



Intrusiveness of behavioral treatments for adults with intellectual disability



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ABSTRACT

The current study examined treatment intrusiveness within behavior intervention programs developed for adults with intellectual disability (ID). Behavior analysts provided demographic information about themselves, their adult clients with ID, and their clients' behavior intervention plans, and they completed an online version of the Treatment Intrusiveness Measure (Carter et al., 2009), an instrument that provides a Base Level Intrusiveness Score (BLIS; a score computed across five areas of categorization, such as, Health and Safety) and a Modified Level of Intrusiveness Score (MLIS), which assesses the presence or absence of intrusiveness-reducing practices. Among other findings, various statistical analyses revealed (a) a significant difference between BLIS and modified (BLIS minus MLIS) intrusiveness scores, (b) the practices within which most of the intrusiveness was concentrated within behavioral treatment programs, and (c) the least- and most-utilized intrusiveness-reducing practices. Implications are provided to assist professionals working with adults with ID who engage in challenging behavior and are supported through behavior intervention services.

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1. Introduction

Individuals with intellectual and developmental disabilities may display challenging behaviors that prevent them from learning new skills, participating in integrated activities, and developing meaningful relationships with others. These behaviors may frequently include violent outbursts, aggression toward others, self-injury, and stereotypy (Rojahn, Matson, Lott, Esbensen, & Smalls, 2001). Challenging behaviors such as aggression, self-injury, and property destruction frequently require the development and implementation of a behavior intervention plan, and such plans may incorporate applied behavior analysis techniques that are ethically required to promote the use of the most effective treatment while using the least restrictive techniques (Shook, 2002; Van Houten et al., 1988). While the most effective treatment for a particular challenging behavior may be discerned from the evidence base that exists within the research literature, there is often little guidance toward determining the restrictiveness that an intervention may have when implemented (Mayton, Carter, Zhang, & Wheeler, in press).

Restrictiveness is but one dimension of a more complex construct referred to as intrusiveness, an effect that can result from the implementation of intended components of behavior intervention plans as well as from unintended outcomes or

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side effects that may result from implementation. Interventions become more or less intrusive to the degree that they alter relevant aspects of an individual's typical functioning or environment (Carter, Mayton, & Wheeler, 2009). In order to effectively reduce challenging behavior and teach the use of appropriate replacement behaviors, behavioral interventions must manipulate relevant antecedent and consequence events, and therefore some level of intrusiveness is expected and even desired within effective treatment programs. However, in seeking to use the most effective treatment while maintaining the lowest possible level of intrusiveness, a range of factors must be considered, such as an individual's level of physical discomfort, an intervention's reliance on other parties such as peers to influence an individual's behavior, and the presence or absence of opportunities for the individual to resist or compromise with certain treatment options or components. Other, more indirect factors can also influence the level of intrusiveness, including treatment integrity/fidelity, adequacy of operational definitions of treatment components, and the use of evidence-based practices (e.g., designing interventions based on the results of a prior functional behavior assessment).

Thomas and McGuire (1988) initially noted that "... there is no general or universal agreement on a hierarchy of intrusiveness" (p. 213), while more recently others have noted some general consistency regarding the types of interventions that are more or less intrusive when evaluated in isolation, primarily based on the presence of reinforcement or punishment (Alberto & Troutman, 2003; Jacob-Timm & Hartshorne, 1998). Kazdin (1980) indicated that reinforcement, time-out, drug use, and electric shock represented an increasing hierarchy of intrusiveness. Similarly, Alberto and Troutman (2003) separated intrusive procedures into four categories that progress from least to most intrusive: reinforcement procedures, extinction procedures, response cost procedures, and use of aversive stimuli. The use of these types of hierarchies can become difficult to interpret when interventions have been modified for use with a specific individual, or when the interventions are used in combination with interventions sometimes referred to as "treatment packages" (Carter, Mayton, & Wheeler, 2011). In addition, Mayton et al. (in press) explained how procedures that might initially be considered non-intrusive could result in situations that, for example, cause a person to become isolated from others or be subjected to unnecessary or overly burdensome tasks. When considering all these variables, the evaluation of treatment intrusiveness can become rather complex.

Carter et al. (2009) addressed the limited guidance on determining the intrusiveness of interventions, the complexities related with treatment packages and other issues by developing an instrument to evaluate the intrusiveness of a solitary intervention or a treatment package designed to address challenging behavior. The instrument, titled the *Treatment Intrusiveness Measure* (TIM), was based on a review of the literature that focused on the factors most relevant to intervention intrusiveness with adults with an intellectual disability (ID). Professional and preprofessional participants in the study used the instrument to evaluate the intrusiveness of interventions described within case vignettes that manipulated a variety of variables to make them more or less intrusive. The results indicated that the participants who used the instrument were able to differentiate among interventions with varying levels of intrusiveness.

While behavior analysts are expected to utilize interventions that are the least intrusive as well as the most effective, little is known about how this is carried out in actual practice. Schreck and Mazur (2008) conducted a survey of behavior analysts regarding their use of treatments and their beliefs about treatments for individuals with autism. They found that although behavior analysts recognized that they were ethically obligated to use evidence-based behavior interventions, the actual practice of the behavior analysts included using interventions that were not supported by scientific evidence. In addition, they found that the behavior analysts endorsed numerous interventions despite indicating difficulty with implementation, problems of cost effectiveness, and lack of support for the interventions in the research literature.

The current study examined the level of intervention intrusiveness within behavior intervention programs developed by behavior analysts, expressly for their adult clients with ID. The study was designed to address the following research questions: (a) to what extent does the use of intrusive and intrusiveness-reducing support plan components differ; (b) where is most of the intrusiveness/non-intrusiveness concentrated within these plans; (c) to what extent do levels of intrusiveness and non-intrusiveness vary across characteristics of behavior analysts, support plans, and service recipients; and (d) what are the significant interrelationships among intrusive and intrusiveness-reducing support plan components, and behavior analyst, support plan, and service recipient characteristics?

2. Method

2.1. Participants and plans

The first author obtained approval from the Behavior Analyst Certification Board[®] for an invitation to be sent (via the organization's email database) to 906 behavior analysts (BAs) who had identified themselves as professionals currently working with adults with ID. One week after the initial invitation, a second email invitation was delivered as a reminder. Respondents who agreed to participate in the current study ($N = 287$, or 32% of those invited to participate) used the supplied password to access a link allowing them to complete an online version of the TIM (Carter et al.) regarding the behavioral intervention programs for their adult clients. They also supplied demographic information about themselves, their clients, and their clients' behavior intervention plans. No identifying data such as client or behavior analyst names, agencies, or locations were collected, making it impossible to trace any information back to its original source once it was submitted.

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