Mental health as motivational operation: Service-user and caregiver emotional states in the context of challenging behaviour

Dr Nick Gore

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Who Am I and Why am I here?!

Dr Nick Gore (DClinPsy, PGCHE, BSc-Hons)

- Clinical Psychologist and Senior Lecturer / Researcher in Field of Intellectual and Developmental Disabilities

- Tizard Centre, University of Kent – South-East of England

- Special Interest in Challenging Behaviour, Emotional/Mental Wellbeing and Positive Behavioural support

Tizard Centre – University of Kent

One of the leading UK academic groups working in **learning disability** and community care.

Members of the Centre are selected both for their **academic record** and for their **practical experience** in services.

Teaching

- Short courses as well as degree and diploma programmes
- PhD students

Consultancy

- Training for services, commissioners
- Clinical support for individuals, families, services

Research

- Applied research focused predominantly on improving support and quality of life for people with disabilities.

Policy

- Support for development of policy and best practice guidance

TIZARD
University of Kent

Tizard Centre

The Tizard Centre is named after Professor **Jack Tizard** (1919-1979).

His work on alternatives to institutional care in the nineteen-fifties and sixties underpinned the subsequent development of ‘ordinary life’ models for children and adults with intellectual disabilities.

The centre was set up by **Jim Mansell** who joined the University in 1983 to develop ground-breaking initiative to create community services for people with seriously challenging behaviour

- Courses to build a strong workforce followed and research expanded. Jim continued to be a respected and influential figure in the field of learning disabilities and care environments as well as Director of the Tizard Centre
- He was appointed Commander of the Order of the British Empire (CBE) for services to people with intellectual disabilities. He retired from the University in December 2010, sadly passing away in March 2012.
- The Centre's work reflects both Jack and Jim’s commitment to social justice, by bridging policy, research and practice across disciplines.

Nobody *gets through life without* ***experiencing emotional difficulties or displaying behaviour some find challenging*** *– at least sometimes*

We are ***all living in the same world,*** *with* ***bodies and brains*** *that work in* ***roughly similar*** *ways*

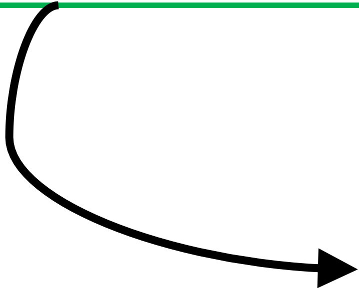
And ***none of us are an island unto ourselves*** *– we set the occasion and provide consequences for each others experiences and behaviour*

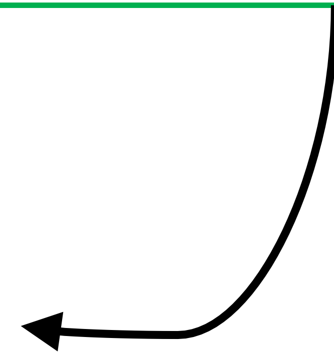
We are all in the same boat

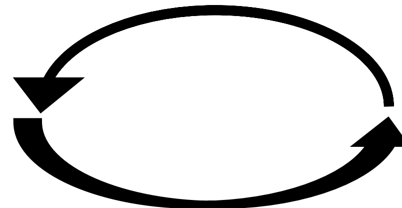
We have to live, support and ***decide*** *together*

If this is the case what we need is a common framework or model that……….

Can help us understand the experience, behaviours and interactions of ***PEOPLE****………whether we are talking about children, adults, people with or without intellectual disabilities*







Empowerment

- Doing this is one major way to balance out power
- It’s not about the ‘wise healthy practitioner/caregiver’ deciding what's best for another person and putting that in place
- But about practitioners/caregivers and those they serve working together to discover what everyone needs – and creating systems where those needs can be met

If we could get this right – people would get to live the lives they want and need, and emotional and behavioural difficulties would become less likely – for everyone…..

What does prior research tell us?

People with intellectual / developmental disabilities are:

- At **heightened risk** of developing **behaviour that challenges**
- At least as **likely** (and sometimes more likely) **to develop mental health/emotional difficulties**

Caregivers (staff and family members) are:

- **Likely to experience mental health/emotional difficulties** when supporting people who display behaviour that challenges
- Have a significant **influence on the behaviour of people with intellectual disabilities**

Challenging Behaviour amongst people with intellectual disabilities*:*

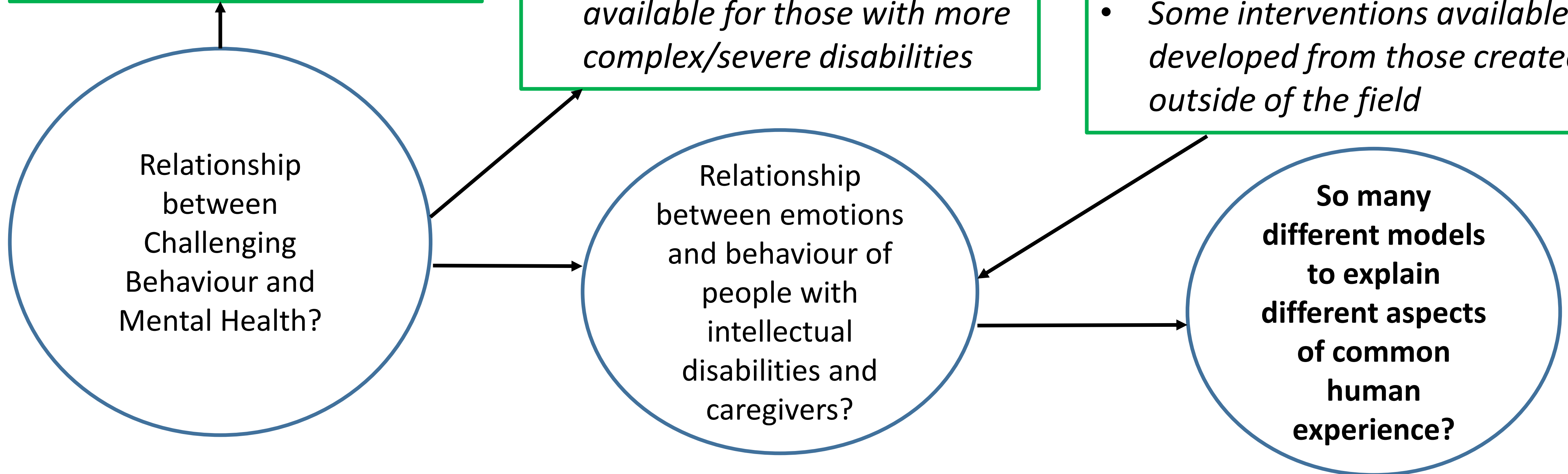
- *Predominantly operant/behavioural models*
- *Positive Behavioural Support*

Mental Health amongst people with intellectual disabilities:

- *Historically less attention (diagnostic overshadowing)*
- *Medical and/or non-operant models*
- *Very few interventions available for those with more complex/severe disabilities*

Mental Health amongst caregivers with intellectual disabilities:

- *Less attention (relative to CB of people with intellectual disability)*
- *Non-operant psychological models*
- *Some interventions available developed from those created outside of the field*



Introduction

Mental health as motivational operation: Service-user and caregiver emotional states in the context of challenging behaviour

Nick Gore and and Peter Baker
Tizard Centre, University of Kent

Abstract

This brief conceptual paper seeks to address the role of mental health and the experience of negative life events in the positive behavioural support framework in relation to the behaviour of both service users and caregivers and some of the implications this may suggest for intervention. It is argued that the conceptualisation of mental health related variables as motivating operations is parsimonious at a theoretical and practical level and may create one way of generating further synergies within the field of IDD.

Keywords: Intellectual disability, mental health, trauma, motivational operations

Introduction

Proponents of trauma informed care have often been critical of traditional behavioural interventions offered to individuals with intellectual disabilities who present challenging behaviour. In particular, Harvey (2012), who provided a seminal text in this area, highlighted concerns such as a disregard of physical health issues, reliance on brief periods of observation, over-reliance on medication, the use of restrictive practices that may perpetuate behavioural crisis and over reliance on contingency management. Of note is that the same criticisms of traditional behavioural interventions were raised by early proponents and developers of PBS (Carr et al, 2002; Baker and Shepard 2005; Dunlap, Sailor, Horner and Sugai, 2009). Similarly, there is commonality between PBS and many of the approaches promoted by Harvey; for example, an emphasis on prevention and manipulation of antecedents, a focus on relationships and rapport and avoiding behavioural crisis through secondary preventions strategies. Yet Harvey (2012) does not appear to effectively distinguish PBS from traditional behavioural approaches, leading to claims that are at times inaccurate and may ultimately perpetuate poor practice in the support of people with intellectual disabilities.

Most noticeably, Harvey, in her trauma informed behavioural interventions book, rejects the use of functional behavioural assessment (FBA) on the grounds that it is about controlling people and instils a narrative of the person being manipulative. These criticisms are difficult to sustain when considering FBA within a PBS framework, where practices are primarily concerned with generating hypotheses that relate to a broad range of contextual factors which will ultimately be used to inform the support of greater individual choice, predictability and personal control (Gore et al, 2013). The overriding message surrounding PBS's use of FBA is that behaviours are not random, but serve key communication functions and are displayed by the individual to support fundamental needs.

As an alternative to FBA, Harvey argues for a thorough social history, a focus on behaviours as recognisable symptoms of trauma and listing of all possible triggers and anniversaries. Whilst this assessment methodology has some commonalities with FBA, it could present major problems to the practitioner in terms of arriving at a useful and valid formulation, as much of the data could be correlational and unverifiable. Although the fluctuating nature of trauma related responses both

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- ***A brief presentation of a relatively brief article – recently published!***

- **Gore, N.J., & Baker, P. *International Journal of Positive Behavioural Support* (2017), 7 (1), 15-23**

- ***Builds on Special Edition of IJPBS*** Autumn 2013 – outline, describe and clarify PBS Framework

- *Draw closer connections between approaches to understanding challenging behaviour and emotional health for people with intellectual disabilities and those who support them*

What can we agree on?!

A conceptual framework for understanding why challenging behaviours occur in people with developmental disabilities

Richard P Hastings, David Allen, Peter Baker, Nick J Gore, J Carl Hughes, Peter McGill, Stephen J Noone and Sandy Toogood

Abstract

Background: To be able to define positive behavioural support (PBS), describe PBS interventions and clarify the individual and organisational competencies needed to support PBS, a clear underlying conceptual framework is needed to identify why challenging behaviours occur.

Method and materials: Non-systematic review and discussion of the state of research and theoretical evidence focusing on vulnerability factors for challenging behaviours, maintaining processes, and the social impact of challenging behaviour.

Results: Understanding challenging behaviour is related most strongly to context. First, challenging behaviours are defined in terms of their social effects. Second, vulnerability factors for challenging behaviour include some biological factors, but mainly psycho-social risks relating to the life situation and inequalities experienced by people with developmental disabilities. Third, social contextual processes are primarily responsible for maintaining challenging behaviours.

Conclusions: PBS is a broad approach to understanding and intervention referring to multiple contributing factors and processes. To describe PBS without reference to an underlying theoretically grounded conceptual framework would lead to an impoverished version of the approach.

Keywords: Challenging behaviour, positive behavioural support, causation, conceptual framework

Introduction

Interventions designed to ameliorate problems faced by individuals with developmental disabilities[1] need to be informed by a model or framework that describes an understanding of the problem (Hastings, 2013). Positive behavioural support (PBS) is no exception. To learn about PBS without understanding what the intervention approach is designed to do, or why PBS exists in the form that it does, would represent an incomplete and impoverished picture.

The need to elucidate the assumptions about the origins of a clinical problem to inform an intervention approach should not be a surprise to anyone reading this paper. In individual clinical practice, especially when applying psychological interventions, a professional will develop a formulation of the problem and use that formulation to inform the focus of therapeutic intervention (see chapters in Taylor et al, 2013). Within PBS, formulation may be given a different name (generation of causal hypotheses, hypotheses about the function of a challenging behaviour) but it is a similar process. For example, any PBS intervention should be informed by functional assessment data (O'Neill et al, 1990). Indeed, there is evidence that including a functional analysis as a part of intervention for challenging behaviour significantly improves outcomes (e.g. Scotti et al, 1991).

[1] Developmental disability will be used as a term including children and adults with intellectual disability (ID) and those with autism, following international terminological conventions. Where evidence cited refers specifically to individuals with ID or with autism, this will be made explicit.

Definition and scope for positive behavioural support

Nick J Gore, Peter McGill, Sandy Toogood, David Allen, J Carl Hughes, Peter Baker, Richard P Hastings, Stephen J Noone and Louise D Denne

Abstract

Background: In light of forthcoming policy and guidance in the UK regarding services for people who display behaviour that challenges, we provide a refreshed definition and scope for positive behavioural support (PBS). Through doing this we aim to outline a framework for the delivery of PBS that is of practical and strategic value to a number of stakeholders.

Method and materials: We draw extensively on previous definitions of PBS, relevant research and our professional experience to create a multi-component framework of PBS, together with an overall definition and a breakdown of the key ways in which PBS may be utilised.

Results: The framework consists of ten core components, categorised in terms of values, theory and evidence-base and process. Each component is described in detail with reference to research literature and discussion regarding the interconnections and distinctions between these.

Conclusions: We suggest the framework captures what is known and understood about best practice for supporting people with behaviour that displays as challenging and may usefully inform the development of competences in PBS practice, service delivery, training and research.

Keywords: Positive behavioural support, definition, core concepts

Introduction

International evidence regarding challenging behaviour displayed by children, young people and adults with intellectual or developmental disabilities is strongly in favour of positive behavioural support (PBS) as a model of intervention. This now includes systematic and meta-analytic reviews of single-case and small group designs that demonstrate significant reductions (typically greater than 50 per cent) in challenging behaviour following PBS intervention (Carr et al, 1999; Dunlap and Carr, 2007; Goh and Bambara, 2013; LaVigna and Willis, 2012;). It also includes a smaller number of randomised trials, including a two-treatment study focusing on support for families in community settings (Durand et al, 2012) and a UK randomised controlled trial in which challenging behaviour displayed by adults with intellectual disabilities reduced by 43 per cent after PBS intervention compared with standard treatment (Hassiotis et al, 2009).

Whilst developments and implementations in the UK have generally advanced more slowly than those in the US, in the last ten years a variety of policy documents and professional guidelines have drawn on PBS as a model of best practice for supporting people who display challenging behaviour (British Psychological Society, 2004; Department of Health 2007; Royal College of Psychiatrists, British Psychological Society & Royal College of Speech & Language Therapists, 2007). At times these documents have also incorporated guidance from authors who either advocate alternative approaches to the management of challenging behaviour or embed the principles and procedures of PBS within broader recommendations in an attempt to reach a variety of audiences and serve a variety of aims.

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Developing a core competencies framework for positive behavioural support: issues and recommendations

Louise D Denne, Stephen J Noone, Nick J Gore, Sandy Toogood, J Carl Hughes, Richard P Hastings, David Allen, Peter Baker and Peter McGill

Implementing positive behavioural support: changing social and organisational contexts

David Allen, Peter McGill, Richard P Hastings, Sandy Toogood, Peter Baker, Nick J Gore and J Carl Hughes

The International Journal of Positive Behavioural Support

Defining and promoting good practice in the use of PBS, bridging the gap between academic research and service practice.

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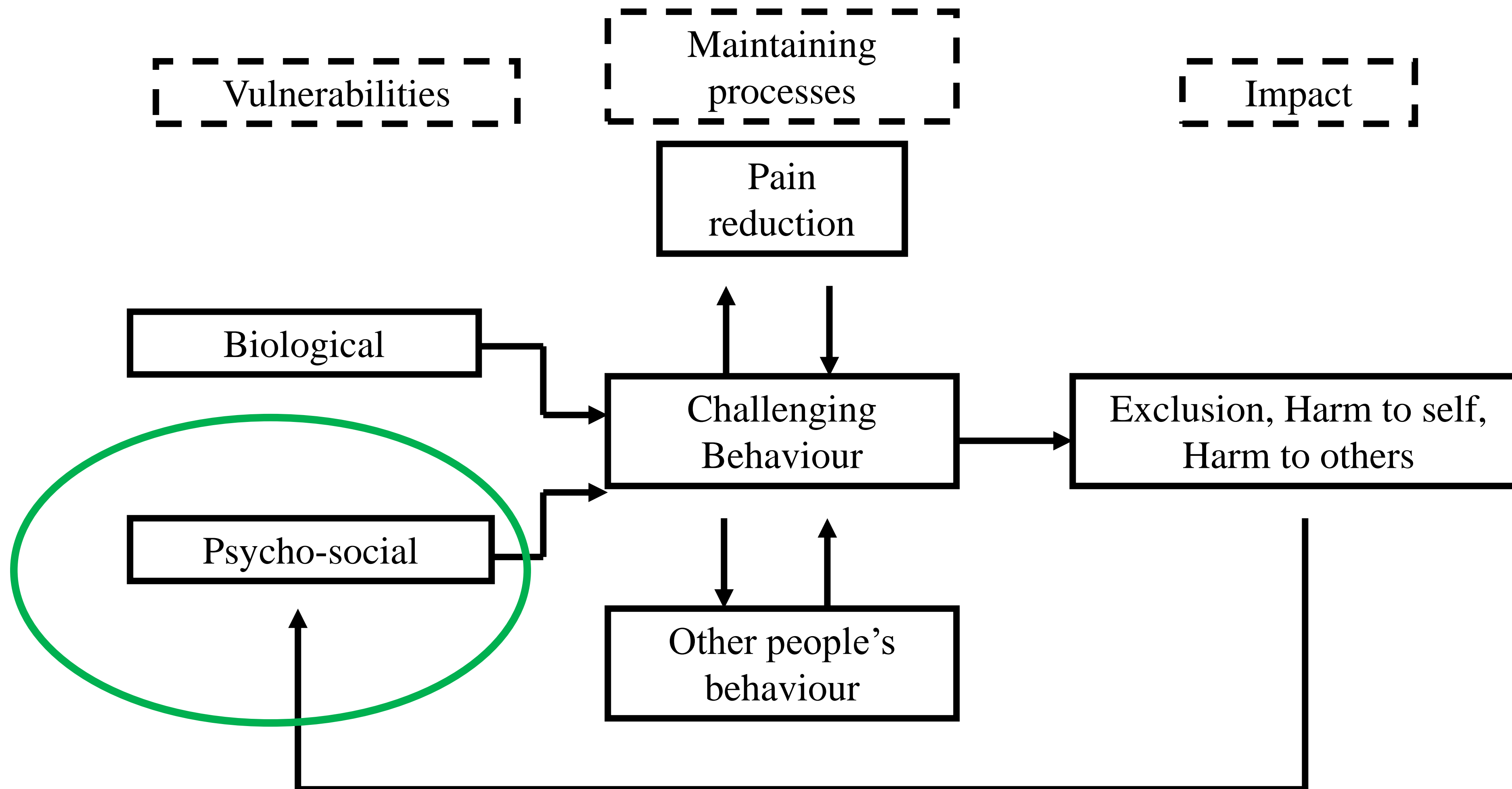
We would argue that PBS **does *explicitly*** recognise and support mental health variables in the context of challenging behaviour……………………………



From Hastings et al. *International Journal of PBS*, December 2013

Vulnerabilities

Biological

Sensory problem –
Physical health problems – especially causing pain
Genetic factors – reflux in CdLS, SIB and pain

Psycho-social

Negative life events, including abuse
Lack of communication skills
Impoverished social networks, few +ve relationships
Lack of meaningful activity
Mental health problems, mood/emotional problems

All are more likely for people with learning disabilities AND make challenging behaviour more likely

Definition and scope for positive behavioural support

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Gore, **N.J.,** McGill, P., Toogood, S., Allen, D., Hughes, C., Baker, P., Hastings, R.P., Noone S., & Denne, L. (2013). Definition and Scope for Positive Behaviour Support. *International Journal of Positive behavioural Support*

Values	1. Prevention and reduction of challenging behaviour occurs within the context of increased quality of life, inclusion, participation, and the defence and support of valued social roles
	2. Constructional approaches to intervention design build stakeholder skills and opportunities and eschew aversive and restrictive practices
	3. Stakeholder participation informs, implements and validates assessment and intervention practices
Theory and Evidence Base	4. An understanding that challenging behaviour develops to serve important functions for people
	5. The primary use of Applied Behaviour Analysis to assess and support behaviour change
	6. The secondary use of other complementary, evidence-based approaches to support behaviour change at multiple levels of a system
Process	7. A data-driven approach to decision making at every stage
	8. Functional assessment to inform function-based intervention
	9. Multicomponent interventions to change behaviour (proactively)and manage behaviour (reactively)
	10. Implementation support, monitoring and evaluation of interventions over the long term

However, the ***finer detail*** of exactly how mental health variables may relate to behaviour that challenges have not been explored sufficiently

There is *a danger therefore* that even when recognised in PBS, assessment formulation and intervention for mental health needs are a kind of *add on in practice*……

In this paper we try to ***start*** the process of developing a more integrated understanding of ***some of the ways*** in which mental health variables might operate and best be understood in PBS

Just a start…..

4-Term Contingency Diagrams

- **4 term** contingency diagrams **are integral to the conceptual model that informs PBS** and assessment, formulation and intervention practices within the framework

- **3 term** contingencies describe the relationship between **a discriminative stimulus** (antecedent), **a given behaviour and a maintaining consequence**.

- **4 term** contingencies increase the complexity and power of explanation with inclusion of a further level of antecedent, **the motivational operation**

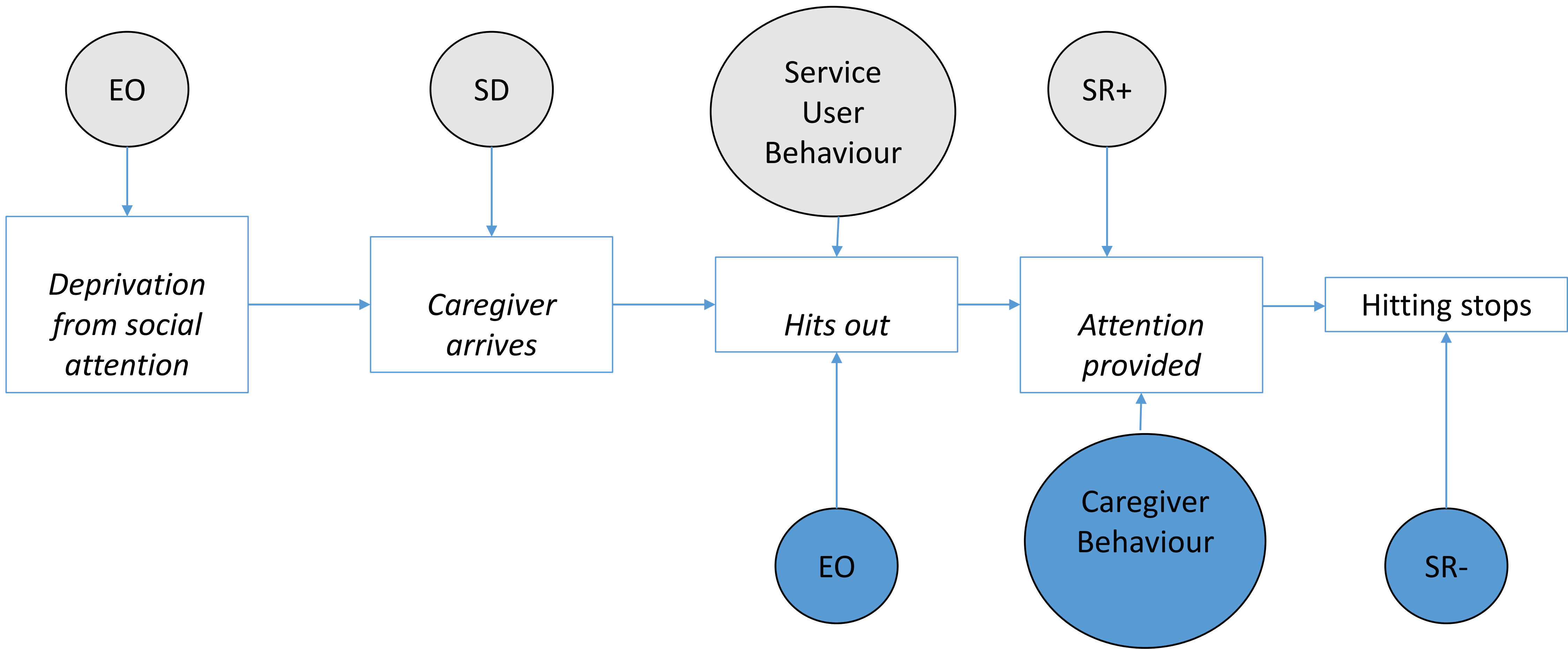
- Whilst a discriminative stimulus effectively signals the **availability of a reinforcing consequence** contingent upon a given behaviour….

- Motivational operations **concern the value of that reinforcing consequence**

2 Types of MO:

Establishing Operations (increase the value of a reinforcer and are associated with increases in behaviour)

Abolishing Operations (decrease the value of a reinforcer and are associated with reductions in behaviour



Toogood, S (2012) ‘Using contingency diagrams in the functional assessment of challenging behaviour’. *International Journal of Positive Behavioural Support*, 2(1), 3–10.

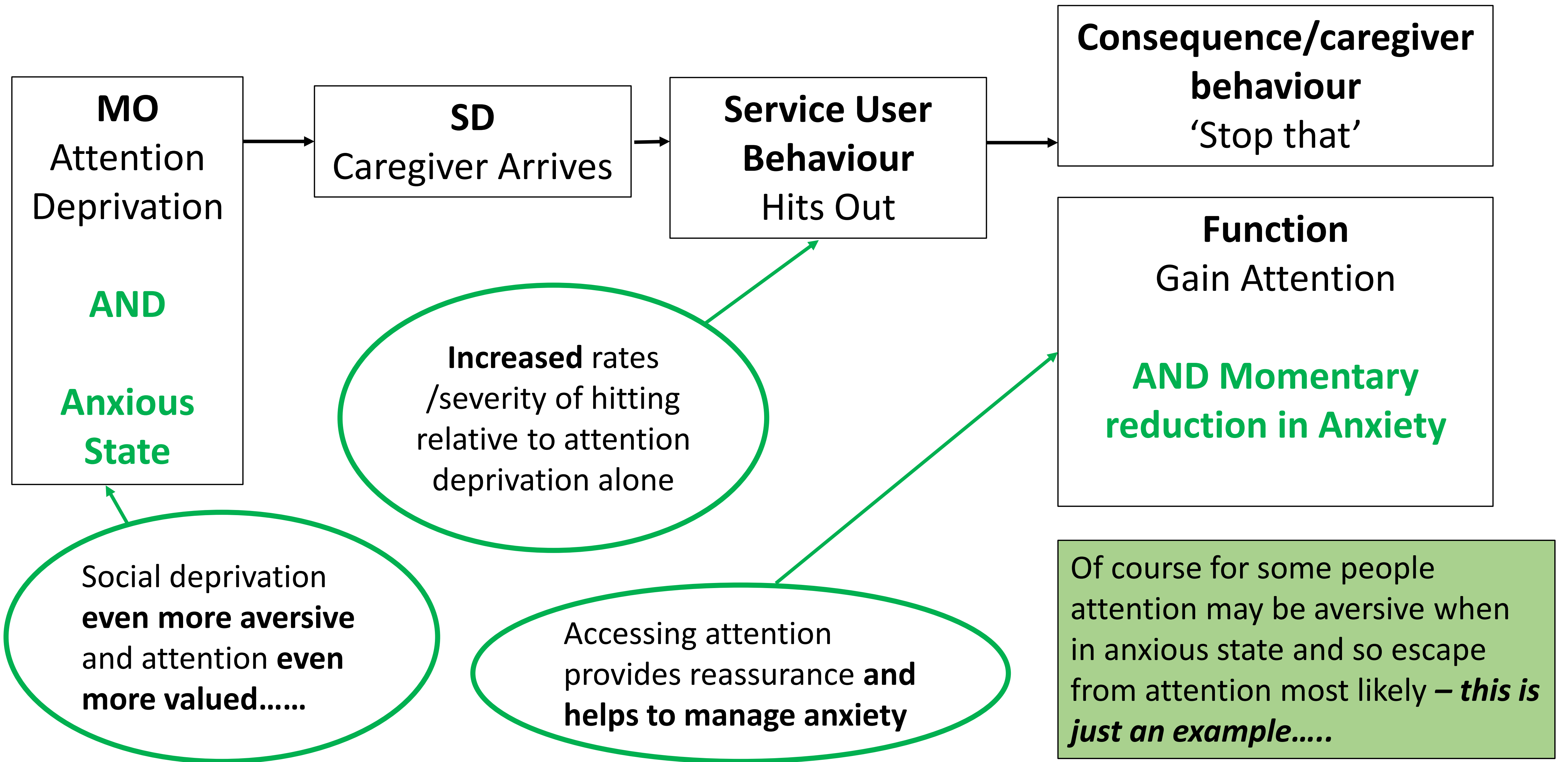
In this article we use **4-term contingencies** to provide illustrative examples of how ***mental health variables*** might relate to:

- **Service-user** *behaviour that challenges*
- **Service user** *adaptive behaviour*

- **Caregiver** *unhelpful behaviour in the context of service-user challenging behaviour*
- **Caregiver** *helpful behaviour in general*
- **Caregiver** *helpful behaviour in the context of service-user challenging behaviour*

I will present just a few of the examples we provide……

Variability in Service User Challenging Behaviour



Variability in Service User Adaptive and Challenging Behaviour

Stable mood establishes attention as reinforcing

MO
Stable Mood

SD
Caregiver asks 'how are you?

Service User Behaviour 1
Smiles

Consequence/caregiver behaviour
'let's sit together'

Function
Access Attention

Low mood establishes avoidance of attention as reinforcing

MO
Low Mood

Service User Behaviour 2
Hits Out

Consequence/caregiver behaviour
'I'll leave you alone'

Function
Avoid Attention

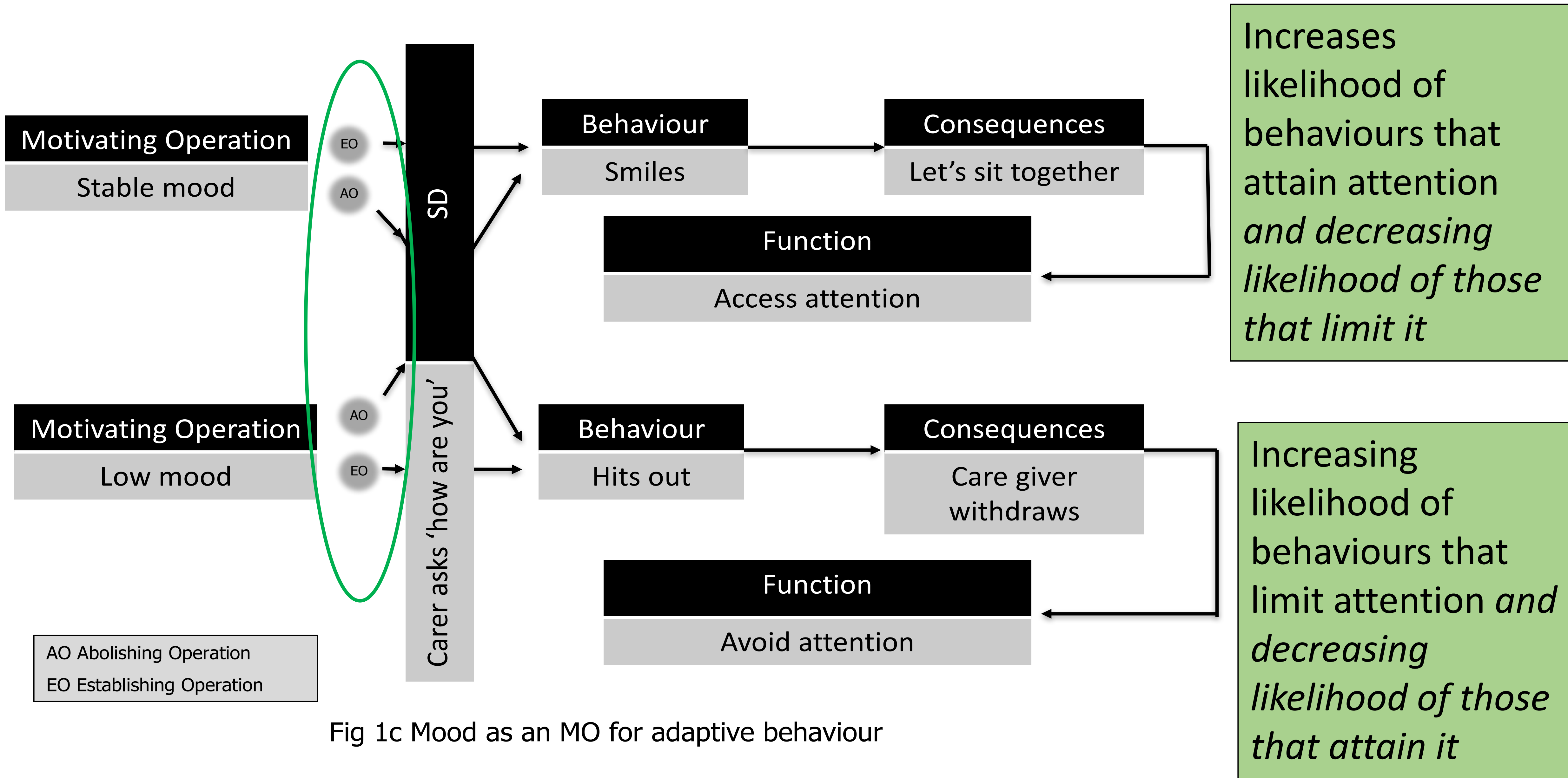
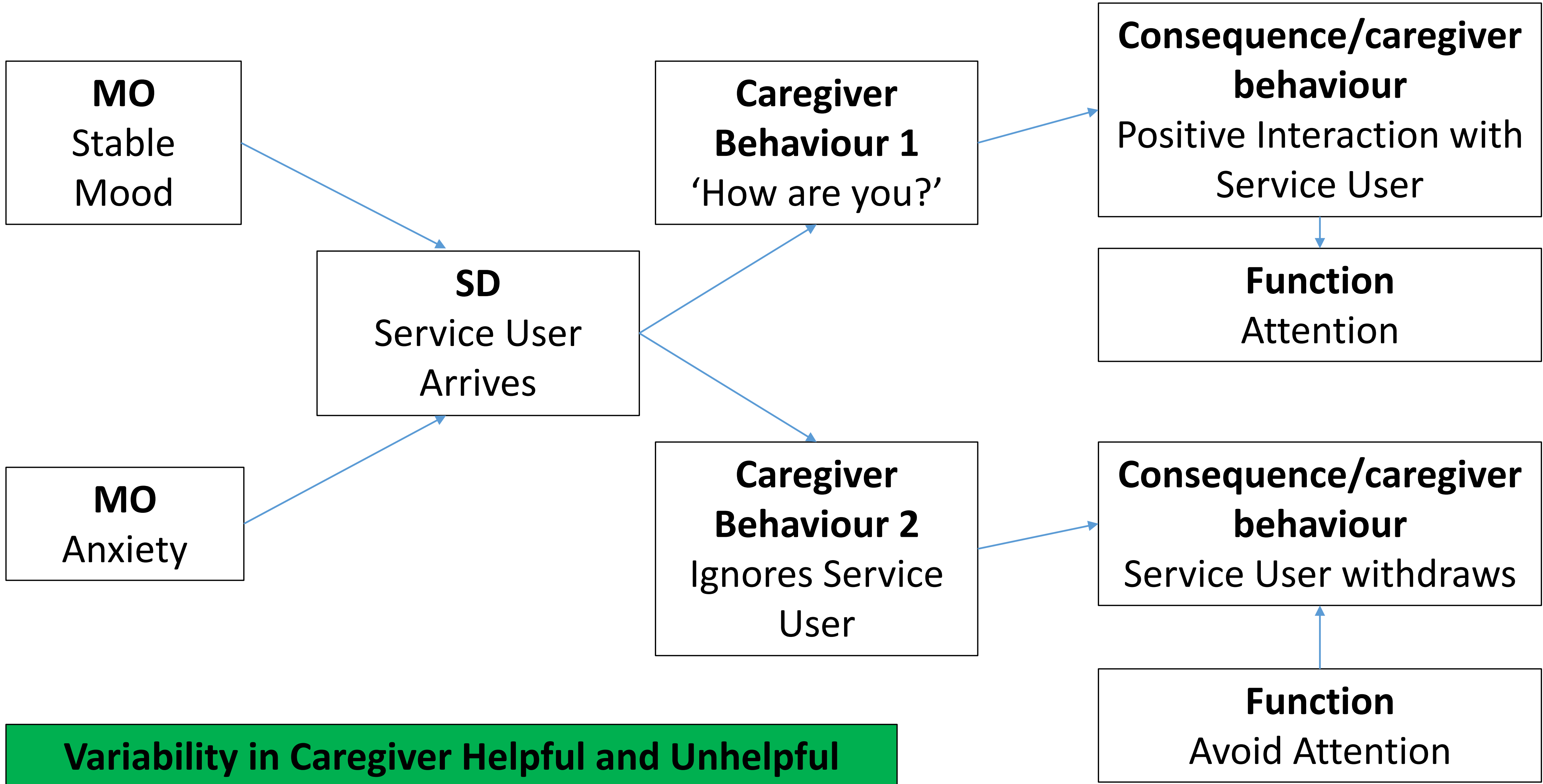


Fig 1c Mood as an MO for adaptive behaviour



Variability in Caregiver Helpful and Unhelpful Behaviour in General

Variability in Caregiver Helpful and Unhelpful Behaviour in Response to Challenging Behaviour

MO
Service User Challenging Behaviour
AND Anxiety

Caregiver Behaviour 1
Reprimand

Consequence
Challenging behaviour reduces momentarily

AND anxiety reduces momentarily

Unhelpful caregiver behaviour that reduces CB in immediate term **even more likely** in context of caregiver anxiety

MO
Service user challenging Behaviour
AND Stable Mood

Caregiver Behaviour 2
'How can I help you?'

Consequence
Challenging behaviour reduces and positive interaction / long term gains

In the context of a stable mood more helpful caregiver behaviour may be possible **even in presence of challenging behaviour….**

Discussion

- These are only ***some*** of the possible relationships
- That consider only **some aspects of mental health** in the context of challenging behaviour
- **Multiple variants and additional relations are likely!**
- In the article we have also not provided a behavioural account of ***how the mental health variables arise* or *are maintained* as the focus of analysis** (rather the part they may play in maintenance of caregiver and service user challenging behaviour)

There are some **interesting possibilities** to consider (for the future) if the development and maintenance of **a mental health difficulty itself is taken as the focus of behavioral analysis:**

Whilst **NOT** saying challenging behavior and mental health difficulties are inseparable, it is the case that both share some common environmental and physiological risk factors:

- Exposure to adversity
- Experience of trauma
- Impoverished social networks
- Lack of meaningful activity
- Physical health condition

…….that can readily be accommodated within a broad behavioral framework

Similarly it is interesting to then **start considering interventions** to support mental health difficulties in and of themselves and in the context of challenging behavior within a behavioral framework

Whilst **pharmacological interventions** may continue to be utilised in specific situations within such a framework – wider use and further development of behaviourally orientated approaches would make good sense:

- **Acceptance Commitment Therapy** Hoffman, Contreras, Clay and Twohig, 2016; Jackson-Brown and Hooper, 2009
- **Behavioral Activation** Jahoda et al, 2015
- **Mindfulness Based Cognitive Therapy** Idusohan-Moizer, Sawicka, Dendle and Albany, 2015
- **Dialectical Behaviour Therapy** McNair, Woodrow and Hare, 2016

- The ideas presented **do provide a start** at integrating conceptual models for PBS in a way that could inform assessment and intervention practices in a manner **consistent with the values and theory of the framework more broadly**

- **Fundamentally** here we see the possibility that mental health or emotional factors can be incorporated into an operant model – which is common to all people (whether or not you have an intellectual disability)

- **Highlighting these relationships in practice could be a useful step towards understanding and <u>deciding together</u> how best to live in the same boat**

Thank You and Questions