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Research Paper

Behavior Modification in a Case with Mild Intellectual Disability

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ABSTRACT

The purpose of this study was to determine and illustrate the course of behaviour modification for a patient diagnosed with Mild Intellectual Disability who was referred for treatment at a private mental health facility. The patient was presented with complaints of throwing temper tantrums, aggressive and assaultive behavior when things are not done according to him, outburst of anger, overeating, lack of money management. The patient was assessed, diagnosed and a treatment plan was developed. Implemented treatment consisted of behavioural oriented psychotherapy. The intellectual assessment was conducted to assess the IQ level. Behaviour Analysis was conducted to identify the behaviour excess, behaviour deficits and behaviour assets. At the onset of intervention, clarification of the problem situations was done through antecedent, behaviours and consequences (ABC), motivational interviewing (MI) was also done as it has shown promising results in improving motivation to change and individuals' confidence in their ability to do so. It also examines how well a programme of positive reinforcement would be accepted in that particular environment.

Keywords: *Behaviour Modification, Mild Intellectual Disability, Behaviour Oriented Psychotherapy, Motivational Interviewing, Positive Reinforcement.*

Behavior disorders are common in children with an Intellectual Disability (ID), it can create problems in everyday life. The diagnosis of an ID relates to a varied group of individuals, approximately 3% of the population, whose intelligence quotient is <70. They also have a wide range of needs and most display behavioural problems. Around 7-15% of people with ID have severely challenging behavioural problems. The nature and severity of these behavioural problems vary with the categorization of ID. In children with ID, the social environment in which they live and interact also shapes their behaviour. Having a child diagnosed with ID is stressful for family members and the child's behavioural problems can produce further stress and burden for parents and caretakers. Furthermore, behavioural problems also delay the child's learning in a number of settings, including at school and at home. Many children with ID in communities are isolated from their peers and are therefore deprived of interaction and play because of their behavioural issues. This isolation limits their chances to learn through observation and interaction with other children. Due to a deficiency of awareness and information, such behavioural problems are erroneously considered manifestations of mental illness. Nevertheless, in people with ID, behavioural problems do

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increase the probability of mental illness and can lead to serious life-threatening circumstances if not treated.

The term “challenging behavior” is now often used to describe behavior problems. Emerson (2001) defines it as “culturally abnormal behavior(s) of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behavior which is likely to seriously limit use, or result in the person being denied access to, ordinary community facilities” (Emerson 2001, p. 3). Challenging behaviors, as defined by Emerson (2001), are severe behavior problems.

Many studies have found a high prevalence of behavior problems in people with intellectual disability (Emerson, 2001; von Tetzchner, 2003). Emerson and Bromley (1995) found that 33 people per 100 000 of the general population in a metropolitan borough in the north-west of England showed challenging behavior. A somewhat higher prevalence rate was found in a study published by Emerson and associates in 2001. In this study data collected in seven areas in 1988 and in two areas in 1995 were analyzed. In the seven areas studied in 1988 they found a prevalence of challenging behavior of 45.3 of per 100 000 base population and in the two areas studied in 1995 they found a prevalence of 58.5 per 100 000. Various forms of behaviors have been reported to be serious behavior problems for people with intellectual disability. Qureshi and Alborz (1992) found that physical attacks were the most serious problem for 23 percent of adults with behavior problems, self-injury for 17 percent, destructiveness for 16 percent and other socially or sexually unacceptable behavior was the most serious problem for 52 percent. In a study by Emerson and associates (2001b), aggression was reported for seven percent of people with administratively defined intellectual disability, destructive behavior for four to five percent, self-injury was reported for four percent and “other behavior” was reported for nine to twelve percent. Among the behaviors included in the category “other behavior” were non-compliance, temper tantrums, screaming, running away, over activity, stealing and inappropriate sexual behavior.

Managing behavioural problems is a major concern in the people with ID. Behavior modification based on the principles of operant conditioning that replaces undesirable behaviors with more desirable ones through positive or negative reinforcement. Behavior modification techniques vary with reference to strengthening skill behaviors and managing problem behaviors.

A review of 109 articles evaluating positive behavioral support interventions (Carr 1999) concluded that 52% of interventions reduced challenging behavior by at least 90% from baseline levels and 68% by at least 80%. For about two-thirds of the interventions the effect was maintained for between 1 and 24 months. Positive behavioral support involves identifying the purpose of the challenging behavior and working out a support plan that encourages the development of new skills to reduce the individual’s need to engage in the behavior (Carr 2002; Allen 2005). Its focus is on individualized interventions that are based on a clear understanding of the person and the purpose of the behavior. The interventions aim to develop appropriate social, communication and behavioral skills that enable the individual to replace the problem behavior with a functionally equivalent behavior that is more appropriate.

Challenging behavior can be an attempt to communicate unmet needs, so strategies that are proactive and flexible in addressing these should be put in place, positive behavioral development should be promoted and the response of professionals and care givers to

challenging behavior should be socially enabling rather than restricting (Royal College of Psychiatrists 2007).

CASE SUMMARY

The patient, addressed as D.K., 18 years old male, belonging to an urban background and currently studying in 9th standard was diagnosed as F70 Mild Mental Retardation. He was presented with long history of behavior problems. As reported by his mother, as early as 9 to 10 years of age, his mother recalled consistent difficulty in waking him up in the morning. He presented with several behavioral problems, as well as problems interacting with individuals of his own age. His mother reported that his problems with his anger kept increasing from a very early age; he would get angry over very little things. She started to notice his aggressive behavior when she use to wake him up in the morning for school, at that time he would never wake up, would throw things at her and even slapped her at times. His behaviors extended to other family members who included his sister and father. He would throw things at his family members or tell inappropriate words when he was asked to do things which he did not like, for example to exercise, to not overeat, wake up in the morning and to study. He also frequently refused teacher requests or participation in school activities. His noncompliance often escalated into aggressive behaviors that were sufficiently serious to warrant regular complaints. This pattern of aggression and lack of concentration during classes and poor academic performance continued throughout his childhood and adolescence. She also reported that he was unable to do work similar to the pace of other children of his age. As reported he would not understand the concept of money till the age of 10 years and then after his mother with lot efforts was able to make him recognize money but still he cannot make purchases at the store.

A developmental interview with the informant (mother) indicated that he was born following a normal pregnancy and delivery at 38 weeks' gestation, weighing around 3 ½ kilograms. She even reported that during her brother had expired due to which she was under a lot of stress. The place of delivery was hospital and only abnormal presentation after the delivery was oxygen deficiency in the neonatal. She also reported that after 3 days there were convulsions in the baby which subsided after taking medications, he was on anti- epileptic drugs (AEDs) since then till the age of 8 years. However, some of his developmental milestones were delayed: He did not walk until 18 months of age and he was not fully toilet-trained until 4 years of age. Speech delay was also present; for example, his first words were not spoken until 17 or 18 months of age. She described her son as a slow learner compared to other children in her house. She reported that till the age of 7 he would not take his own bath or wear his clothes. She taught him everything for several years so that he could at least a desirable level of self care and grooming. He was described by his parents as an extremely moody child, with unpredictable and aggressive behaviors. His father worked full time and his job required long hours and frequent travelling. Interpersonal relationship among the family members has always been cordial and supportive and the status of the family is also intact. The patient has no significant distortion in the family environment. There is no lack of warmth in intra familial relationship and adequate parental control but as reported father is more dominant in the family. There is no significant mental illness reported in the family.

INTELLECTUAL ASSESSMENT

Binet-Kamat Test of Intelligence

On Binet-Kamat Test of Intelligence the patient obtained a mental age of 88 months and prorated intelligence quotient (I.Q) of 56.65 indicating mild mental retardation.

Vineland Social Maturity Scale

On Vineland Social Maturity the patient obtained a social age of 8.5 with a social quotient (S.Q) of 53.12 which indicates mild mental retardation.

BEHAVIORAL ANALYSIS

Initial Analysis of the Problem Situation

a) Behavior Excess identified in D.K. was frequent anger over till things. For example when asked to do something he would aggressively shout or throw things. His frequency of anger was about 5-7 times in a day and would vary in intensity depending on the situation; his anger would last from 15 minutes to entire day at times. Overeating was another behavior excess. He would not realize when to stop until told.

b) Behavior Deficits identified were lack of social skills; he did not know how to behave in a socially appropriate manner. He would at times reveal his house secrets in front of others or would ask inappropriate questions. He also lacked money skills and would know the account of his money. His academic performance was also not good. He was neither able to pay attention in the class nor do self study at home.

c) Behavior assets included his ability to remember things; he had good computer skills and wanted to take further training in computer. His interaction with others, although limited, is usually friendly, respectful and focuses around his great sense of humor and ability to make people laugh. He has a positive and caring relationship with his parents and younger sister.

CLARIFICATION OF THE PROBLEM SITUATION

Antecedent: - In an antecedent analysis, it was tried to identify the events, situations and circumstances that set the occasion for a higher likelihood of the behavior and those that set the occasion for a lower likelihood. It was observed that D.K. would get angry always when his mother or father would constantly nag him to do one thing. He would also at times become very aggressive when he was not included in a conversation or treated in a disrespectful manner. It was also seen that his anger at times also preceded events when his parents or sister would negatively predicted his outcome or bring his past failures to current situations. His anger would also go before when someone refuses to do things according to him. Another important antecedent or environmental trigger recognized was unstructured time, D.K. did not know when to do what which also lead to frustration in him and his family. His internal thoughts like "he's a complete failure, he would not meet anyone's expectations" would also lead to feelings of anger which would further lead to verbal or physical aggression due to any other external environmental triggers.

Behavior: - He would argue with his parents or sister, even his parent and sister would in return reply aggressively and which lead to further aggravation of the situation. Then he would also throw thing or break household items. His family members at times use to hit him. At times he even avoided talking to his father.

Consequences: - It would lead to D.K. and his family members feeling depressed and sad. His mother and sister would not talk to him for days and then D.K. would again try to convince them when he got no attention for if they still would not talk to him it would and lead to anger in him.

Motivational Analysis

A motivational analysis was carried out to identify those events, opportunities and activities that D.K. enjoyed and that may be used to enhance his quality of life and provide him with incentives to improve his behavior and to enhance his academic progress. The results of the analysis showed a number of events that could be used effectively as positive reinforcement in a well-designed support plan to reduce the identified behavior problems. Potential reinforcers include watching TV and movies. His favorite foods were burgers, fries and cake He also enjoyed shopping. These reinforcers and others should be used in a variety of ways, the least of which would be through the contingencies of formal reinforcement schedules. Specific factors that were identified as maintaining factors of his problems were constant nagging of his family members, over expectations form the family which lead to reduced satisfaction even after he did anything positive, comparison of D.K. to other children lead to feelings of inferiority in him which further lead to feelings of anger.

Case Formulation

In reviewing the D.K.'s history and assessment some significant prenatal and postnatal factors were identified which was maternal stress during pregnancy, neonatal oxygen deficiency and convulsions. Therefore, it can be inferred that these factors would have contributed for the development of intellectual disability. Furthermore from record of antecedents, behaviors, and consequences pertaining to the maladaptive behaviors, it was clear that the majority of his problem was because of lack of self-regulation, over instructions, lecturing method and no presence of any consistent, contingent and immediate reinforcement. He had learned to avoid or escape from requests that he found unpleasant by refusing to comply. Further, he had learned to quickly escalate his behavior into aggression to avoid repeated requests from others. Based on this analysis combined with the client's behavioral history and present developmental level, a treatment plan was developed and implemented to address these concerns. Given the long history of the client's aggressive behavior pattern and other social deficits, it was evident that the treatment program would need to be gradual, additive in nature, and long-term to reverse this well-ingrained behavior pattern. Cognitive and behavioral theory is also combined to explain and treat his emotional and behavioral problems. The basic assumption was that D.K's behavior was caused by current environmental events and the way he perceived and appraised these events. In this case formulation, his aggression was evoked by certain antecedent stimuli, such as being treated in a disrespectful manner, and was maintained by its reinforcing consequences, for example escape from and avoidance of being treated disrespectfully. Furthermore, he lacked appropriate social skills and had a poor understanding of social situations. These variables were causally related to the development of his aggression. His poor social network and features of autism were precipitating factors. Cognitive-behavioral treatment has many behavioral and cognitive elements. It consisted of teaching D.K appropriate assertive and other adaptive skills, restructuring his distorted cognitions and educating him about social relationships.

Course of Intervention

A rapport between D.K and the therapist had already been achieved during the initial sessions of clinical interviewing as well as assessments. A working alliance between therapist and client was established where the two established a bond and agreed on the goals of therapy and tasks to be undertaken to achieve them. The information presented in the previous sections regarding his presenting problems was obtained through semi structured clinical interviews with D.K. and his parents and the assessments were conducted, in particular, for the first two sessions.

Initial Sessions/Phase (1-4 Sessions)

In the initial phase of the treatment given above information was collected and various types of assessments were done. The family was psycho educated about his intellectual capacity and was given hope that with constant training his intellectual capacity can reach up to an adequate level where he can function independently. The rationale for the therapy of behavior modification was explained to the family members. They were told that it is useful for them in helping their child to change an undesirable behavior to a desired one. They also told that this technique is useful in common behavior problems when usual discipline is not working. They were asked about the antecedent or what is triggering the behavior, next they were asked about the behaviors, what behavior is actually occurring and then the consequences, what finally happens or the consequences are currently being applied following the behavior. They were asked about the behavior they wish to stop and start with what desirable behavior. They specified stopping fights, talking back and reduced anger. D.K. and his family members were asked to review his presenting problems to set goals for therapy. These goals were then refined and classified further. The major short term goals that were agreed upon included the following:

1. Reduce the incidents of Aggressive behavior
2. Identify feelings of Anger
3. Developing Coping and Tolerance Skills
4. Developing Social Skills
5. Improving Academic Skills
6. Money management
7. Food management

Long- Term Goals: The long-range goal for D.K is to establish enough self control over his behavior that he will be able to live and work in the least restrictive setting possible that is capable of meeting his developmental and behavioral needs. Additionally, the goal is to transfer the control of D. K's behavior from external mediators (family members) to internally generated controls.

Middle Sessions/ Phase (5- 17 Session)

Token Reinforcement and Response Cost was initially used with him in the treatment plan. A routine was established for daily activities, bedtime at night and wakeup time in the morning with clear requests that were provided in a firm, matter-of-fact manner. For example, on weekdays he was required to get up in the morning at a specified time and get ready for school, including completing basic personal hygiene tasks, getting dressed, having breakfast, and getting on an auto to transport him to school. There also were activities that he participated in the evening such as exercise, room care, and a bedtime routine to ensure that he went to sleep at a reasonable time. A simple reinforcement program was instituted, where the client could earn stickers for complying with his a.m. and p.m. routine, with 10 stickers needed to earn a special outing with his mother. If he chose to refuse a request or became aggressive, he lost the opportunity to earn a sticker. Although initial success was observed in reducing noncompliance and aggressive episodes, it reported that the client continued to have consistent problems getting up in the morning and studying in the evening. As a routine was set for him, constant nagging form the parents reduced because he knew what to do when, as the results there was a reduction in his frequency of aggressive behavior. Gradually he was showing less interest in the token program. Therefore Monetary Reinforcement and Time-Out methods were used. For the first major programmatic change, the stickers were replaced with money and expanded it to include not only his a.m. and p.m. routines but also other activities throughout the day. He could earn 250 rupees weekly each week he completed his

routine on time. He was also asked to maintain a record of his money which included what he did with his money earned over the week. It was noticed that gradually he was able keep a correct account of his money. Similar to the sticker program, he could also earn a one-on-one outing or could buy anything of his liking for having collected a predetermined number tokens each day. For noncompliance, the client was given one reminder that he needed to follow requests. If he failed to comply, he received a 5-minute time-out in a room that was free from distractions and attention from others. If he refused to go to the time-out location, he was escorted. If his behavior escalated into aggression, his hands were held at his sides for 1 minute or until he was calm. The second phase of the treatment plan was having a positive effect. Also, episodes of his aggression also reduced in the intensity. During the course of the therapy it was also recognized that many behavior problems are a reflection of conflicts between the individual needs of a person and the environmental or interpersonal context, in which the person must live, to study or otherwise behave. As part of the above evaluation, several possible contextual conflicts were identified. It is possible, that by altering these contextual conflicts, that D.K.'s behavior may change and his progress may improve. In the following paragraphs, a number of "Contextual Manipulations" were presented with the intention of providing a better mesh between D.K.'s needs and the environments in which he must behave:

a) To reduce the number of distractions during studying by turning the televisions off at the home so that he can focus on the task at hand. As he can become distracted by the TV's being on, it would be a better it the T.V was put off when he's studying in order to eliminate distraction. His academic skills were further improved by proper task distribution. He was asked to study according to the portions divided and was not asked to move to the next chapter until he was thorough with the previous ones.
b) D.K. should also increase his level of exercise to aid him in relaxation. Exercising tends to result in greater reduction or displacement of anxiety. Therefore, he was asked to increase his exercise level as it would assist him in increasing his feeling of well being and will, in hopes, decrease his feelings of anxiety and frustration leading to anger.
c) To reduce his tendency to overeat his family members was asked to not let him self serve his food and he was also asked to avoid entering the kitchen. His mother was asked to give him sufficient amount of food and then his second taking of the share was not allowed. It was also observed that his overeating would precede entering into the kitchen when free; therefore, reducing that behavior also reduced unnecessary eating.
d) Implementing a scheduled interaction time each in the morning with his family members was included in the routine as it would benefit him and his family and start the day of with positive interaction and promote a positive environment.

To address his anger three distinct interventions: motivational interviewing, anger management and anger treatment were used. He displayed no motivation to change his pattern of anger so this was the first therapeutic target, using motivational interviewing he was helped to recognize that anger is a problem for him that he would benefit from addressing. He then gradually recognized that there are several better ways of expressing anger which would not lead to the consequences which he was facing currently. Then the next stage should be to teach him some anger-coping skills. He was first taught to recognize that he was becoming angry. When he was able to do this, the particular coping skills that was of benefit to him in provocative situations were: (a) stopping to think before expressing his feelings; (b) assertiveness skills that would enable him to express his anger in a socially acceptable manner; and (c) learning how to use his range of hobbies and interests to distract

himself, rather than expanding his frustration. The therapy also involved helping him to restructure his cognitions around his self-concept and his perceptions. This involved helping him (d) to gain a more balanced view of his abilities and recognize that others may sometimes know better, so that his identity is not threatened by difference; and (e) to address his self-serving appraisals and misattributions of fault, through learning that responsibility in social situations is shared between the participants and that there may be legitimate reasons why people sometimes behave differently to how he thinks they should. His family members were asked to constantly praise him for desired behaviors and bring his positive traits to focus.

Many of D.K.'s seriously challenging behaviors were the reflection of his inability to cope with aversive events such as delay in gratification, denial, the need to perform a non preferred activity, etc. Mike's coping responses have not had the opportunity to develop much beyond the primitive responses of a young child. Rather, it was necessary to be systematic with the objective of teaching him these very important coping and tolerance skills. It was proceeded with an initial focus being on D.K.'s establish boundaries. , helping him establish and understand boundaries between his feelings and others was focused. It was beneficial in that it assisted him in decreasing his feelings of anger. A task done to develop these boundaries was to use a comic strip conversation script to help D.K. establish boundaries between his feelings and those of others. He was explained about the comic strip, then he was asked to identify the feelings and then identify the people and their respective feelings and finally visually show him how his feeling and those of others over lap but do not control or consume. Later he was praised for a job well done.

To instill adequate social skills was also included in the treatment plan; social skills through role-playing of situation in which he might meet unfamiliar person were conducted. He was instructed to pay attention to body language (eye contact, facial expression, seated position) to determine whether the other person was interested in engaging in conversation and given his tendency to ask or reveal personal information, to keep initial conversations light. He was also instructed not to stare and he also practiced varying eye gaze. Different ways of greeting communicative patterns were also introduced: shaking hands, waving goodbye, saying goodbye. The ultimate test of his social skills took place when he had an outing with a group of students in a public restaurant. He reported that his interactions were appropriate.

Termination Phase/Sessions (Session 18 - 19)

In the last two sessions, D.K. and his family were prepared for termination. The progress of the patient was evaluated and their attributions were known. It was noticed that his frequency and intensity of aggression had reduce. He also became a little sensitive toward his family's needs and emotions. The parents reported that they were now able to take him out to several social outings like marriages and parties. Not much improvement was seen in his money management; though he was able to make purchases and keep an account of his spending he was not able to do any type of savings. Even his academic skills improved but his math skills did not show a desired change. In the termination phase the patient and the family also had plans on shifting to Singapore, therefore details regarding following the treatment procedures was emphasized. Information regarding the various other intervention centers in Singapore was also provided to them so that they can continue with the process. His parents noted that he did appear to be more aware of his tendency toward socially inappropriate behavior and that they had indeed seen improvements.

REFLECTIONS ABOUT THE SESSIONS

Contributing to the historical development of this patient's behavior problems was a long, documented history of various delays and aggression issues. The ability to report about the occurrence of internal events may vary across individuals and may be affected by cognitive impairments associated with mental retardation. Presence of internalizing symptoms is considered best assessed by self-report. During D.K.'s assessment and treatment, there were a number of occasions when it was difficult to determine whether he accurately reported about his experiences. Another complicating factor in this therapy was that his parent had over expectations from their child. With consistent efforts their expectation levels were brought to realistic levels. D.K.'s father mostly remained out of country therefore his greater involvement was not present. The family also at times had difficulty in maintain a consistent, contingent and immediate pattern of reinforcements which at times led to increase in undesired behaviors. It was also difficult for the mother to give up her habit of nagging and lecturing D.K. his sister was a great support to the therapy too. As the patient was very close to his sister many goals of the therapy were achieved through her. She helped him a lot in overcoming his feelings of inferiority. Despite his positive response to this intervention, there were times when treatment gains had declined.

CONCLUSION

Behavioral problems are a common manifestation in children with an ID, and frequently have unfavorable consequences on the functioning of the child and the caregivers. In the present case study, we reviewed the literature to understand the most common co-occurring behavior also known as challenging behaviors in children with an ID. Based on this knowledge, practical information is offered in the form of a case study routine where behavior modification strategies are implemented in routine clinical practice. The current management of behavior problems in the child with Mild ID focuses on symptomatic treatment using behavior modification. It is clear that further research is essential to help categorize best practices for behavior disorders in children and youth with an ID along with methods where the data can be quantified. Parents and professionals must be educated about the significance of behaviors strategies in comprehensive management of such challenges.

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Conflict of Interest

The author declared no conflict of interests.

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