6-1-2003

Treatment or Accommodation for Adults with Challenging Behaviors

Robert A. Fox
Marquette University, robert.fox@marquette.edu

Published version. *Mental Retardation*, Vol, 41, No. 3 (June 2003): 205-206. DOI.

Treatment or Accommodation for Adults With Challenging Behaviors

Robert A. Fox

When an adult with developmental disabilities is referred for a significant behavior problem such as aggression, oppositional behavior, self-abuse, or destructiveness, it is customary practice in residential care settings to develop and implement a behavioral treatment plan that involves a number of interrelated steps. Typically, a history is taken to determine the strength of the behavior, circumstances related to its occurrence, and past efforts to treat it. Next, presently occurring and potentially contributing physical factors are addressed and ruled out to the extent possible by referral to appropriate medical professionals. The present status of the individual is then assessed through (a) direct observation in the individual's natural environment; (b) interviews with the individual, when appropriate, and staff members, family, or others familiar with the person; and (c) relevant testing (e.g., as an evaluation of cognitive and adaptive skills and screening for psychopathology, Alzheimer's disease, or other disorders) and identifying reinforcer preferences. A detailed functional analysis follows to obtain a baseline of the challenging behavior and to identify possible related environmental factors. At this point, internal factors that may be contributing to the problem behaviors as well as relevant psychiatric diagnoses are considered and, when appropriate, a referral is made for a consultation and possible medical management of the disorder. Finally, a behavioral treatment plan appropriate to the individual's developmental level is designed and implemented, including appropriate staff training and monitoring. Typically, treatment programs involve procedures to reinforce behaviors incompatible with the challenging behavior and to apply least restrictive consequences for the referral problem. Broadly speaking, the objective of behavioral treatment is to make systematic changes in the individual's environment, including antecedents and consequences, that will support the individual as new adaptive behaviors are learned and old problem behaviors are reduced and ultimately extinguished. The long-term goal of behavioral treatment is to have the individual maintain behavioral gains in the absence of continued treatment. The final outcome should be an improved quality of life for the person in treatment as well as the other residents and staff members whom this individual encounters on a daily basis.

The professional literature is replete with studies that document the effectiveness of behavioral treatment programs, and practitioners can easily cite numerous successful treatment cases of their own. However, not all individuals with challenging behaviors experience positive treatment outcomes. We all have cases that despite our best efforts do not respond well to behavioral treatment and for some, they actually become worse. A number of factors contribute to poorer outcomes among individuals with developmental disabilities, including chronological age, a long history of problem behaviors, comorbid psychiatric diagnoses, medical complications, and an intractable treatment record. The purpose of this perspective is to suggest an alternative to traditional behavioral treatment programs that we have experienced good success with over the past 10 years. We call this approach *accommodation*.

Accommodation is rearranging an individual's environment to prevent or lower the occurrence of challenging behaviors. More specifically, the primary focus is to identify precursors or antecedents to problem behaviors and then to alter them to reduce or eliminate their impact on the individual. Recently published guidelines for the treatment of psychiatric and behavioral problems in mental retardation (Rush & Frances, 2000) referred to this approach as "managing the environment" (p. 171). Unfortunately, there seem to be no studies that use this form of psychosocial treatment as the primary or only mode of intervention for problem behaviors in this population. Further, unlike behavioral treatment programs, the goal of accommodation is not to make changes in the individual but rather to make changes in the environment that work to minimize behavior disturbances in the individual. In fact, an assumption of accommodation plans is that their removal could very likely result in a return of the challenging behaviors.

In illustration, Lori is a 36-year-old woman

with moderate mental retardation and autism. She is a large and strong individual with a history of severe aggressive behaviors that caused injuries to vulnerable residents and staff members responsible for managing her. Lori had been on several unsuccessful behavior programs. We identified "intruding in Lori's space" as a consistent precursor for aggressive behaviors. That is, when staff would request that Lori do something or get involved in an activity, either immediate or delayed aggression often resulted. Her accommodation plan involved respecting Lori's space by reducing staff requests to the minimum to ensure that her basic needs were met. (Her fellow residents had already learned to accommodate Lori by staying clear of her to avoid getting hurt!) Also, whenever Lori initiated interactions on her own, she was immediately given appropriate attention. Over a period of a few months, Lori's aggressive behaviors diminished in frequency and severity. Now, years later, her aggression only occurs when a new staff member fails to follow her accommodation plan.

As another example, Bill is a 55-year-old man with Down syndrome and severe mental retardation. Staff referred him for increasing oppositional, destructive, and aggressive behaviors. A review of past adaptive behavior assessments indicated a gradual deterioration of skills. In addition, a staff-completed dementia checklist noted distinct behavioral changes, including loss of memory, increased confusion, personality changes, and regression in daily living and occupational skills. Behavioral treatment programs that had been effective in the past no longer were working. Through discussions with direct care and supervisory staff, it became apparent that we had not changed our expectations for Bill to correspond with his insidious regression. Our accommodation plan involved modifying our expectations for Bill. We reduced daily programs to those necessary to maintain rather than attempt to improve his present skills and to ensure that his health and hygiene needs were met. A significantly reduced workday was designed with tasks more in keeping with Bill's skill level and interests. Basically, we created a retirement environment for Bill. Again, a fairly rapid improvement in challenging behaviors was observed. Bill also seemed happier and more like his old self until he passed away 5 years later.

We have had a number of other difficult cases that have responded well to accommodation plans. Accommodation certainly should not be the first option considered when an individual with challenging behaviors is referred. Every effort should be made first to use appropriate behavioral treatments to teach individuals adaptive alternatives to challenging behaviors within the context of their unique characteristics and environments. However, if our goal is to improve the quality of life of those individuals that we serve, for some, the best treatment may be no treatment at all.

Reference

Rush, A. J., & Frances, A. (Eds.). (2000). Treatment of psychiatric and behavioral problems in mental retardation [Special issue]. *American Journal on Mental Retardation, 105*(3).

Author:
Robert A. Fox, PhD, Professor of Counseling Psychology, Marquette University, School of Education, PO Box 1881, Milwaukee, WI 53201-1881 and Consulting Psychologist, Milestone, Inc., Rockford IL 53201-1881. E-mail: Robert.fox@marquette.edu.

