Education

14

BEHAVIOUR MODIFICATION

Medha Khadye
Madhuri Pai

REFERENCE

BEHAVIOUR MODIFICATION

Medha Khadye
Madhuri Pai

Many writers and researchers in the last twenty years have started considering learning disabilities not as a medical model but rather as a maladaptive behaviour pattern. An unacceptable behaviour pattern is no more considered a disease that should be treated with drugs but rather a condition that has to be studied and modified with a very different, specialised and professional approach.

According to this approach, hyperactivity, academic or activity problems are not symptoms of underlying neurological or psychological disorders but behaviour problems that can be modified in the same manner as any other simple behaviour disorder like rudeness or arrogance. The treatment in this approach is no more directed towards some abstract, unseen mental or neurological process but is focused towards some definite identified elements. These theories have since been tested, researched into and well documented. Obviously, the process can begin with the identification of inappropriate or questionable behaviour followed by strategies to modify it. At the Spastics Society of India's Centres for Special Education, we take this approach to unacceptable behaviour in the class

room, shop floor or at the vocational training centre. Special educators, instructors, supervisors, social workers and other professionals who come in close contact with the client, inform the behaviour therapist about what they *'think'* is the behaviour problem.

The specialist then analyses the problem to evaluate whether the case merits intervention. Quite often what is *'thought'* to be a problem by experienced professionals is indeed a pattern that can be modified to improve the performance of a client.

The common targets for behaviour intervention are attention deficits, impulsivity and high motor activity. Studies on behaviour modification further point to the cognitive and perceptual deficits among the target group.

If we accept that most justifiable targets for behaviour intervention are low concentration span hyper-activity, distractibility, monotonous, loud talk often causing irritation and disturbance to a group, aggression or other related problems, the question arises what should be the strategy for modification? How should parental involvement be combined

with therapeutic intervention ? Do parents and families need to be involved in the behaviour modification programme? Does the programme always an individual session? How frequently are sessions held? We begin here with the basic discussion on what behaviour modification is. The underlying assumption in behaviour therapy is that, capacity to learn would improve when behaviour impediments are removed. In short, behaviour therapists primarily try to reduce the frequency of inappropriate behaviour. Experts point out that academic progress and classroom instructions are a very small and specialised part of learning. The correlation between improvement in academic learning and activity levels is not implied. In fact, a number of researchers have shown that there is no change in such levels. In other words, the behaviour modification procedure is no magic wand. It cannot transform a person completely. What it does is to try to bring a person closer to average social norms, within the limits of his physical and mental capacities. Families and friends play a crucial role in the process. There is no formula to predict how long or how frequently an individual must see the therapist. Taking into account several factors or variables she decides on the pattern and sets limits on the type of sessions conducted.

In a classroom set-up, special educators warn against over-emphasis on behaviour modification as it results in unnecessarily regimented, rigid and controlled classroom environments not conducive to learning at all.

Behaviour therapy is a relatively new and complex procedure. Generalisation, standardisation or labelling is not possible and should be avoided because every individual is unique. Research and documentation in this field is, therefore, difficult. In published literature, one often finds detailed case-studies. In the ten cases we have studied, the awards or reinforcements given, change in behaviour pattern with time, personalisation of procedures, and type of therapy were given special attention. Our study reinforcement procedure is evaluated using multiple baseline designs. The discussion here is based on the results obtained by a behaviour therapist on a relatively large sample size of ten students with different behaviour deficits.

Due to the complexity and abstract nature of the procedure, it is tempting to see a *'pattern'* and draw quick conclusions. The therapist has to make many assumptions and fix many variables to draw out a modification procedure. As researchers, empirical evidence is most welcome and always respected by us. However, we have refrained from subjecting each of the assumptions to immediate experimental scrutiny and have relied on repetitive observations and analysis. The following discussion is based on experiences with all these cases. Obviously the reinforcements, punishments and tokens varied from case to case. We have not made any attempt to plot the behaviour and therefore the whole analysis is qualitative in nature.

INITIAL OBSERVATIONS

Observations under normal baseline conditions in an environment in which unacceptable behaviour is reported were carried out. A structured schedule was used for the purpose. Meticulous records of the frequency of inappropriate behaviour, motivation levels, number of accurate responses and social behaviour patterns were kept for a one month period. The data was supplemented through discussions with parents, teachers and vocational instructors. A check-list of unacceptable behaviour was prepared. Personal observations of this type are necessary to remove any subjectivity on the part of the professional who reports inappropriate behaviour. Since almost the whole of our sample consisted of people with varying degrees of mental retardation and physical impairment as well as being from different socio-economic backgrounds, the reinforcement pattern, tokens and control system were different in every case. Even the extent of family and parental involvement is taken into account while deciding on reinforcement.

Many clients depend on different types of medication for various associated problems. Documented side-effects of these medicines must be kept in mind while selecting the modification programme and analyzing the behaviour. Identified behaviour problems are examined to decide the extent of severity. All related problems are clubbed together in groups or clusters. As a rule, a specific model programme is selected to change only one type of unacceptable behaviour. For example, if poor concentration span and aggression figure

on the check-list, the two cannot be modified with a single programme. The specialist, decides the priority and consults other professionals while selecting the problem that needs immediate intervention.

THERAPY SESSIONS

After selecting the most suitable model for modification the therapist establishes a rapport with the students. This first step is most crucial and time-consuming. The primary objective is achieved through informal discussions, gathering information noting individual likes and dislikes, personal preferences, family relationships, leisure-time activities, individual work habits and inter-personal relationships. A humanistic approach is always taken - an individual is made aware of his pivotal role in therapy and is always encouraged to focus on the most desirable *'terminal'* behaviour.

Frequency of sessions, type of therapy required, i.e. group or individual and the environment suitable for therapy vary from case to case. Behaviour therapists continually assess and evaluate the sessions. Upgradation of the procedure is simultaneously carried out. Meticulous records are kept so that any changes become apparent immediately. Care is always taken not to label the sessions as a modification programme. This is often counter-productive as the client either feels very special or some times develops an inferiority complex and a feeling of being *'picked on'*. The behaviour specialist therefore makes the sessions informal and attractive as far as possible. In all cases, the individual sessions are initially preferred.

Over eighty percent of our clients were meeting the therapist every week for a one-hour session. As the therapy progressed, the frequency of sessions was either reduced or group sessions were initiated.

The duration of the sessions was half an hour to forty-five minutes and activities chosen were in accordance with the cognitive level of the individual. For low concentration span, the activities chosen included, bead-stringing, sorting, pasting, gathering, stacking etc. For the more intelligent clients, other activities like providing reading material and music etc. were preferred. Obviously, the activities change as the sessions progress.

Care is taken to analyse the behaviour objectively to make the control of behaviour less subject to bias and more *'fair'* overall. The behaviour therapist, through question / answer sessions encourages the clients to *'analyse'* which behaviour pattern is truly incompatible and unacceptable in society. This helps them to be more focussed and also encourages them to strive harder for achieving the goals which are set.

REINFORCEMENTS

Awards and reinforcements occupy a key position in the therapy programme. As mentioned earlier, every individual responds to different types of awards or reinforcement. The detailed case studies help the behaviour therapist in selecting appropriate reinforcements and award systems. In fifty percent of cases positive reinforcement materials are used. For

example, eatables are a most common form of reward. However, stamps, pictures, family photographs, listening to a favourite song, reading a story or just taking home a completed article have worked as reinforcers in some of our clients. The family is kept informed about the award system. In the case of clients with mental handicaps, it is very important to make it clear that the award is received only on obtaining a positive desirable response. The frequency of this is a primary reinforcement; its nature, implications and objectives to be achieved were explained to parents, instructors, teachers and supervisors. For the success of the programme, it is very important to maintain consistency and uniformity. The primary reinforcers used were explained to the entire group mentioned above as they most frequently come in contact with the client. The therapists held frequent meetings and discussions with the group to keep them up-to-date about progress made or any changes in reinforcement procedures. Difficulties faced by the family were also discussed during these sessions.

About thirty percent of our sample, basically consisting of hyperactive or attention-deficit students from the academic stream were provided with secondary reinforcements. They ranged from ignoring emotional out-bursts, temper tantrums or other attention-seeking tactics, to giving special recognition and public appreciation or a special mention for a positive behaviour. As in any behaviour therapy programme, over a period of time, as the desirable changes in behaviour occurred primary reinforcers were withdrawn.

PROGRESS MONITORING

The therapist, as mentioned earlier, maintains a list, set or cluster of the unacceptable behaviour patterns of the client. The targets for most desirable change are also set. As the modification progresses and reinforcements start taking effect, the desired changes are evident. When progress reaches a satisfactory level, any unwanted behaviour not actually interfering with the ultimate goal is ignored. For example, when acceptable socialisation was the goal and the cluster of unacceptable behaviour included fidgeting in the seat, after a six month period of treatment there was a marked improvement in the client. However, the restlessness persisted. The therapist decided that other associated problems were being manifested in this behaviour pattern and decided to ignore the fidgeting. As the therapy progressed, soon it was apparent that a further change in this pattern was possible. The only rationale that the therapist could use was to demonstrate with evidence that this pattern was disruptive to others. At this stage, the student could appreciate the expert's point of view and strived to change his behaviour pattern. This is, of course, an isolated example and quite often a plateau is reached beyond which progress may not take place or would be very slow. In short, when an optimal level of acceptable behaviour is reached, a professional can make a decision about terminating the therapy sessions.

In summary, behaviour modification to internalise socially acceptable behaviour has been practised in the last few years with the help of teachers, professionals, parents and social workers. To identify the unacceptable behaviour, the therapist makes a valued judgement after a thorough case study. Progress is meticulously monitored. Parents, friends, peers, supervisors and teachers all form the part of the team working on modification under the guidance and recommendations of a therapist.

ACKNOWLEDGEMENT

I am grateful to Smt. Mithu Alur, Chairperson, The Spastics Society of India for her continuous support and encouragement. Endless discussions with her have cleared many a doubts in my mind. Her constructive criticisms and suggestions are gratefully acknowledged.

I have gained so much from our active interactions with Miss. Pamela Stretch, Director, National Centre for Cerebral Palsy. She has patiently explained many clinical terms and discussed various issues which clarified doubts.

I thank Malini Chib-Alur for editing and publishing this report and Iddris Parmar for untiringly typing the manuscript.

Edited and Published by
MALINI CHIB-ALUR