Chapter 8

Low arousal approaches in the management of challenging behaviours

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Introduction

Aggressive behaviour in people with learning disabilities is a major concern of service providers (Allen, 2000). Many of these behaviours are likely to be long-term, and often it is not possible to completely eliminate them from behavioural repertoires (Reiss & Havercamp, 1997). It has therefore been suggested that successful non-aversive intervention should contain long-term pro-active intervention strategies combined with short-term reactive strategies (Donnellan, La Vigna, Negri-Schoulz & Fassbender, 1988; Horner, Dunlap, Koegel, Carr, Sailor, Anderson, Albin, & O'Neill, 1990; LaVigna & Donnellan, 1986). Although LaVigna, Willis & Donnellan, (1989) recognised that 'a major goal of research should be to develop reactive strategies that minimize the potential of either reinforcing or aversive qualities' (p62), it remains the case that little information exists about the content of effective behaviour management strategies (McDonnell & Sturmey, 1993).

Strategies for defusing incidents.

While there are numerous outcome studies on long-term non-aversive interventions (e.g., Whitaker, 1993, Emerson, 1993, Ager & O'May, 2001), there appears to be no coherent academic model or rationale for the content of non-aversive short- term behaviour management strategies (McDonnell &

Sturmey, 1993), and no equivalent supporting evidence base (Allen, 2001). Anecdotal evidence would suggest that the two most common strategies adopted in clinical practice involve stimulus change and ignoring behaviours. These will be discussed in turn.

Stimulus change has been defined as 'the sudden and non-contingent introduction of a new stimulus or the dramatic alteration of stimulus conditions resulting in a temporary period of target response reduction' (p.128) (Donnellan, LaVigna, Negri-Shoultz & Fassbender, 1988). This can involve doing something 'odd or bizarre' to interrupt a behaviour. Suggested strategies can include 'singing, jumping up and down, giving a ridiculous instruction, telling the other clients to jump up and down, laughing hysterically'. (Willis & LaVigna, 1985).

While this may be a theoretically valid strategy, practical applications of stimulus change could be potentially quite dangerous if utilised with high-risk behaviours. There is very little research conducted into the effectiveness of these types of procedures (McDonnell & Sturmey, 1993), and the social validity of some of these strategies must also be questioned (McDonnell & Sturmey, 1993; chapter). Even if a strategy of this type was effective, it is still important to consider how other people might perceive its use. What would a lay observer think, for example, if they saw a member of staff apparently laughing hysterically at a person with a learning disability who appeared to be in distress?

Low arousal approaches

McDonnell, McEvoy & Dearden, (1994) reviewed a number of defusion strategies and recommended the adoption of low arousal approaches as a first option when designing reactive strategies. A low arousal approach:

> *" attempts to alter staff behaviour by avoiding confrontational situations and seeking the least line of resistance."*
>
> (McDonnell, Reeves, Johnson & Lane, 1998, p164)

In recognition of the potential role of cognitive behavioural frameworks in shaping staff behaviour (Kushlick, Trower & Dagnan, 1997), the approach has now been expanded to include cognitive as well as behavioural elements. Four key components are now considered central to low arousal approaches:

The reduction of potential points of conflict around an individual by decreasing staff demands and requests.

The adoption of verbal and non-verbal strategies that avoid potentially arousing triggers (direct eye contact, touch, avoidance of non-verbal behaviours that may lead to conflict, aggressive postures and stances).

The exploration of staff beliefs about the short-term management of challenging behaviours.

The provision of emotional support to staff working with challenging individuals

In most low arousal behaviour management plans all four components will be addressed. In some plans specific aspects may take precedence. The remainder of this chapter will attempt to examine these behavioural, cognitive and emotional elements.

Behavioural Factors

1. Reducing staff demands / requests

Staff behaviour has become a major focus of recent research (Hastings & Brown, 2001). It has also been reported that staff demands often precede incidents of challenging behaviour (McDonnell, Johnson & Allen, 2001), and placing demands on a person who is probably already upset can lead to behavioural incidents (Carr & Newsom, 1985; Carr, Newsom & Binkoff, 1980).. Much of this behaviour may well operate on negative reinforcement principles (Taylor & Carr, 1992; Cipani & Spooner, 1997) in that its function is to remove aversive stimuli.

In a recent review of strategies to enhance compliance (Cipani & Spooner, 1997) four approaches were suggested as being appropriate: errorless learning, differential reinforcement of alternate escape behaviour, behavioural momentum (Mace, Lalli, Belifore, Pinter & Brown, 1990) and functional

communication training strategies (Carr, et al. 1994). These strategies may help an individual comply and cope with demands and requests. However, it is interesting to note that the reduction of demands per se was not even suggested as an option. A behaviour management strategy might consider the reduction of demands to low rates per se as a viable option. This is especially true when the consequence of placing a demand may increase the likelihood of physical assault.

Engaging people in purposeful activities can also reduce the frequency of challenging behaviours (Hill & Chamberlain, 1987). However, this process can produce the opposite effect and lead to challenging behaviours (Weld & Evans, 1990) and in extreme circumstances 'extinction bursts' (Iwata, et al, 1994).

A low arousal approach suggests that staff demands and requests should be minimized as a short-term goal. From a behaviour analytic perspective, an appropriate question to pose would be 'Under what conditions and circumstances should a demand be made?' Carers should attempt to be flexible in how they introduce activities to people who present with challenges. The fact that a person is scheduled to go swimming at 10am does not necessarily mean that the activity should take place at that specified time. If the person appears to be upset, then the opportunity to go swimming could be re-presented gently every 10 or 15 minutes.

Case example: *Peter was a young person with learning disabilities who presented with high frequency aggressive behaviours when requested by staff to get up and go to work. He attended a day care centre which he stated that he 'did not like'. A wide range of day activities and positive incentives were tried to encourage him to get up with little success. Care staff had attempted a number of strategies to get him out of bed in the morning. These included: shouting at him, offering him incentives, getting him up first in the morning, and alternatively getting him up last, all with limited success. A low arousal approach was adopted (given that he could not stay in bed all day). Every 20 minutes starting from approximately 7.00am, a member of staff would knock on his door and ask him to get up (he would usually swear at them). They were told not to argue with him under any circumstances. These polite requests were repeated calmly every 20 minutes. On average he would usually get up after 90 minutes, although there were still some days where he still refused to get up or became aggressive. On these 'bad days' staff were encouraged to 'give in'.*

The staff in effect learned to manage his behaviour more appropriately in the short term. They did not change him as a person, but merely reduced the frequency and intensity of the request.

2. Avoidance of provocative verbal and non-verbal behaviours

Heightened physiological arousal is often associated with aggression (McDonnell, McEvoy & Dearden, 1994). The development of self-control procedures offers promise as a therapeutic intervention in such circumstances (Benson, Rice & Miranti, 1986; Black, Cullen, Dickens & Turnbull, 1988), but these approaches do not provide any significant advice as to what carers should do when confronted with an angry and highly aroused individual. There are a number interpersonal factors to consider when attempting to avoid increasing the physiological arousal of people with learning disabilities.

Non-verbal communication

While direct eye contact clearly has a communicative function (Argyle, 1988), it is also one of the most physiologically arousing phenomena known to man (Mehrabian, 1972). For this reason, it may not be advisable to maintain eye contact with a person who is already aroused and /or angry.

Similarly, while touch is a sign of warmth and dominance in the animal kingdom (Major & Heslin, 1982), it is also a sign of hostility, (McDonnell & Sturmey, 1993). Touch may also have paradoxical effects particularly among people with autism (O'Neill & Jones, 1997). While some research has suggested that touch can have a positive therapeutic effect on people who present with challenges (Hegarty & Gale, 1996), it has to be perceived by the person as comforting, and this is not necessarily a universal reaction. While

the authors would not advocate that a person never touches somebody who is angry or upset, carers should be wary of doing so when an individual is clearly in an aroused state.

Research has also demonstrated that individuals are often wary about people invading their personal space (Hayduk, 1983). Invading a person's space can lead to increased physiological arousal and in some circumstances even assault (Kinzel, 1970). A low arousal approach would suggest that when a person is upset we should be wary about invading their space.

Verbal communication

High speech volumes have been shown to be physiologically arousing (Argyle, 1986). People with autism can have marked sensitivity to sounds that can cause distress reactions (Bettison, 1994). Indeed, Temple Grandin (1994) reported that " loud noises were a problem often feeling like a dentist's drill hitting a nerve (p67)". In addition, receptive and expressive language problems are common place in individuals with learning disabilities. Carers should therefore be even more wary about how they speak to people, especially when they appear to be upset. They should be aware of the tone of their voices, speaking slowly and calmly may be useful and most importantly of all try to avoid raising their voice.

Cognitive Factors

1. Challenging belief systems

Staff beliefs about challenging behaviours can have a strong influence on their actions (Hastings & Remington, 1994; Hastings & Brown 2000). In a cognitive framework, staff 'self rules' that influence their responses to challenging behaviours are equivalent to staff beliefs about intervening with challenging behaviours. Low arousal approaches can involve challenging such beliefs.

For example, the low arousal approach is often criticised by carers for encouraging them to 'give in' (McDonnell et al, 1998). This usually occurs because there is often a failure to appreciate the difference between managing and changing challenging behaviours, and can sometime s result in staff becoming locked in a 'battle of wills' with service users. The following example illustrates this point.

> *Case example: A young person with learning disabilities was taken out on a day trip that he appeared to enjoy. When the members of staff asked him to return to their car so he could go home he sat on the ground saying 'No!'. A crowd began to gather with the young man refusing to move from the spot. Both members of staff knew that he really liked ice cream. One member of staff bought him an ice cream and then asked him to move, which he duly did. After the person returned home the two staff members began to argue. One person*

felt that giving him an ice cream was 'reinforcing bad behaviour'. However, the second member of staff asked the question what would they be reinforcing by grappling and wrestling with the person?

This example illustrates quite neatly that people often fail to understand the distinction between avoiding conflict in the short-term and long-term behaviour change goals. There is often an underlying fear about 'giving in' to demands and requests that is termed *'catastrophic thinking'*. In the above example catastrophic thinking would lead to a number of assumptions. First, once the person has learned to get an ice cream in this manner they will sit on the ground *every time* they go out until they get one (this assumes that the person has control over their behaviour). Second, the client will run out of money and the staff will have to use theirs to satisfy this need. Third, the client will become so overweight that they will become ill. Fourth, this strategy will generalise to every aspect of the person's life, he literally won't do anything unless he gets an ice cream. The outcomes described could happen, but how likely is this to be the case in reality? The only way to examine assumptions such as these is to gently test them out over time. The goal of short-term management is to keep all people involved safe and to avoid unnecessary conflict. Long-term goals involve changing a person's lifestyle and removing the need for the person to present challenges. Thus, to '*give in*' occasionally may seem a problem, but in reality it is a step towards developing a behaviour change programme.

Low arousal approaches may also involve exploring more fundamental beliefs. A number of studies suggest that staff attribute the challenging behaviours of persons with learning disabilities to a variety of causes (McDonnell, et al, 1997; Watts, et al, 1997, Hastings, 1996). Weiner (1980, 1986) proposed an attributional model of helping behaviour. In this model, the perceived controllability and the stability of the attributions are critical in carer decisions to help individuals. Challenging behaviours should be viewed more positively if the behaviour is perceived to be outside the persons control and stable (e.g., a person had epilepsy), whereas a carer may be more angry and negative towards a person if they perceive the person to be in control of their behaviour (Dagnan, Trower & Smith, 1998). It is the authors experience that many staff tend to perceive service users as attempting to assert control by employing challenging behaviours in a purposive and deliberate manner. Low arousal methods when successfully employed can at times make carers feel that they are 'giving in' (McDonnell, et al, 1998) and consequently, that service users are 'controlling' them.

Low arousal approaches encourage staff to attribute causes of challenging behaviours to external unstable factors. There is research that implies that staff who attribute the cause of behaviours to unstable factors tend to report higher levels of optimism and helping behaviour Sharrock, Day, Qazi & Brewin, 1990). While research has yet to empirically demonstrate that externalising the causes of challenging behaviours may effect staff interactions with people with learning disabilities (Hastings, 1997), it would

seem logical that staff beliefs need to be addressed if their own behaviour is to change.

> *Case example: A person with learning disabilities presented with both physically aggressive behaviours and verbal threats on a daily basis. After an initial assessment it was discovered that staff attributed causes to stable dispositional characteristics of the person. The negative attributions were summarised by one member of staff: 'The verbal threats are methods (disposition) he has always (stable) used to control others. He will never change (stable). That's the way he always behaves when he does not get what he wants (controllability)".*
>
> *It was found on analysis that the person was sensitive to noise, heat and mood swings which were not always under his control. He also had problems controlling his anger. A rationale was presented to his carers which argued that the person was rarely in control of his behaviours. At one year follow up it was found that the frequency of behaviours had not radically altered, however, the majority of staff felt that these same behaviours were less problematic as they understood that there were many times where the person 'just loses control'.*

Emotional factors

Aggressive behaviours can evoke powerful emotions in carers (Bromley & Emerson, 1997; Oliver, 1993, Singh, Lloyd & Kendall, 1990). In some cases it may not always be possible to directly modify behaviour for technological and ethical reasons. The following case example illustrates these points.

> *Case Example: For the last year a young woman with autism and challenging behaviours has been eating large amounts of food in her residential home. In this time she has gained nearly three stone in weight and her carers are concerned that it is affecting her health. She has demonstrated a capacity to understand the implications of not dieting on her health. She was placed on a low fat diet by her consultant psychiatrist and her assaults on staff became very frequent. After seeking advice from an advocate she was taken off this diet and allowed to eat foods of her choice. Although the staff accept that it is her right to eat food of her choice they remain worried about her potential health related problems'.*

In the above example emotional support was provided to the care staff. There beliefs about maintaining this persons health appeared to focus on we need to do this for her good' were extremely robust and almost impossible to change. One member of staff was overheard stating that it was much better in the '*old days'.* In this case the staff were provided with regular support sessions where they were encouraged to accept the choice of the service user. Many individuals required re-assurance that they were not being

negligent of their duty of care. In this situation providing a forum for staff to express there strong feelings did appear to have an impact on their behaviour. Ultimately, the service user continued to eat what *she* liked.

Conclusions

Low arousal approaches should not be viewed as a panacea, However, further developing this short term technology could potentially make significant changes to both carers and people with learning disabilities. While the low arousal approaches described in this chapter may have some face validity, care should be taken when interpreting their utility as much more controlled research is needed into their efficacy. It is still a little disconcerting that the majority of behaviour management advice given to carers would appear to be anecdotal in nature (McDonnell & Sturmey, 1993). If the same standards were applied to behavioural interventions we would have no empirical basis to design such plans. Finally, low arousal approaches are as much a philosophy as well as a set of behaviour management techniques. Whilst, they do not represent a panacea for challenging behaviours, they may increase the possibility that less fearful staff may adopt more proactive behavioural supports

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