Chronic Vs. Intermittent Behavior Problems: Why they happen and what you can do about them

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Overview

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High frequency, regularly occurring behavior problems are often very different in nature than their low frequency, irregularly occurring counterparts.

Low frequency/irregular problems can present special difficulties in terms of their analysis and treatment.

We will look at some of the issues regarding these two kinds of problems and why these different kinds of problems may occur.
We’ll take a look at:
- Chronic problems
- Intermittent problems
- Motivators that may cause intermittent problems
- Medication/Medical Issues
- Treatment directions for intermittent problems
“Chronic”
- High-frequency, regularly occurring
- Daily or multiple times per day or per hour
- You can use a “frequency guesstimate” for when there are not yet any data collected or there is some doubt about the reliability/quality of the data
- Would you say that the behavior occurs hourly, daily, or weekly?
- Afterwards you can narrow down the parameters (10 times per hour or 100 times per hour?)
Chronic Vs. Intermittent Problems

- With chronic problems, rarely a day goes by in which the behavior doesn’t occur.
- Intermittent problems means that the individual can go for at least a full day (and there are many “good days”) in which the problem doesn’t occur.
- With intermittent problems (as I’m defining them here) the behavior doesn’t occur regularly.
- For example, the behavior might always happen on Mondays and Fridays, which is certainly intermittent, but it is ALSO regularly occurring.
- The intermittent problems we are talking about certainly have days in between, but also have no discernible pattern!
The “classic” Functional Analysis would not exist if it weren’t for chronic problems!

These high-frequency problems, especially when multiply maintained, are what we might call “insidious” behavior problems

These insidious problems occur everywhere with everyone!
At School
At Home
These behaviors are often “used” by the individual all day long to meet needs that are also present all day long.

Individuals displaying these behaviors, very often, have extremely limited repertoires in a variety of areas including language, leisure skills, social and self-care and daily living skills.

These chronic problems sometimes express themselves as highly-developed repertoires of inappropriate/dangerous behavior.

In some instances the individual is a “One-trick Pony” when it comes to being able to effectively interact with his/her surroundings.
These behaviors are often used in all the ways we use language and may cover the so-called “communicative intent” type of behavior problem.

- You’re mad: head bang
- You’re really excited: head bang
- You want more: head bang
- You want less: head bang
- The government is about to shut down-BIG HEAD BANG
- All is right with the world..
- head bang
Self-stimulatory behavior typically falls under the “chronic” category as it’s something that you usually don’t stop doing for very long.

Not many people will take a week off from hand-flapping to go skiing in Aspen.

A chronic problem is like the American Express Card®, you don’t leave home without it!

If you were born after 1985, disregard previous bullet.

If someone is exhibiting chronic behavior, is there anything that might cause that individual to “give up” the behavior for a full day or even longer?

Yes!
There are (at least) 4 reasons why you may see an interruption in what otherwise appears to be a chronic behavior problem:

1. The individual (temporarily) has very few needs (sad, sick, satiated, sleepy, etc.)
2. The behavior is primarily motivated by the presence of a key reinforcer/aversive that simply (accidently) isn’t present today (computer is gone, no demands are made, a key individual is absent, Joe Biden said nothing stupid today)
3. The individual has the same needs today that he did yesterday, but everyone has become acutely aware of his needs and is anticipating and meeting every single one of them (eliminating all aversives, ensuring a steady stream of reinforcers)

4. The behavior is actively being suppressed by the use or threat of a very powerful punisher
These problems, in many ways, are great! They provide multiple trials per day/hour for analysis/probes and/or teaching replacement behaviors. The person is clearly motivated all day long, because the behavior is occurring all day long. You don’t get caught “off-guard” like you would with someone who’s “been good” for several days in a row.
Intermittent Problems

PIC UNRELATED

No really
Its not related
Private Aversives (PAs)
These are events that are not directly observable and are occurring RIGHT NOW
Like many MOs these events can easily alter the efficacy of reinforcers and the potency of aversives
What are we talking about here?
Headaches, stomachaches, toothaches, cramps, etc. Really, any source of aversive stimulation we can’t see (including various states of deprivation)
These PAs (like any public aversive) may even increase the efficacy of “opportunity for aggression” as a reinforcer (Azrin Hutchinson & McLaughlin 1965)
Many people (erroneously) believe that if aggression occurs when an item is removed (aversive event) that the aggression is “maintained by” access to the item.

In fact it may be that aversive stimulation (reinforcer removal in this case) increases the efficacy of opportunity for aggression as a reinforcer and that aggression NEVER produced the reinforcer.
Short and Long-range Behavior Bombs! (MOs of the recent past)
Behavior Bombs: External MOs that may cause some immediate behavior problems, but may ALSO alter the efficacy of future reinforcers and aversives.

The bomb itself is over and done at the time the future behavior problem occurs.

These “bombs” once dropped can have their effects for varying amounts of time depending upon the size of the bomb (megatons), the individual’s developmental level and verbal skills.
These “bombs” are very often some form of aversive stimulation, but they don’t necessarily have to be.

You can also see bombs that increase the efficacy of specific reinforcers or classes of reinforcers (TV advertisements).

These kinds of bombs would have implications for behaviors that are maintained by access to attention/tangibles.
Short-Range Behavior Bombs
Short-Range Behavior Bombs

- May affect subsequent interactions/reinforcers/aversives for only a few minutes
- Typically developing very young children will often recover quickly from these minor events
- Adults with few or no verbal skills will usually do likewise, that is these minor events are not limited to minors…
May cause long-lasting physiological arousal
May occur in individuals with better verbal skills (those who can ruminate on the days events)
Can be re-detonated when people/objects in the environment may have the same effect as the original event (being denied a reinforcer and then seeing someone access that same reinforcer later in the day)
To make matters worse, in many instances, not only are we oblivious to the nature of the bomb, we don’t even know that it was dropped!

These kinds of bombs can create situations that cause staff to say “He just bit me out of the blue!”
Cluster Bombs!
These have their “MO” effect in a cumulative fashion and are therefore much “sneakier” than the larger bombs.

Normal behavior bombs will often cause an initial behavior problem AND subsequent problems.

Each cluster bomb will cause no discernible immediate behavior problem until the last one is dropped (the proverbial straw that broke the camel’s back).
Deprivation
Deprivation is another MO, and it builds somewhat like cluster bombs, however, instead of the presence of something or the steady accumulation of aversives, it is the absence of something for a particular duration.

Chronic problems may be masquerading as intermittent problems because caregivers/parents/teachers have become particularly good at keeping deprivation very low.

Consequently, the only time you see behavior problems is when staff/parents/teachers forget to keep deprivation levels in check.
The only real way to make clinical progress with these kinds of problems is to deal with this “wolf in sheep’s clothing” by teaching individuals how to cope with various levels of deprivation!

- He’s great as long as:
  - He’s eating
  - He’s watching a video
  - You are holding his hand
  - He’s using his iPhone 5s
Digital Vs. Analogue causes

Digital

Analogue
Deprivation makes things seem more mysterious because it is a time-based (analogue) phenomenon as opposed to an event-based (digital) phenomenon.

We as behavior analysts are generally more focused on “digital” (on-off) events.

- What triggered the behavior?
- Who walked in?
- What did you take away?
- What event just started?
- What did you ask him to do?
- Who did Miley Cyrus twerk with this time?
Deprivation is more of an “analogue” event with no clear onset/offset. To explain in more behavioral terms:

- Deprivation is a sneaky little bastard!
- It’s not just that Bobby lost mom’s attention, it’s that he lost it for seven minutes.
- This may lead to phrases like, “He was doing fine and then he turned over the table for no reason!”
- Like deprivation, some events only reach a functional status of “aversive” after a certain duration of exposure.
- This is why the ability to tolerate events must be viewed as a “commodity” that gets used up.
Medical Problems
Intermittent problems are a big red flag for medical problems as they too are very often intermittent.

Recurrent medical problems might be associated with long periods of time with no behavior problems at all.

Be VERY careful about assuming that a PSYCHIATRIC diagnosis is “causing a problem”

Saying that a behavior problem is worse because the person’s “mania” is flaring up is not the same as saying that person’s eczema is flaring up.

Remember, for any given person, a DSM diagnosis is not (typically) based on lab results of ANY hypothesized chemical imbalance, instead it is based on BEHAVIOR.
Medical Problems

- Mental health diagnoses all too often end up as the “causality whipping boy” because of the absence of any (obvious) “digital” antecedents
3 Categories of Medical Problems

- Undiagnosed problems
- Unresolved problems
- Managed problems

Undiagnosed are the most difficult to deal with as they can cause us to misinterpret the efficacy of pharmacological or behavioral interventions.

Many individuals with disabilities, verbal or nonverbal, cannot tact internal painful/unusual stimulation.
Some medical problems DO have behavioral and/or other observable correlates (a runny nose with a cold), but many do not.

People with headaches may rub their temples, but this is a learned skill.

Many persons with disabilities are no more skilled at tacting painful stimulation than an infant, yet those same individuals still have large repertoires of problem behavior that may be affected by this stimulation.

When in pain, infants can only cry. Children and adults with disabilities can do much more than just cry!
One big difference between typically developing infants and children and adults with disabilities is that we may attempt to explain worsening behavior as a medication problem, “The Autism,” or just one of many unexplained fluctuations in the frequency/severity of behavior.

Because of the presence of known diagnoses (autism/pdd) we may stop theorizing about possible unknown problems.

If an infant shows a sudden increase in crying you look for problems like earaches, wet diaper, gas, or other illness. You don’t say it’s his HID acting up.
1. Excessive crying
2. Rapid mood cycling
3. Poor bowel/bladder control
4. Drooling
5. Pica/Mouthing
6. Poor Judgment
7. Boundary issues
8. Mammary Addiction
Unresolved Medical Problems

- A better problem
- This is when there is a proper diagnosis of the problem, and we recognize it when we see it, but we cannot yet predict the problem and may not be able to alleviate the problem when it occurs
- Constipation may be recognized when it occurs, but it is difficult to predict when it is going to happen and it cannot (typically) be alleviated immediately upon recognition
Managed Medical Problems

- Arguably the best kind of medical problem
- The medical problem still occurs, but it may be at least somewhat predictable and/or controllable
- You may be able to alleviate the problem immediately upon recognition, or even predict and prevent the problem (blood sugar fluctuations in diabetics)
Medications, particularly psychotropic medications, can absolutely wreak havoc with individuals and MAY cause a host of private aversives.

The two biggest problems are side-effects and unstable medication regimens (substitutions, additions, deletions, dosage manipulations and inconsistent administration).
What is the difference between a main effect and a side effect?
- Main effects are intended!
- One man’s side effect is another man’s main effect.
- Viagra (originally developed to treat blood pressure and angina)
- Best side effect ever!
Used for:
- Schizophrenia
- Bi-polar I disorder
- Depression
- Autism
- Parkinson’s
- Eating disorders
- Alcoholism
- PTSD
- Anxiety

“When you just don’t know why….ABILIFY!”
1. Neuroleptic Malignant Syndrome (NMS) (This is rare but can be lethal if not caught in time)
2. Extrapyramidal Symptoms (EPS) (These can be rapid regular tremors, like six cycles per second, almost like Parkinson’s disease)
3. Tardive Dyskinesia (TD) (Involuntary movements of the eyes, lips, facial muscles, tongue, fingers, neck, trunk, feet and toes and these movements are sometimes permanent even after discontinuation of the drug; really nasty)
4. Dystonia (EPS) (twisting repetitive movements and unusual posturing, retrocollis, torticollis)
5. Stroke
6. TIA (Transient Ischemic Attack, stroke-like symptoms for 1-2 hours)
7. Syncope (fainting)
8. Hypotension (low blood pressure)
9. Seizures
10. Hyperglycemia (high blood sugar)
11. Diabetes Mellitus
12. Dysphagia (trouble swallowing)
13. Hyperthermia (over heating)
14. HTN (Hypertension)
15. Tachycardia/Bradycardia (racing pulse, slow pulse)
16. Hemorrhage
17. Intestinal Obstruction
18. Cholecystitis (gall bladder inflammation)
19. Pancreatitis (Pancreas inflammation)
20. Blood Dyscrasias (part of the blood is not present in normal supply)
21. Leukopenia (decrease in the number of white blood cells)
22. Neutropenia (number of neutrophils [most common white blood cells] in the blood are too low)
23. Agranulocytosis (Severe and dangerous Leukopenia)
24. Hypokalemia (lower than normal potassium in the blood, symptoms are abnormal heart rhythms, constipation, fatigue, muscle weakness paralysis and breakdown of muscle fibers)
25. Hyperkalemia (higher than normal potassium in the blood, often there are no symptoms but may include irregular heartbeat, nausea, slow/weak/absent pulse)
26. Rhabdomyolysis (breakdown of muscle fibers)
27. Suicidality
28. Depression, worsening
Sure, those are quite a few possible serious reactions, but in defense of Abilify, other than those 28 HORRIBLE THINGS, not much can go wrong... Of course, if you’re lucky you may simply experience one or more of the common reactions.
Less Nasty Common Reactions

1. Headache
2. Weight Gain
3. Anxiety
4. Insomnia
5. Nausea/Vomiting
6. Lightheadedness
7. Dizziness
8. Somnolence (sleepiness)
9. Sedation
10. Akathisia (EPS) (a.k.a. restless leg syndrome, individuals are highly motivated to keep moving and become extremely uncomfortable if made to sit still for even short periods of time; this is reportedly actually really nasty)

11. Constipation

12. Incontinence

13. Blurred Vision

14. Tremor

15. Dry Mouth

16. Cough
17. Restlessness
18. Fatigue
19. Arthralgia/Myalgia (joint pain/muscle pain)
20. Sialorrhea (excess saliva, drooling)
21. Diarrhea
22. Pyrexia (fever)
23. Appetite Increase
That’s a lot of side effects!

- If you’re really worried about all these side-effects it’s ok!
- Remember, Abilify is also used to treat anxiety!
- It is the only medication that can be given to counteract the anxiety produced by worrying about it’s side effects!
- Worried about taking Abilify?
- You need Abilify!
3 Classes of side-effects

- Patient-Dependent-side effect requires patient report
- Patient-Independent-side effect can be observed by anyone (who knows what to look for)
- Physician-Dependent-side effect can only be detected by a qualified medical professional and/or medical tests
How would you determine the presence of a side-effect that requires patient report?

This is an important question if working with ANY person with no or limited verbal skills who is also taking psychotropic medications.

Behaviors that may be affected by patient-dependent side effects will often be misinterpreted by staff, parents, teachers and medical professionals.
Unstable Medication Regimens

- Physician By Proxy! (parents)
- Polypharmacy! (more in residential)
- Frequent medication changes/adjustments
- Discontinuation
- Inconsistent administration (not typically a problem in residential settings)
Treatment directions

- Medical
- Behavior Bombs
- Deprivation
- Medication
Treatment Directions-Medical/Medication

- Medication/Medical PAs
- Stabilize condition/medications (seems so obvious, and yet…)
- Know the problems the person is experiencing
- What strategies would you and I use to cope with these problems?
- Could the individual be taught the same or similar problem solving strategies?
You have service goals (things we do for the person)

Acquisition goals (things we teach the person to do)

Some possible steps to take when pain/discomfort cannot be stopped immediately

1. Eliminate those events that are temporarily aversive (short term strategy)
2. If indicated, provide alternate forms of stimulation that might mitigate pain and/or comfort the individual (we rock infants and/or pat them/move them up and down)

3. Reduce other sources of unnecessary stimulation

4. Teach relaxation skills if the individual is capable of learning a skill that is functional

5. Attempt to eliminate any potential targets for aggression
Short-range Behavior Bombs

Unlike PAs, which are present NOW, the behavior bomb that was dropped occurred in the past and there is no current PRIMARY aversive stimulation but there may be residual physiological arousal

These MOs CAN be crushed with the proper manipulation immediately
1. (gently) Prompt a high-probability behavior/routine (not the person’s favorite activity)

2. Stop all interactions for a few minutes to let the physiological arousal dissipate. That is, don’t “try” to make the individual feel better, just allow the person to feel better. This is best used when there is currently no behavior problem (just agitation)
3. Try a reinforcer probe to pull the individual out of his “funk” and to test whether or not the individual is becoming more reasonable

- Arrange for the nearby availability of a known reinforcer and observe the individual’s reaction
- DO NOT bring the alleged reinforcer to the person, but you may allow the person to approach the reinforcer (playing ball example)
Treatment Directions: Long-range Behavior Bombs

- More frequent in typically developing individuals who are older and/or those with disabilities who have better verbal skills.
- If the bomb was particularly nasty, allow the person to calm down a bit first as even reasonable requests can be met with hostility.
- You may attempt to give information that might crush the MO, but if you say the wrong thing at the wrong time you can send the individual into crisis.
1. Try to discover the source of the bomb, it may help you figure out what to say. It isn’t always necessary but it may help.

2. Be careful about “problem behavior talk.” There is a big difference between “venting” to a friend and seeking attention via talk about how bad you were this morning.

Venting is more or less a negative reinforcement paradigm (you feel better after venting) and problem behavior talk is typically more of a positive reinforcement paradigm.
Also be careful about asking for information from an individual who is still “too hot.”

In this case it may be better to give empathy or sympathy and a gentle redirection to a familiar routine/activity.

3. Try to establish a different routine that is to be followed when a bomb has been dropped (a difficult van ride on the way to the day program). Don’t bring a “hot” individual right into the classroom/treatment area.
4. follow up with probes by asking the person to engage in a familiar routine. If the response is negative the person is still too hot.

5. Look for signs of stabilization (smiling more, asking about reinforcers, breathing more normally, moving more slowly, etc.) Everyone should be familiar with the signs that this particular person is starting to “come around”
6. If the bomb is a reliable one, then look at *contriving* small versions of the same bomb while using pre-teaching to prepare the person for what is about to happen and how he or she should handle the event.

- Haphazard bombs cause some of the biggest problems in applied settings. The only REAL answer is to eliminate them altogether (which is not always advisable) or to *contrive* these bombs to create regularity and predictability and allow the person *more trials* to learn what to do.
1. You can address the deprivation directly by meeting the individual’s needs (the person learns nothing)

It is better to meet these needs BEFORE the deprivation builds to the point of physiological arousal

It’s very difficult to fix a deprivation problem that is occurring right now without supplying what the person needs (at least in some small amount)
2. Teach the individual to address his/her own deprivation problems

Many times the individual tries to meet his/her needs, but is told “no” or to wait, and the individual is ill-equipped to deal with either scenario

How do we deal with deprivation? First we may start by telling someone about our current state
We have all sorts of ways of dealing with deprivation. If one strategy doesn’t work we have others. We have long histories of knowing how to wait and how to tolerate demands and delays (even during states of high deprivation).

Individuals with disabilities are often far less well equipped
We can deal with deprivation in 3 ways:

1. On the front-end: Making sure Jimmy eats every 2 hours BEFORE deprivation even starts (give a man a fish strategy)

2. In the middle: Teach the individual the necessary skills to meet his/her needs when deprivation is starting to rise (teach a man how to fish strategy)

3. On the back-end: Give food when the person is just about to go into a crisis (give a man a fish and run like hell).

P.S., # 2 is where it’s at treatment-wise…
Unlike medical problems, deprivation problems, like behavior-bombs, can be *contrived*!

To contrive a deprivation-based MO you need a baseline on the average amount of time since _____ that results in behavior problems and make your contrived condition shorter than that interval.

The interval needs to be short enough so that the person doesn’t freak out but long enough to allow the MO to build *slightly*. If the MO builds too quickly it will make skill acquisition difficult at best.
Chronic problems are often easier to analyze and provide more teaching opportunities.

Intermittent problems are a mega-biotch!

Analogue events (deprivation) are sneaky little bastards.

Meds: bad

Teaching skills: good

If they cannot be resolved, try to get medical problems to a “managed” level.
You can download this presentation as a .pdf file at www.pcma.com
Go to the “resources” section of our menu and choose “public downloads” and look for “presentations”