

Introduction to the Heijkoop approach to challenging behaviour in ID

Jacques Heijkoop, Developmental Psychologist, the Netherlands, &

Jennifer Clegg, Associate Professor & Consultant Clinical Psychologist, University of Nottingham & Nottinghamshire Healthcare NHS Trust

January 2012

The Heijkoop method is used widely in ID challenging behaviour services across Northern Europe; the lack of an English-language account has inhibited its uptake in the UK. The method is fundamentally experiential and aimed at understanding the 'Who' of the client to complement the objectified 'What' knowledge of standard diagnostics. It is conceptually grounded in developmental psychology, focusing on interpersonal relationships and intersubjectivity, in particular Daniel Stern's combination of clinical and empirical perspectives on attachment and the emerging sense of self. This working paper is informed by 5 years' clinical use in Nottingham of Discovery Awareness, a process of video-analysis that is the core instrument in Heijkoop's approach. Heijkoop introduced and developed this during three separate week-long periods of service consultancy into two NHS Assessment and Treatment Units within Nottinghamshire Healthcare NHS Trust's specialist service for adults with ID.

When challenging behaviour exists, we assume that the self of the patient is in some way precarious and vulnerable, and seek to identify aspects of it for consideration. The best way we can come to understand the nature of their self is by becoming aware of the impact they have on us while striving to understand the world from their point of view. Yet the staff's view of the patient's personhood can get clouded by serious concerns regarding deterioration of the general development; by negative experiences resulting from the threat emanating from problem behaviour; and/or by difficulty making contact or communicating. In professional services, the view of a person can also be clouded by lack of time to think about them at all. Yet only really seeing this person brings back the possibility of connecting. It is the very first step to self-strengthening.

We study the here and now with people who are important within the person's daily life. This is a particular type of investigation that depends upon an active and open communication between those present as they talk with each other. The subject of study is on the one hand the feelings, expectations, thoughts, doubts, insecurities, worries, contacts and cooperation which the person with ID (hereafter referred to as 'the patient' because the second author's context of practice is a specialist ATU) brings to meetings with important people. On the other hand it is about the feelings, expectations, thoughts, doubts, insecurities, worries, contacts and cooperation these important people themselves bring to their meetings with the patient. Most of all, the method enhances awareness of how these two sides fit and sometimes misfit. Conversation about these issues is conducted from an open and interested attitude, in particular without blaming or shaming anyone.

The process addresses multiple aims. It seeks to increase general sensitivity to the patient and the motivation of staff to engage with them, since interaction is the fertiliser that strengthens the person's self. To identify deficits which require compensation from important others so that the patient's capabilities can flourish. And to start and support a process of individual and collective movement which leads to a more (inter)personal and safe space in which both important others and the patient can move.

Different instruments increase consciousness as well as insight about who this patient is as a person for important others, and how those important others are as persons for the patient. Although an understanding of these internal affects is created by studying patterns of relating in the here and now, the method also brings the needs and demands of the client into the picture. Such needs and demands were already there before admission, and they will be there after the patient leaves and enters a new living situation.

There are five instruments in this method. Each instrument makes its own contribution; each contribution has a mutual effect. They affect the thoughts, beliefs and expectations each individual caretaker holds about the patient and themselves. Becoming aware of these has an almost immediate impact on the attitude that frames the way each patient is met, contacted, cared for and co-operated with. In turn that has an almost immediate effect on the experiences the patient has with the caretaker. In the short run it has a calming and relaxing influence on both parties. In the long run it builds self-confidence and mutual trust.

The instruments

1. Discovery Awareness: video review to raise awareness of what is going on for and between people
2. Functional Developmental Profiles that help staff to become aware of expectations and open the way to insight about over- and or under estimations
3. Relationship Dynamics that compensate for the vulnerable self
4. Problem-solving Co-operation
5. Enabling important others to develop, by supporting them to validate their own personal ways of interaction based on insights from the process

This document details Discovery Awareness and outlines Functional Developmental Profiles.

1. Discovery Awareness

In short, Discovery Awareness is a tried, tested and unique way of video analysis. The patient is filmed in familiar surroundings. Chaired by a Methode Heijkoop Practitioner (MHP), video footage is watched together with the patient's clinical team with the intention of analysing the visual material. There is always room for everyone's contribution; the focus while watching is on the client. The footage is watched twice; the first time without interruption and without openly reacting to the images. After everyone has given their first impressions, the same images are watched for a second time. This time, the MHP uses the remote control to freeze the screen when one of the participants notices something or finds something interesting. In the conclusion, each participant is invited to explore that which has drawn his or her attention. It is customary to organise a Discovery Awareness meeting twice.

Discovery Awareness leads to the possibility of being able to watch and to listen to the patient's personhood in a more balanced way: a unique form of video analysis that enables the staff to take the patient's point of view while shifting points of view from different participants opens up the staff's perspective. In doing so, he becomes aware of his personal perspective on the patient. What used to be meaningless behaviour is now seen as signals of experience, emotions, involvement, taking initiative, communication, being in touch and self-management. Taking an interest is the motivational source of getting to know him or her better. The staff experience this as becoming newly acquainted with someone they thought they had known for a very long time.

This changed staff attitude engenders an increasing degree of relaxed involvement with the patient in the moment. The increased incidence of shared attention, and contact and guidance better attuned to the person's interest dispels frustration, irritation or stress. This instrument influences the relationship between staff and client. As a result of meaningful observation there is a simultaneity: change happening to the staff as a result of meaningful observation during contact brings about a change in the patient at the same time.

A Discovery Awareness meeting consists of the following parts:

- The opening
- First viewing session
- First impression
- Second viewing session
- Conclusion

Participants

The participants of Discovering Awareness are the people who guide the patient in their daily lives, such as team members of the ATU, therapists and care co-ordinators. Heijkoop recommends that family members in touch with the patient are involved in some way, either by active participation or by ensuring what came up in the meeting is shared with them.

Practicality sets limitations to the number of participants. This limitation is determined by the number of participants that can be handled by the MHP while still being able to practice Discovery Awareness responsibly. An obvious and logical form of limiting the number of participants originates in making a distinction between the different environments the patient moves in.

How to make a DA video

Procedure for making a Discovery Awareness video: 5-10 minutes

Gain consent in principle: sign consent form if can give informed consent otherwise seek assent from NoK if appropriate, if none or n/a then an advocate, if none then a member of the clinical team. At the moment of filming, get consent again – it may vary from time to time for the person.

Cameraperson instructions:

- Never film by concealing the camera: the person and staff should always know they are being filmed.
- Films are only 5-10 minutes maximum. 5 minutes usually enough. Half of this time is 'without expectation': perhaps walking around their space, or doing something ordinary like sitting in the garden. The other half is under expectation: could be doing a task like setting a table or playing a computer game – anything that is slightly demanding that the person would not do alone.
- Start by panning around the environment to show what/who is there
- Film continuously for the agreed time (2 ½ minutes & 2 ½ minutes is plenty) unless there is a good reason not to
- Keep the person centre-screen, the staff they're engaging with peripheral
- Try to understand the person's view-point, by staying at their eye-level (standing if they stand, sitting if they sit) – and by panning to something or someone if they look outside the frame, to understand their interest

Do not zoom – that would make the camera-person's interest too big. Take a general view so everybody can look at whatever they think is important. The only exception to this rule is if, after watching the first few videos, the whole clinical team agree to focus in on one very close aspect of the person, such as their facial expressions.

- Once you have made and studied videos using these procedures a few times with one person, more variety might help to elaborate their understanding or experience of the world. Half of later videos could be made of the person alone and half of them with other people.

Immediately afterwards

- Person leading the process offers patient opportunity to watch the video in privacy, accompanied by the caretaker who was in the film with them.
- Aim to make the situation comfortable but not demanding. Allow the patient to watch in silence, answer any questions or respond to any comments. Their reactions to being presented with this version of themselves, and the impact this has on them may be relevant. If they appear to be concerned about any part of the video, check that they give consent for others to see them. Occasionally, for example if there has been challenging behaviour, the patient may withdraw consent for others to watch the video or a section of it, in which case their views must be respected.
- Patient returns to unit. MHP watches the video with the care staff on the film, again making this as comfortable and undemanding as possible. This is neither analysis nor clinical supervision: it accompanies their first watch through, and provides a check that they are happy for others to see them filmed in a Discovery Awareness session.

Details of a DA session

1. The opening orientates: which behaviour are we discussing, what does it mean for the surrounding people and what does it mean for the client?
2. First viewing session: participants are asked to watch the material in silence and not to react out loud.
3. First impression

Each participant is invited to give a first impression by taking turns by a question such as 'what struck you as you were watching? Realising that the staff member who is on screen is very vulnerable, the MHP has an extra responsibility towards that person. He or she is offered the opportunity to speak first. They may wish to comment on the situation on film before saying what they were focussing on as they watched now. This is not a command: they can choose to turn the opportunity down. After this all others present are invited to comment, but not to react to one another yet. Comments are accepted out loud and the participant's key points noted on the flipchart before their turn is concluded. There is room for all types of comments during the first impression, especially for feelings and experiences of the staff. While listening to the impressions, the MHP makes a distinction between descriptions, meanings and explanations

4. Second viewing session

Now the MHP lets his observation direction be guided by the person commenting at that time, using the remote control to still, rewind, fast-forward and slow-motion functions in order to freeze the image that is being referred to during conversation. The reference image is the image to which the participant is responding, because something strikes or interests him/her. Using the remote control in such a way that the reacting person is immediately shown the image that stood out for him/her. The MHP is of service to the people who are speaking or reacting at that time. There may be different views on what is seen: each person's distinct perspective is given space for exploration valued without struggle towards agreement.

There is constant shifting between what can be seen and heard (description) and the meaning that can be derived from it. Each person's comments are heard and reduced to what can be seen and its meaning. This can be a complicated job for the facilitator as professionals are very well trained in giving explanations and solutions. Such comments are therefore 'parked' to another moment of the process because they disturb the discovery process.

5. Conclusion

First, there is a joint review of what has stuck in every individual participant's mind.

Second, a joint preview in which participants are invited to explore the subject of their interests in practice.

2. Creating a functional developmental profile

This stands alongside formal assessments which have objective results. The clinical team pool their impressions of the patient, to make explicit the ideas that can both help and impede staff becoming attuned to the patient's needs. In turn this helps staff to develop the ability to work in co-operation with the person. The team discuss their impressions under each heading, then assign an approximate developmental age to each component.

Name and age: Reflections on name (does it evoke any thoughts or expectations?) and apparent age – how old they seem to be.

Presentation: Manner, style. Important to consider because people can elicit from others the reverse of what they need (e.g. avoidant people may be desperate for human contact).

Skills: ADL, cooking, road-safety; what can he arrange himself, with what type of external support?

Language: Their understanding: what is easy, what types of information/ideas does the person struggle with?

Social: Do they tend to be teased/abused? How is contact sought, started, continued and finished?

Emotional: Intensity; Which emotions are recognized? Speed of shifts in emotion state, does arousal become overwhelming, especially joy?

Self in relation to others: how developed is the patient's sense of themselves? Do they try to dominate others, or get taken over by others, or can they negotiate within relationships?

Often we feel less and less certain as we go down this list. It is difficult to be confident about the person's socio-emotional world – yet understanding and working at those points of the profile often makes the most important contribution towards supporting them. It shows how uneven the person's skills are: we often make assumptions about one aspect of the person from information gleaned from another. The most common error is to believe that a person who has good verbal skills is just as able in the other parts of the profile. This exercise helps us to see the gaps, as a prelude to working out the strategies we need to use or approaches we need to offer the person in order to help them develop where they can. It tells us where we need to offer support which compensates for gaps that will only change very slowly.

3. Discharge

Recognition of developmental needs and demands of the patient that do not change influences what information needs to be transferred for her or him at the moment that they leave. The ATU service seeks to help the receiving team to become conscious of, and have more insight into, the Who side of the patients alongside an understanding of how this relates to the What information. A Discovery Awareness session with receiving team sometimes helps them to tune into the ways of looking and attempting to understand how the world looks to the patient/person as a first step towards stimulating a process of bonding between them and their new staff team.

Jacques Heijkoop - Biography

Jacques is a private practitioner in developmental psychology, and as such frequently approached by mental health and school services. He also offers supervision and training courses for various facilities in the juvenile and psychiatric care sectors. His orientation is international and stretches from his base in the Netherlands outward to Belgium, Germany and Scandinavia especially Norway.

His career related to people with learning disabilities has lasted more than thirty years. In the 70s and 80s he published many articles about his specific way of observing and answering to persons with ID and challenging behaviour. In 1991 he published the book *Stuck Fast* in which his basic assumptions are worked out. An English translation of the introduction can be downloaded from the website address below.

From 1990 he started a formal, though non-academic, education in a systematic approach in dealing with these extra demands. This is a practice-based approach. In the Netherlands it is called 'Methode Heijkoop, 'Anders kijken naar ...' (Another perspective on ...). This approach is based on active cooperation between the trainer and the social system which ask for help or support. Different instruments are developed to support a change process based on growing awareness and insight. Awareness and insight about how the needs and motivation of client and caretakers can be matched in such a way that it supports each other's self-confidence and their interpersonal trust.

The more this practice based approach has become explicit, the more its use has broadened to general raising of service quality and to other client groups.

Further information about the Heijkoop method: www.heijkoop.nu/english/

Contact details: info@heijkoop.nu & Jennifer.Clegg@Nottingham.ac.uk