himself/herself as the model. The un-intrusiveness of this procedure allows the person to absorb the information needed to confirm their accomplishments and safety. This may explain why, as in Ann's case, the

strategy was so successful in generalizing results across other situations and remained stable over time. That is, Ann resumed speaking in the classroom setting after the summer break. In addition, she showed other improvements throughout the fourth grade. For example: 1) she began to raise her hand in class, seeking out the opportunity to participate, 2) she began to make telephone calls on her own and to answer the telephone, and 3) she made restaurant orders without assistance. During the first two weeks of fourth grade she received encouragement and was expected to speak. After that initial period, no further strategies were implemented. Generalization of treatment effects for selective mutism are paramount for the prevention of lifelong disabilities associated with childhood social phobia. Studies have suggested that adults who suffered from social phobias and anxieties in childhood, continued to demonstrate co-morbidity with other disorders: simple phobia, agoraphobia, major depres-

sion, dysthymia, alcohol and other drug abuse (Black & Uhde, 1995).

The use of relaxation techniques were incorporated as a coping strategy to manage anxiety in general and also, used as a primer for the video procedure. It is also important to establish a non-stigmatizing environment for the person. An ecological strategy was put into place by establishing home visits for the teacher and social worker. The rationale of this strategy was to have significant school personnel witness her "normal" behavior in a situation that did not promote the mute response. Unfortunately she did not directly verbalize to the staff persons, but the visits did help to establish a "therapeutic commitment." The other ecological strategies included the preparation of school staff and peers to expect speech from Ann.

Ann made a gradual eight-week progression into speech. According to Kehle et al., this may have taken place because the tape did not depict a sufficient amount of time showing the child talking. In Kehle's study, his focus person demonstrated no speech after viewing the videotape; which depicted less than 4 seconds of actual speech. The same procedure was implemented as the first, but with an increase of speaking time (7.78 seconds). After the second day, using the revised tape, the focus person began to converse spontaneously. The total speaking time for the focus person in this study was approximately 1 minute. In hindsight the focus person may have demonstrated spontaneous speech several weeks sooner if the video depicted an increase in talking time.

Other related questions also arise. What is the best stage at which to employ these strategies? Is there an age threshold under which these strategies would not be effective? Would these techniques work with other behavioral challenges such as: depression; hyperactivity; attention disorders; explosive disorders or any other behavioral challenges which

Generalization of treatment effects for selective mutism are paramount for the prevention of life-long disabilities associated with childhood social phobia.

tion in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual's fear is that he or she will act in a way that will be humiliating or embarrassing (American Psychiatric Association, 1994). In recent literature, authors have noted a resemblance between selectively mute children and socially phobic adults (Black & Uhde, 1992; Crumbley, 1990; Goldwyn & Weinstock, 1990). The major difference in adults with social phobia is their ability to control anxiety situations through avoidance of the actual situation. In turn, children with social phobia are unable to select their situations and therefore may develop situation specific responses (i.e. mutism) in order to manage their intense anxiety.

Exposure with desensitization is a common therapeutic technique used to treat phobias. The therapist tries to create a hierarchy of frightening situations coupled with physical relaxation. The relaxed person is then gradually exposed to the

have traditionally responded to some aspect of modeling and anxiety reduction strategies?

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Continued from page 1

Such a definition introduces the idea that one aspect of challenging behavior is that it prevents people from participating in a high quality of life. Many services for people with learning disabilities use the concept of 'quality of life' as an outcome (Kushlick, 1975; Kushlick, Felce, & Lunt, 1983; Felce & Perry, 1995; Dagnan, Look, Ruddick, & Jones, 1995; Schalock, Keith, Hoffman, & Karen, 1989). Challenging behaviors may exist throughout life (Emerson, 1992) and we assert that, even when the challenging behaviors remain, it is still vital that the opportunities for a high quality of life with ensuing opportunities to develop functional alternative behaviors are offered despite the challenging behaviors.

We suggest that seeking a high quality life for oneself and others is a valuable and widely accepted goal. A definition of challenging behavior as a behavior that impedes our achievement of this allows us to understand our own behavior and that of our clients in the same way. This chapter shows how one of the most well-accepted and ecologically valid behavioral technologies, positive programming (LaVigna & Donnellan, 1986) can be integrated

with a cognitive psychotherapy approach for carers. This cognitive-behavioral method will be described in some detail in the context of a training course for carers of people with learning disabilities. The approach described assumes that the goal of working with people with learning disabilities and challenging behavior is to enable our clients and ourselves to work creatively and effectively towards a high quality of life.

Behavioral Approaches

By far the biggest contribution to understanding and intervention in challenging behavior has come from the behavioral approach. A major advance within this has been the shift from behavior reducing techniques to suppress or eliminate behaviors labeled 'challenging' to using non-aversive contingencies to develop new, and maintain existing positive behaviors; the constructional approach. (Goldiamond, 1970).

Positive Programming

One of the most widely used multi-component packages of non-

aversive behavioral interventions is that assembled by LaVigna and Donnellan (1986). This approach begins to offer the techniques needed to maintain a high quality of life in 'ordinary' environments. They offer a constructional approach that celebrates, rewards and extends each person's existing current valuable repertoire. The approach has three components.

1. *Assessment*. Positive programming requires thorough assess-

This chapter shows how ...positive programming ...can be integrated with a cognitive psychotherapy approach for carers.

ment. This should involve assessment of the strengths of the client, their preferences and their adaptive behavior. It will also involve assessment to identify the functions of the challenging behavior. One of the main com-

ponents of the 'non-aversive' approaches is an emphasis upon functional analysis (Bijou & Baer, 1961; Bijou, Peterson, & Ault, 1968; Carr, 1988; Horner et al., 1990). Functional analysis is the attempt to identify factors af-

fecting a particular behavior. These include events immediately preceding and following the behavior and broader ecological variables. From this it has been possible to infer some possible communication functions of challenges. For example, 'I feel...', 'I want...', or 'I don't want...'. Using such formulations it has been possible to teach carers to respond immediately to the challenging behavior in the 'hot' situation as if the person had communicated more effectively and appropriately and to begin to teach the person presenting the challenges, in the 'cold' situation to communicate more effectively (Carr & Durand, 1985).

In this section we turn to cognitive-behavioral approaches which we believe can provide us with an understanding of staff responses to challenging behavior.

2. *Positive proactive interventions* to teach more appropriate ways for the person to communicate their needs and feelings. This may include positive programming of the constructional development of general skills and skills that are functionally equivalent to the challenges presented. This may then replace the challenging behavior provided it achieves

the same function as the challenging behavior at least as easily. Proactive interventions may also include direct behavioral treatment such as arranging differential schedules of reinforcement and stimulus control methods and ecological manipulations to change settings, styles of interaction etc.

3. *A range of reactive strategies* to be implemented to keep clients, carers and others safe and to limit any damage caused by the challenging behaviors until the proactive strategies have an effect. This may include active listening, stimulus change and other forms of crisis intervention.

The Importance of Staff Behavior

The positive programming approach requires staff and carers to implement a complex set of procedures over long periods. Increasingly there has been recognition of the cognitive, behavioral and emotional challenges presented to carers if they are to arrange high quality environments for their clients. Evidence shows that, without accessible support, care staff 'survive' by responding to challenges in the best way known to them (Hall & Oliver, 1992; Hastings & Remington, 1994a). Such reactive strategies may successfully stop the behavior in the short-term, but they may have long-term negative effects. For example, giving the client what they want, or removing what they don't want in response to challenging behaviors, may reduce escalations to more serious behaviors. However, unless also accompanied by procedures to increase frustration tolerance, or to teach appropriate alternative ways of attaining objectives, they will strengthen the earlier component of the challenging behavior in the long-term. This

is so particularly if such consequences are delivered only intermittently (Ferster & Skinner, 1957).

Effective intervention packages will often be complex and must be carried out consistently over long periods of time if they are to work. There have been few attempts to study the barriers to successful implementation of such behavioral programs. Indeed Hastings and Remington (1994a) point out that 'researchers and practitioners have rarely considered the motivational factors that may underlie the origins and current determinants of staff behavior' (p.281). Hastings and Remington (1994b) recommend that, in trying to understand the determinants of staff behavior, we should look at the relationships between a behavior and its consequences as a two-term contingency. They suggest that, components of staff behavior may be 'under the control of contingencies relating to the aversive nature of challenging behavior itself' (p. 282). Some care staff behavior may arise from attempts to reduce their aversive experiences.

Cognitive-Behavioral Models

In this section we turn to cognitive-behavioral approaches which we believe can provide us with an understanding of staff responses to challenging behavior. The virtue of these approaches is that they provide a framework for explaining such staff responses at the emotional and cognitive as well as the behavioral level. These approaches also enable us to specify and test the kind of cognitive-behavioral training intervention that may be effective in producing beneficial change in carer behavior. We draw mainly on rational-emotive behavior therapy (REBT; see Ellis, 1995).

The results of a study by Dagnan, Trower and Smith (1996) and other studies that show a relation between staff attitudes and staff behavior can be understood within a rational-

emotive behavior therapy (REBT; Ellis, 1995) perspective. Ellis offers an ABC model in which A is an activating event, B is a belief about that activating event and C is the consequence in behavior or emotion. For example the A may be a client's challenging behavior in a particular situation. B is a belief about that behavior, for example the inference that, 'the behavior is under the person's control' and that the person is 'attention seeking' and hence is 'bad' or 'worthless' and 'should be punished or avoided.' C is the emotional or behavioral consequence that may involve feeling anger and avoiding the person. The main point of the theory is that the person's feelings and behavior can be predicted from a knowledge of their beliefs. Rational-emotive behavior therapy is then designed to help a person identify their beliefs, feelings and behaviors. Beliefs that are found to be 'irrational' (i.e. that are unsupported by evidence) and that appear to be an obstacle to working towards a high quality of life may be systematically appraised. They may then be changed for beliefs that are supported by evidence and that empower the individual to work for the attainment of a high quality of life for themselves and others.

In setting the scene for describing the training workshops we make the following assumptions. Humans want to live high quality lives for themselves and, where they can see ways of doing it, to help other humans to also live high quality lives. However, challenging behavior, by definition is a barrier to high quality living. It is predictable that we all will, at times, respond unhelpfully at the behavioral level, experience anxiety or anger at the emotional level, and make negative attributions to the challenger ('blame' the client) at the cognitive level (Weiner, 1980; 1985). We may also make inappropriate positive attributions to the challenger.

Ellis and Harper (1975) have drawn attention to the tendency of most humans with sufficient expressive language to exaggerate and over generalize their healthy 'preferences' about themselves, others, and the universe into unhealthy 'demands.' For example, a healthy preference may take the form, 'I like to perform well,' and a healthy inference, 'If I want to get things the way I prefer, I had better accept my uncomfortable feelings and work creatively towards getting what I want.' Our tendency to exaggerate and over generalize as 'demands' may take the form 'I must, ought and should always perform perfectly,' and unhealthy inferences drawn from this may include, 'If I don't get what I demand of myself then I deserve condemnation and punishment as a worthless wimp, I feel totally depressed, the future is hopeless and it is awful and terrible and I can't stand it.' Because of these very widespread and fallible tendencies in most humans, we conclude that most will need special forms of support if they are to problem-solve effectively and implement detailed multi-component procedures of the constructional behavioral approach over long periods that will include both successes and severe setbacks.

Overview of an Integrated Cognitive-Behavioral Training Approach

In describing a substantial cognitive-behavior training approach in the space available here we inevitably have to be selective. We therefore concentrate at the level of detail on the innovative and cognitive components of the training. In order to make use of this material readers will need to have a detailed knowledge of positive programming from sources such as LaVigna and

Donnellan (1986). The bulk of this chapter takes the form of a description of the framework and some of the content of a training course developed by the first author. The training takes the form of two or more workshops that are best integrated with ongoing supervision of carers and people themselves, focusing on issues of concern.

Preparation

Before the first training meeting participants are asked to collect data concerning an individual client. The data may consist of:

1. The Behavioral Assessment Guide (Willis & LaVigna, 1989). This substantial assessment provides descriptive data on the person's strengths and the daily routine they follow. It provides sufficient data on the challenging behavior to make an informed hypothesis about its function.
2. Staff are requested to send a video of parts of the client's daily activities. People sometimes apolo-

Rational-emotive behavior therapy is then designed to help a person identify their beliefs, feelings and behaviors.

gize that the video taken does not include illustrations of the challenging behaviors. However, examples of the clients behaviors that are not challenging provide the key information on what is already working and it is on this type of material that future interventions can be built. Staff are asked to take about one or two hours of video 'as it occurs' so that the sequence can be seen in 'real time.'

3. If the client has an extensive verbal repertoire or is self-conscious about being videoed, staff are asked to do a tape recording of a conversation or a counseling session and send that.
4. Staff are asked to keep a daily diary of 'good news' and 'bad news.' If the client is able to write, the client is asked to do this with as much support as they need. Some clients do this using pictures and symbols, otherwise staff do it with them.

Who Constitutes the 'Service'?

Before starting the workshops we review the service in which people work. Participants are often unaware of the numbers of professionals whose participation will need to be supported and aligned if procedures are to be effectively and efficiently implemented. In particular it is useful to highlight the different amounts of time carers of different types spend with clients. This varies from clients, parents, residential and day-care staff who interact intensively with one-another over long periods of the day or night, to the interactions of professionals who interact intensively, and often individually, for much shorter periods of any day, and who may only do so at long intervals (weekly, or monthly, or even annually). The failure of service managers and planners to address this challenge may result in a waste and duplication of effort that is often ineffective. It is also often perceived very negatively by clients, parents and other front-line workers.

The Training

To work successfully with people with learning disabilities and challenging behavior it is important to:

1. Have a goal and know what we are trying to achieve.
2. Know how to achieve this goal.
3. Have a way of 'surviving' the journey, that is to be able to act

constructively, calmly and lovingly to ourselves and others despite the set-backs we will experience and the accompanying emotions that will be felt during the journey.

The goal is to attain a high quality of life for the client and those working or living with them. The method of attaining this goal is the constructional, non-aversive behavioral approach (Skinner, 1953; Goldiamond, 1970; 1974; LaVigna & Donnellan, 1986). The ways of keeping calm and accepting along the way involve the use of techniques and ideas from Rational Emotive Behavior Therapy (Ellis & Harper, 1975) by those working or living with the client and by the client themselves if they are able to participate.

What Are Our Goals?

We begin this section with a discussion of our goals. Through discussion these are brought together under the heading of achieving a high quality of life. We use the abbreviated form 'HQL' to make this a specific goal rather than a general concept.

Table 1 lists some components of a 'menu' of what constitutes a high quality of life for most people. Most people seeing the menu agree that the main challenge they face is the priority given to different components of the menu. 'How much time

should I spend on my house, my clothes, my finances, my relationships, my spiritual life or being creative.' Few people find a good balance for very long. We strongly emphasize that our most important relationship is with ourselves. Ellis (1979) summarizes this as 'me first, others a close second.' Participants may claim that this is a selfish position, and that their most important relationship is with their partner, parent, or children. During discussion, most agree that the better I am getting on with myself, the better I am also likely to respond to the interests of others and help them towards their own high quality life. On the other hand, if I am relating badly with myself and putting myself down, I am less likely to notice others and their needs. The commitment to work for goals relating to a high quality life constitutes what Ellis calls 'medium and long-term (as opposed to short-term) hedonism' (Ellis, 1979).

There is a qualification to a high quality life menu. This is that it is very important to be committed to work for a high quality of life despite failure. Most people have a tendency to work for their and others high quality life, 'as long as I don't have failures or too many of them.' We discuss the issue of 'failure' (we offer Table 2 as a 'menu') and help trainees to the conclusion that 'failure' is best defined as, 'not getting what I want,' or, 'getting

<p>Housing, shelter, clothing, food, furnishings, money, paid work</p> <p>Social relationships with: ourselves, children, parents, family, friends, partners, colleagues, neighbors, town</p> <p>Privacy and choice</p> <p>Expression of sexuality</p> <p>Security from abuse</p> <p>Education, qualifications, information</p> <p>Physical and emotional health</p> <p>Recreation</p> <p>Political decision-making, protesting, access to legal help, rights</p> <p>Exploring and creating, helping self and others</p> <p>Spiritual</p>

Table 1 -A Menu for a High Quality of Life

what I don't want.' The items on the failures menu are discussed in some depth. It is noted that the items listed on Table 2 are either synonyms for failure, or particular forms of it, e.g. 'obstacles,' 'hassles,' or, in the case of 'uncertainty' or 'risk,' predictions that I may not get what I want, or that I may get what I do not want.

The value to the species of the commitment to work at HQL activities despite discomfort is illustrated from the observation that very important valued activities take place despite the fact that people are experiencing extreme forms of discomfort. For example, women continue to bear children despite the fact that the confinement and birth is clearly very uncomfortable and painful! Parents of very young children who do not sleep choose to practice walking and doing other parenting tasks when they are virtually asleep! Similarly, important and valuable tasks are carried out despite the fact that the people doing so feel depressed, panicky, or angry. Indeed, the evidence suggests that people 'get better' and even 'feel better' to the extent that they practice and learn to work for high quality lives despite their negative feelings and the discomfort of 'failing.'

Often for people working in health and social services lack of resources is a big issue and people

often resist committing themselves to working for a high quality of life for themselves or others because their resources are inadequate. However, whenever we are working towards high quality lives we use those resources that are available to us (if our resources were not adequate to do what we are doing, we would not be doing what we are!). If we want to do new things, we had better budget for what we want to do and set about getting or re-arranging our resources to do what we want.

A quick exercise we often use is to ask participants to raise their hands if, on the day of the meeting they have already not got some things they wanted or got others they didn't want; all do. Some add comments about what the failures have been, such as attending the workshop when they would rather be doing something else. We point out that this exercise shows that people have experience of working towards a high quality of life despite the fact that they experience failures. The commitment to work and support others to work for their high quality life despite failing some of the time, is what is referred to by Ellis (1979) as 'high frustration tolerance.' The commitment to procrastinate or give up because it is too difficult at present and to wait until things get better before working toward high quality life is use-

fully categorized as 'low frustration tolerance.'

Low frustration tolerance relates directly to the issue of challenging behavior. A challenging behavior is one that gets in the way of us or others attaining a high quality of life. Self-harming behaviors such as smoking, overeating and procrastination (putting off completing assignments, taking up issues to improve relationships) are usually acknowledged by workshop participants as challenging behaviors that they have. Next they are asked if they believe that they will ever be able to give them up entirely. Wisely, very few think they will. Nevertheless, most can conclude that they are committed to continue working for their own and others' high quality of life despite their own continuing challenging behaviors. The same principle can be applied in working with the challenging behaviors of others.

Why Are Challenging Behaviors So Difficult to Give Up?

We explore with trainees the idea that challenging behaviors virtually always have a function, for example, under some conditions they get the person immediate results or relief from discomfort. This relief is often exaggerated by the person, for example smokers say they are 'dying' for a smoke and proceed to kill themselves smoking; overeaters say they are 'starving' despite being overweight and munch cheese sandwiches; procrastinators say 'I'll do it later' and leave important tasks undone. The immediate common result of each challenge is the 'relief' felt by the person expressing the challenge. In this way, challenging behaviors can be seen as having a 'communicative function' i.e. they communicate, 'I feel...', 'I want...' and 'I don't want...'. We set trainees the task of working out what their own challenging behaviors communicate.

<p>Failure Obstacles Hassles Uncertainty Risk Just and unjust criticism My own and other's obnoxious behavior Inadequate resources Physical impairments, mental health impairments, intellectual impairments Felling 'yukkie': depressed, panicky, angry, jealous, tired, nauseous, in pain, sweaty, shaky, breathless Severe challenging behavior</p>
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Table 2 -A Menu for Setbacks in Working Towards a High Quality of Life

One of the aims of this section is to help participants to identify the power of immediate relief from discomfort as a motivator of human behavior. We also identify the tendency of humans to use their creative verbal behavior to derive inac-

found in other works (LaVigna & Donnellan, 1986). In this chapter we give an overview with issues highlighted where they are of particular interest.

Assessment

We continually stress that we are taking a constructional approach and that any new developments will take place 'on top' of what is already there. Therefore, we stress that we assess the challenging behavior in great detail and also assess the strengths of the person and people working with them. We add to the non-verbal behavioral assessment an assessment of the person's verbal (cognitive) behavior.

Direct Treatment and Reinforcers

At this point the value of 'catching people getting it right' rather than 'getting it wrong' is raised. If we want to teach new behaviors effectively we need to reward people more for getting things right than for getting things wrong. In doing this it is important that we find out what are the things that function as rewards for individuals, and that we do not assume that these are the same for everyone. We also highlight issues surrounding schedules of reinforcement.

Positive Programming

A number of staff or carer skills are discussed here including Discrete Trial Compliance Training (Koegel, Russo, & Rincover, 1977), an effective and non-aversive way of getting compliance for practicing skills, and Functional Communication Training (Carr & Durand, 1985) which is an approach that teaches people an appropriate way to communicate the preference or demand expressed by the challenging behavior.

At this stage participants are also introduced to the procedures of 'thank you for saying 'no' ' and 'I'll

come back soon and ask again' (Kushlick, 1988). This is very helpful in allowing staff to back off appropriately from a request to a client who says or indicates "no." Staff who have been told "no!" can then get on with other tasks before going back to try another way with the client. Without such a procedure, carers tend to feel very rejected by the person's refusal. They may tell themselves catastrophic things about their having 'no power' or 'a low value,' and about being 'manipulated.' They may then express these beliefs and engage in nagging, over-prompting, abuse or avoidance of the client.

Within this section participants also learn to value high frustration tolerance referred to earlier. That is, the carer will at first respond immediately to the client's want or not want only because at that stage the evidence is that the client is unable to respond appropriately to the frustration of not getting what they want immediately. However, it is the medium and long-term aim to teach the client the skill of tolerating frustration for longer periods, without escalating. Staff and parents will therefore be supported in gradually increasing the delay in responding to the client's requests. In relation to clients with conversational skills, this aim can be agreed with them. For clients without such skills, the increases in delay are arranged subtly so that they are not noticed by the client.

If this strategy is to work, staff have to agree to comply by 'actively listening' to (e.g. Egan, 1986) and problem-solving around the clients' requests. This has to be done repeatedly and with great precision if the client is to learn that it works better than interacting in ways that do not involve active listening. The regular participation of clients in goal-setting and problem solving relating to their high quality of life is a key ingredient for those clients with the skills to participate in this

One of the aims of this section is to help participants to identify the power of immediate relief from discomfort as a motivator of human behavior.

curate inferences on which they then proceed to act as if they were true or a part of their real experience. This helps to introduce them to what Ellis (1977) calls 'irrational beliefs' or 'inferences'; a point we return to later.

What Tools Do We Have to Work Towards a High Quality of Life for Our Clients?

This part of the training includes a checklist of procedures drawn largely from the package developed by LaVigna and Donnellan (1986). These procedures are the tools that people will need in order to work towards and maintain a high quality life for themselves and for the people with challenging behavior. Later in the training and in later supervision meetings they will be going over and implementing these components in detail. At this stage the aim is to familiarize participants with all of the components and to highlight that many of them are similar to the 'ordinary' activities that they and others now do. Most of what we cover here can be

way. Staff who learn to ‘actively listen’ also have to learn the importance of accepting, without arguing, what clients express as their beliefs at that time, however unlikely these may be.

Ecological Strategies

In the past most attention in this domain was focused on conditions like noise, crowding and temperature (e.g. Aiello & Thompson, 1980; Boe, 1977; Rago, Parker, & Cleland, 1978). These conditions are still relevant, but more attention is now focused on the staff/parent interaction with the client, and the training is aimed at familiarizing participants with these competencies. These may include the manner in which staff approach a client before making a request, whether the client’s attention is negotiated before making requests or giving instructions, the clarity and tone of the instruction, whether the person repeats the instruction several times (nags), whether and how prompts are given, how client successes are rewarded, how clients’ requests are responded to, how carers respond to the client’s non-compliance.

Reactive Strategies

These are procedures aimed at limiting damage to the client and others, and returning the client to agreed high quality of life activities as soon as possible. Reactive procedures are needed to keep people safe when challenges occur until the other components of the overall package begin to render challenging behavior less relevant as a form of communication. Indeed, we believe that parental and staff credibility in the skills of an outside consultant who uses a non-aversive, constructional approach is seriously reduced if the consultant fails to address the vital issue of ‘what do we do that is acceptable (and will not result in our being disciplined) to keep safe when the challenging behavior occurs?’ On the other hand,

experience shows that staff and parents who have got agreed, safe and well-practiced reactive procedures (preferably agreed and role-played with the client), will work creatively and lovingly, despite the persistence of challenging behaviors over long periods.

Reactive procedures are taught in the form of a hierarchy from the least intrusive to the most. The most valuable by far, particularly in relation to people who have some conversational or verbal receptive and expressive skills is active listening (Egan, 1986). Simply listening to the person can diffuse difficult situations and allows jointly prioritizing clarified issues in a way that can lead to creative problem solving. Where this fails or is not applicable other strategies are needed. These include ignoring or diverting to high quality living activities, stimulus change and blocking to limit the impact of physical violence. Where other methods fail restraint and relocation may be needed. All of these procedures are better designed individually for (and wherever possible with) the client during emotionally ‘cold’ periods of calm discussion. They had better be practiced, with feedback, regularly in role-plays, if they are to be used effectively when emotionally ‘hot’ situations arise.

Setbacks

We ensure that our trainees will also have strategies for coping with ‘setbacks.’ The aim in this work is not to eliminate setbacks, but to monitor them systematically, and to use the data to modify the procedures used. Indeed, the most important component of the workshop is to communicate the value of accepting the data of the situation in relation to the high quality life of staff, parents and client just as it is at any time, and working energetically and creatively at nearly all times towards high quality lives despite the

severe challenging behaviors. In this context, setbacks, although always healthily uncomfortable, had better be viewed as useful data indicating that changes are needed to prevent damage, and to enable a high quality of life to be attained. Another way of putting this is that setbacks illustrate that the strategies being followed do not work. The challenge to staff is to describe what will happen in that situation if the strategy works and to set about problem-solving to find ways of making things work.

The A-B-C of Emotions

The next part of the workshop addresses the ways staff, parents and some clients with sufficient verbal skills can apply rational-emotive procedures to help the task of working creatively for a high quality of life as calmly and effectively as possible. This is developed through the ‘birthday exercise.’ The aims of the exercise are,

1. to help participants to distinguish feelings from beliefs.
2. to identify and name negative and positive feelings.

... ‘what do we do that is acceptable ... to keep safe when the challenging behavior occurs?’

3. to clarify that there are healthy and good negative feelings that protect us through highlighting situations in which we are not getting what we want or getting what we do not want.
4. to distinguish healthy negative feelings which help us defend and expand our high quality of life and that of those we care

about, from unhealthy negative feelings which help us to destroy and sabotage high quality life goals.

The Birthday Exercise

First we ask participants to rate their own feelings as they are at

...if one's beliefs about 'A' or 'C' are positive, one feels 'cheery' and does 'cheery' things; if one's beliefs about 'A' or 'C' are negative, one feels 'yukkie' and does 'yukkie' things.

that point in time. They are told, 'Rate yourself zero if you are feeling such that you are considering suicide as a solution to your problems. Rate yourself 10 if you are feeling so energized that you are looking forward to making this workshop/ session the best you have ever created.' We then ask some participants to volunteer their score and the reasons for this. Their responses usually illustrate the A-C theory of emotions; that events cause the emotional consequence. For example some one may say, 'My score is two, the baby didn't sleep last night, my partner was in a foul mood at breakfast, the car didn't start for an hour and the credit card account shows we owe £500.' We point out that if the events (the As) are the cause of the feeling (the Cs), then until the events are changed, the feeling (C) would not change. However, most people experience that their score does indeed change during the day even though the As remain the same.

Participants are then introduced to the cognitive A-B-C theory. There

are still activating events and emotional consequences. However, between 'A' and 'C' we now consider our beliefs (B) or thoughts about 'A' or 'C.' At its simplest level this theory suggests that if one's beliefs about 'A' or 'C' are positive, one feels 'cheery' and does 'cheery' things; if one's beliefs about 'A' or 'C' are negative, one feels 'yukkie' and does 'yukkie' things.

We then suggest that we test this theory out. We ask for volunteers who are told that they will be given an activating event that occurs regularly in everyone's life. The volunteers will be asked to share with the group their beliefs or thoughts in relation to this 'A.' The first volunteer is asked to give us depressed thoughts in relation to the 'A.' It is explained that depressed thinking is offered to the earliest volunteer because most people are very good at it. Indeed, participants are told that they will now be given a recipe for having a 'great depression' because if they know how to create one, they will also know how to get out of it. A second volunteer is then sought for the equally easy task of offering anxious thoughts. Participants are reassured that like depressed thinking, this too is well developed among most people. Recruiting of volunteers continues until they are also available for angry, calm, and loving.

Volunteers are told that the 'A' for the experiment is, 'It's your birthday,' and they have woken up with depressed thoughts. They are then asked 'what are these thoughts?' The first volunteer may start with 'I'm a year older. I haven't done the things I had wanted to do. No one has remembered my birthday. I'm a year closer to death. I have wrinkles on my face/I am getting bald or

grey.' (It is useful to stop the listing at three to make the exercise manageable). It is asserted that these beliefs will not cause depression. If at one's birthday one believes that one is other than a year older, it would be a source for serious concern. The point is made that scientifically accurate thinking supported by evidence may well be accompanied by healthy feelings of sadness. This is appropriate because this may set the occasion for healthy problem-solving. However, with only healthy sadness people will not succeed in the difficult task of creating depression. It is asserted at this stage that additional effort will be needed for this. If no one has already offered this, we then prompt participants in the core belief leading to depression (as opposed to healthy sadness), that of global negative self-rating. Thus the accurate beliefs that people have forgotten my birthday, that I have not attained my targets, that I am now nearer death will only lead to depression if they are linked by a common cause, that I am 'a failure, a loser, a nobody, a fool.' We suggest that this is covered by the general label of 'a worthless shit.'

Most 'depressed' beliefs follow logically from the belief, 'I am a worthless shit.' In giving the recipe for depression this can be taken as the first ingredient. The second ingredient is a response to the question, 'what is the future for us worthless shits?' with the reply, 'the future is bleak, none, hopeless.' We then ask 'how should the future be?' and the third ingredient is offered, 'it should be perfect and easy like it is for everyone else and I should get the things I want, and I should not get the things I don't want.' We add 'like it is for every one else. This leads to the fourth ingredient: 'poor me.' The participants then complete the sentence 'I can't...' with 'I can't cope' or 'I can't stand it' as the fifth ingredient. We suggest that the repetition of these five beliefs many thousands of times in all the waking

hours of each day will probably be accompanied by 'yukkie' feelings labeled 'depressed.' It is also suggested that this sequence occurs because it has been reinforced by expressions of sympathy, special forms of attention, and relief from unpleasant activities that attain high quality of life, 'until the person feels better again.'

We then ask the participants to address systematically the evidence supporting or challenging the five beliefs. Participants have so far enjoyed laughing at the expression of the beliefs without examining the appropriateness of their humorous rejection of the beliefs. First they are asked if they know a 'worthless shit.' We remind participants that people who, like us, behave 'shittily some of the time' do not count. We make the point that if the rating was to be used meaningfully it would have to be applied only to humans who behave worthlessly 24 hours of the day and 365 days of the year. We suggest that fallible humans like us who try hard to be committed to such 'worthless' behavior all of the time would, occasionally, by mistake, get something 'right' and do something 'worthy.' We suggest that the only generalization which can, therefore, be usefully made about people is that we are all 'fallible human beings' (FHBs) who sometimes get things right and sometimes get things wrong. Most people are delighted to see themselves in this way. They are advised that as FHBs, they will continue to use global ratings of themselves and others as they have been doing (like all of us) for many years. However, if they practice the new skills from the workshop, they may do so less frequently, may not take their global ratings so seriously, and they may treat them more humorously than they have done in the past. We highlight the value of giving up the habit of giving general values or ratings to themselves and other humans.

We then take the same approach

to the belief that 'the future is hopeless.' Participants quickly conclude that they and others cannot predict the future because they do not have crystal balls or time machines. They note the extent to which they are in control of vital care activities like getting up, washing up, getting dressed, eating, going to work. These are activities that are more valuable if performed in difficult circumstances. They are also helped to see that the things they have gained in their own high quality lives have been attained by their own work and efforts (sometimes supported by others). Participants also note that the behavior of fallible human beings other than themselves is very much more difficult to predict, let alone to control. They therefore note the folly of making their efforts to work for their or other's high quality of life dependent on whether other FHBs act lovingly to them. They note, often for the first time, that they are their own best and most reliable friends.

The belief that, 'the future should be great, and that I should get everything I want and nothing that I don't want' is addressed by asking participants for evidence that this is so. The first author describes how he asks clients to look out of the window to check whether it is written in the sky that they should have a great life. It is pointed out how some depressed clients with a developed healthy sense of humor, say "it was there but someone's rubbed it out." The belief that, 'everyone else is having a better time than I am' is addressed by asking what evidence would be required to support it. It is agreed that a telephone or door-to-door survey is required but that this is not often done by people who feel depressed.

If we take the depressed thoughts and feelings that we have on our birthday seriously, how does this affect our behavior? The first volun-

teer is asked: 'If you were energetically rehearsing the five beliefs that lead to depression, which room of the house would you be in?' The volunteer generally replies 'in my bedroom. I would probably be in bed looking very gloomy.' In reply to the question 'and how would the bedroom look if these thoughts have been practiced for several weeks?', the person generally replies, 'The curtains would be drawn; the floor would be covered with dirty clothes, unwashed cups and plates, filled ashtrays, empty beer cans or other containers of alcohol, unopened mail and unread newspapers.' Asked what arrangements they have made about their birthday, volunteers shake their heads and say 'none.'

In this exercise we have begun to demonstrate the links between the beliefs and the emotional and behavioral consequences. We then proceed to carry out the same process for anxious, angry, calm and loving thoughts. This chapter does not allow enough space to describe these in the same detail as have for depressive thoughts. However we summarize some points of these discussions below.

...we are all 'fallible human beings' (FHBs) who sometimes get things right and sometimes get things wrong.

For 'anxious' thoughts the prompt is given that anxious thinking is generally about the terrible things that will happen today in relation to my birthday. The person starts listing things like 'no one will turn up,' 'I will not have enough food.' We point out that expert

panickers can catastrophize in both directions. For example, 'Either no one will turn up or there will be droves of people,' 'Either there will not be enough food and drink or there will be too much.' Whatever

ceiving themselves as victim is to avoid becoming depressed and 'worthless.' Finally, participants are helped to see that expression of anger (calling others a worthless shit) is a very inefficient anti-depressant.

The calm volunteer generally begins with 'I feel really calm because I have everything prepared for today's celebrations; the invitations, the food and the house is organized and I can now choose to go back

to sleep until I need to get up to go to work.' We challenge them 'to assume that they have the radio on and hear the weather forecast. It is that it will rain for the next two days and that they have prepared to have a barbecue in the evening.' The volunteer responds 'Oh well, we will grill the food inside.' We then challenge further 'but you also note there has been no card from your partner.' The person responds 'She probably forgot,' 'But why did she forget?,' 'Because she was very busy arranging other things for the party, or because she is fallible.'

The loving volunteer is first told that there are two components to loving, loving of yourself and loving of others. The person is asked to start with loving thoughts about themselves, for example to list some of their performances during the last year about which they are proud. This generally seems to take the volunteer by surprise. We ask other participants to put their hands up if at this point they are pleased that they did not volunteer to give loving thoughts. Most raise their hands. It is suggested that we are more practiced at listing 'depressed' and 'anxious' thoughts than at listing positive things that we have done.

We ask the volunteer to shamelessly list three things they have done about which they are proud, for example to list things they have done as a parent, or as a son or

daughter. We then ask the volunteer, 'given that you have done these loving things for others during the last year, what special treat would you like to give yourself on your birthday?' We point out that while the actions of people who think depressed, anxious, or angry thoughts are boringly predictable, the performances of people who think calmly or lovingly are quite unpredictable. The volunteer might say, 'I will take the morning off' or 'I will take a long bath with scented oil' or 'I will go out and get my hair done/ have a massage/ buy some new clothes for myself.' We then ask the volunteer to name some people who have done nice things for them during the last year. The volunteer is then asked to list people, describe some things the person has done during the year which they have appreciated and then to describe how they can communicate this appreciation to the person today. Many people have great difficulty describing loving thoughts and feelings for themselves and others. This form of prompting helps them to express the thoughts simply and in performance terms on which they can easily act. It helps them to list ways in which they can easily express love, towards themselves, or towards others, today or on any other day. For example, they can phone, send cards, cuddle, make food for, invite out, perform chores for, send flowers. Participants are helped to see that there is no harm from the expression of loving thoughts either to oneself or to others. This active loving which is healthy, is carefully distinguished from unhealthy demands that others express love to us. We are able to control our own thoughts and performances, but we are not able to control those of others. Therefore, if we believe that our 'worth' as humans depends on the expression of love to us by other fallible human beings, we are likely to seriously upset ourselves. On the other hand, we may healthily want or prefer others to express love toward us,

...there are two components to loving, loving of yourself and loving of others.

happens, other people will discover today that 'I'm a worthless shit and I will feel very yukkie.' Participants list details of their 'yukkie' symptoms associated with panic. They note two key fears; the fear of being uncomfortable and the fear of getting depressed, discovering that they are worthless and having a 'nervous breakdown.' They note that most discomforts are not damaging and can be relieved. They note that 'nervous breakdowns' do not happen and that depression only arises out of practicing depressed beliefs.

For the angry volunteer the clue is to find someone who has let them down on their birthday and to think angry thoughts about them. For example, 'Joe didn't send me a birthday card or sent me the wrong present.' The volunteer is then asked '...and what are you planning to do to Joe on Joe's birthday?' The volunteer usually responds 'I'm not going to send him a card or I'm going to send him an inappropriate present.' The workshop leader then asks the volunteer what they will be if they do not do this, but merely send Joe a card or an appropriate present. The volunteer usually replies 'I will be a fool/ idiot/ doormat/ worthless shit.' The leader emphasizes how the main feature of angry thinking is the need to exact revenge against the person who was at fault. It is also pointed out how the revenge is believed necessary if the person per-

and healthily feel disappointed, sad or annoyed when they do not do so. Participants are helped to see that it is particularly helpful to be able to express loving thoughts about people about whom we also have angry thoughts. This is contrasted with the belief that if we do so it would prove that we are wimps, two-faced, insincere or worthless shits.

We then draw some conclusions from the birthday exercise. We suggest that we all have the ability to think both healthy and unhealthy negative and positive thoughts about any event occurring in our lives. We can begin to use this ability in relation to the sorts of events that occur in our lives by asking participants to think in these styles about some home and work situations. Examples from home include, 'We were burgled last night,' 'My son passed his driving test,' 'The baby didn't sleep, the car won't start, the washing machine has broken down and the Inland Revenue want £500.' Examples from work include 'My supervisor gives me no feedback,' 'My client has kicked me on the shin for the seventh time this morning,' 'My client hits her head on the wall very hard.' We also draw the conclusion that without special help we will all continue to respond to events in the same way we, and everyone else, always have. We hope this will be accepted as a very human, fallible tendency. We can make our healthy emotional pain even worse by thinking depressed, panicky or anxious thoughts about the fact that we have this pain, we can even label ourselves 'abnormal' for doing this; however, this is not compulsory! We hope that being aware of our ability to think in a variety of ways will help us work creatively with our healthy negative thoughts through focusing on what is not working and through celebrating things that are working. Through a goal planning and Prioritization process we can describe in detail what needs to be done if things are

to work in a situation that has become problematic. If review shows they are now working then this can be celebrated, if it is not working then this can be accompanied by healthy negative feelings and set the occasion for trying another way.

Conclusions

The approach described here is best seen as the beginning of a process of continuing personal development. As in other forms of personal development staff, carer and client skills will accelerate with more precision if it takes place in the context of individual or group supervision. We note that without special help and attention, we are all likely, intuitively, to respond to events in ways that we have practiced and are now good at. It is valuable to accept this fallible tendency of all humans with full creative awareness. The first author has at least seven years of experience applying these approaches alongside staff and carers whose clients have severe, moderate, mild and no learning disabilities. Many of these clients have presented severely aggressive behavior to staff and clients or have damaged themselves severely. Even when challenges continue over a long period, carers supported in this model may value learning to become aware of and to accept their own feelings and beliefs about their clients when they (the carers) get things wrong. They can also learn how to avoid escalating the challenges, respond better to the early communications, how to design and get client's agreements in practicing new and more effective ways of communicating their feelings, 'wants' and 'not wants,' and how they can create more positive opportunities for high quality living for the client and themselves, despite the expression of severe challenging behavior some of the time.

Learning new approaches is always uncomfortable. Like clients who present challenges, professionals also feel more comfortable using ineffective but well practiced approaches. Like clients, they feel comfortable with new approaches only when they begin to get better results from using them than from their current approaches. In the early stages of applying new approaches staff, carers and clients may experience 'cognitive dissonance,' (Festinger, 1957). That is they may believe new approaches are right, but feel uncomfortable about applying them. This is likely to continue until the results they get from applying the new approaches work better for them and their clients than do the old approaches. A key aim for individual and group supervision is, therefore, to support new learners through this phase and to help them avoid giving up too early. The key indicators that things are working will arise from well-kept data on what works for the individual concerned and whether it is being attained better with the new methods.

There are a number of ways forward with this work. Training and support with care staff working with people with learning disabilities and challenging behavior often focuses on the non-

... we all have the ability to think both healthy and unhealthy negative and positive thoughts about any event occurring in our lives.

verbal behavior of the client and carers. However staff values, beliefs and ideologies have been acknowledged as important issues to be addressed by service (Emerson, Hastings, & McGill, 1994b). The

training described here addresses these issues, in relation to staff, carers and clients from a coherent and well established theoretical base. There is a need for properly documented and systematic evaluation of the effect of introducing a cognitive-behavioral component into such training. The first author has applied these approaches with carers and clients who have psychiatric and medical problems as well as challenging behavior. They have potential for use with carers and clients with a range of ages, disabilities and challenges.

This chapter has described a comprehensive and innovative approach that introduces into training in constructional behavioral methods a consideration of our and our clients responses to events at a cognitive-behavioral level. The approach offers an overall direction within which to view our lives and work with people with learning disabilities and challenging behavior. The implications of this approach are important. Much of our current service and research practice views disabled people as 'abnormal' and as presenting unique 'problems' or 'burdens' to the 'normal' carers, family members and professionals. This frequently leads to 'solutions' involving mainly changing the behavior of the disabled person to make it less stressful to the carer. However, in supporting carers and celebrating their emotional and cognitive responses to their work we can create services where we can enjoy supporting our own development in designing effective environments which enable people with a wide range of different behaviors to live together creatively and safely. In this way we can work with people with learning disabilities and challenging behavior whilst working towards high quality lives for them and ourselves. This is a demanding but worthwhile goal.

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Description and Operational Definition of Problem Behavior

Editors' Note: This issue's behavioral definition is for Perseveration. This can sometimes be hard to operationally define in such a way as to provide reliable data collection. While the specific of a given situation should always dictate the definition, we hope that this may give you some ideas that you will find helpful. As you will see, in this particular case, perseveration is not just a problem in its own right but also can and does sometimes escalate to "tantrum" behavior, including self-injury and aggression.

If you would like us to provide sample definitions for a particular problem that you have come across, please let us know.

Tantrum Perseveration

1. *Topography*. Two variations of perseveration have been defined:
 - a. *Type 1 Perseveration*: Defined as saying "I want to call daddy," at any other time than the previously agreed upon time of 5 o'clock P.M. (Darrel has the opportunity to call his father one time a day as agreed upon between him and his father.)
 - b. *Type 2 Perseveration*: Defined as saying nonsense phrases or "out of context" phrases which have no literal communicative value, e.g., "Alex Trevecchio."
2. *Cycle*. For the purposes of counting the number of times perseveration occurs, the onset criterion, i.e., the criterion for counting an episode of perseveration as having begun, is the occurrence of either of the above topographies. The offset criterion, i.e., the end of the episode, is considered to have occurred when the 15-minute interval during which the behavior is counted ends.
3. *Course*. Precursors to perseveration typically begin when Darrel approaches a staff member while giving eye contact, leans his body

in the direction of that person, and says simultaneously, "I want to talk to daddy" or makes a non-sensical or out of context statement. After perseveration begins, it is repeated rapidly, and continuously until the staff member gives a response. During these repetitions, Darrel's voice becomes increasingly louder and higher, and Darrel moves closer and closer to the staff member.

If perseveration involves verbally expressing, "I want to talk to daddy," one of three things typically occurs: (a) the request is acknowledged, Darrel makes a telephone call, and the incident is finished; (b) the request is denied, e.g., "It's not time to call now, Darrel. You can call at 5 o'clock." and this postponement is accepted and the incident is finished; or, (c) the request is denied (same as "b"), and Darrel's behavior escalates into tantrum behavior, which may or may not include self-injurious behavior. Perseveration, therefore, is a precursor to tantrum behavior.

In contrast, if the perseveration involves a nonsense or "out of context" phrase, one of three other things typically occur: (a) a staff member responds to Darrel

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and replies, "I don't understand. Please speak slowly and tell me what you mean," and Darrel gives an appropriate verbal request; (b) the staff member replies, "I don't understand. Please speak slowly and tell me what you mean," and Darrel continues to persevere and his behavior escalates into tantrum behavior, which may or may not include self-injurious behavior; or (c) the nonsensical phrase is followed by, "I want to call Daddy," and is continued as described in the preceding paragraph. Perseveration lasts from 30 seconds to four minutes before it either ends, or escalates into tantrum behavior, which may last up to ten minutes. Perseveration ends when the interval during which perseveration has been counted ends.

This behavior typically begins suddenly, and escalates quickly. It becomes immediately intense, and if it is not responded to immediately, it will continue and escalate until tantrum behavior begins. Tantrum behavior is considered to have occurred when two or more of the following behaviors are observed: jumping up and down, screaming, bouncing his right leg up and down,

hitting himself or his head with his hand, biting the pointer finger on his hand, and pressing his body up against another person's body while in an agitated state. The onset of a tantrum involves the emission of two or more of the above within a 10-second interval and the offset is defined as five minutes after all of the above behaviors have stopped. Hence, the extreme nature of Darrel's perseveration is exhibited in its potential escalation to self-injurious behavior and aggression, which has in the past caused staff injury.

When perseveration occurs after 10 p.m. it has been called "nighttime disturbance." Nighttime disturbances occur when Darrel comes out of his room after ten o'clock and perseverates about calling dad, and/or talks in nonsense words, and/or "out of context" phrases. However, from now on, I recommend that "nighttime disturbances" be categorized and recorded as "perseverative behavior," since there appears to be no difference between perseveration which occurs during the day, and "nighttime disturbance."

4. *Rate.* The current rates (during the last six months) of perse-

veration are estimated to be from 16 to 315 perseverative events per month based on current data recording records, with an average of five incidents per day. This, in fact, may be an underestimation, since during my observation four perseverative events occurred in one hour. Only three aggressive outbursts occurred (during the last six months) at the end of the chain of behaviors beginning with perseveration. Tantrum behavior for the same time period occurred from 4 to 28 times per month, and self-injurious behavior occurred from 3 to 23 times per month.

5. *Severity.* An episode of perseveration can be over quite quickly (30 seconds to 4 minutes), or can escalate into tantrum, self-injurious and aggressive behavior. In severe incidents the chain of events can last up to ten minutes, and staff injury is possible. However, during the past six months, aggression has been rare. Self injury is more common, but Darrel has not injured himself seriously during the past year. Because perseveration is a high frequency behavior it is frustrating to staff who feel helpless in controlling it.

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Procedural Protocol - Stimulus Change

Editors' Note: This issue's procedural protocol is for a stimulus change procedure. While the use of Stimulus Change should, if it is appropriately used, appear spontaneous, it is really very well planned and only one small part of a comprehensive, multielement support plan. Further, as a reactive strategy, good judgment is always required and typically, a real time decision must be made by the person on the spot as to what to do at the time. Accordingly, the protocol acts not as an absolute prescription but rather as a set of operational guidelines.

Protocol:

Name: Henry Jones

Date Protocol Developed: January 22, 1996

Protocol Name: Stimulus Change

Materials: None

Schedule: Whenever Henry is upset and agitated, and active listening and the relevant scripts have been tried and have failed to help Henry relax and be willing to move on to the regularly scheduled activities, and he is escalating to or has already started to be aggressive or destructive of property, stimulus change should be employed.

Responsible Person: Primary support staff.

General Statement: At the time of an incident or an apparently impending incident of aggression or property destruction, the introduction of a novel stimulus may interrupt the course of or terminate these behaviors. This takes advantage of Henry's extreme responsiveness to the environment around him. While his distractibility may be considered a problem in most contexts, it can be used here as a very effective strategy for getting control over an escalating or dangerous situation when active listening has not been sufficient. For example, a loud noise, a flick of the lights, a staff member doing something entirely unexpected (e.g., sitting down), is likely to stop the occurrence of the behavior. Additionally, providing an instruction that evokes a competing behavior might stop an aggressive

or property destructive episode (e.g., "Give me the ____." "Get me the ____." "Help me ____.", especially if these requests are those to which Henry is known to be very likely to respond.). Asking a question may evoke a response that also competes with such behavior (e.g., "What did you do at ____?" "Where is your ____?" "Where is your radio?").

Methods:

1. If active listening and the prepared scripts are not effective in helping Henry get control over his overt behavior, and if aggression or property destruction continue to represent a serious danger to Henry, to others, or to property, a "stimulus change" should be attempted.
 - a. This strategy involves the "non-contingent" delivery or a sudden addition of a novel stimulus or the alteration of incidental stimulus conditions.
 - b. This method involves introducing something entirely new (novel stimulus) or making slight changes in the existing situation (alter incidental stimuli) as a way of temporarily managing or stopping a behavior.
 - 1) This procedure has the usual effect of decreasing all behavior, including the target behavior.
 - 2) The momentary response reduction is only tempo-

rary. The stimulus change is likely to become ineffective with repeated usage.

- 3) The particular tactic you employ may be useful when Henry is in the process of an aggressive or property destructive act, when such situations are imminent or are already occurring; and in situations where serious behavior is occurring in a seemingly unending chain. Of course, it may take some experience to identify the specific stimuli that have the desired properties for interrupting Henry's behavior. Some examples of stimulus change tactics you might try include the following:

- a) When Henry is approaching to aggress against you, or has already begun the assault:
 - Going completely limp.
 - Dropping to the ground and going into a fetal position.
 - Inviting him to sit down, on a couch or even on the ground for you to learn what he is upset about (with tone of voice and body language that this is a new and interesting idea you just had).
 - Quickly walking to his room saying "We have to talk about this, we have to talk about this, we have to talk about this, we have to talk about this."
- b) When Henry is either preparing for or is actively engaged in property destruction:

- Turning up the volume of the music or turning on the radio.
 - Doing any one of the above.
 - Using a remote control device to turn on the tape machine playing a tape of his dad asking him to please calm down so that someone can help him solve the problem.
- c. Other potential novel stimuli might include: calling "dial-a-prayer" on the telephone and telling Henry there is an important message for him, using a remote control to set off an alarm and reacting to it with surprise, saying "Oh, listen to that alarm, that means we are supposed to sit down and talk about this," and using a remote control which turns the TV and video tape machine on, which will play one of
- his pep talks from his friends, etc.
- d. Each day, at the beginning of your shift, list on the master data sheet, what stimulus change tactic you plan to use if you should need it, and what tactic you will use as a back up. You may need different ones for the different environments you plan to access that day.
2. If stimulus change is going to work, it will work immediately.
- a. If Henry terminates his escalation, aggression and/or property destruction, immediately go back to active listening and or the script for dealing with the particular situation. If you do not resolve the initiating situation, trying to move on with the regularly scheduled activities may cause the behavior to start up again.
- b. If the tactic you have employed has not worked, make a quick judgment as to whether to try active listening again, whether, to try your back up stimulus change tactic, or whether to use geographic containment. You may also decide to do nothing and just "ride it out" if you believe that nobody is going to be hurt.

Comments:

Although specific reactive strategies have been planned for Henry, Including active listening, stimulus change, geographic containment, and physical management, and although these are intended to be used in a hierarchical attempt to get control over aggression and/or property destruction, timing and judgment as to how long or whether to try each can't be prescribed. The use and timing of these strategies should be a function of the situation and rapid judgments as to which of these strategies to use and when to use them.

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G.W. LaVigna & A.M. Donnellan

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T.J. Willis, G.W. LaVigna & A.M. Donnellan

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A.M. Donnellan, G.W. LaVigna, N. Negri-Schultz, & L. Fassbender

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R.P. Liberman, W.J. DeRisi, & K.T. Mueser

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G.W. LaVigna, T.J. Willis, & A.M. Donnellan

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