Explaining challenging behaviour

Staff attributions about the causes of challenging behaviour in people with profound intellectual and multiple disabilities

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Research questions

• Type and frequency of challenging behaviour
• Perceived severity by DSP
• Addressing challenging behaviour
• Explaining challenging behaviour
Challenging behaviour: behaviour of such intensity, frequency or duration as to threaten the quality of life and/or the physical safety of the individual or others and is likely to lead to responses that are restrictive, aversive or result in exclusion (RCP, BPS & RCLT, 2007, p.10)

Prevelance of challenging behaviour (CB) in Persons with PIMD high identified with Behaviour Problem Inventory (BPI) (Rojahn et al, 2001; Poppes, van der Putten & Vlaskamp, 2010)
High prevalence *(Poppes et al., 2010, 2016)*

<table>
<thead>
<tr>
<th></th>
<th>Number of participants</th>
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<tbody>
<tr>
<td></td>
<td>(%)</td>
</tr>
<tr>
<td>N= 198</td>
<td></td>
</tr>
<tr>
<td>Self-injurious behaviour</td>
<td>168 (95)</td>
</tr>
<tr>
<td>Stereotypical behaviour</td>
<td>185 (93)</td>
</tr>
<tr>
<td>Withdrawn behaviour</td>
<td>167 (84)</td>
</tr>
<tr>
<td>Aggressive/destructive behaviour</td>
<td>93 (47)</td>
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</table>
High frequency vs low severity

• Self-injurious, stereotypical a withdrawn behaviour daily and even hourly
• Low perceived severity
• High prevalence and frequency versus low (perceived) severity
• Are CBs viewed as a fundamental problem? If so: methodical and systematic approach imperative

• Individual comprehensive service plans (IP)
• Challenging behaviour in IPS:
  - half of ‘identified’ problems not described in IP;
  - little and unclear information on setting, consequences, support and goals

(Poppes, et al, 2014)
• DSPs do not view CB as a problem
• No problem, no ‘action’

• How does staff explain challenging behaviour?
Research question

- How does staff attribute challenging behaviour in people with PIMD?
Participants

• **DSP’s**
  – N=195 (age: range 20-64; mean 38,5; SD 11,3)
  – 186 female, 9 male
  – 122 senior secondary vocational education, 55 vocational college
  – Average years of working experience 14 (range: 1-40, SD 9,1)

• **Children and adults with PIMD**
  – n= 195 (age: range 3-67; mean 30,4; SD 16,1)
  – 44 children
  – 90 female, 105 male
  – PIMD
  – 145 in grouphomes from 9 different organizations
  – 44 children lived at home
Measures

Staff attributions of challenging behaviour

**Challenging Behavior Attributions Scale (CHABA)**
*(Hastings, 1997)*

*Five causal models*
- Learned behaviour
- Medical/biological
- Emotional
- Physical environment
- Self-stimulation
Analyses

• Scale means were calculated for each causal model of the CHABA.

• Subscale scores less than zero → not a likely explanation for the behaviour

• Subscale scores more than zero → likely explanation for the behaviour
## Results

Mean scores and frequency distribution on the challenging behaviour attribution scale (CHABA)

<table>
<thead>
<tr>
<th>Scale</th>
<th>N</th>
<th>range</th>
<th>mean</th>
<th>SD</th>
<th>-2 to -1.01</th>
<th>Range</th>
<th>0</th>
<th>0.01 to 0.99</th>
<th>1-2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biomedical</td>
<td>180</td>
<td>-2 to 2</td>
<td>0.09</td>
<td>0.85</td>
<td>8.9</td>
<td>29.4</td>
<td>6.1</td>
<td>40</td>
<td>15.6</td>
</tr>
<tr>
<td>Emotional</td>
<td>180</td>
<td>-2 to 2</td>
<td>-0.12</td>
<td>0.75</td>
<td>11.1</td>
<td>38.9</td>
<td>8.9</td>
<td>33.3</td>
<td>7.8</td>
</tr>
<tr>
<td>Learned behaviour</td>
<td>180</td>
<td>-2 to 1.8</td>
<td>-0.20</td>
<td>0.84</td>
<td>15</td>
<td>36.7</td>
<td>9.4</td>
<td>30.6</td>
<td>8.3</td>
</tr>
<tr>
<td>Stimulation</td>
<td>180</td>
<td>-2 to 1.7</td>
<td>-0.33</td>
<td>0.81</td>
<td>18.3</td>
<td>40.6</td>
<td>11.7</td>
<td>24.4</td>
<td>5</td>
</tr>
<tr>
<td>Physical environment</td>
<td>180</td>
<td>-2 to 1</td>
<td>-0.39</td>
<td>0.68</td>
<td>17.8</td>
<td>47.8</td>
<td>7.2</td>
<td>26.1</td>
<td>1.1</td>
</tr>
</tbody>
</table>
Conclusion

- Biomedical model plausible explanation challenging behaviour
- 55.6% of DSPs scored biomedical model
- Physical environment model lowest: least relevant
Discussion

• CB part of the person with PIMD (no control over their behaviour)? Non-changeable? Belonging to the person/their disabilities

• Mean scores on all models are low
  - Might indicate staff found none of the models useful as possible explanations
    - Difficult stating cause
    - Additional explanations not mentioned in CHABA
Change?

• Biomedical attributions and low perceived severity behaviours not systematically addressed in daily practice?
• Training targeted at changing beliefs and attitudes?
• Staff play key role in both identifying and treating challenging behaviour
Thank you for your attention!