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When supporting replaces treatment: A clash of vision and philosophy of treatment for persons with special needs

Taking a second look at the "low arousal" approach to crisis intervention as described in the crisis intervention book by Bo Hejlskov Elvén titled No fighting No Biting No Screaming

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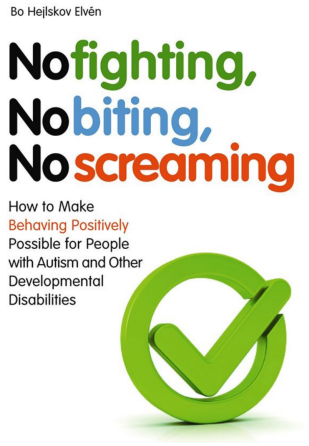
The Illusion of restraint reduction



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A quote from the book…

- "If we think that the service-user should change, we must acknowledge that we cannot influence this very much. We only have the ability to exert an influence by changing the world around the service-user and our own way of meeting him or her. We must find out what it is the service-user is unable to do in situations where he or she has challenging behaviour, so we can change the conditions."

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A quote from the book…

- "I don't think it is that easy to reward and consequently strengthen negative behaviour in people with an intellectual disability or neuropsychiatric disorders. If it were that easy, we could probably also reward and strengthen positive behaviour, and then we would probably not have many service-users with challenging behaviour."

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Creating Diversions…

- "Sometimes I hear people say: 'If you divert concretely there is a risk that you reward the negative behaviour.' We have already discussed that, but repetition may be good at times."
- "I do not think that the risk is particularly great. If we could simply reward and thereby support negative behaviour, we could probably also easily reward and support positive behaviour, and **then you probably would not need to take the time to read this book**."
- "If you are using rewards in the field of special education or care, you must do it very consciously by telling the person why the reward is given and at the same time make sure the reward is given immediately. That is not done when diverting. Nobody would think of saying: 'As you're fighting you'll get a cup of hot chocolate.' Besides, our service-users have difficulties generalizing one situation to another, which means that where they see a connection in one situation they will not necessarily understand that is also true in other similar situations."

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Low Arousal!

- This is part of the Low Arousal Approach promulgated by Studio 3 in the UK
- The idea is maintain very low levels of "arousal" so that no citizen ever gets upset
- Restraints go down
- Problems are solved

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Assumptions of the low arousal strategy: Behavior Management

- The low arousal approach assumes that the way to deal with problem behaviors like aggression, self-injury and property destruction is to eliminate, to the greatest extent possible all sources of stress. Behavior analysts would call these stressors aversive stimuli
- These aversives can be wide ranging and constitute really anything that might cause significant physiological arousal, specifically the para-sympathetic nervous system
- Such aversives include but are not limited to:
  - Demands
  - Unmet basic needs (deprivation-based aversive stimulation like a growling stomach from not eating)
  - Blocked access to reinforcement (being denied access to certain reinforcers)
  - Being exposed to any of a variety of aversive events/conditions e.g., loud noises, crowding, excessive heat/cold, or place/people that have been paired with other aversive events in the past

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Assumptions of the low arousal strategy: Behavior Management

- The philosophy of this approach is one which behavior analysts would call "antecedent manipulations"
- That is, we track down what "triggers" the crisis behaviors (SIB, Aggression, etc.) and we either modify them or eliminate them entirely
- Example: Johnny becomes aggressive and bites his hand whenever his teacher told "No." For example, if Johnny asks for ice-cream and staff say "No" then he will begin to hand bite
- A sample strategy is to teach staff to always say "Yes" and give him ice-cream whenever he asks for it thus removing the "blocked access" condition
- Another strategy is to modify the staff reaction so that instead of saying "No" they simply say "Yes, but first we have to finish dinner"
- Because the client no longer hears "No" he may tend to stay calmer

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Assumptions of the low arousal strategy: Behavior Management

- Although this is a seemingly reasonable strategy to manage crisis behaviors, and it will result in a quick decrease in crisis behaviors, it teaches the individual absolutely nothing
- As the individual is not asked to learn the appropriate things to do when he cannot get his way, and since the individual is not taught how to tolerate and accept that certain things are sometimes unavailable, this seemingly innocuous and simple strategy will have to be used for the rest of the person's life. The moment the strategy is stopped the behavior will reappear in full force as the individual has never learned to remain calm during slightly unpleasant events or what to do to resolve their problem in a socially acceptable manner

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Assumptions of the low arousal strategy: Behavior Management

- It is certainly reasonable to eliminate some stressors to achieve quick stability in behavior, especially when those stressors are highly unreasonable, e.g., staff who scream at clients who are non-compliant with requests
- It is also certainly reasonable to eliminate or avoid those situations that aren't a necessary part of life and that the individual may have no interest in, like going to a football game in a crowded noisy stadium.
- There are however, unfortunately, a myriad of stressors that are simply a part of life and that cannot be completely avoided by all persons in all situations. Some of these stressors are predictable, like medical visits while others are unpredictable like a sudden thunderstorm that causes a preferred activity to be cancelled resulting in an upset client

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Assumptions of the low arousal strategy: Behavior Management

- One of the assumptions of the low arousal strategy is that individuals diagnosed with Autism, Intellectual Disabilities, Schizophrenia, ADHD, or any of a variety of "mental illness" diagnoses have neurological, neurochemical or neuroanatomical problems that preclude learning from consequences (reinforcing or aversive).
- The major premise is that the INDIVIDUAL should never be asked to change for they are incapable of change. That is, if a person gets upset when he is denied a treat that he will ALWAYS be upset when denied a treat for the rest of his life and there is nothing we CAN do and nothing that we SHOULD do to try and change their reaction to any given stressor
- Another premise is that ONLY the staff should be asked to learn new ways of doing things and that the client should NEVER be asked to learn new ways of coping. In fact the clients are doomed to a life of NEVER learning to cope with any of life's stressors. Instead, we will craft for them a "perfect" life that is free of stressors. If stressors occur, it is the fault of staff for failing to maintain this perfect world.

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Assumptions of the low arousal strategy: Behavior Management

- This philosophy of "they are who they are" and that we should NEVER ask the person to overcome difficulties in their lives is little more than an elaborate means for therapists to avoid learning how to teach individuals with special needs **the coping skills they need to have as normal a life as possible free from unnecessary restrictions** (like 1 to 1 staffing wherever they go).
- This philosophy is typically adopted readily and easily because it does not require the therapist to be skilled in **assessing skill deficits** and **building new adaptive repertoires** that will assist the individual in both overcoming common, unavoidable stressors and being more independent

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Assumptions of the low arousal strategy: Behavior Management

- Example:
- Timothy has Autism and gets very upset and starts to head bang whenever his mother takes a left-hand turn in the car
- His mother, assumes that because he is diagnosed with Autism, he will never tolerate left-hand turns and that this is simply "who he is"
- To deal with the problem, mom only takes right hand turns on the way home from school and it takes her twenty minutes longer than normal because she must take a highly circuitous route that is void of left hand turns
- This results in an immediate decrease in Timothy's head banging

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Assumptions of the low arousal strategy: Behavior Management

- Our philosophy is that cessation of the problem behavior is NOT the only goal. If this were the ONLY goal then we would need to go no further in Timothy's "treatment"
- Unfortunately this is merely a "stop-gap" measure to bring about quick stability
- It is an impractical solution as there is no "Right hand turn only" buses in the public transportation system. Furthermore, there will be times that it will be impossible to turn left and crisis behaviors will occur again immediately
- Now, what if this were only one of say twenty strategies that involved eliminating common everyday experiences for the sake of behavioral stability
- What kind of a life will this person have? How many things will they be unable to participate in? How will his needs impact other members of society? What if his needs are in direct conflict with the needs of others or even with his own safety?

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Assumptions of the low arousal strategy: Behavior Management

- The answer to this problem lies in teaching coping skills
- Learning how to ask if it is possible to take a right turn instead of left
- Learning how prepare for the left hand turn by being given ample warning of the upcoming left hand turn and how to take a deep breath and blow it out as the turn approaches
- Practicing taking very small left-hand deviations in a parking lot until these small deviations can be handled calmly (systematic desensitization)
- Providing positive reinforcement for engaging in self-calming behaviors during left hand turns

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Passive versus active calming

- One of the assumptions of the low arousal theory is that individuals "regain control" when staff terminate the stressor
- This is not really "regaining control." That is, let's say that we are getting angry in a meeting and are about to start screaming when our co-worker prompts us to take a deep breath before proceeding, he reminds us this is a very important account and that we cannot afford to anger the customer
- The stressor is still present (the customer is disagreeing with us) but we take a deep breath and sit back in the chair and let all our muscles go limp. We then begin to talk calmly again
- This is "regaining control" this is what we would call "active calming," that is we are engaging in several related behaviors that all have the effect of accelerating the calming process

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Passive versus active calming

- Passive calming requires no skill
- EVERYONE WILL CALM DOWN EVENTUALLY ONCE THE STRESSOR IS REMOVED AS IT IS A BASIC PHYSIOLOGICAL PROCESS THAT REQUIRES NO EFFORT AND NO PARTICULAR SKILL
- What allows us to be social creatures is that we have learned either stay calm during stressful events and/or regain our state of calm during stressful events. If all patrons in all restaurants started punching their servers when they are informed that the restaurant has run out of their favorite dish, there would be absolute chaos.
- The solution is not to attempt to institute a system in which it is impossible to run out of certain menu items for this itself would be virtually impossible
- The solution lies in teaching people what to do and say when their favorite item is unavailable and to prepare them by informing them that their favorite item may not be available and that they should try to think of 2 or 3 back ups in case their favorite is unavailable
- That is, we can teach people how to either stay calm in the face of mild adversity or to do things that will allow them to get something similar (learning to choose an alternative)

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Assumption of the low arousal theory: You needn't worry about reinforcing problem behavior

- Regardless of its initial cause, operant behavior, purposeful behavior involving the striated muscles, can evolve and change over time as all organisms are sensitive to the consequences of their behavior.
- If we were insensitive to these consequences (good or bad ones) we would fail to function. Regardless of the diagnosis, behavior will change based on consequences. The behavioral literature is rich with research on this topic and it is well established that even non-verbal individuals with no measurable IQ can still learn based on consequences of their actions
- Is it possible that some of these individuals might learn more slowly? Is it possible they may not be able to learn the same skills and perform them at the same level as persons with no diagnosis? Yes, certainly, but also they most certainly can and do learn based on the consequences of their actions

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Assumption of the low arousal theory: You needn't worry about reinforcing problem behavior

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- Problem behavior can initially occur for one reason, and become far worse for another, completely different reason
- Example: James is **nonverbal** and has an ear infection. Much in the same way we will scratch a mosquito bite to momentarily relieve that pain, James has learned, through trial and error (naturally occurring consequences that do not involve to actions of other people) that slapping his hear temporarily alleviates the pain
- As staff do not wish for him to hurt himself, staff approach and begin to interact with James. They use the approach taught by the low arousal theory and provide James with a dish of his favorite ice-cream and this does indeed distract him, temporarily, from the ear pain.

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Assumption of the low arousal theory: You needn't worry about reinforcing problem behavior

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- In fact the strategy works so well that several staff have started using the same tactic which has the same result every time. James stops hitting his ear and eats the ice-cream
- 2 weeks later the ear problems have been treated, yet James continues to hit his ear. Not only does he now hit his ear when he wants ice-cream, but he also has learned to hit his ear for attention, and to make staff remove demands
- James ear hitting has gone from 3 episodes per day to 30 per day and he now has a cauliflower ear from all the trauma
- Many behavior problems happen exactly like this and can be maintained indefinitely as long as the behavior remains functional (gets you what you want).

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Assumption of the low arousal theory: You needn't worry about reinforcing problem behavior

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- In keeping with the low arousal theory, one might inform all staff that prevent all ear hitting we must be extremely keen in predicting James' every need.
- Staff learn all the things James could want in a day and they make sure he gets it before he even realizes he needs it and then staff PERFECTLY anticipate all his needs and ALWAYS are able to meet those needs, rain or shine, 24/7/365
- This is exactly what won't happen as it is impossible
- This is why we do treatment and teach James functional communication skills so that he can now get his needs met appropriately
- We also teach him how to wait, and how to accept alternatives
- This is a very typical treatment scenario where we teach the individual how to request what they want and what to do when the request cannot be met. This both eliminates problem behavior AND ensures that the individual has now learned how to cope with a common problem we all encounter. Now the individual does not need staff to anticipate his needs. He makes he needs known through communication and becomes an active participant in the world instead of a "recipient of goods and services"

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The difference between treatment and crisis management

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- Treatments include documented and formal assessment which gives us information about the function and the ability to design programs that can have deep impact on an induvial functioning, adaption and inclusion
- Treatments include documented and powerful methodologies which are designed to be consistent and designed across time, people, and places
- Treatments have target behaviors and data collection methodologies which allow us to evaluate progress
- Treatments often work in conjunction with formal curriculum
- Treatments include formally documented and scheduled training protocols

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The difference between treatment and crisis management

- Crisis management is often less documented, inconsistent across time, people and places because of how different people will interpret what is dangerous and what should be the course of action
- Crisis management is often confusing regarding the definition of the target behavior and does not lend itself easily to long term change or evaluation

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Physical Assistance and Restraint: What's the difference?

- For decades, professionals working with individuals with special needs have used physical prompting to teach them all sorts of skills including but not limited to activities of daily living (cooking, cleaning, grooming, etc.)
- Physical prompting, or physical assistance involves touching/grasping/ supporting some part of the individual (typically the arm/hand) to produce the desired behavior that can then be reinforced
- Using these physical prompts is necessary when teaching ANYONE a physical skill as verbal prompts alone are typically insufficient to teach complex motor movements even with high-functioning adults with no disabilities (Teaching a golf swing for example)
- These physical prompts are also necessary for very young children and adults who are non-verbal as verbal prompts alone, very often, will not generate the desired behavior

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Physical Assistance and Restraint: What's the difference?

- Restraint, speaking very broadly, is a physical prompt to either **remain still** or a physical prompt to **induce movement** and this physical prompt involves **extreme resistance** on the part of the individual and this type of prompting is used in what most people would call "a crisis"
- There is **NO universally accepted definition** of the **amount of resistance** on the part of the individual that causes us to label an interaction as "restraint"
- Different states and agencies use different definitions
- Colorado "If it's 5 minutes or less it's not restraint" (regardless of level of resistance)
- The US Department of Education defines restraint as holding someone in a **standing or horizontal position**. They do not include **escorts** as restraint although the escorts may involve extreme resistance on the part of the individual

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Physical Assistance and Restraint: What's the difference?

- Whether or not someone chooses to call a physical interaction restraint has to do with a number of factors, none of them based on any scientific data. Some of these factors are:
- 1) Duration: was it just a few seconds or 10 minutes?
- 2) Perceived level of invasiveness: Some individuals do not even recognize escorts as restraint as they allow more freedom of movement of some parts of the individual's body
- 3) Perceived level of resistance: If a teacher grabs a pre-schooler by arm to take him off the playground and the child only resists a small amount, most individuals would not perceive that a restraint has been used, yet the child would not have left the playground with verbal prompts alone
- 4) Whether or not staff/teachers used a "formal" procedure. Many people will tend to see a physical interaction as restraint if it is a procedure with a name. That is, someone may stop a child from hitting by hugging the child. Is it just a hug or it a restraint that has no specific topography and no name?

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Physical Assistance and Restraint: What's the difference?

- You could use a systematic procedures with formal names to transport a child who only resists mildly and **most individuals would not recognize the interaction as a restraint**
- You could use typical physical prompting (hand over hand guidance) with a very resistant learner who is showing *considerable resistance* and, again, **most individuals would not recognize the interaction as a restraint**

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Using physical assistance not "AS" treatment but as part of treatment

- There are numerous local, state and federal laws that prohibit the use of restraint AS treatment. That is, there is no behavioral treatment, only an attempt to "punish" the behavior by delivering restraint as a consequence for bad behavior
- We do not use restraint (physical assistance) as treatment. Treatment involves data collection, assessment, program plan writing, staff training and revision as necessary based on behavior change or the lack thereof
- We use physical assistance in treatment in two ways:
  - 1) To stop behavior that must be stopped (usually at resistance levels that cause people to label it "restraint") and
  - 2) To initiate behavior that must happen for treatment to take place (usually at resistance levels that would NOT cause people to label it "restraint")

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Using physical assistance not "AS" treatment but as part of treatment

- Of course, there are gray areas in the use of physical assistance when using it to initiate behavior. An individual might show full cooperation, partial cooperation, or almost none at all, yet the individual may not be "in crisis." That is, they may be resisting, but also not showing high levels of arousal or distress.
- The police may move "conscientious objectors" away from the entrance to a building, and these individual show no cooperation at all but are described as "peaceful protestors"
- Certainly, even when trying to move a client or teach a new skill, it is possible that in overcoming their level of resistance the individual may go into a crisis.
- There are judgment calls to be made by clinicians in which they must take into account the **level of resistance**, the **probability of a crisis**, and the **priority** of the situation

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Using physical assistance not "AS" treatment but as part of treatment

- As an example:
- James is 5 years old and nonverbal and there is a fire drill at his school
- During the drill ALL CHILDREN MUST BE EVACUTATED FROM THE BUILDING otherwise it is a breach of law
- The school must be able to demonstrate during a drill that they are capable of moving all students to safety in a very short period of time
- James refuses to leave the classroom and tries to stay near the computer
- Staff use a formal transportation procedure to remove James from the classroom and James is struggling at full resistance

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Using physical assistance not "AS" treatment but as part of treatment

- In this example James was showing what many call "non-compliance" and when the alarm went off he was calm
- After staff initiated the procedure he went from calm and non-compliant to combative almost instantly and they transported him out of the room
- The priority in this situation was high, even though there WAS NO IMMEDIATE DANGER
- The same scenario happens with adults at group homes who must go on a medical visit even though there is no current emergency.

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Using physical assistance not "AS" treatment but as part of treatment

- As another example, Joey is running around the classroom and it is time for speech therapy so that he can learn to communicate
- Joey does not respond to any verbal or gestural prompts to come to the table
- He has been running around for 10 minutes and the session is only 50 minutes long
- The therapist uses a formal crisis management transportation procedure to guide the child to the table. The child shows very little resistance
- The therapist begins to work with the child
- This is an example of physical assistance using a formal procedure with little resistance to allow treatment to take place

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What are the consequences of never using physical assistance?

- Just as there may be unintended consequences of using physical assistance there can be unintended consequences for a failure to use some form of physical assistance when it is warranted
- Parents would not be able to get their own children into and out of stores and other places in the community
- Teachers would not be able to get students off of buses in the morning or onto them in the afternoon
- Parents/teachers/staff would not be able to maintain any kind of schedule because they would have to wait for the individual to "feel like" working/ moving/participating

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What are the consequences of never using physical assistance?

- The previous were examples in which physical assistance allows treatment to happen with mild resistance and no dangerous crisis behaviors
- There are also consequences for a failure to move/immobilize individuals who are exhibiting severe aggression/property destruction/self-injurious behavior
- Staff get injured, property gets destroyed, the individual can be harmed, other students/clients can be harmed and the individual's placement can be jeopardized
- The individual's aberrant/dangerous behavior can **continue to be functional** for that person (it produces reinforcers and removes aversives)
- Maladaptive behavior that remains functional may significantly decrease the likelihood of the individual engaging in an appropriate replacement behavior because "the old behavior still works well"

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Further Information

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